Agenda

Health and Social Services
Haldimand and Norfolk

Haldimand-Norfolk
Health and Social Services Advisory Committee

February 26, 2024
9:30 a.m.
Council Chambers
Norfolk County Administration Building
50 Colborne St. S., Simcoe ON

Pages

Haldimand-Norfolk

Health and Social Services Advisory Committee

January 22, 2024
9:30 a.m.
Council Chambers
Norfolk County Administration Building
50 Colborne St. S., Simcoe ON

Present:	Chris Van Paassen, John Metcalfe Linda Vandendriessche, Alan Duthie
Absent with Regrets:	Shelley Ann Bentley, Patrick O'Neill
Also Present:	Syed Shah, Stephanie Rice, Sarah. Page, Eric Robertson, Dr. Joyce Lock, Mandy Babbey, Lori Friesen, Angela Butcher

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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 Haldimand-Norfolk Health and Social Services Advisory Committee - November 27, 2023

Moved By: John Metcalfe
Seconded By: Chris Van Paassen

The Minutes of the Health and Social Services Advisory Committee meeting dated November 27, 2023, having been distributed to all

Committee Members and there being no errors reported. Minutes have been adopted and signed by Co Chair Vandendriessche.

Carried.

5. Update on Reports

General Manager of Health and Social Services, Sarah Page mentions that all reports have been approved at Board of Health and Council. No other updates to provide.

6. Consent Items

7. Staff Reports

7.1 Public Health

7.1.1 Immunization of School Pupils Act (ISPA) Suspension Process, HSS-24-001

Moved By: Alan Duthie
Seconded By: John Metcalfe

That Report HSS-24-001 Immunization of School Pupils Act (ISPA) Suspension Process, be received as information.

Carried.

8. Sub-Committee Reports

9. Communications

9.1 December 2023 alPHa InfoBreak

9.2 January 2024 alPHA InfoBreak

10. Other Business

11. Closed Session

11.1 Verbal Update - Strengthening Public Health

Section 239(2) of the Municipal Act, 2001 as amended as the subject matter pertains to:

(b) personal matters about an identifiable individual, including municipal or local board employees;

(d) labour relations or employee negotiations.

Moved By: A. Duthie
Seconded By: Chris Van Paassen

THAT Verbal Update - Strengthening Public Health be received as information.

Carried.

12. Next Meeting

12.1 Monday, February 26, 2024

Moved By: John Metcalfe
Seconded By: Chris Van Paassen

In addition to the March 25, 2024 Health and Social Services Advisory Committee Meeting, a special Board of Health meeting will be held on March 26, 2024 at 11:00 a.m..

Carried.

13. Adjournment

Moved By: Alan Duthie
Seconded By: John Metcalfe

10:14 a.m.

Carried.

To: Members of Health and Social Services Advisory Committee

From: Dr. Joyce Lock, Medical Officer of Health

Date: February 26, 2024

Re: Medical Officer of Health Update

Expansion of Alcohol Distribution

The Province of Ontario announced the "largest expansion of consumer choice and convenience since the end of prohibition". Starting in 2026, Ontarians will be able to buy alcoholic drinks at convenience stores, big box outlets, some gas stations, and more supermarkets. Research has shown that higher outlet density is associated with more alcohol consumptions and residing further from an outlet was associated with less alcohol consumption. The societal costs of alcohol use include Health care, economic loss of production, criminal justice, and other indirect costs. Estimates from the Canadian Substance Use Costs and Harms Project note that the net societal costs outweigh government alcohol related income by 3.7 billion nationally in 2014. In response to the Provincial announcement, the Association of Public Health Agencies (alPHa) wrote to Dr. Kieran Moore, Chief Medical Officer of Health. The letter focused on encouraging the development of a provincial alcohol strategy (as per alPHa's Resolution) with the additional aim of supporting efforts with regards to addressing alcohol-related issues in the CMOH's upcoming annual report. A copy of the letter is attached.

Nicotine Pouches

In November, 2023 Health Canada approved the sale of flavoured nicotine pouches by Imperial Tobacco Canada Ltd. as a product to help smokers quit. However, the approval allows the products to be legally sold to children of any age. Imperial Tobacco may also promote these products on TV or on billboards across from schools, on social media, through lifestyle advertising, through free samples and by other means. Nicotine pouches are positioned between the upper lip and the gum. Nicotine exposure is addictive and influences adolescent brain development. Thousands of young Canadians continue to initiate smoking every year facilitate by an increasing popularity of alternative tobacco products. At the requests of the local health units, alPHa directed a letter to the Minister of Health expressing our concern about the approval of nicotine pouches for sale and promotion with even less regulation than e-cigarettes. The letter called for a reclassification of nicotine pouches as a prescription product or to suspend the sale of the pouches until the regulatory gap is closed. On February 7th, British Colombia ordered that flavoured nicotine pouches be moved behind pharmacy counters instead of being sold openly. A copy of the letter is attached

COVID-19 Vaccine Coverage Data

In January, Public Health Ontario (PHO) announced that is no longer updating COVID-19 coverage data on a monthly basis. It is exploring opportunities to access and update COVID-19 coverage data periodically in the future. In the early part of COVID-19 vaccine distribution, data was collected daily. With the move to normalization after the pandemic, vaccine reporting declined to weekly and then monthly. The frequency of reports for vaccine coverage by priority groups and by neighbourhood will also be decreased. As of December, 2023 83.7% of the Canadian population had at least one dose of COVID-19 vaccine, while only 15% of the population had received on XBB.1.5 vaccine. Vaccination rates for those under 4 years of age continues to be low at less than 10% in December, 2023

Canadian Dental Care Plan

Canadian residents with annual adjusted family net income of less than $90,000 who do not have access to dental insurance will have access to dental care under the Canadian Dental Care Plan (CDCP). Applications will be opened in phases and began in December, 2023 for those 87 years or older. Those with a valid disability tax credit and children under 18 will be able to apply online June 2024. The health unit is waiting for direction on how this Federal program will impact the Healthy Smiles Ontario Program and the Ontario Seniors' Dental Care Plan

Chronic Disease Prevention Indicators

The Locally Driven Collaborative Projects (LDCP) program brings together public health units along with academic and community partners to collaboratively design and implement applied research and program evaluation projects. A new project, led by Thunder Bay District Health Unit, Ottawa Public Health, and the Dalla Lana School of Public Health and funded by Public Health Ontario aims to develop a core set of chronic disease prevention indicators. The project aims to increase the capacity of public health units to plan, monitor and evaluate chronic disease prevention programs. The initial focus will be nutrition-related indicators. The list of nutrition indicators will be narrowed down to a core set via a prioritization survey. Haldimand Norfolk Health Unit will be a contributing partner to the prioritization survey.

Antimicrobial Resistance in Common Hospital Pathogens

Every year, PHO and IQMH (Institute for Quality Healthcare) conduct a survey on antimicrobial resistant organisms (AROs) across all laboratories and hospitals. The survey also looks at infection and prevention control programs. Key findings show that the incidence rates of some key pathogens such as Methicillin Resistant Staphylococcal Auras (MRSA) are increasing. The pandemic led to disruptions in routine screening and management of AROs. Most of these disruptions have been restored. It is incumbent on all of us to use antibiotics wisely to avoid the development of AROs.

Vaccine Safety in Ontario

As general knowledge of the life impacts of vaccine preventable disease such as Polio decrease, it becomes important to assure the safety of vaccines for concerned recipients. To this end there are robust, local, provincial, national, and international vaccine safety monitoring program. Recently PHO announced that it is preparing an update to the Vaccine Safety Surveillance Tool. This interactive too provides vaccine safety data in Ontario by trends over time, age, sex, public health unit, type of vaccine and type of adverse event. The tool is available on PHO's website. In 202, 8.6 million doses of publicly-funded vaccines were distributed in Ontario. There were 447 adverse events (0.006% of doses distributed) reported. Of these 95.5% were mild consisting of local redness or allergic skin reactions, or rash.

Respectfully submitted,

Dr. Joyce Lock, M.D. , MSc

Association of Local PUBLIC HEALTH Agencies

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Toronto, Ontario M6C 4A7
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E-mail: info@alphaweb.org

alPHa's members are the public health units in Ontario.

alPHa Sections:

- Boards of Health Section
- Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

- Association of Ontario Public Health Business Administrators
- Association of Public Health Epidemiologists in Ontario
- Association of Supervisors of Public Health Inspectors of Ontario
- Health Promotion Ontario
- Ontario Association of Public Health Dentistry
- Ontario Association of Public Health Nursing Leaders
- Ontario Dietitians in Public Health

Dr. Kieran Moore
Chief Medical Officer of Health
Box 12, Toronto, ON M7A 1N3

December 14, 2023

Dear Dr. Moore,

Re: Expansion of Alcohol Distribution

On behalf of the Association of Local Public Health Agencies (alPHa) and its Boards of Health Section, Council of Ontario Medical Officers of Health Section, and Affiliate Associations, we are writing to you on today's announcement regarding the expansion of alcohol distribution.

Public health has an important mandate in key areas related to the use of alcohol and other drugs, including activities in chronic disease prevention, injury prevention, substance abuse prevention and harm reduction. In keeping with this, public health carries out duties under the Ontario Public Health Standards to evaluate the impacts of alcohol consumption and develop health promotion and protection strategies.

To augment the government providing an additional $10 million over five years in funding to the Ministry of Health to support social responsibility and public health efforts, we recommend the creation of a Provincial Alcohol Strategy in line with alPHa's previous Resolution.

To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Sincerely,

C. Gardner

Dr. Charles Gardner,
President

alPHa
Association of Local PUBLIC HEALTH Agencies

480 University Ave., Suite 300
Toronto, Ontario M5G 1V2
Tel: (416) 595-0006
E-mail: info@alphaweb.org

December 1, 2023

Hon. Mark Holland
Minister of Health,
House of Commons
Ottawa, Ontario, K1A 0A6

Dear Minister Holland,

Re: Regulation of Nicotine Products

On behalf of the Association of Local Public Health Agencies (alPHa) and its Council of Ontario Medical Officers of Health, Boards of Health Section and Affiliate Organizations, I am writing to request that Health Canada take swift action to stop the sale and promotion of nicotine pouches to youth and continue progress towards eliminating commercial tobacco and nicotine use and in keeping with our Association's call for a comprehensive smoking, vaping, and nicotine strategy in the attached resolution.

While smoking rates are at an all-time low, commercial tobacco use remains the leading preventable cause of death and disability in Ontario, as well as in Canada.[i, iii] Emerging nicotine products such as e-cigarettes and nicotine pouches threaten to increase nicotine addiction amongst youth and adults who do not smoke. Research in nicotine addiction continues to show a path to tobacco. For example, youth who use e-cigarettes have been shown to be three to four times more likely to start smoking tobacco cigarettes [iii].

alPHa is very concerned that nicotine pouches have been approved for sale and promotion in the Canadian market with even less regulation than e-cigarettes. Nicotine pouches have been approved for sale to children of *any* age and are legal to be promoted to all audiences, including on television, billboards and using social media and lifestyle ads. Colourful displays at points of sale and free samples are also permitted. Regulations prohibiting the sale and advertising of tobacco and vapour products to those under 18 years (19 years in Ontario) serve to protect youth from a lifetime of nicotine addiction and are thus among the strategies included within Canada's *Tobacco and Vaping Products Act* and the *Smoke-Free Ontario Act, 2017*.

Similar restrictions are urgently required for nicotine pouches including restricting flavouring that appeals to youth. Flavours were removed from tobacco cigarettes to help reduce their appeal to youth, though they continue to be a driving force of youth vaping [iv]. Restricting all flavours except those that impart a tobacco flavour in both e-cigarettes and nicotine pouches would further reduce the risk of nicotine addiction among youth and adults who have never smoked.

alPHa supports the immediate calls to action recently made by health organizations such as Physicians for a Smoke-Free Canada, requiring reclassification of nicotine pouches as a prescription product, or to suspend the sale of nicotine pouches until the regulatory gap is closed, both of which being approaches that could be done quickly and administratively without the need for regulatory amendment. Further, alPHa supports the recommendation to establish a temporary moratorium on the approval of any further nicotine pouch products, or any new category of nicotine products, under the Natural Health Product Regulations, until the regulatory gap is closed, unless the products are sold on a prescription basis.

This emerging nicotine product highlights the need for a federal smoking, vaping, and nicotine strategy that aligns with Canada's current Tobacco Strategy target of less than 5% commercial tobacco use by 2035 with respect to all nicotine delivery products. Such a strategy would complement the call for a renewed and comprehensive smoking, vaping, and nicotine strategy in Ontario that was introduced via alPHa Resolution A23-02, passed by our membership at our 2023 Annual Conference as attached for your reference.

We look forward to working with you and welcome any questions regarding this issue. Please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Sincerely,

Dr. Charles Gardner
President

Copy: Dr. Kieran Moore, Chief Medical Officer of Health, Ontario

i Ontario Agency for Health Protection and Promotion (Public Health Ontario). Ontario Tobacco Monitoring Report 2018 [Internet]. Toronto, ON: Queen's Printer for Ontario; 2019. Available from: https://www.publichealthontario.ca/-/media/documents/T/2019/tobacco-report-2018.pdf

ii Murray CJL, Aravkin AY, Zheng P, Abbafati C, Abbas KM, Abbasi-Kangevari M, et al. Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. The Lancet. 2020 Oct;396(10258):1223–49.

iii Collishaw, N. (2022, February 14). Science has marched on: it is time to update the advice to Canadians. *Physicians for a Smoke-Free Canada*. https://smoke-free-canada.blogspot.com/2022/02/science-has-marched-on-it-is-time-to.html

iv Hammond, D., Reid, J. L., Rynard, V. L., & Burkhalter, R. (2019). ITC youth tobacco and vaping survey: Technical report – Wave 3 (2019). University Of Waterloo. Updated May 2020.

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to Ontario's boards of health. alPHa represents all of Ontario's 34 boards of health, medical officers and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology, and business administration. As public health leaders, alPHa advises and lends expertise to members on the governance, administration, and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective, and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.

Association of Local PUBLIC HEALTH Agencies

RESOLUTION A23-02

TITLE: **Toward a Renewed Smoking, Vaping, and Nicotine Strategy in Ontario**

SPONSOR: **Simcoe Muskoka District Health Unit (SMDHU)**

WHEREAS commercial tobacco use remains the leading preventable cause of death and disease in Ontario and Canada; and

WHEREAS the direct and indirect financial costs of tobacco smoking are substantial and were estimated at $7 billion in Cancer Care Ontario and Public Health Ontario's 2019 report The Burden of Chronic Diseases in Ontario; and

WHEREAS the prevalence of cigarette smoking among Ontarians aged 15 years and older in 2020 was 9.9%, amounting to 1,222,000 people; and

WHEREAS the commercial tobacco control landscape has become more complex with the rapid rise of vaping among youth, as well as the concerning prevalence of waterpipe and cannabis smoking; and

WHEREAS the membership previously carried resolution A21-1 proposing policy measures to address youth vaping for implementation at the provincial and federal levels, several of which have yet to be implemented; and

WHEREAS the membership previously carried resolution A17-5 recommending that the provincial tobacco control strategy be aligned with the tobacco endgame in Canada; and

WHEREAS Ontario and Canada have made great strides in commercial tobacco control in Ontario, which are now endangered by the lack of a provincial strategy and infrastructure to support its continuation; and

WHEREAS disproportionate commercial tobacco and nicotine use and associated health burdens exist among certain priority populations;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies write to the Ontario Minister of Health recommending that a renewed and comprehensive smoking, vaping, and nicotine strategy be developed with the support of a multidisciplinary panel of experts, local public health, and people with lived experience;

AND FURTHER that the Association of Local Public Health Agencies recommend that, in the development of a target for such a provincial strategy, the expert panel examine the sufficiency and inclusiveness of Canada's Tobacco Strategy target of less than 5% commercial tobacco use by 2035 with respect to all nicotine delivery products;

AND FURTHER that the Association of Local Public Health Agencies recommend that the pursuit of health equity be foundational to such a provincial strategy;

AND FURTHER that a copy be sent to the Chief Medical Officer of Health of Ontario.

BACKGROUND:
TOWARD A RENEWED COMMERCIAL TOBACCO AND NICOTINE STRATEGY IN ONTARIO

1. Commercial Tobacco

Canada has made great strides in commercial tobacco[1] control, and Ontario has until recent years been a leader among our provinces and territories, having made tremendous progress in decreasing smoking rates and in turn the negative health outcomes of smoking. Smoking prevalence among Canadians and Ontarians 15 years and older have dropped from 25% and 23%, respectively, in 1999 down to around 10% in 2020.[1] This decrease is representative of a remarkable downward trend nationally and provincially that appear to be on track to reach the endgame goal of less than 5% tobacco use by 2035, a target adopted by the federal government in Canada's Tobacco Strategy[2] and previously recommended for adoption in Ontario[3]. The recent Report of the First Legislative Review of the *Tobacco and Vaping Products Act* elaborates on this trend, noting that "declines in the number of young persons who smoke played an important role in declining prevalence rates overall; smoking rates among Canadians aged 15-19 are currently at an all-time low."[4]

However, it is crucial to note that this progress was achieved over decades, with explicit commercial tobacco control strategies in place to guide tobacco control research, policy development, and policy implementation; all this work was also undergirded by a robust infrastructure. Recent examples of progress in the federal policy arena include the implementation of policies around plain and standardized packaging for commercial tobacco products and enhanced package health warnings, as well as a ban on flavours in cigarettes and most cigars. Provincially, Ontario has strengthened its commercial tobacco contraband measures.

While Canada retains a strategy, Ontario is now operating without one—and there is still much work to be done: Tobacco use remains the leading preventable cause of death and disability in Canada,[5,6] killing approximately 48,000 Canadians each year,[2] of which nearly 17,000 are Ontarians.[7] The Ontario Public Health Standards' *Tobacco, Vapour and Smoke Guideline, 2021* states that "[e]very day tobacco kills more Ontarians than alcohol, illegal drugs, accidents, suicides and homicides combined. People who use tobacco are more likely to go to the hospital and stay longer. They are also likely to die younger."[8] The economic burden is similarly immense: While updated data on the economic burden of tobacco use is needed, 2017 data indicated health care costs of $6.1 billion and overall costs of $12.3 billion nationally.[9] In Ontario, a separate report determined the overall annual economic burden of tobacco smoking to be around $7 billion, exceeding that of alcohol consumption, physical inactivity, or unhealthy eating, taken separately.[10]

2. Vaping

The landscape of commercial tobacco and nicotine products has become more complex with the advent of vaping products containing nicotine, which includes electronic cigarettes (e-cigarettes), the primary users of which are youth. Vaping is the "act of inhaling and exhaling an aerosol produced by a vaping product, such as an electronic cigarette."[11] Most vaping devices use electrical power from a battery to heat a liquid solution to produce an aerosol that is breathed in by the user through the mouthpiece. Most vaping liquids contain nicotine, the levels of which range from very low to more than what is found in a typical tobacco cigarette, together with flavouring compounds that are dissolved in a liquid mixture

[1] Commercial tobacco is distinct from traditional or ceremonial use of tobacco by Indigenous peoples. In the implementation and enforcement of the *Smoke-Free Ontario Act, 2017*, the Ministry of Health protects the use of tobacco by Indigenous peoples and communities when used for traditional or ceremonial purposes.

composed typically of propylene glycol and/or glycerol (i.e., vegetable glycerin).[11] Some vaping liquids also contain cannabis.[12]

National data from 2021 indicates that 13% of adolescents aged 15 to 19 years and 17% of young adults aged 20 to 24 years in Canada reported having vaped at least once during the 30-day period before the survey, compared with 4% of adults aged 25 or older.[13] Provincially, there has been a meteoric rise in youth vaping rates in recent years: According to the Ontario Student Drug and Health Survey, grade 7–12 students who reported used vaping products in the past year doubled from 11% in 2017 to 23% in 2019, with 13%—representing approximately 105,600 students—vaping weekly or daily.[14] These rates are particularly alarming among students in higher grades: The 2019 survey indicated that 35% of students in grade 12 vaped in the past year, of which 21% were vaping weekly or daily.[14] Moreover, among students who vaped in the past year, those who reported using a nicotine-containing product doubled from 28% in 2017 to 56% in 2019.[14] The more recent 2021 survey noted a decrease of past-year vaping among students to 15%. However, those who reported using a nicotine-containing product increased further to 84%, implying that the overall percentage of students vaping nicotine-containing products remained approximately the same as in 2019. There are several challenges to interpretation of the 2021 survey results. For example, the change to an online mode of questionnaire delivery for 2021 led to dramatically decreased response rates that may impact the provincial representativeness of the results.[15] The report also indicates that "because of the significant changes to the methodology in 2021, caution is warranted when comparing these estimates with those from previous OSDUHS cycles."[15] More broadly, both the COVID-19 pandemic as well as changes to the federal and provincial regulatory and policy environments since 2019 have likely impacted the prevalence of youth vaping; however, longitudinal assessments have been disrupted by the pandemic and therefore the extent of impacts is unknown. Further monitoring, data collection and evaluation is needed to understand the impact of these changes and events on adolescent vaping initiation, escalation, and overall prevalence.

Regardless of the method of delivery, the highly addictive effects of nicotine are fundamentally the same, and may have particularly insidious effects on the developing brains of youth.[16,17] Although vaping products have been advertised in part as a harm reduction and smoking cessation product that may reduce health risks and possibly save lives for people who smoke, with some evidence to support this claim,[18,19] there has been no discernible population-level change in smoking cessation rates since vaping products entered the market.[20] Therefore, any individual-level efficacy of vaping products as a smoking cessation tool does not appear to translate to population-level impact. Furthermore, the vast majority of uptake has been among youth without a smoking history. In fact, among those who reported having vaped in the past 30 days, a majority (61%) of youth aged 15 to 19 and more than one-quarter (27%) of young adults aged 20 to 24 had never tried a tobacco cigarette in their life, which suggests that the majority of youth are not using vaping devices to reduce or quit smoking.[13] Therefore, the current evidence around the benefits of vaping products for the purpose of smoking cessation, while still evolving, is not of relevance to youth. In contrast, the evidence to date around the harms of vaping is becoming increasingly clear; in particular, people who vape but do not smoke are on average around three times more likely than those who do not vape to initiate cigarette smoking,[21,22] lending credence to the concern of a gateway effect. Additional evidence of harms from vaping includes the following:

- A variety of substances known to be toxic, carcinogenic, or cause disease have been identified in vaping products.[23]
- Intentional or accidental exposure to nicotine e-liquids can lead to poisoning, which can be lethal, with a significant number of accidental poisonings occurring in children under the age of six.[21]
- Vaping can cause burns and injuries, which can be lethal.[21]
- Vaping can cause respiratory disease in the form of E-cigarette or Vaping Use-Associated Lung Injury (EVALI).[21]
- Vaping can lead to seizures.[21]

- Vaping products contribute to environmental waste.[21]

Moreover, there are differences between vaping and smoking dependence that may impact attempts to quit, including the greater variability in vaping products compared to cigarettes, the discreteness and convenience of vaping, and the greater social acceptability of vaping among youth.[24] To address the rise of vaping, Ontario has required retail registration with local public health units for sale of flavoured vaping products (except mint-menthol or tobacco flavours), restricted sale of flavoured products (except mint-menthol and tobacco flavours) to specialty vape stores, banned sale of vaping products in several public premises, and banned their use in most public premises, though with notable exceptions such as post-secondary institutions. There are also several promising local and regional campaigns such as "Not an Experiment"[25] aiming to raise awareness among youth, parents, and educators about the risks of vaping. However, more control measures and interventions, as well as evaluation of their effectiveness, are needed to protect youth from the harms of both vaping as well as all future commercial nicotine delivery products.

3. Waterpipe smoking

Also referred to as "shisha" or "hookah", waterpipe smoking involves smoking a heated tobacco or non-tobacco "herbal" product.[26] Its increase in prevalence globally may be explained in part by misconceptions of lesser harm relative to other forms of tobacco smoking, its social nature, and the availability of various flavours and nicotine-free products.[26] However, waterpipe smoking of both tobacco and non-tobacco products results in inhalation of various carcinogens and toxins, and results in similar negative health effects to cigarette smoking.[26] Moreover, while the *Smoke-Free Ontario Act, 2017* prohibits the use of tobacco in waterpipes in restaurants and bar patios, the use of non-tobacco products in waterpipes is still permitted, impacting not only waterpipe smokers but also the public through secondhand and thirdhand smoke.[26]

4. Cannabis smoking

Cannabis, which can be consumed by various means including smoking, vaping, and ingestion, refers to all products derived from the *Cannabis sativa* plant, and can consist of up to approximately 540 different chemical substances, among which the main psychoactive constituent is tetrahydrocannabinol (THC).[27] The federal *Cannabis Act* came into force in October 2018, resulting in legalization and regulation of production, distribution, sale, import, export, and possession of cannabis for adults of legal age.[28] The 2021 Canadian Cannabis Survey indicates that approximately 25% of Canadians have reported using cannabis in the past 12 months, of whom 74% reported smoking as one method of cannabis consumption.[12] In addition to an array of health effects associated with cannabis consumption, smoked cannabis in particular can increase risk of bronchitis, lung infections, and chronic cough.[29] The *Smoke-Free Ontario Act, 2017* prohibits the smoking of cannabis in enclosed workplaces, enclosed public places, and other designated places.

5. Ontario's commercial tobacco and nicotine control landscape

Despite concerted efforts through research and reports providing evidence-informed recommendations towards a "tobacco endgame" culminating in the *Smoke-Free Ontario Modernization* report in 2017,[3] there has been limited incorporation of these recommendations into the province's approach to commercial tobacco and nicotine control.[30] For example, actions to increase the cost of commercial tobacco products through tax and other pricing policies have been limited; Ontario continues to have the second lowest retail price and total tobacco tax for tobacco products in Canada.[31,32] Moreover, among the many programs and services that have been lost during the COVID-19 pandemic, commercial tobacco and nicotine prevention, protection, and cessation programs have been significantly impacted. Indeed, the

broader commercial tobacco control infrastructure in Ontario has declined substantially both before and during the pandemic, a decline that is closely tied to the loss of a provincial strategy. With the loss of the Smoke-Free Ontario Strategy, the following crucial infrastructure has been lost: the Smoking and Health Action Foundation, the Leave the Pack Behind program, the Youth Advocacy Training Institute as well as the associated youth advocacy programming, the Program Training and Consultation Centre, funding to public health units for youth and young adults as staff, Smokers' Helpline telephone counselling, Registered Nurses Association of Ontario special projects for tobacco control, Heart & Stroke Foundation of Ontario mass media campaigns, and provincial mass media campaigns. In addition, provincial funding has been reduced for monitoring, research, and evaluation, which has impacted the activities of organizations such as the Ontario Tobacco Research Unit. Funding from other sources such as NGOs has also been lost for organizations such as the Ontario Campaign for Action on Tobacco. Furthermore, many stakeholder engagement opportunities at the provincial level, such as through the Tobacco Control System Committee, the Youth Prevention Task Force, the Communications and Marketing Advisory Committee, the Protection and Enforcement Task Force, the Research and Evaluation Task Force, the Capacity Building and Training Task Force, and monthly calls between Tobacco Control Area Networks and Ministry staff, have been discontinued. Finally, organizations such as Public Health Ontario have had a reduced focus on commercial tobacco and nicotine as an inevitable consequence of the significant resources that have been committed to combatting the COVID-19 pandemic, although their recent re-engagement in this area is inspiring.

These setbacks are compounded by ongoing inequities in the health impacts of tobacco and nicotine use among certain populations. Smoking is a socioeconomically stratified behaviour, as evidenced by decreasing prevalence rates with increasing education.[33] Disproportionate commercial tobacco and nicotine use and associated health burdens exist among Indigenous populations, members of the LGBTQ2S+ community, low-income populations, people with less formal education, people working in certain occupations (e.g., trades), individuals with mental health needs, individuals who use other substances, and incarcerated individuals.[2,9,31,34] Moreover, while reaching less than 5% tobacco use by 2035 may be possible with current strategies, such a target on its own does not sufficiently address this disproportionate burden among these populations. When addressing such health inequities among Indigenous peoples, it is also important to take a culturally safe approach that distinguishes between commercial tobacco use and traditional or ceremonial use of tobacco.

6. Examining the policy options

In late 2022, the Simcoe Muskoka District Health Unit (SMDHU) performed a brief jurisdictional scan focusing on recently implemented commercial tobacco and nicotine control policies (see Appendix A) and explored the grey literature to both identify existing policies at the federal and provincial levels, as well as determine some of the priority areas for action for a renewed smoking and nicotine strategy. SMDHU also conducted a conversation with key informants, the key points of which were summarized through the lens of an adapted version of the World Health Organization's MPOWER framework[2] (see Appendix B).[36]

Given the relative recency of vaping as a phenomenon, evidence is emerging related to the effectiveness of interventions to reduce vaping[23,37–41] as well the cost-effectiveness of doing so.[42] Lessons learned from interventions used to combat commercial tobacco use may also be applied to address vaping.[40] However, evaluation will be needed to confirm effectiveness. There have already been a variety of effective

[2] The World Health Organization Framework Convention on Tobacco Control (FCTC) is a legally binding international health treaty on tobacco control, which 182 countries including Canada have ratified.[35] To help countries reduce demand for tobacco, the WHO developed the MPOWER measures: Monitor tobacco use and prevention policies; Protect people from tobacco smoke; Offer help to quit tobacco use; Warn about the dangers of tobacco; Enforce bans on tobacco advertising, promotion and sponsorship; and Raise taxes on tobacco.[36]

commercial tobacco and nicotine control interventions implemented in Ontario and other Canadian jurisdictions over the years, but a coordinated, comprehensive, multi-level, evidence-informed, and enduring strategy is needed to achieve the target of less than 5% tobacco use by 2035. Such a strategy would continue to be informed by evidence and focus on the traditional pillars of prevention, cessation, and protection, as well as industry denormalization and engagement of disproportionately impacted groups such as First Nations, Inuit and Métis (FNIM) organizations and communities.[3,9,34,43,44] However, for such a strategy to work, there must be provincial and federal commitments to strong regulations around all alternative methods of nicotine delivery. In particular, the Council of the Chief Medical Officers of Health has recommended a "broad regulatory approach to all alternative methods of nicotine delivery (i.e. other than tobacco products) that offers strong youth protection while allowing appropriate access for adult who smoke to products if they are proven effective in decreasing or stopping the use of all nicotine-containing products."[45]

7. Conclusion

Despite significant progress in commercial tobacco control, the health and economic burdens of tobacco-related disease in Canada remain unconscionably high. Moreover, vaping, waterpipe smoking, and cannabis smoking have added further complexity to the smoking and nicotine control landscape that risks undoing the tremendous progress that has been made. A coordinated, comprehensive, and enduring provincial smoking and nicotine control strategy is needed to save lives, protect young minds, reduce health inequities, and save money.

References

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Appendix A: Jurisdictional Scan of Tobacco and Nicotine Control Policies in Canada

Summary: A jurisdictional scan of Canadian federal, provincial, and territorial tobacco and nicotine control strategies was performed. An array of pre-existing documents[32,46–48] (environmental scans, briefing notes, etc.) produced by Physicians for a Smoke-Free Canada (PSC) cover similar objectives, and therefore constitute a major contribution to this scan. Overall, strategies have continued to focus on efforts surrounding the four pillars of prevention, cessation, protection and denormalization, with varying degrees of emphasis on each. However, the last few years have seen a deceleration in commercial tobacco control efforts, while vaping products have taken the spotlight, particularly following the amendment of the *Tobacco Act* in 2018 to become the *Tobacco and Vaping Products Act* (TVPA).

With respect to commercial tobacco control, the following recent changes have occurred at the federal, provincial, and/or territorial levels:

- plain and standardized packaging
- enhanced package health warnings
- ban on flavours in cigarettes and most cigars including menthol and cloves
- additional contraband measures in some jurisdictions

With respect to vaping control, the following recent changes have occurred at the federal, provincial, and/or territorial levels:

- taxes on vaping products
- retail licensing/registration
- minimum age restrictions
- requiring proof of age in stores
- display bans in stores
- restriction to sale in specialty vape stores
- bans on internet sales
- bans on incentives to retailers
- bans on non-tobacco flavours
- bans on various forms of advertisement
- restrictions on nicotine content
- health warnings

There are also plans at the federal level for implementing "reporting requirements that would require vaping product manufacturers to submit information to Health Canada about sales and ingredients used in vaping products."[4]

Limitations: While such a scan would be most useful if it summarized the implementation of the jurisdictional strategies that were identified (in addition to effects of implementation, technical feasibility, political viability, alignment with the Canadian regulatory landscape, etc.), the scan was largely limited to information that could be gleaned from web-based searches of the grey literature. Furthermore, jurisdictions outside of Canada such as New Zealand,[49] Australia,[50,51] Finland[52] and California[53] may provide further insights into tobacco and nicotine control, but were not covered in this scan.

Table A1: Jurisdictional Scan Results

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
Fed	Canada's Tobacco Strategy[2] (2018)	• Supports endgame goal of less than 5% by 2035. • Note: In 2020/2021, Health Canada changed its progress indicator from "percentage of Canadians (aged 15+) who have used any tobacco product in the last 30 days" to "Percentage of Canadians (aged 15+) who are current cigarette smokers."[54]	• Vaping products: ban on ads in stores (except age-restricted stores), display ban, ban on broadcast ads, ban on billboards/outdoor signs, ban on lifestyle ads, ban on sponsorships, ban on youth-appealing ads, health warnings / labelling requirements, restriction on nicotine content (max 20 mg/mL), excise tax, plan to ban all flavours except tobacco and mint-menthol, plan to impose vaping product reporting requirements, compliance and enforcement activities • Tobacco products: Plain and standardized packaging, enhanced package health warnings, ban on flavours in cigarettes and most cigars including menthol and cloves
BC	BC's Tobacco Control Strategy: targeting our efforts[55]	• No endorsement of endgame goal • BC's 2013 Guiding Framework for Public Health[56] targets a reduction of smoking to 10% by 2023. • In the 2018 report First to 5% by 2035[57], the Clean Air Coalition of BC recommended that BC be the first jurisdiction to achieve 5% by 2035, but there is no evidence of endorsement by government.	• Vaping products: tax, retail notification and reporting requirement, sale of flavoured products restricted to specialty vape stores, ban on sale and use in some public premises • Tobacco products: subsidized nicotine replacement therapy (NRT) to all residents, second highest level of overall taxation on cigarettes ($15.30 for a 20-pack), highly regarded stop-smoking service model, some exemplary practices in Indigenous stewardship
AB	Creating Tobacco-free Futures: Alberta's Strategy to Prevent and Reduce Tobacco Use 2012-2022[58]	• No endorsement of endgame goal • 10-year targets set for 2022: - Albertans ages 15 and over: 12 % - Albertans ages 12 to 19: 6% - Albertans ages 20 to 24: 20% - Pregnant women in Alberta: 11%	• Vaping products: ban on possession below minimum legal age, ban on sale in some public premises, ban on use in most public premises including outdoor cultural events

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
		- Reduce estimated per capita tobacco sales by 50 per cent to 745 units in 2022.	
SK	No strategic document identified. Public-facing Information available on their Tobacco and Vapour Products webpage.	• No endorsement of endgame goal • The Saskatchewan Coalition for Tobacco Reduction produced a report entitled Protecting our Future: Recommendations to reduce tobacco use in Saskatchewan, but this document does not appear to have been endorsement by government.	• Vaping products: tax, ban on sale and use in some public premises
MB	No strategic document identified. Public-facing information available on their Smoking, Vaping Control & Cessation webpage.	• No endorsement of endgame goal	• Vaping products: ban on sale and use in some public premises
ON	Smoke-Free Ontario: The Next Chapter - 2018[30] Note: This strategy was neither adopted nor implemented by the present government.	• No endorsement of endgame goal • Reduce smoking to 10% by 2023 • Reduce the number of smoking-related deaths by 5,000 each year. • Reduce exposure to the harmful effects of tobacco and the potentially harmful effects of other inhaled substances and emerging products (including medical cannabis).	• Vaping products: retail registration with local public health unit required for sale of flavoured products (not tobacco or mint-menthol), sale of flavoured products (except tobacco and menthol) restricted to specialty vape stores, ban on sale in several public premises, ban on use in most public premises (post-secondary institutions excluded) • Tobacco products: additional contraband measures
QC	Stratégie pour un Québec sans tabac 2020-2025[59] (see Appendix A for summary English translation)	• No endorsement of endgame goal • Reduce smoking to 10% by 2025.	• Vaping products: retail notification requirement, ban on internet sale and on incentives to vaping product retailers, ban on sale in most public premises, ban on use in many public premises • Tobacco products: subsidized nicotine replacement therapy (NRT) to all residents
NB	New Brunswick's Tobacco-Free	• **Supports endgame goal of less than 5% by 2035.**	• Vaping products: retail licensing/registration, ban on all

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
	Living Strategy: A Tobacco and Smoke-Free Province for All[60] (2019-2023) was produced by the NB Anti-Tobacco Coalition, funded by the Government of NB.		flavours except tobacco, ban on use in most public premises
NS	Moving toward a Tobacco-Free Nova Scotia: Comprehensive Tobacco Control Strategy for Nova Scotia[61] (2011) Public-facing information available on their Tobacco Free Nova Scotia webpage.	• No endorsement of endgame goal • Decrease tobacco use rates individuals aged 15-19 years to 10%, 20-24 years to 20%, and 25 years and older to 15%.	• Vaping products: retail licensing/registration, tax, ban on all flavours except tobacco, ban on sale and use in most public premises (post-secondary institutions included)
PEI	No strategic document specific to tobacco control identified. Tobacco control is addressed in PEI's Wellness Strategy[62] (2015-2018)	• No endorsement of endgame goal	• Vaping products: Sale restricted to age 21 years and above and only in specialty stores, ban on all flavours except tobacco, ban on sale in many public premises, ban on use in several public premises (post-secondary institutions included)
NL	Tobacco and Vaping Reduction Strategy[63] (2021) produced by the Newfoundland and Labrador Alliance for the Control of Tobacco, which is an alliance of government and non-government partners.	• No endorsement of endgame goal Action areas: • Community capacity building • Education and awareness • Healthy public policy • Cessation and treatment services • Research, monitoring and evaluation	• Vaping products: retail licensing/registration, tax, ban on sale in many public premises, ban on use in several public premises (post-secondary institutions included) • Highest level of overall taxation on cigarettes ($15.71 for a 20-pack)
YT	No strategic document identified. Public-facing information available on	• No endorsement of endgame goal	• Vaping products: ban on use in many public premises

F/P/T	Strategic Document	Alignment with Endgame Target[47] (less than 5% by 2035)	Recent Policy Implementation[4,32,44,46] (listed if not already implemented in Ontario)
	government webpage.		
NWT	No strategic document identified. Public-facing information available on Tobacco Control webpage.	• No endorsement of endgame goal	• Vaping products: ban on all flavours except tobacco, ban on possession below minimum legal age, ban on sale in some public premises, ban on use in many public premises
NU	Nunavut Tobacco Reduction Framework for Action[64] (2011-2016)	• No endorsement of endgame goal • Guiding principles draw from Inuit culture and practices. • Supports a coordinated communications plan using a range of media tools and using both universal and targeted approaches (including youth, pregnant women and their partners, and parents and Elders). • Younger age group is targeted through school and community youth programs because youth initiate tobacco use largely between 8 and 16 years of age.	• Vaping products (per Tobacco and Smoking Act[65], which received Assent on June 8, 2021, but is not anticipated to come into force until 2023): plan to consider vaping product price restrictions, plan to ban incentives to vaping product retailers, plan to ban sale and use in most public premises, plan to ban all flavours except tobacco and any product designed for use as flavouring for any smoking product, plan to make all publicly funding housing smoke-free, plan for biennial reporting requirements for vape retailers

Appendix B: Priorities for a Provincial Smoking and Nicotine Strategy — Key Informant Conversation Summary

To inform the call for a renewed and comprehensive provincial commercial tobacco and nicotine strategy, the Simcoe Muskoka District Health Unit (SMDHU) conducted a conversation on November 17, 2022, with a panel of key informants with extensive experience in commercial tobacco control in Ontario and Canada, in addition to following up individually upon request from some key informants for further discussion. The meeting was framed as an informal discussion around commercial tobacco and nicotine control, using past strategies and reports as a springboard to identify provincial priorities for a renewed commercial tobacco and nicotine strategy, as well as federal priorities to address relevant policy gaps.

Participants included:

- John Atkinson, Executive Director, Ontario Public Health Association
- Cindy Baker-Barill, Smoke-Free Program Manager, Smoke-Free Program and Central East Tobacco Control Area Network, Environmental Health Department, SMDHU
- Hillary Buchan-Terrell, Advocacy Manager (Ontario), Canadian Cancer Society
- Cynthia Callard, Executive Director, Physicians for a Smoke-Free Canada
- Vito Chiefari, Manager, Health Protection, Community & Health Services Dept, York Region
- Rob Cunningham, Senior Policy Analyst, Canadian Cancer Society
- Dr. Charles Gardner, Medical Officer of Health and Chief Executive Officer, SMDHU
- Dr. Lesley James, Director, Health Policy & Systems, Heart & Stroke Foundation
- David Neeson, Supervisor, Tobacco and Electronic Cigarette Control Team, Health Protection Division, Community and Health Services, York Region
- Michael Perley, former Director, Ontario Campaign for Action on Tobacco
- Dr. Emil Prikryl, Public Health and Preventive Medicine Resident, NOSM University
- Dr. Steven Rebellato, Vice President, Environmental Health Department, SMDHU
- Dr. Robert Schwartz, Executive Director, Ontario Tobacco Research Unit and Professor, Dalla Lana School of Public Health
- Linda Stobo, Program Manager, Substance Use Program, Healthy Living Division, Middlesex-London Health Unit
- Melissa van Zandvoort, Health Promotion Specialist, Smoke-Free Program and Central East Tobacco Control Area Network, Environmental Health Department, SMDHU

While it is our recommendation that the development of a renewed strategy be supported by a multidisciplinary panel of experts, Table B1 frames the priorities identified during the key informant conversation through the lens of an expanded version of the World Health Organization's MPOWER framework (i.e., MPOWER+):

Table B1: Priorities within the MPOWER+ Framework

MPOWER+ Measure	Priorities
Monitor tobacco and vaping use and prevention, cessation and protection/enforcement programs and policies.	• Re-invest in research/monitoring and evaluation to ensure practice and policy decisions are based on evidence. • Continue to explore age restrictions for smoking and vaping.
Protect people from tobacco smoke and e-cigarette aerosol.	• Further expand smoke- and vape-free public places. • Continue to increase access to smoke- and vape-free housing. • Direct focus towards consumer rights to be protected from marketing of nicotine products.
Offer help to quit smoking and vaping.	• Increase subsidization of smoking cessation pharmacotherapy for all residents.
Warn about the dangers of commercial tobacco and vaping products.	• Implement mass media and social marketing campaigns of greater intensity and duration targeted at youth and young adults addressing the real and potential harms of vaping such as its impacts on mental health, addiction, and environmental waste. • Implement mass media and social marketing campaigns of greater intensity and duration targeted at high-risk populations addressing the harms of smoking and the benefits of quitting.
Enforce bans on commercial tobacco and vaping product advertising, promotion and sponsorship.	• Return the focus of nicotine control efforts to the industry through activities such as leveraging litigation opportunities to further denormalize the industry and hold industry accountable for past and future harms to society. • Ban all flavours except tobacco flavour (if not achieved federally). • Restrict availability in brick-and-mortar settings and online access. • Strengthen retail registration and licensing requirements. • Further regulate vaping product design (e.g., plain and standardized packaging for vaping, health warnings). • Intensify tobacco and vaping product advertising promotion and sponsorship bans.

MPOWER+ Measure	Priorities
	• Ensure continued funding for enforcement through the *Smoke-Free Ontario Act, 2017*.
Raise taxes on commercial tobacco and vaping products.	• Implement a tax on vaping products, as well as regulatory fees as a means of cost recovery. • Further increase taxes on combustible tobacco products.
+ **Add** a strong health equity lens by linking commercial tobacco and nicotine control approaches to broader objectives addressing health inequities. **Add** bold interventions as indicated by evidence to further reduce the supply, demand, and access of all current and future industry nicotine delivery systems.	• Address the disproportionate use of commercial tobacco and nicotine use and associated health burdens among Indigenous populations, members of the LGBTQ2S+ community, youth, low-income populations, people with less formal education, people working in certain occupations (e.g., trades), individuals with mental health needs, individuals who use other substances, and incarcerated individuals. • Implement recommendations from the Council of Chief Medical Officers of Health to develop a "broad regulatory approach to all alternative methods of nicotine delivery (i.e. other than tobacco products) that offers strong youth protection while allowing appropriate access for adult smokers to products if they are proven effective in decreasing or stopping the use of all nicotine-containing products."[45]

Vaccine Safety in Ontario

This infographic provides a summary of AEFIs reported in Ontario following vaccines administered in 2022. This does not include data on COVID-19 vaccine AEFIs.

Vaccines are very safe

Ongoing monitoring is a key component of vaccine safety

Ontario continues to closely monitor vaccine safety data in collaboration with local, provincial, territorial, and national partners.

8.6 million doses

of publicly-funded vaccine distributed in Ontario (2022)

447 AEFIs reported

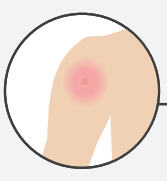
(0.006% of doses distributed)

95.5% were non-serious

What is an adverse event?

An adverse event following immunization (AEFI) is an unwanted or unexpected health effect that happens after someone receives a vaccine, which may or may not be caused by the vaccine.

Most reported adverse events were mild.



36% Pain, redness or swelling at the injection site

23% Allergic skin reaction

19% Rash

Age and sex distribution

Infants under one year and children aged one to three years had the highest AEFI reporting rates. The likely explanation is the relatively high number of vaccines given to children under 2 years, which creates more opportunities for AEFIs to occur and to be reported to a health care provider.

Infants under one year

20.9 per 100,000 population

Children aged one to three years

12.2 per 100,000 population

64% of reported AEFIs came from females

Vaccines

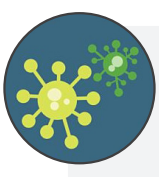
The highest AEFI reporting rates by doses distributed were in recombinant zoster vaccine (RZV), meningococcal (Men-C-ACWY) and HPV9.

RZV became publicly-funded in late 2020. Newer vaccines tend to have a higher proportion of reported AEFIs compared to older vaccines. Men-C-ACWY and HPV9 are school–based vaccines administered by public health units, which may create more opportunities for AEFI reporting.

Reporting Rate: 28.8 per 100,000

Reporting Rate: 19.8 per 100,000

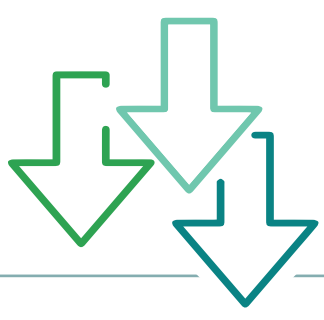
Reporting Rate: 17.8 per 100,000



Although Influenza vaccine had the **highest number of AEFI reports** (100), it had the **lowest reporting rate** (2.6 per 100,000 doses distributed).

AEFI reports were lower during the COVID-19 pandemic

The COVID-19 pandemic posed significant challenges to health care, including to the delivery of routine, non-COVID immunization programs, resulting in lower AEFI reports during the pandemic (2020-2022) compared to previous years.



Immunization lowers the risk of getting and spreading vaccine-preventable diseases to others.

Vaccination can prevent illness, including acute severe illness, hospitalization and death, as well as serious and long-term complications from vaccine-preventable diseases.

How to report an AEFI

Vaccine recipients can report AEFIs to their health care provider or local public health unit.

Physicians and other health care providers

are required to report AEFIs to their local public health unit.

For more information on how to report an AEFI, please see AEFI reporting for Health Care Providers in Ontario.

For more information on vaccine safety data in Ontario, please refer to the **Vaccine Safety Surveillance Tool** at publichealthontario.ca/vaccinesafety

For more information on AEFIs reported for COVID-19 vaccines, please see the surveillance report on AEFIs for COVID-19 in Ontario

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Ontario

Board of Health Meeting – March 05, 2024

Advisory Committee Meeting – February 26, 2024

Subject:	Food Insecurity and the 2023 Ontario Nutritious Food Basket Survey
Report Number:	HSS-24-007
Division:	Health and Social Services
Department:	Public Health
Purpose:	For Decision

Recommendation(s):

That staff report HSS-24-007 be received as information;

And that the Board of Health correspond with the provincial government applauding recent changes to Ontario Disability Support Program that indexed rates to inflation and recommend the same change for Ontario Works recipients. This would ensure that everyone receiving social assistance could afford their basic needs;

And further that the Board of Health write a letter to the Minister of Health and Long-Term Care in support of continued monitoring of food affordability by public health units as part of the revised 2025 Ontario Public Health Standards;

And further that this Staff Report be forwarded to The Association of Local Public Health Agencies and Ontario Boards of Health.

Executive Summary:

Boards of Health are mandated to monitor food affordability at the local level. Results from the Ontario Nutritious Food Basket survey show that the average monthly cost of a healthy diet for a family of four in Haldimand and Norfolk Counties in 2023 was $1,122.43.

Food affordability data is analyzed in relation to income and housing costs to determine whether people in our communities have enough money to afford a healthy dietary pattern. The 2023 analysis reveals that for many, incomes are not enough to cover even basic expenses with the most urgent situation being recipients of Ontario Works benefits. In 2022, Canada observed the highest rate of inflation recorded in four decades. Despite this, Ontario Works recipients have not received an increase in payments since 2018.

This report examines linkages between food costs, food insecurity and adequate incomes, and outlines actions the Board of Health can take to address this important public health issue.

Discussion:

Background

For the purpose of this report, the definition of household food insecurity is inadequate or insecure access to food due to financial constraints[1]. Food insecurity is considered an important social determinant of health as living with food insecurity can impact early childhood growth and development and have long-term physical and mental health implications[2]. In 2021-2022, 16.7% or 1 in 6 households in Haldimand and Norfolk Counties were food insecure[3].

Boards of Health are mandated to monitor food affordability at the local level as outlined in the Population Health Assessment and Surveillance Protocol (2018) of the Ontario Public Health Standards (OPHS)[4]. Further guidance is provided in the Monitoring Food Affordability Reference Document, 2018. Routine monitoring of food affordability aids public health units and their partners in the monitoring of income adequacy and supports work to address food insecurity.

In 2018, modernized OPHS were released. Monitoring food affordability remained a mandated task, however a standardized tool was no longer provided. In 2019, an updated Canada's food guide was released, rendering the old data collection tool outdated. Due to the COVID-19 pandemic, the Haldimand-Norfolk Health Unit (HNHU) was unable to collect data from 2020-2021, however during this time Ontario Dietitians in Public Health (ODPH) and Public Health Ontario (PHO) partnered to create an updated standardized survey tool and methodology to ensure consistent data collection across Ontario. In 2022, HNHU participated in the pilot of the updated Ontario Nutritious Food Basket (ONFB) tool, which is now the preferred data collection tool to monitor food affordability. As such, results from 2022 and 2023 should not be compared to previous years' results.

The ONFB contains 61 items based on the 2019 Canada's food guide (CFG). Nine stores across both counties participated in the survey to generate local food affordability data. The results generate the cost of eating a nutritious diet with 5% added for miscellaneous items such as spices and condiments. There are several assumptions of the survey, including that individuals are buying lowest cost items, have the time, ability, food skills and equipment required to prepare meals, have access to a grocery store, and regularly grocery shop every 1-2 weeks. In addition, ONFB items are based on CFG and are therefore not representative of culturally diverse diets.

Results

Based on results from the ONFB, the average cost to feed a **family of four** a healthy diet in Haldimand and Norfolk Counties was:

- 2023: $1,122.43 per month or $259.22 per week
- 2022: $1,064.49 per month or $245.84 per week

Income scenarios help to put local food costs into a realistic context. A variety of income scenarios, including households receiving social assistance, minimum wage earners, and median incomes are calculated and presented in Appendix A. Please note that due to a lack of housing data, scenarios 1-3 do not contain the leftover income portion of the spreadsheet, however % income for food is still available. For this report, the social assistance scenarios are highlighted in Table 1.

Table 1: Social Assistance Scenarios

Monthly Expenses	One Person, Ontario Works	One Person, Ontario Disability Support Program
Total income[a]	$868.00	$1,372.00
Average rent[b]	$610.00 (bachelor)	$882.00 (1 bedroom)
Cost of food[c]	$404.58	$404.58
Leftover income for other basic expenses	-$146.58	$85.42
% Income for rent	70%	64%
% Income for food	47%	29%

a Includes benefits and credits after tax
b Rental costs from Canada Mortgage and Housing Corporation (October 2022)*
c 2023 Haldimand-Norfolk Health Unit Ontario Nutritious Food Basket data

*Canadian Mortgage and Housing Corporation (CMHC) Rental Market Survey data. Three-bedroom data suppressed to protect confidentiality or not statistically reliable.

Income scenarios include food and rent only. Examples of basic expenses that leftover income would go towards include utilities, internet, phone, transportation, personal care items and childcare for households with children. In the Ontario Works (OW) scenario above, income does not even cover rent and food, the most basic necessities of life. OW rates have been frozen without increase for five years and are one of the few Ontario benefits not indexed to inflation.

Analysis

Findings from the analysis of income scenarios (Appendix A) demonstrate that incomes and social assistance rates are not in alignment with the current cost of living, with this situation likely becoming more severe in recent years due to unprecedented inflation[5]. Food insecurity is a significant public health problem as it is associated with increased rates of chronic disease, such as hypertension, diabetes, and heart disease, mood and anxiety disorders, infectious disease, injury, oral health issues, and premature death in adults[6]. In children, experiencing severe food insecurity increases risk of asthma,

depression and suicidal ideation in adolescence and early adulthood[7,8]. Food insecurity also costs the healthcare system greatly. As food insecurity worsens, healthcare costs rise. Research shows that health care costs for adults in severely food-insecure households are 121% higher than their food secure counterparts[9].
While this report highlights the inadequacy of social assistance in our province, working households are not immune to food insecurity. In 2021, 51.9% of food insecure households in Ontario were earning employment income[1]. For many who earn minimum wage, work part time jobs or have precarious employment, income is still inadequate.

Effective Interventions to Address Food Insecurity

Reducing the prevalence of food insecurity in our communities requires interventions that effectively increase household income and/or address related issues such as housing, transportation and food inflation[10]. Community food programs, such as food banks and meal programs, provide emergency relief to the most severely food insecure individuals in our community. However, research shows that food charity does not reduce rates of food insecurity[11]. Additionally, estimates show that only 21% of food insecure households use food banks, indicating that food charity does not reach the vast majority of those in need[12]. Evidence supports upstream, income-based interventions[10]. Examples of successful interventions in the past include the introduction of the Canada Child Benefit in 2016, which saw the rate of severe food insecurity drop by one-third among low-income families[13-14]. Similarly, people aged 65 and older have the lowest rates of poverty in Canada at 4.7%, attributed to the guaranteed annual income program, which includes the Old Age Security Pension and Guaranteed Income Supplement for low income seniors aged 65 and older[15]. This has resulted in a 50 per cent reduction in rates of food insecurity among seniors 65 to 69, compared to those aged 60 to 64[16].

Certain Ontario Disability Support Program (ODSP) rates are now indexed to annual inflation, a program change that began in 2023[17]. As a result, in July of each year ODSP rates will increase by the same amount that the Consumer Price Index (CPI) for Ontario increases. In 2023, ODSP increased by 6.5% due to inflation, resulting in a single person with a maximum shelter allowance receiving $1,308 per month vs. $1,228[17].

Local Efforts to Address Food Insecurity

Any initiative that supports residents with inadequate incomes helps to address food insecurity, as food insecurity is a result of not having enough money to purchase food. Examples of local initiatives include, but are not limited to:

- Affordable housing (e.g., rent-geared-to-income housing, rent supplement agreements, housing allowances and benefits, homelessness prevention programs)
- Ride Norfolk affordable public transportation
- Child care fee subsidy
- Dental care for low-income children and seniors (Healthy Smiles and Ontario Seniors Dental Care)

- Prenatal nutrition programs (H-N REACH Healthy Moms Eating Well for 2)
- Food banks and community meal programs across both counties
- The Mayor's Affordability Roundtable in Norfolk County
- Free income tax clinics through the Haldimand County Public Library and Norfolk County Public Library
- *Emergency Food in Norfolk* and *Emergency Food in Haldimand* brochures, maintained by HNHU and Church Out Serving

Local food affordability data is shared with the public and community partners to raise awareness and support work that addresses food insecurity, and more broadly poverty. Specific examples include:

- Data sharing with community partners to support funding
- Data sharing with the Ontario Living Wage Network for living wage calculations
    - Brant Niagara Haldimand Norfolk 2023 living wage: $20.35 per hour[18]
- HNHU Food Insecurity webpage with information and resources
- HNHU RD participation in the 2023 RISE panel discuss on local food insecurity

Policy decisions are often made at the provincial and federal levels, however municipalities and Boards of Health can support standards that support the continued monitoring of food affordability and policies aimed at improving rates of food insecurity and addressing poverty reduction.

Previous Resolutions

H.S.S. 18-02
AND THAT the Board of Health write a letter to the Minister of Community and Social Services in support of the report "Income Security: A Roadmap for Change"

AND FURTHER THAT the Board of Health write a letter to the Minister of Health and Long-Term Care in support of continued monitoring of food affordability by public health units through a standardized protocol and guidance document under the modernized Ontario Public Health Standards: Requirements for Programs, Services and Accountability

H.S. 17-02
AND THAT the Board of Health correspond with the Premier of Ontario, Minister Responsible for the Poverty Reduction Strategy, Minister of Community and Social Services and the Minister of Health and Long-Term Care regarding the urgent need for income responses to food insecurity and supporting the establishment of a Social Assistance Research Commission.

H.S. 15-35
AND THAT the Board of Health endorses the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Position Statement on Responses to Food Insecurity

AND FURTHER THAT the Board of Health correspond with the Minister of Community and Social Services commending her for the 3.8% increase ($25 per month) to the OW basic needs amount for a single person without children, and also requests an update on plans for future increases to all recipients to a level that reflects the true cost of food and housing.

Financial Services Comments:

Norfolk County

There are no direct financial implications within the report as presented.

As discussed within the report, and shown in Table 1, the municipally delivered Ontario Works program funding freeze for social assistance since October 2018 has greatly impacted recipient food scarcity. Without an annual inflationary increase as proposed in the staff recommendation, these financial hardships will only increase for Ontario Works recipients. The program remains 100% funded by the province to a capped allocation.

A few of the initiatives listed are municipally run by Haldimand-Norfolk Health & Social Services, inclusive of the Affordable Housing, Child Care Fee Subsidy, and Ontario Seniors Dental Care programs. These programs also remain 100% funded by the province to a capped allocation.

Additionally, Ride Norfolk public transportation saw affordability measures addressed through CS-23-150 Proposed User Fees and Service Charges, with discounted passes now being offered for families, students and seniors/youth.

Haldimand County

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

Interdepartmental Implications:

Haldimand County

Supporting standards for food affordability and policies aimed at improving rates of food insecurity and addressing poverty reduction from the Board of Health align with Haldimand's strategic pillar in promoting the well-being of communities.

Consultation(s):

None.

Strategic Plan Linkage:

This report aligns with the 2022-2026 Council Strategic Priority Building Norfolk - Develop the infrastructure and supports needed to ensure complete communities.

Explanation: Ensure the health, safety and well-being of the community: facilitating the necessary supports to ensure affordable, accessible and equitable service options.

Conclusion:

Food insecurity is a significant public health problem, affecting 1 in 6 households in Haldimand and Norfolk counties. Upstream, income based interventions can effectively reduce food insecurity and improve the health of our community.

Attachment(s):

- Appendix A: Income Scenario Spreadsheet
- Appendix B: 2023 Food Affordability Infographic

Approval:

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Appendix A: 2023 - Monitoring Food Affordability in Ontario (MFAO) Income Scenarios Spreadsheet [a]

	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5	Scenario 6	Scenario 7	Scenario 8	Scenario 9	Scenario 10
	Family of Four, Ontario Works	Family of Four, Full-Time Minimum Wage Earner [n]	Family of Four, Median Income (after tax) [o]	Single Parent Household with 2 Children, Ontario Works	One Person Household, Ontario Works	One Person Household, Ontario Disability Support Program [p]	One Person Household, Old Age Security/ Guaranteed Income Supplement	Married Couple, Ontario Disability Support Program	Single Pregnant Person, Ontario Disability Support Program	Single Parent Household with 2 Children, Full-Time Minimum Wage Earner [n]
Monthly Calculations										
Income										
Income from Employment		$ 2,687.00	$ 9,575.00							$ 2,687.00
Basic Allowance [b]	$ 494.00			$ 360.00	$ 343.00	$ 706.00		$ 1,409.00	$ 706.00	
Maximum Shelter Allowance [b]	$ 756.00			$ 697.00	$ 390.00	$ 522.00		$ 821.00	$ 522.00	
Old Age Security/Guaranteed Income							$ 1,723.00			
Ontario Guaranteed Annual Income System [d]							$ 83.00			
Canada Child Benefit [e]	$ 1,235.00	$ 1,192.00	$ 248.00	$ 1,235.00						$ 1,375.00
GST/HST credit [f]	$ 78.00	$ 78.00		$ 78.00	$ 26.00	$ 32.00	$ 39.00	$ 51.00	$ 32.00	$ 78.00
Ontario Trillium Benefit [g]	$ 169.00	$ 169.00		$ 136.00	$ 75.00	$ 78.00	$ 117.00	$ 105.00	$ 78.00	$ 136.00
Canada Worker Benefit [h]		$ 159.00								$ 159.00
Employment Insurance paid [i]		$ (44.00)	$ (137.00)							$ (44.00)
Canada Pension Plan paid [j]		$ (143.00)	$ (464.00)							$ (143.00)
Climate Action Incentive Payment (CAIP)[k]	$68.00	$68.00	$68.00	$60.00	$34.00	$34.00	$34.00	$51.00	$34.00	$60.00
Pregnancy/Breast-feeding Nutritional Allowance (non-lactose intolerant)									$40.00	
Total Income	**$ 2,800.00**	**$ 4,166.00**	**$ 9,290.00**	**$ 2,566.00**	**$ 868.00**	**$ 1,372.00**	**$ 1,996.00**	**$ 2,437.00**	**$ 1,412.00**	**$ 4,308.00**
Selected Expenses										
	(3 Bdr.)	(3 Bdr.)	(3 Bdr.)	(2 Bdr.)	(Bachelor)	(1 Bdr.) [p]	(1 Bdr.)	(1 Bdr.)	(1 Bdr.)	(2 Bdr.)
Average Monthly Rent (may or may not include heat/hydro) [l]	Not available	Not available	Not available	$ 1,021.00	$ 610.00	$ 882.00	$ 882.00	$ 882.00	$ 882.00	$ 1,021.00
Food [m]	$ 1,122.43	$ 1,122.43	$ 1,122.43	$ 824.54	$ 404.58	$ 404.58	$ 289.34	$ 673.17	$ 383.72	$ 682.88
Total Selected Expenses	**$ 1,122.43**	**$ 1,122.43**	**$ 1,122.43**	**$ 1,845.54**	**$ 1,014.58**	**$ 1,286.58**	**$ 1,171.34**	**$ 1,555.17**	**$ 1,265.72**	**$ 1,703.88**
Funds Remaining (for other basic needs e.g. telephone, transportation, child care, household and personal care items, clothing, school supplies etc.)	**$ 1,677.57**	**$ 3,043.57**	**$ 8,167.57**	**$ 720.46**	**$ (146.58)**	**$ 85.42**	**$ 824.66**	**$ 881.83**	**$ 146.28**	**$ 2,604.12**
Percentage of income required for rent	#VALUE!	#VALUE!	#VALUE!	40%	70%	64%	44%	36%	62%	24%
Percentage of income required to purchase healthy food	40%	27%	12%	32%	47%	29%	14%	28%	27%	16%

Note: All dollars rounded to nearest whole number.

Scenario References:

Scenario 1 - 2 adults (male and female ages 31-50), 2 children (girl age 8, boy age 14); Ontario Works (OW).
Scenario 2 - 2 adults (male and female ages 31-50), 2 children (girl age 8, boy age 14); income is based on one minimum wage earner, 40hr/wk, $15.50/hr (minimum wage in May 2023).
Scenario 3 - 2 adults (male and female ages 31-50), 2 children (girl age 8, boy age 14).
NOTE: Income from employment is based on median after-tax income- couples with children; however, EI and CPP contributions are calculated using median total income- couples with children. Assumption of a dual income family with a split of 65% / 35% between partners.
Scenario 4 - 1 adult (female age 31-50), 2 children (girl age 8, boy age 14); Ontario Works.
Scenario 5 - 1 adult (male age 31-50); Ontario Works.
Scenario 6 - 1 adult (male age 31-50); Ontario Disability Support Program (ODSP).
Scenario 7 - 1 adult (female age 70+); income based on Old Age Security and Guaranteed Income Supplement (OAS/GIS).
Scenario 8 - 2 adults (male and female age 31-50); Ontario Disability Support Program (ODSP).
Scenario 9 - 1 adult (female pregnant 19-30); Ontario Disability Support Program (ODSP).
Scenario 10 - 1 adult (female age 31-50), 2 children (girl age 3, boy age 4); income is based on one minimum wage earner, 40hr/wk, $15.50/hr (minimum wage in May 2023).

a- Due to the Northern Ontario Energy Credit portion of the Ontario Trillium Benefit (OTB), this spreadsheet is applicable for Ontario excluding the districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Rainy River, Sudbury (including the City of Greater Sudbury), Thunder Bay, and Timiskaming.

b - Basic and maximum shelter allowance. Ontario Works (OW) and Ontario Disability Support Payment (ODSP) rates as of May 2023. Source: Social Assistance, Pension and Tax Credit Rates April to June 2023 Ministry of Children, Community and Social Services. https://www.odph.ca/upload/membership/document/2023-06/april-june-2023-social-assistance-pension-tax-credit-rates_1.pdf#upload/membership/document/2023-06/april-june-2023-social-assistance-pension-tax-credit-rates_1.pdf https://www.odph.ca/upload/membership/document/2023-09/social-assistance-pension-tax-credit-rates-brochure-october-to-d.pdf#upload/membership/document/2023-09/social-assistance-pension-tax-credit-rates-brochure-october-to-d.pdf (Acccessed 16 Oct 2023).

c - Old Age Security and Guaranteed Income Supplement (OAS/GIS) rates as of May 2023. Source: Social Assistance, Pension and Tax Credit Rates April to June 2023. https://www.odph.ca/upload/membership/document/2023-06/april-june-2023-social-assistance-pension-tax-credit-rates_1.pdf#upload/membership/document/2023-06/april-june-2023-social-assistance-pension-tax-credit-rates_1.pdf (Accessed 16 October 2023).

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e - Canada Child Benefit (CCB) includes Canada Child Benefit monthly amount, and Ontario Child Benefit monthly amount. Figures derived from Child and Family Benefits Calculator https://www.canada.ca/en/revenue-agency/services/child-family-benefits/child-family-benefits-calculator.html for Tax Year 2021 (accessed 16 October 2023).

f - Based on net annual income. GST/HST is issued on a quarterly basis, but calculated on a monthly basis. Figures derived from Child and Family Benefits Calculator https://www.canada.ca/en/revenue-agency/services/child-family-benefits/child-family-benefits-calculator.html for Tax Year 2021 (accessed 16 October 2023).

g - Ontario Trillium Benefit (OTB) includes Ontario Energy and Property Tax Credit, the Northern Ontario Energy Credit, and Ontario Sales Tax Credit. Based on average apartment rental rates for Ontario and net annual income in 2021. Benefit is issued on a monthly basis. Figures derived from Child and Family Benefits Calculator https://www.canada.ca/en/revenue-agency/services/child-family-benefits/child-family-benefits-calculator.html for Tax Year 2021 (accessed 16 October 2023).

h - Canada Worker Benefit. Eligiblity with net income less than $42,197 (2021 tax year Basic CWB for eligible dependants) ARCHIVED - 5000-S6 Schedule 6 - Canada Workers Benefit (for all except QC, AB, and NU) - Canada.ca https://www.canada.ca/content/dam/cra-arc/formspubs/pbg/5000-s6/5000-s6-21e.pdf (accessed 04 October 2023).

i - EI premium rates and maximums 2023. https://www.canada.ca/en/revenue-agency/services/tax/businesses/topics/payroll/payroll-deductions-contributions/employment-insurance-ei/ei-premium-rates-maximums.html (accessed 04 October 2023).

j - CPP contribution rates, maximums and exemptions 2023. https://www.canada.ca/en/revenue-agency/services/tax/businesses/topics/payroll/payroll-deductions-contributions/canada-pension-plan-cpp/cpp-contribution-rates-maximums-exemptions.html (accessed 04 October 2023).

k - Climate Action Incentive Payment Amounts. Based on rate for living outside a Census Metropolitan Area (CMA). Benefit is issued on a quarterly basis. Figures derived from Child and Family Benefits Calculator https://www.canada.ca/en/revenue-agency/services/child-family-benefits/child-family-benefits-calculator.html for Tax Year 2021 (accessed 16 October 2023).

l - Rental Market Report. Canada Mortgage and Housing Corporation, Oct 2022. Some communities may need to add utility costs. https://www03.cmhc-schl.gc.ca/hmip-pimh/en/TableMapChart/Table?TableId=2.1.31.2&GeographyId=35&GeographyTypeId=2&DisplayAs=Table&GeograghyName=Ontario#Apartment (accessed November 1, 2023).

m - Reference: Ontario Nutritious Food Basket data 2023 for Haldimand-Norfolk Health Unit - Includes Family size adjustment factors.

n - Reference: Minimum wage. https://www.ontario.ca/document/your-guide-employment-standards-act-0/minimum-wage (accessed 04 October 2023).

o - Source: Statistics Canada. Table 11-10-0190-01 Market income, government transfers, total income, income tax and after-tax income by economic family type (accessed 04 October 2023).

p- Housing for Scenario 6 was changed from a Bachelor apartment in 2010 to 1-bedroom in 2011. This change reflects a more accurate housing need for persons with a disability.

Table adapted from Ministry of Health Promotion. (2010). Nutritious food basket guidance document. Retrieved from http://www.ontla.on.ca/library/repository/mon/24006/302017.pdf
Excel document developed by North Bay Parry Sound District Health Unit.
Updated by Ontario Dietitians in Public Health Food Insecurity Work Group, October 2023

FOOD AFFORDABILITY
IN HALDIMAND & NORFOLK COUNTIES

Health and Social Services
Haldimand and Norfolk

In 2021-2022, about **1** in **6** households in Haldimand and Norfolk Counties experienced food insecurity[1].

For children in Ontario, almost **1** in **4** lived in food insecure households[2].

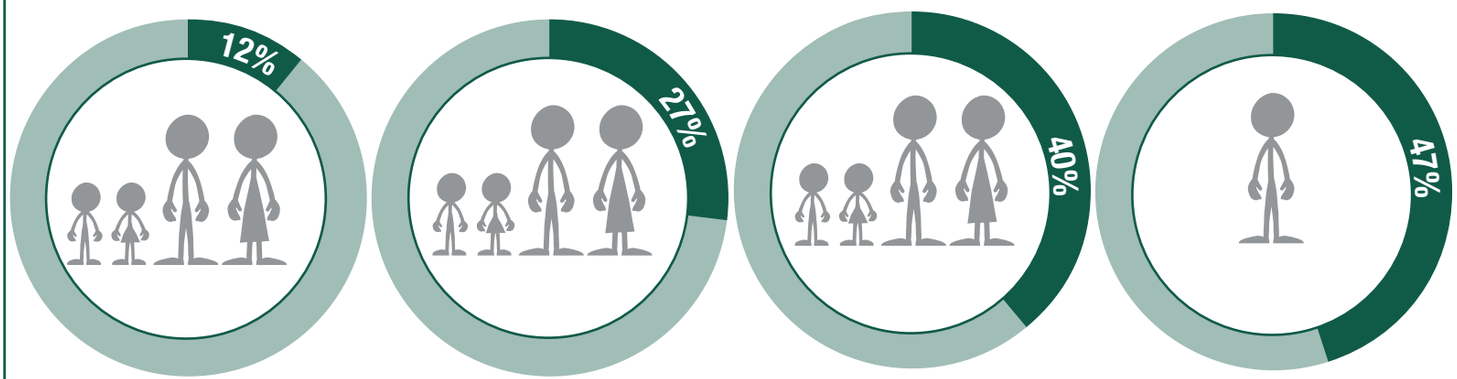
FOOD INSECURITY = Not having enough money to buy food

Why is food insecurity such a serious public health problem? Food insecurity has been associated with[3]:

Chronic Diseases | Infectious Diseases | Injury | Poor Oral Health | Poor Mental Health | Premature Death | Higher Healthcare Costs

In 2023, the average monthly cost of a healthy diet for a family of four in Haldimand and Norfolk Counties was **$1122.43**[4].

What percentage of income does it take for people in Haldimand and Norfolk Counties to follow a healthy eating pattern?



12% of income for a family of four earning a median income

27% of income for a family of four with a full-time minimum wage earner

40% of income for a family of four with an Ontario Works recipient

47% of income for a single male on Ontario Works

Solutions that focus on income can make a lasting impact. **What can you do?**

1. **Be aware.** Visit hnhu.org/food-insecurity to learn more.
2. **Advocate** for income solutions, such as adequate social assistance rates, affordable childcare and affordable housing. Talk to your MP or MPP about these important issues.
3. **Donate** time, skills or money to local organizations that support people whose income does not meet the cost of living.
4. **Support** local businesses that provide a living wage.
5. **Share** these messages with others.

1. Statistics Canada, Canadian Income Survey. Custom table C1143221. Canadian Income Surveys (CIS) 2018, 2019, 2020, and 2021. Available from: Household Food Insecurity Snapshot | Public Health Ontario
2. Li T, Fafard St-Germain AA, Tarasuk V. (2023) Household food insecurity in Canada, 2022. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from https://proof.utoronto.ca/
3. Tarasuk, V., Cheng, J., de Oliveira, C., Dachner, N., Gundersen, C., & Kurdyak, P. (2015). Association between household food insecurity and annual health care costs. Can Med Assoc J. 187(14), E429-E436.
4. Haldimand Norfolk Health and Social Services (2023). Ontario Nutritious Food Basket Survey.

Board of Health Meeting – March 05, 2024

Advisory Committee Meeting – February 26, 2024

Subject:	Rabies Program Update 2022-2023
Report Number:	HSS-24-006
Division:	Health and Social Services
Department:	Public Health
Purpose:	For Information

Recommendation(s):

THAT the report HSS-24-006 regarding the Rabies Program Update 2022-2023 be received as information;

AND THAT the Board of Health support the HNHU's Rabies Prevention Program activities which include rabies response investigations and risk assessments, testing, surveillance, and education regarding rabies illness and prevention strategies to mitigate risk.

Executive Summary:

This report provides information about the Haldimand-Norfolk Health Unit's (HNHU) comprehensive Rabies Prevention Program. Rabies is a preventable fatal disease that attacks the nervous system. Due to the prognosis of nearly 100% fatality of a preventable illness from the rabies virus, HNHU's Public Health Inspectors (PHIs) provide 24-hour response to address potential human exposures. The purpose of the Rabies Prevention Program is to investigate incidences of potential exposures and conduct risk assessments. Based on the results of the risk assessments, management strategies for exposed individuals may be initiated. In addition to rabies response, Public Health Inspectors address inquiries from the public and provide education as well as referrals to partner agencies. The Haldimand Norfolk Health Unit collaborates with public and agency partners to manage suspect cases as well as assist with surveillance of the virus in Ontario.

Discussion:

Rabies is a fatal viral disease that attacks the nervous system of all warm-blooded animals, including humans. Rabies illness can be prevented with treatment with Post Exposure Prophylaxis (PEP) when addressed within 10 days of potential exposure before symptoms occur.

Transmission

Rabies is transmitted through the saliva or brain/nervous system tissue of an infected animal and is commonly found in raccoons, foxes, skunks, bats, cats, dogs and cattle. Most exposures result from a bite or scratch. Transmission can also occur from saliva or neural tissue being introduced into fresh, open cuts or scratches in skin or onto mucous membranes (e.g., eyes, nasal passages). Unfortunately, once symptoms appear, the disease is nearly 100% fatal and animals do not have to show symptoms before transmission of the virus can occur. This is why it is imperative to initiate treatment after a potential exposure as this virus can be treated with Post Exposure Prophylaxis (PEP), in collaboration with primary health care providers.

Symptoms

Symptoms in animals may present in two different forms: paralytic (dumb) or furious rabies.

- Animals displaying symptoms of paralytic rabies may have difficulties walking, swallowing, appear to be drooling or unbalanced, and may act unafraid of humans.

- Animals displaying symptoms of furious rabies may behave in an anxious or excited manner, may appear aggressive or violent, and may be foaming at the mouth.

Post Exposure Prophylaxis

A full course of post exposure prophylaxis (PEP) includes rabies vaccine, which is administered on a standard schedule of Day 0, Day 3, Day 7, and Day 14 (Day 28 if immunocompromised) to provide protection against the virus. On Day 0, Rabies Immune Globulin (Rablg) is also administered. The amount of Rablg is based on the client's weight and is typically injected around the wounded area. The antibodies provide immediate passive protection until the individual develops an immune response from the vaccine. It is important to adhere to the vaccine schedule because failure to do so may reduce the effectiveness of PEP.

Administration of PEP is recommended based on a risk assessment of the potential exposure reported. In 2023, PEP was provided to 51 potentially exposed individuals in Haldimand and Norfolk Counties. In 2022, PEP was administered to 33 individuals.

HNHU's Role

Rabies virus is found within the wildlife population throughout Haldimand and Norfolk Counties. The Health Unit responds to all reported potential human exposures to rabies from wild and domestic animals. Public Health Inspectors follow the guidance outlined by the Ministry of Health in the *Management of Potential Rabies Exposures Guideline, 2020.* In 2023, a total of 478 potential rabies exposure reports were received. Follow-up

must be initiated within 24 hours as per ministry requirements due to the severity of the illness. Public Health Inspectors are available 24 hours a day to immediately respond to suspected rabies exposures with the utilization of our on-call system.

By law, all persons aware of an incident where rabies may have been transmitted to a person must report the incident to the Health Unit. In most instances, healthcare providers, veterinarians, animal control workers and the police will report such incidents, but any person can do so. The Health Unit works to help assess the risk of rabies in the individual exposed. Following notification, Public Health Inspectors will assess the incident and take action to protect the victim from acquiring rabies. Actions taken by the Health Unit depend on the type of animal involved, as well as the animal's history. The Health Unit begins the assessment by contacting the potentially exposed individuals, pet owners, medical professionals and other applicable people involved in the exposure. During this initial assessment, the Public Health Inspector investigates the case by collecting preliminary information such as history of the animal, circumstance of the incident, vaccination status of the animal, and condition of the exposed individual. Based on the findings of the risk assessment, management for the potentially exposed individual will be initiated.

If the incident involves a wild animal, and that animal is available, it can be humanely euthanized and tested for the rabies virus to confirm if the person has been exposed. If the animal involved in the potential exposure is a domestic dog or cat, the Health Unit will confine the animal for 10 days, usually on the pet owner's property, to rule out transmission at the time of the exposure.

If a domestic pet is alive and healthy in appearance at the end of the 10-day confinement period, it is unlikely rabies was transmitted to the person during the exposure. Public Health Inspectors conduct visual site visits at both the beginning and end of the confinement period to verify the animal's health status. If the domestic pet becomes sick or goes missing during the 10-day confinement period, the exposed person is advised to contact their healthcare provider to discuss obtaining post exposure prophylaxis.

In the case of stray animals, and animals not available for confinement, the Health Unit is unable to rule out exposure to the rabies virus, therefore the individual is advised to consult their health care provider. The Health Unit communicates the risk of rabies exposure to the victim and/or medical professionals, and the medical professionals then work with the individual to determine if PEP should be administered. High risk cases and those individuals exposed to animals positive for the rabies virus are advised to receive PEP, which is provided by the Health Unit and administered by the healthcare provider. Animals that are deceased after potential rabies exposure may be tested for the rabies virus.

The Health Unit is able to submit specimens through partnership with the Ontario Association of Veterinary Technicians (OAVT) who assist with specimen collection. In

addition, the Health Unit works with veterinarian clinics and animal control agencies to assist with capturing animals if applicable and/or euthanasia.

In 2023, a total of 18 specimens were submitted for rabies testing, none of these have tested positive for rabies. In 2022, there were 32 animals submitted for testing. Of these, three specimens were laboratory confirmed positives which were all bats. Of note, unlike other mammals, bats cannot be vaccinated using baits. In addition, the small teeth of bats make it difficult to identify a bite. For these reasons risk assessments involving bats can be more difficult to assess and is why the ministry's Algorithm for Bat Exposures and PEP Administration is used.

The Ministry of Natural Resources and Forestry (MNRF) distributes rabies vaccine-containing bait within Haldimand-Norfolk Counties to help protect local wildlife from contracting and spreading the virus. Bait containing the rabies vaccine is distributed by air or by hand within control zones. Control zones are located within 50km of a rabies positive animal case. The Health Unit works with the MNRF to establish control zones by providing location details for positive rabies cases that have occurred within the last two years within the Health Unit's jurisdiction. If the rabies vaccine-containing bait is consumed by a domestic animal, protection against the virus is not acquired.

Public Inquires and Education

Public education occurs through media releases and social media advertisements as well as during investigations or responding to specific public inquiries.

The HNHU responds to public inquiries and educates the public on transmission, signs and symptoms of an infected animal and how to prevent exposure to a rabies positive animal. If an animal is determined to be infected with the rabies virus, the inquiry is forwarded to the MNRF for surveillance purposes.

The HNHU also responds to public inquiries regarding animal-to-animal exposures (e.g., pets encounter with a wild animal), suspect rabid animals with no human exposure, and diseased animals. The Health Unit provides education through media releases and social media advertisement and through specific inquiries. Public Health Inspectors are also able to refer cases or incidences to the correct agency. This may be their veterinarian, the Ontario Ministry of Agriculture and Rural Affairs (OMAFRA), an animal control agency, or the MNRF.

Humans are not typically exposed to the rabies virus directly through infected wildlife; however, pets can present opportunity for infection as they may encounter wildlife more often than humans. While Public Health Inspectors conduct risk assessments of rabies investigations, verifying rabies vaccination status of pets is also done. If an animal is not current on their rabies vaccination at the time of the incident, Public Health Inspectors follow-up to ensure they are brought up to date by the end of the investigation, as pets commonly act as a link between wildlife and humans.

Rabies Prevention Program Plans for 2024

The HNHU will continue to conduct routine follow-up for investigations, consult with external agencies and partners, as well as continue provide education to the public through media releases and social media campaigns.

Financial Services Comments:

Norfolk County

There are no direct financial implications within the report as presented.

The Rabies Prevention Program is one of many programs offered by the Environmental Health Team (EHT). The Approved 2024 Haldimand-Norfolk Health Unit operating budget includes $1,992,400 for the EHT, funded in line with the Ministry of Health's most recent amending agreement (2023) with respect to Mandatory Programs. Any levy costs for the Health Unit are shared between Haldimand and Norfolk as per the arbitration agreement.

Haldimand County

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

Interdepartmental Implications:

Haldimand County

Haldimand staff have reviewed the report and have no additional comments.

Consultation(s):

Strategic Plan Linkage:

This report aligns with the 2022-2026 Council Strategic Priority Empowering Norfolk - Putting the tools and resources in place to ensure our businesses' and residents' success

Explanation: The Haldimand Norfolk Health Unit's Rabies Response Program ensures residents of Haldimand and Norfolk counties are empowered with knowledge on how to protect themselves against the rabies virus through education and 24/7 response to

bite/scratch report by Public Health Inspectors to prevent infection in the case of potential exposure.

Conclusion:

The rabies prevention program will focus on the public health services required to protect the health of the community. The key is prompt follow-up, public awareness and education, with the goal of assessing the risk of rabies transmission to the individual exposed.

Attachment(s):

N/A

Approval:

Approved By:
Sarah Page
General Manager, Health and Social Services

Reviewed By:
Syed Shah
Director of Public Health

Prepared By:
Alexis Atkinson
Program Manager, Environmental Health

Council-In-Committee Meeting – March 19, 2024

Advisory Committee Meeting – February 26, 2024

Subject:	Ontario Works Service Plan 2024
Report Number:	HSS-24-004
Division:	Health and Social Services
Department:	Social Services and Housing
Purpose:	For Decision

Recommendation(s):

That staff report HSS-24-004 be received as information; and

That Council direct staff to submit the Ontario Works Service Plan for 2024 to the Ministry of Children, Community and Social Services (MCCSS) for approval.

Executive Summary:

The Ministry of Children, Community and Social Services (MCCSS) and Social Assistance (SA) delivery sites share the common goal of improving employment results for people relying on social assistance. This service plan is the tool used for Social Assistance delivery sites to document the service planning required activities, including the strategies to achieve performance outcomes.

Receipt of Ontario Works funding from the MCCSS is contingent upon the completion of a Service Plan. The 2024 Service Plan (attached to this report) is to be submitted to MCCSS along with the annual budget submission.

Discussion:

The Ontario Works Service Plan provides an opportunity for SA delivery sites to demonstrate linkages between local service delivery and provincial investments to support the delivery of Ontario Works (OW). SA delivery sites will be accountable for developing a service plan that clearly describes what is to be achieved within the service contract period. The service plan outlines the delivery site's strategies towards meeting performance outcome targets, while taking into consideration internal resources, caseload demographics, community needs in relation to social assistance and high risks to achieving performance outcome targets. The province will work in

collaboration with SA delivery sites, taking a proactive and supportive role to increase accountability and success in meeting set outcome targets.

The development of the attached Service Plan was completed by the Ontario Works management team and our Norfolk County colleagues in Financial Management & Planning; guided by the vision, mandate, and guidelines set by the MCCSS.

Vision

Our vision is to create an efficient, effective, and streamlined social services system that focuses on people, providing them with a range of services and supports to respond to their unique needs and address barriers so they can move towards employment readiness and independence, where possible.

Mandate

To provide employment assistance and financial assistance, including person-centered supports and services and supports to those in financial need.

The Ontario Works program:

- recognizes individual responsibility and promotes self-reliance through employment
- provides financial assistance to those most in need while they meet obligations to become and stay employed
- effectively serves people needing assistance
- is accountable to the taxpayers of Ontario

Service plans are to reflect:

- The needs of the community, including service gaps that may impact the achievement of performance outcomes
- The structured approach to identify high risk areas that may impact achievement of performance outcomes*(*see notes below on performance outcomes)*
- The strategies that SA delivery sites will undertake to achieve performance outcomes and should consider the internal resources, community needs, caseload demographics, and high-risk areas
- Linkage to French Language Services strategy(if applicable) and an Equity, Diversity, and Inclusion Strategy

**Performance outcome targets for the Employment Transformation Sites (EST) have been set and provided by the MCCSS.*

Performance Outcome Targets for Haldimand-Norfolk:

1. Ontario Works adults and Ontario Disability Support Program (ODSP) non-disabled adults with participation requirements have an Action Plan: 100%

2. Ontario Works adults and ODSP non-disabled adults with participation requirements are referred to Employment Ontario (EO): 33%
3. Ontario Works cases exit to employment: 12%
4. Cases that exit Ontario Works do not return to the program within one year: 20%

These targets were set based on the best year performance of either 2021 or 2022 outcomes for Haldimand-Norfolk.

The Service Plan includes the completion of the activities under the following four sections:
1. Conduct community analysis
2. Review performance outcome targets
3. Develop service strategies
4. Manage program delivery

Ontario Works Case managers work with the clients to complete an Action Plan and in doing so assess the client for readiness for employment; allowing staff to determine if a referral to Employment Ontario is appropriate. If a referral is not appropriate, Life Stabilization supports and services are determined to address barriers to employment referral readiness. Case Managers work collaboratively with Community Support Workers, Employment Ontario staff, Social Services and Housing staff, and community agency partners to support clients along the path to employment.

Life stabilization supports are services that support an individual in attaining stable living conditions, community inclusion and readiness for employment. It includes providing a continuum of supports and services to people in financial need, while recognizing individual responsibility and promoting self-reliance. All of these factors are important in supporting an individual along their path towards employment.

Financial Services Comments:

Norfolk County

There are no direct financial implications within the report as presented.

The Ontario Works Service Plan is largely focused on program delivery, with a few items that required financial input. The Budget Submission that accompanies the Service Plan is completed by Financial Management & Planning.

The 2024 Budget Submission is being proposed to MCCSS as it was approved by Norfolk County Council. Net expenditures for the program total $4,690,200 with revenues provided by MCCSS ($2,390,100) and the shared Haldimand and Norfolk levies ($2,300,100).

In addition to the base budget, the approved new budget initiative for a temporary full time Senior Case Manager, scheduling software and pilot service delivery materials has been included. The pre-approved MCCSS funding for this project is $98,300, with the shared levy providing a matching amount, for a total cost of $196,600.

The share of levy costs will change between the budget and the final year-end reconciliation, however the current share for Ontario Works (inclusive of one-time funding) is estimated at $954,200 for Haldimand and $1,444,200 for Norfolk.

Haldimand County

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

Interdepartmental Implications:

Haldimand County

The report and Service Plan have been reviewed and staff have no additional comments.

Consultation(s):

The Ontario Works Service Plan was completed via collaboration with members of our Financial Management & Planning team.

Strategic Plan Linkage:

This report aligns with the 2022-2026 Council Strategic Priority Serving Norfolk - Ensuring a fiscally responsible organization with engaged employees who value excellent service.

Explanation: The delivery of the Ontario Works program provides financial and life stabilization assistance to people in financial need.

Conclusion:

The Ontario Works Service Plan for 2024 must be submitted to the MCCSS in order to secure on-going funding. The Service Plan is a living document, reviewed by the Haldimand & Norfolk Social Services Management Team on a regular basis. If necessary, adjustments to targets will be made to reflect any major changes in our local environment.

Attachment(s):

- OW Service Plan 2024

Approval:

Reviewed and Approved By:
Sarah Page
General Manager,
Health and Social Services

Prepared By:
Stephanie Rice
Director,
Social Services and Housing

Ontario

Ontario Works Service Planning Template

2024

Table of content

Overview

The Ministry of Children, Community and Social Services (MCCSS) and Social Assistance (SA) delivery sites share the common goal of improving employment results for people relying on social assistance. This service plan template is the tool used for SA delivery sites to document the service planning required activities, including the strategies to achieve performance outcomes.

How to use this template

This template is **used in conjunction with the Main Guidelines Document**, which outlines key information, including required and optional planning activities.

This template is mandatory and is to be completed using the allotted space and uploaded to TPON as part of the service agreement.

Corresponding Guides, Tools, and Templates

Please refer to the following guides/tool if you require assistance:

1. Main Guidelines Document
2. Supplementary Guidelines Document
3. Community Service Inventory Tool (optional)
4. Performance Outcomes Risk Assessment Template
5. Privacy Risk Assessment and Privacy Maturity Self-Reporting Tool

Section 1 – Conduct Community Analysis

In this section, SA delivery sites provide a summary of the community context in which Ontario Works person-centered supports and services and employment assistance is delivered over the four-year service planning period.

1.1 Key Caseload Demographics

Enter a **focused overview of the key findings** from the current demographic composition of the caseload and anticipated changes over the service plan cycle:

Enter a focused overview of key caseload findings (500 words max recommended)
1. Caseload increase by 11.7% in 2023. • This shows the growth within our municipality in relations to caseload size for Case Managers. While our caseload has grown, our staffing compliment has remained the same. 2. 67% of the caseload are singles without children. • This reflects the population of client's services in Haldimand and Norfolk counties. Individuals are assessed individually, and plans created per the employment service transformation guidelines. 3. 62% of the caseload has been on assistance for more than 12 months. • Over half of our caseload has been on assistance for more than 12 months. Individuals would have been assessed for referral to for employment services previously or upon file transfer to office. Individuals are continually supported through case managers and other support staff. 4. 87% of the caseload is in a rental situation; 83% is private market and 4% subsidized. • This reflects the number of individuals in with private market rent. Through case management activities, rent vs shelter discussion occur on a frequent and regular basis. Many of the individuals residing in Haldimand and Norfolk County has rental/shelter expenses exceeding monthly entitlements for shelter. 5. 45% of the caseload have advised of a level Gr 12/13 education. • This reflects opportunity for further education and referral readiness. Many individuals will require pre-employment engagement.

1.2 Service Needs (EST Prototype sites only for 2024)

A **focused assessment of key service needs** (in relation to your caseload) that have linkages to meeting the performance outcomes:

Enter focused assessment of service needs (500 words max recommended)

1. As of November 2023: 82% of OW and ODSP (non-disabled adults) have a completed common assessment module 1.
   - As common assessments are completed with every individual at time of application or within 30 days, knowledge on individuals' readiness can be determined. Action Plans are developed once the common assessment is complete and will capture the individuals plan moving forward. Barriers are identified and worked on throughout this process.

2. As of November 2023: 91% of OW and ODSP (non-disabled adult) have an action plan completed.
   - Action plans and discussion on an individual's plan are completed for all individuals over the age of 18. These plans identify and acknowledge the needs of the individual. Many individuals will work closely with their SA Case Managers in the beginning and hope to transition to Employment Ontario for employment supports.

3. As of November 2023: 43.1% of OW and ODSP (non-disabled adults) referred to EO.
   - Individuals not referred are working on current barriers directly with supporting agencies. Ontario Works Case Managers are completing referrals based on individual circumstance and situation. Barriers identified include Mental Health, Housing, Education and Transportation.

4. As of November 2023: 18.69% of Ontario Works cases exiting OW for any reason
   - Of the 18.69% exiting OW, 6.39% were exiting to employment.

1.3 Community Needs Assessment

Use the information from your community needs assessment and parts 1-2 to identify the following as it relates to social assistance:

Strengths: Identify existing strengths and resources

1. Haldimand and Norfolk has a very strong relationship with local community partners who work together to support client needs. Some of these community partners: Employment Ontario, RAAM Clinic, Women's Shelter, ODSP, Learning Centre, Homelessness Prevention Services Department.

2. Strong communication and knowledge of programs offered by local agencies to support client needs. Team building exercises to build rapport with local agencies such as a day away spent with Service Provider, Employment Ontario/Fanshawe College in June 2023. Local agencies attend staff meetings where information can be shared, and relationships developed.

3. Completion of the Common Assessment: November 2023, 82% of the caseload had a common assessment completed by OW and ODSP/Non-Disabled Adult's. (Power BI report)

4. Completion of the Action Plan: November 2023, 91% of the caseload had a completed action plan for OW and ODSP/Non-Disabled Adult's (Power BI report)

5. As of November 2023, 41.3% of the caseload has been referred to Employment Ontario (Fanshawe College and St. Leonard's) (Power BI report)

6. Community Support Workers: working one on one with individuals to help reach their goals. The Community Support Workers are in the community, attending medical appointments and supporting individuals with their Ontario Disability Support Application
.
7. As of November 2023, Haldimand Norfolk had only 54 individuals deferred meaning recipients of Ontario Works and ODSP Non-Disabled Adults are participating towards a goal (Power BI report)

8. Resources in Haldimand and Norfolk supporting clients with Life Stabilization:
- Local hospitals (Simcoe, Hagersville & Dunnville)
- Addiction Services & Counselling (Alcoholics Anon & Al-Anon, Community Addiction & Mental Health Services of H&N, RAAM Clinics Simcoe and Dunnville, Holmes House)
- Mental Health & Counselling (Mental Health Helpline, Community Addiction & Mental Health Service of H-N, H-N REACH Child, Family, Adult Counselling
- Food Support (Norfolk and Haldimand)
- Supports for Education (H-N London Learning Centers, Grand Erie Learning Alternatives)

9. Community Drop-In Clinics in H&N: individuals can meet with their case manager in the community where they reside which supports transportation barriers and limits long distance travel in our rural communities.

10. Haldimand & Norfolk Health Unit: supporting individuals with community and school-based programs.

11. Internal business practices across programs (Homelessness Prevention Services and Children Services)

Gaps: Determine where there may be gaps in services or required resources

1. Mental Health- individuals wanting to access mental health services are facing challenges such as lack of transportation, cultural stigmatization, and language barriers. Other barriers include not knowing where/how to access help and long wait lists due to a shortage of accessible mental health professionals. Intentional self-harm rate for HN counties is 83 per 100,000 population which is significantly higher than for Ontario, 60 per 100,000 population (2022 CNA)

2. Housing- limited housing available, market rent has increased therefore is unobtainable for the individuals we support. Limited Homelessness Prevention Services staff (an estimate of approximately 36,000 people needing direct service for eleven full time staff in Haldimand Norfolk, this is based on 120,000 people across H N with an estimated 30% seeking service)

3. Education- Haldimand & Norfolk offer limited education for members in our community. Fanshawe College has 9 full time courses and The Haldimand & Norfolk Learning Centres in Simcoe and Dunnville support individuals with basic education, one on one tutoring, computer technology and literacy and basic skills. It is challenging for individuals to attend class due to transportation and childcare. All costs associated with the education plan may not be covered which creates additional challenges and barriers.

4. Transportation- transportation is limited in Haldimand & Norfolk and there is considerable distance when travelling from one rural community to the next (it takes 1 hour to drive from the West end of Norfolk County to the East end of Haldimand County- Homeless Enumeration 2021 in HN). Local taxi services are limited and expensive. For anyone owning a vehicle the cost of repairs, gas and vehicle insurance are obtainable for some, but not maintainable as a long-term solution.

Challenges: Common themes around concerns/challenges that impact SA

Mental Health

1. Individuals wanting to access mental health services are facing challenges such as lack of transportation, cultural stigmatization, and language barriers (5,000 Low-German speaking Mennonites reside in H N and approximately 4,200 residents identify as Indigenous CNA 2022). Other barriers include not knowing where/how to access help and long wait lists due to a shortage of accessible mental health professionals and facilities. (i.e. Crisis Stabilization Bed Program in Norfolk has 6 available beds with 24-hour staffing and short-term respite care for anyone 16 years and older)
2. Clients are not ready to be referred, however, for fear reprisal of their financial assistance, they agree to the referral. Once the appointment becomes available, they fail to attend and need to go back on the wait list.
3. Ontario Works Case Manager carrying a caseload of both financial and life stabilization does not allow sufficient time to build a rapport with clients, therefore the individual may not feel safe or confident to share personal information about themselves (current caseload size in HN is 110 to 120 benefit units).
4. Staff could benefit from more training surrounding Mental Health and Addictions which could support a better client pathway, however, still recognizing that a person needs to want the support and help with their mental health.
5. Due to the Covid-19 pandemic there are restrictions still in place, such as reduced in–person programming.

Housing

1. There is limited rent geared to income housing options to support the number of residents in our communities. This results in long wait lists, (7.9% of Haldimand County residents live in low-income households compared to 10.0% of Norfolk County residents CNA 2022).
2. When individuals cannot afford full market rent, circumstances often involve sharing accommodations with others, temporarily accessing someone's home for a short period of time and homelessness (hourly living wage for HN was $17.35 in 2021 CNA 2022).
3. Through the Emergency Shelter Program HN offers a 14-bed shelter.
4. In Haldimand Norfolk, 35% of participants reported not enough income to afford housing (Enumeration 2021).
5. Difficulties reaching the client due to homelessness, often clients do not have access to reliable technology.
6. Once a client enters the office, a face-to-face connection can be made, however with reduced in-office days and planned, scheduled appointments it can be challenging to see people. Planning appointments can become difficult due to the client being transient.
7. In Haldimand-Norfolk the Ontario Works Case Manager has a caseload of financial and life stabilization which does not allow sufficient time to meet with everyone in need.
8. More individuals in the office are searching for a staff member to support them with available housing (CNA 2022 5% of individuals stated they go to their Ontario Works office when in a crisis).

Education/Literacy

1. Once an individual meets with a Case Manager they will discuss education and employment. Often individuals have not completed grade 12 (22.8% residents of HN have not completed high school CNA 2022) and they are unable to read or write (17% of Canadian adults in 2021 scored in the lowest skill level for reading CNA 2022).

2. All costs associated with the education plan may not be covered which creates challenges and barriers.

3. Recipients are in need of money to cover costs for computer technology, childcare, transportation, and books. The limited amount of PB- ERE (Employment Related Expenses) is not enough to cover what is needed and the individuals do not have the ability to pay the extra funds.

4. Challenges have been met with the new Employment Services Transformation whereby the individuals working with Employment Ontario are still being provided what they need to succeed with employment and/or education. The Case Manager in the SA office is continuing to support the client, however, the PB-ERE is a limited amount which needs to be issued for Life Stabilization.

5. Haldimand-Norfolk's current amount of monthly PB-ERE is $100.00 per person who has active Life Stabilization goals.

Transportation

1. There is limited public transportation and affordable transportation for individuals who reside in Haldimand and Norfolk counties.

2. Transportation is a huge barrier for individuals needing to access Health and Social Services as well as community partners.

3. For individuals with a vehicle, the cost of gas and maintenance is not sustainable. The limited amount of Participation Benefits-Employment Related Expenses (PB-ERE) does not offer enough financial support for these ongoing costs.

4. Due to large rural areas like Haldimand-Norfolk limited transportation causes many challenges for individuals when attending a workshop, training program or employment. For individuals who cannot find reliable transportation they lose employment opportunities and are unable to attend or complete a workshop or training program.

5. Haldimand-Norfolk offers a vast selection of seasonal employment, however with limited transportation, individuals cannot get out to local farms, and therefore they miss the opportunity for employment.

6. In 2022, 10.62% of participants struggled to find transportation to and from work (CNA 2022)

7. Employment plans/outcomes would have greater success if public transportation were available.

8. Ride Norfolk is a single-tier ridership program offered only to the residents of Norfolk County. Daily ridership is 60 people per day with limited capacity of 5 routes.

9. Haldimand County residents do not have the use of Ride Norfolk and there are limited Taxi companies in the local area.

Opportunities: Current or upcoming opportunities that can be leveraged by SA

Community Drop-In Clinics

1. Supporting clients in the community. Staff are travelling to local libraries and community centres to offer support and services to individuals. SA staff will meet individuals in their own community to lessen the transportation barrier.
2. SA staff will team up with community partners for drop-in clinics (i.e. Women's Shelter and Rapid Access Addiction Medicine (RAAM Clinic)
3. With SA moving out into the community, this will enable more in-person supports to our most vulnerable community members.

Ride Norfolk

1. Ride Norfolk is a single-tier ridership program offered only to the residents of Norfolk County. Daily ridership is 60 people per day with limited capacity of 5 routes.
2. Bus passes are offered to SA recipients which supports the transportation barrier and even though ridership is limited it is still available to members in the community.
3. Increase in ridership and routes would be a benefit to SA recipients and will be suggested.

Haldimand-Norfolk Learning Centre

1. Offers occupational prep courses such as Early Childhood Education, Computer Technology Connect Programs and High School Credit Programs.
2. Ontario works PB-ERE (Employment Related Benefits) are available to support individuals with needed items such as books, backpack, and bicycle as a mode of transportation. To help the individual be successful.
3. Supporting the individual in preparation for a referral to Employment Ontario to move into employment or training workshops.

Employment Opportunities

1. SA Case Managers refer individuals to Employment Ontario who are employment and referral ready.
2. Collaboration between SA and EO to support the job seeker.
3. St. Thomas has an Auto Plant being built giving more employment opportunities to SA recipients.
4. NRStor Simcoe Battery Project is currently in the construction phase but will run in partnership with Six Nations of the Grand River Development Corporation. Over 900,000 hours of local employment. Enable Indigenous relationships and more collaborative partnership with Six Nations of the Grand River
5. Local businesses opening: Simcoe will be opening a Burger King and Delhi has current openings for A&W, Gas Bar, Pizza Hut, and M&M Meats
6. SA will continue to work with individuals interested in seasonal employment by referring to EO.
7. New business means more opportunities within our communities for individuals in receipt of assistance.

Community Support Workers

1. One on one support to individuals working towards life stabilization goals such as ODSP.
2. Continue building the CSW position around client pathways through the Action Plans

Monthly meetings with Employment Ontario (Fanshawe College and St. Leonard's)

1. SA will continue navigating next steps for individuals to grow and enhance the program for further success.
2. SA will continue to meet with team members as enhancements to the program are developed.

Employment Ontario/Social Assistance pilot

1. Employment Consultant, SA Case Manager and the client are working together in one meeting to support the client needs.
2. SA Case Manager can build more rapport with EO and the client.
3. Continue to work with the system programs (SAMS and CAMS) to better support the SA recipient as well as staff members in the EST Transition

Newcomers to Haldimand County

1. Mohawk College is offering English as a Second Language through the Haldimand library in the evenings. This will increase support to anyone new in our local area with a language barrier and SA will support with any benefits required.

Social Assistance Website

1. Created for individuals to further their understanding of the program.
2. SA will keep the website up to date and share any new information for individuals seeking support.

Internal Business Practices and Programs

1. In-house programs with Homelessness Prevention Services and Children's Services will provide inclusive support for anyone seeking housing assistance and childcare.

Ontario Disability Program

1. Ongoing connections with ODSP staff
2. Continue monthly meetings to build enhancements to our programs to better serve individuals.

Section 2 – Review Performance Outcome Targets

Enter the ministry prescribed targets in the "Outcome" section in the budget submission in TPON.

Section 3 – Develop Service Strategies

This section establishes the contracted expectations of all SA delivery sites and connects the first two planning components (i.e., community analysis and performance outcome targets).

3.1 Risk Assessment

Complete the risk assessment using the **Performance Outcomes Risk Assessment template**. For more information refer to the Main Guidelines document

3.2 Equity, Diversity, and Inclusion Strategy

Part A: Articulate specific tactics that will consider the needs of equity seeking groups from the initial service planning stages through to delivery.

Enter the local equity, diversity, and inclusion strategy here (500 words max recommended)
Develop a local equity, diversity, and inclusion strategy by: 1. Providing learning opportunities for staff (the first to occur in early 2024) 2. Review of policies and procedures to ensure they are inclusive. 3. Review of locally created forms to ensure they meet AODA standards. 4. Develop a method to have periodic consultation with equity seek groups to obtain feedback on gaps or service improvements that could be made.

Part B: Complete the French Language Services strategy using the ministry provided templates. For more information refer to the Main Guidelines document.

We are not a designated French Language site.

3.3 Logic Model

A logic model maps the linkages between services delivered and performance outcomes. It is a tool to support how service strategies will help to achieve targets and is included as part of the Service Planning template.

Complete one logic model for each of the 4 performance outcomes. For 2024, only complete the "Highest Risk(s) Mitigation" section for only the two identified outcomes. Add or remove rows, as needed. Refer to Main Guidelines Document, Appendix # for completed example.

Definitions:

a. **Inputs:** Describe the organizational, community and/or external inputs within your organization used to coordinate services to meet the stated performance outcome (e.g., staffing, internal processes, training, relationship with community organizations, gaps in services, etc.).

b. **High Risk:** Identify the highest risks as indicated in the Performance Outcomes Risk Assessment Template. Note for 2024, this will only be applicable to 2 performance outcomes and will be indicated on the applicable logic model templates.

c. **Activities:** Operational and strategic activities (e.g., processes, tools, events, actions, etc.) that will be carried out as part of the strategy (e.g., staff training, recruitment, staff supports, community relationships, retention strategies, workshops, etc.).

d. **Expected outputs linked to outcome:** What are your expected results given the planned activities and what changes do you expect to realize?

Performance Outcome 1: Ontario Works adult and ODSP non-disabled adults with participation requirements have an Action Plan		
Inputs (e.g., organization, community, external)	Operational and Strategic Activities	Expected Outputs
1. Training and learning development for staff	1. Ongoing 'refresher' training in various areas related to action planning. • Maximizing the training video/ supplemental items from the Ministry on dedicated EST page. • Developing and creating training to focus on local gaps and solution-based direction on how to support individuals in Haldimand and Norfolk Counties with known gaps in mind. • Ensure investing in staff (not just newly onboarded Case Managers) with planned sessions advertised to staff. • 'Hot Topic' training sessions have started to be offered locally- these target areas identify through survey by front line staff. 2. Further review and investigation into localized Framework • Continue to build on the Framework previously developed in early 2023. • Provide local job aid and resources to staff on a continued basis. 3. Ongoing connection with ODSP staff to engage in supportive approaches for NDAs. • Continue to engage in bi-weekly meetings. • Case coordination for benefits on an ongoing basis between OW case manager and ODSP case worker.	• With better understanding, better action plans may be created efficiently. • Equipping front line staff with the resources in the local community will allow increase referral rate and faster action planning with individuals.
1. Changes to service delivery Individuals do not always have access to transportation or telephone for remote appointments	1. Offering community-based appointments to recipients on Ontario Works. 2. Leveraging our local community drop-in program to complete action plans. • Privacy and confidentiality would be acknowledged. • Safety will be a priority.	• Individuals being seen faster as staff can accommodate meeting individuals in their local community. • In person meetings will create ability to complete various assessments/referrals on the spot

	3. Work directly with community agencies offering supports in person at various sites. • Leverage the opportunity offered from community providers to complete appointments on site with confidentiality/consent in mind. • Complete wrap around meetings as appropriate. • Continue to refer as needed. 4. Update to local office public website to equip public access to information pertaining to supports provided by local office.	• Resources to be readily provided by staff in person (in a way that works for the individual.
1. Caseload structure/planning • The financial component of the programs continues to be a large administrative burden for the staff and often results in action planning not being a priority	1. Continue to investigate opportunity locally for changes to caseload structure. 2. Continue to encourage staff to utilize risk-based case management practice to lessen the financial administrative burden. 3. Leveraging existing Community Support Worker (CSW) position as it relates to life stabilization and action planning. • Provide training to this team of staff on the technical components of the action plan in SAMS. • CSWs already complete many of the supportive pathways with the individuals they are working directly with (including completing referrals) so enhancing their SAMS function for files will allow more time for the Case Manager to follow the financial components.	• If able, dedicated staff focused solely on action planning will allow more available appointment times for OW recipients. • Closer management of support services by staff that are working closely and on a more regular basis with vulnerable individuals (CSWs meet on a more regular basis with individuals). • More availability for meetings will allow stronger supports being offered including more assistance with navigation of supports and services.
Highest Risk(s) from Risk Assessment Template (applicable to the two in the risk assessment only): 1.1 Policies and procedures are in place to create action plan with a client not easily understood by staff. Priority Rating: 12 – Medium High		

Performance Outcome 2: Ontario Works adult and ODSP non-disabled adults with participation requirements are referred to EO		
Inputs (e.g., organization, community, external)	Operational and Strategic Activities	Expected Outputs
1. Limited access to transportation • Many individuals do not have access to transportation thus making it difficult to obtain employment/attend meetings.	1. Continue to work with service providers and gain knowledge into itinerate services offered in communities . 2. Build action plan around goals associated with obtaining access to transportation. 3. Benefit coordination to support with virtual options (i.e.: internet, phone etc.) 4. Leverage Community Drop-In to complete necessary appointments. • This means scheduling mandatory appointments/connection in individuals' local community on community drop-in days.	• Individuals are supported in removing barriers associated with transportation. • Individuals are provided alternates to achieve meaningful connections although transportation continues to be a barrier. This may include connecting virtually and being supported in gaining remote employment/training.
2. Increased volume of Newcomers to Haldimand. Limited access/ability by SP to support. • Language barrier is present. Initially advised SSM would fund interpretation services but have now been advised this is not happening at this time.	1. Work with service providers/ service system managers on access for supports for newcomers. 2. Complete integrated meetings with EO with interpretation services 3. Leverage external agency relationship via SP offering supports in communities for ESL supports (i.e.: Mohawk College). 4. Norfolk CMSM has invested by purchasing voice translators available for staff/client use both in offices and while in the community. Utilizing	• Ability to translate in person to allow more meaningful conversation. • More availability to refer individuals to the appropriate channels (Employment Ontario for job search supports) • More assessments will be completed allowing individual to be better

	this technology for in person services will strengthen our ability to service individuals where English is not their first language.	assessed for other financial assistance programs/supports and services (i.e.: ODSP)
3. Individuals are resisting supports for mental health due to wait lists and inability easily navigate services. • Barriers are not readily being worked on to get to 'referral ready' status.	1. Connect individuals to Community Support Workers to assist in the navigation of supports/services. 2. Commitment to working within budget to provide through cost individuals the opportunity for psychiatrist assessments on a case-by-case basis.	• Plan more appropriate goals on the action plan that meet the individual where they are.
4. Individuals are accepting the referral from Ontario Works but then declining service when meeting with Employment Ontario.	1. Continue to work on EO/OW Pilot for integrated case management. 2. Investigate why individuals are declining service. • Having SA staff follow up when a decline of service will better equip staff on next steps.	

Highest Risk(s) from Risk Assessment Template (applicable to the two in the risk assessment only):

2.3: Client's barriers/needs have not been addressed prior to referral to Employment Ontario. Priority rating: 9 – Medium.

Performance Outcome 3: Ontario Works cases exit to employment		
Inputs (e.g., organization, community, external)	Operational and Strategic Activities	Expected Outputs
1. Invest in continued working relationship with SSM/ SP • Relationship needs to be secured for individual to gain access to support for financial independence.	1. Continue to meet on a regular basis (management level) to discuss trends, ideas and ensure continued connection via scheduled touch point. 2. Continue to plan an annual all staff day for SP and SA front line.	• Enhanced supports will allow individual to gain wrap around services when exiting Ontario Works to employment. Goal to ensure that support provided is

		adequate for individual to remain successful in their employment and financial independence.
	3. Continue engagement for integrated case management with joint meetings between SP, SA, and individual access services.	• Ongoing trust will continue to keep relationships secure.
	4. Continue to follow the service delivery pathways set out by the Ministry and focus on the stabilization of the individuals with focus and goal of being referral ready to SPs. 5. This reflects the scope of our position within Employment Service Transformation (EST). Additionally, the capacity within the office position with implementation to EST requires trust to be placed on the SSM and SP to delivery the services no longer included in our delivery model. 6. Continuing to work in partnership and trusting the mechanism within service delivery set out by the Ministry for individuals to gain meaningful employment. Trusting the processes are in place to support individuals in retention and working closely with the SPs prior to closure of financials. 7. Continue to forward feedback to Ministry from public (clients) and staff on new pathways and roles as it related to EST.	• Feedback from front line personnel and individuals receiving benefits will allow firsthand information to be provided for ongoing decision making/ procedural review. • Individuals will leave Ontario Works supported financially increasing their ability to remain successful.
2. Benefit coordination/access to benefits • Individuals do not always have the accessible funds to be successful in exiting to employment	1. Ensure that benefit coordination is happening between the SP and SA. 2. Ensure OW recipient is aware of earning exemptions, extended health care benefits and report requirements for Ontario Works 3. Formalize termination checklist at the local office. • With a formalization of the termination checklist, we will ensure individuals are advised of all available benefits when they are exiting Ontario Works	• Individuals will be better knowledgeable on extended supports allowing increased chance of success in being gainfully employed to remain financially supported through earnings.

	due to employment. An example of this would be the process/steps for extended health care benefits.	

Highest Risk(s) from Risk Assessment Template

- **<u>Do not complete for this performance outcome for 2024.</u>**

Performance Outcome 4: Ontario Works cases do not return to the program within one year.		
Inputs (e.g., organization, community, external)	Operational and Strategic Activities	Expected Outputs
1. Individuals are wishing to apply to ODSP however, unable to navigate application package. • Many individuals have barriers limiting them from exiting the program with earnings. Individuals are access Ontario Works due to the desire to apply to ODSP but being in immediate financial hardship	1. Continue to utilize the Community Support Worker position to provide further supports on ODSP application process. 2. Ensure that individuals are fully aware of program requirements- this may be completed by continuing to offer ODSP information sessions.	• Individuals wishing to apply to other financial assistance programs for long term financial assistance need to be educated on the application process/requirements to ensure that applications are submitted fully complete. Limiting the 'additional information needed' will improve the success of individuals access long term financial program and not returning to Ontario Works

		3. Both EO/SA will know the status of the individual who has excited with earnings and ensure that all support is provided prior to OW and ensuring that individual is able to stay employed.
2. Limited supports provided for employment retention at the local SA site. • Now that individuals are working directly with EO partners the retention end no longer falls with SA	1. Continue to work on integrated case management for individuals on SA but working with local EO site. 2. Ensuring the individual exits Ontario Works fully supported for ongoing success with employment. 3. Those who exit to employment, noting that service manager no longer provides direct supports, trusting that EO process in place to assist individuals in retention. • Recognize retention support is required for longevity of employment for individuals previously on Ontario Works.	
Highest Risk(s) from Risk Assessment Template • **<u>Do not complete for this performance outcome for 2024.</u>**		

Section 4 – Manage Program Delivery

In this section, SA delivery sites will identify key program management activities to ensure the program supports program integrity and is delivered in accordance with legislative and policy requirements.

4.1 Service Delivery Expectations

Develop an outline of how service delivery expectations will be managed to ensure the program is delivered in accordance with legislative and policy requirements and that financial assistance expenditures are accurate and meet ministry expectations (refer to Main Guidelines Document)

Enter outline for each are of focus below (suggest 250 words max recommended per area)
Essential information reviewed and verified by 3rd party checks prior to transferring to ODSP (within the last 12 months)
A local ODSP/OW file transfer process is followed which ensures file information is up to date and mandatory 3rd party checks are completed as part of the transfer process. The dates of 3rd party checks are recorded in the transfer note template and any relevant information from the check is either actioned or flagged for follow up at a later date, as appropriate.
24-month Reassessment (including Third Party Checks) on all OW cases
A combined system of task use and spreadsheet are used to keep track of last application update and records when 24-month update is due. There is a dedicated spot in each case manager's schedule to complete at least one update per week until entire case load is fully updated.
Timely follow up on deferrals from participation in employment readiness activities
SAMS reports are used for manager review to monitor deferral statuses. Case Managers use tasks and spreadsheets to keep track of when participation updates are due. Program Assistants also are provided with a list of participants who need updates booked in the upcoming months with collaboration with CM, they arrange for case manager/client meeting dates and times.
EVP is assigned and completed in established timeframes
EVP is consistently assigned within 2 business days of the audit plan availability. The process of booking appointments and gathering relevant information is completed in the week that follows. All audits are scheduled and completed with outcomes/follow up within the EVP timeframes. This is achieved consistently which is evident in EVP statistics available in SAMS reporting.
Application of up to 10% recovery rate for all overpayments

The ministry directed criteria is consistently used to determine recovery rate. Overpayments newly created are reviewed daily to ensure accuracy and that they are documented in SAMS. Overpayment recovery rate established is also reviewed within days of the overpayment correction. The SAMS report will be used periodically to review overpayment recovery rates are entered on all cases according to ministry criteria.
Financial assistance expenditures (subsidy claims submissions) are accurate and meet ministry expectations (list all Ontario Works benefits managed outside of SAMS and identify supporting documentation that will be provided with adjustments to subsidy claims and describe business practices for Ontario Works benefits managed outside of SAMS)
There is a single benefit managed outside of SAMS for our local transportation service. Ontario Works staff purchase bulk tickets from the Norfolk County Economic Development department (note that Haldimand County does not offer transportation services). A receipt is provided listing the number of tickets purchased, type of ticket (i.e. single use, multi-use), and cost by type of ticket purchased. Tickets are then expensed as distributed to clients. Any tickets unused by the end of the year are considered pre-paid for accounting purposes. Each month, a list is provided to the user completing the SAMS claim for entry. This list is verified and signed off on by a Program Manager and amounts are further verified by Financial Services staff.

4.2 Analysis of Resources

Conduct an analysis of resources using the **Supplementary Reporting Tool.** For more information refer to the Main Guidelines document.

4.3 Monitoring Activities

Demonstrate how SA delivery sites will be prepared to support the monitoring activities by documenting its approach to readiness from combination of resource, awareness and understanding perspectives.

For example, the SA Delivery sites will be ready to support by reviewing and becoming familiar with all relevant materials provided by the ministry to understand the monitoring activities and OW's roles and responsibilities.

Enter the approach for monitoring here (suggested 250 words max recommended per area)
Overall Readiness (i.e., how your site will be ready to continuously support the monitoring activities)
Overall readiness will be achieved by regular review of available reports and data to gauge performance against ministry expectations. There will also continue to be internal team meetings, monthly finance meetings and monthly meetings with the Program Supervisor to guide operations and make corrective actions where necessary.

Submission of actual expenditures (i.e., how to ensure your site will be able to submit the actual expenditures in a timely manner and engage in discussion when varied from budget)
Expenditure reporting has improved due to both the simplified TPON reports and having a reduced number of annual reports required. This has also allowed Program Managers to meet monthly with Financial Services to review variances, discuss forecasts and provide action items to ensure budgets are maintained as best as possible. An update is also provided to the MCCSS Program Supervisor on a quarterly basis for their information and input. While certain month-end expenditures may not be posted for a couple of weeks into the following month, reports comparing budget to actuals (along with forecasted use at the end of a month) are available daily for review.
Submission of outcomes achieved (i.e., how to ensure your site will be able to submit the actuals in a timely manner and engage in discussions on outcome performance)
Review reports and the Power BI reports and work with Finance to ensure TPON uploads are done in accordance with timeline.
Performance reports (i.e., how to ensure your site will be ready to leverage ministry provided reports in monitoring outcomes and key program delivery expectations)
Performance reports are reviewed monthly by Program Managers to monitor compliance with targets established by the ministry and at a local level.
Quality Assurance (QA) reviews (i.e., how to ensure your site will be ready to leverage the results from the ministry performed QA reviews to determine possible course corrections, related monitoring and need for service plan amendments)
Our site will be ready to leverage QA reviews by having dedicated Program Integrity staff who can be mobilized to review QA concerns. These dedicated staff will provide reviews and recommendations to Program Managers to initiate corrective actions, if necessary. If expectations are not being met, Program Managers will work together to change processes to better meet service plan commitments or if necessary to make service plan amendments.
Risk Mitigation Testing (i.e., how to ensure your site will be ready to use ministry provided testing scripts to carry out testing of mitigation for the highest risks impacting performance outcomes as well as how the results of the testing will be used by your site)
Risk assessments completed as part of this service plan did not identify any high-risk areas for improvement. The risk assessments will be completed yearly to compare results to the initial risk

assessment and look for areas of improvement or decline. If areas of decline are found, a mitigation strategy will be implemented. We will be looking for improved scores in all areas of assessment.

4.4 Privacy

Conduct a Privacy Risk Assessment using the **Privacy Risk Assessment Template and Privacy Maturity Self-Reporting Tool**. Instructions are included within the document, but for more information refer to the Supplementary Guidelines.

Board of Health Meeting – March 05, 2024

Advisory Committee Meeting – February 26, 2024

Subject:	HNHU 2023 Q4 Report – BUDGET AMENDMENT
Report Number:	CS-24-025
Division:	Corporate Services
Department:	Financial Management & Planning
Purpose:	For Decision

Recommendation(s):

That report CS-24-025 HNHU 2023 Q4 Report – BUDGET AMENDMENT be received as information;

And that the Approved 2023 Haldimand-Norfolk Health Unit Operating Budget be amended as outlined in the report;

And further that the Board of Health endorse that COVID-19 programs remain 100% funded by the Ministry of Health.

Executive Summary:

The Ministry of Health (MOH) requires Boards of Health with significant Mandatory Program levy-funded surplus to amend their budget in order for COVID-19 programs (General and Vaccine) to remain funded at 100% by the MOH. This report informs the Board of Health (BOH) of the Health Unit's financial status for 2023, as at the end of January 2024, and seeks approval to reduce the Mandatory Programs budget by $1,108,800, with the expectation that any levy surplus realized at year-end be returned proportionately to Haldimand and Norfolk Counties, and that COVID-19 programs remain 100% funded by the Province for 2023.

Discussion:

The Haldimand-Norfolk Health Unit (HNHU) Q4 2023 Standards Activity Report (SAR) includes detailed reporting on financial and program activity as required by the MOH. This includes reporting on COVID-19 programs (General and Vaccine), base programs (Mandatory and Related programs), one-time programs (calendar and fiscal), program data and vaccine reimbursement.

COVID-19 Programs

Both COVID-19 programs combine for a total expected budget surplus of $507,591, split between the General ($81,702) and Vaccine ($488,889) programs. Note that this represents a budget surplus rather than a funding surplus, with the Ministry providing allocations in January 2024 based on Q3 SAR.

For the COVID-19 General Program, budget variance drivers include Maintenance & Cleaning Services ($69,934) and Personal Protective Equipment ($10,000). Both budgets were established based on a smaller than anticipated decrease from the previous year. Deep cleaning of the main Gilbertson Administration Building and satellite Caledonia office was not required in 2023, and PPE needs decreased, along with the health unit having sufficient inventory on hand to support 2023 operations.

For the COVID-19 Vaccine Program, the two largest budget variance drivers are from Salaries & Benefits ($439,590) and Leasing/Rental Costs ($29,157). In general, the program administered fewer doses compared to each of the prior two years. Staff split time between Mandatory Programs and the Vaccine program based on demand, and the health unit was able to utilize the Gilbertson Administration Building more, reducing the need for clinic space rentals.

Base Programs

Base programs consist of Mandatory Programs and the Ontario Seniors Dental Care Program. Any one-time or non-Ministry of Health (third party) programs included in Base Programs for tracking purposes have been removed from this report.

For Mandatory Programs, Appendix A includes an amended budget based on the minimum cost share for 70% Provincial and 30% Municipal funded programs. This is a reduction of $1,108,800; the 2023 Annual Service Plan and Budget Submission included a BOH approved budget of $9,005,200, which has been reduced to $7,896,400. This amendment will ensure COVID-19 programs are not supported through the shared municipal levy and remain 100% funded by the Province. Variances are driven by both Salaries & Benefits and Interdepartmental Charges, where hiring challenges continue to be an issue within the Health Unit and other charging departments.

For the Ontario Seniors Dental Care Program, a deficit of $513,158 is projected. The MOH has not yet communicated approvals on funding for the program. A request was submitted with the Q3 SAR for financial support to ensure the program remains 100% funded. If this request is not approved, the shared municipal levy will be required to support the deficit in the 2023 calendar year. This variance is due to continued uptake in the program without a funding increase that reflects the service delivery costs.

One-Time Programs

One-time programs, exclusive of COVID-19, align with either a calendar year (ending December 31) or a fiscal year (ending March 31). They may include both actuals and a forecast depending on the end date. Programs and their applicable variance explanations are described with a status update in Table 1.

Table 1: One-Time Program Status Update

Program	Approved Allocation ($)	Forecasted Actuals ($)	Variance ($)	Comment/Variance Explanation
Mitigation	325,000	325,000	0	Will reduce levy share from 30% to 25%
School-Focused Nurses	125,000	70,865	54,135	Unable to maintain a full staffing complement
Secure Card Swipe Access	15,300	15,300	0	Funding to be utilized by March 31, 2024
PHI Practicum Program	20,000	24,503	(4,503)	Budgeted levy-funded positions offset deficit
Vaccine Refrigerator Upgrade	48,700	48,700	0	Funding to be utilized by March 31, 2024
Strategic Option Analysis	150,000	150,000	0	Funding to be utilized by March 31, 2024

Financial Services Comments:

Norfolk County

The MOH sent notice during their review of the Haldimand-Norfolk Health Unit's Q3 2023 Standards Activity Report (SAR) that should a BOH have a levy-funded Mandatory Programs budget surplus, the expectation would be that it is used against COVID-19 program ministry-funded costs unless a budget amendment was presented to and approved by the BOH. The Ministry allowed for this amendment to be completed within the Q4 SAR. For the Haldimand-Norfolk Health Unit, this surplus has been adjusted to equal $1,108,800, an amount that brings 100% levy-funded expenditures to zero (i.e. reduces Mandatory Programs to the minimum required cost share). The requested budget amendment is summarized at a high level in Table 2.

Table 2: Budget Amendment Request – Mandatory Programs

Program	Approved Budget ($)	Amended Budget ($)	Variance ($)
Total Expenditures	9,005,200	7,896,400	(1,108,800)
Total Revenues	5,527,500	5,527,500	0
Shared Levy	3,477,700	2,368,900	(1,108,800)

Anticipated Shared Levy Implications:
The net surplus will be the difference between the budget reductions to reach a minimum levy share, against any deficit realized in mandatory programs (compared to the amended budget). As at the Q4 SAR, the anticipated shared levy surplus is $855,656 ($1,108,800 – $253,144).

Haldimand County

Haldimand Finance staff have reviewed this report and agree with the information provided by Norfolk Financial Services. It is expected that the anticipated surplus will reduce Haldimand County's portion of the levy as per the applicable cost sharing agreement.

Interdepartmental Implications:

Haldimand County

Staff have reviewed the report and have no additional comments.

Consultation(s):

None

Strategic Plan Linkage:

This report aligns with the 2022-2026 Council Strategic Priority Serving Norfolk - Ensuring a fiscally responsible organization with engaged employees who value excellent service.

Explanation: This report seeks to reduce local taxpayer burden by utilizing Ministry of Health funding for COVID-19 programs.

Conclusion:

The Haldimand-Norfolk Health Unit, while improved since the start of the pandemic, continues to see significant shared levy surplus resulting in pressures to ensure COVID-19 programs remain ministry funded. By approving the requested budget amendment, the BOH supports base programs being cost shared and COVID-19 programs remaining 100% funded by the province, as set out in the amending agreement.

Attachment(s):

- Appendix A – Haldimand-Norfolk Health Unit Q4 2023 Standards Activity Report

Approval:

Approved By:
Amy Fanning, CPA
Treasurer & Director, Financial Management & Planning

Reviewed By:
Amy Vesprini
Supervisor, Financial Planning & Reporting

Prepared By:
Michael VanSickle
Senior Financial Analyst, Financial Planning & Reporting

Q4

2023 Standards Activity Reports

as of December 31, 2023

To be completed by

Board of Health for the Haldimand-Norfolk Health Unit

2023 Standards Activity Reports

Instructions

The Standards Activity Reports are a set of reporting tools that boards of health are required to submit quarterly as per the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (the “Standards”) and Public Health Funding and Accountability Agreement (the "Accountability Agreement").

The Standards Activity Reports are prepared by boards of health to communicate quarterly financial forecasts and interim information on program achievements. Through these reports, boards of health are required to identify risks, emerging issues, changes in local context, and programmatic and financial adjustments in program plans identified in the 2023 Annual Service Plan and Budget Submission (the “Annual Service Plan”).

The Ministry of Health (the "ministry") requires that the 2023 Standards Activity Reports are completed and returned to the ministry by the following due dates:

- 2nd Quarter (Q2) Standards Activity Report (for the period up to June 30, 2023) – July 31, 2023
- 3rd Quarter (Q3) Standards Activity Report (for the period up to September 30, 2023) – October 31, 2023
- 4th Quarter (Q4) Standards Activity Report (for the period up to December 31, 2023) – January 31, 2024

Boards of health must ensure that the Standards Activity Reports are submitted on time and expenditure forecasts and programmatic data are as accurate as possible.

Any portion of the ministry approved funding declared surplus by boards of health as part of the Q3 and Q4 Standards Activity Reports will be recovered at 100% through adjustments to the board of health's cash flow.

There is only one template for the Standards Activity Reports which has multiple worksheets that should be completed as follows:

- Blue tabs (financial forecasts) are worksheets to be completed for each quarter: **Q2, Q3, and Q4** (with some exceptions for 2023 as noted below)**;**
- Grey tab is for information only and does not require any data input;
- Green tabs (program data) are to be completed for **Q3 & Q4**; and,
- Yellow tab (risk management report) is to be completed for **Q3** only.

Each template has been customized to include programs and budget information submitted as part of the 2023 Annual Service Plan and ministry funding approvals as per the most recent Schedule A of the Accountability Agreement.
In each worksheet, data should be entered in cells highlighted in yellow. In addition, please do not change the format of the report or override formulas.

The Standards Activity Report worksheets have been organized as follows:

1- Cover

This page has been customized to include the name of the board of health for which this report is to be completed.

Cell D20 (yellow data input cell) is a drop-down list that allows the board of health to select the appropriate quarter for the report. Depending on the quarter selected in the drop down list, the time periods for year-to-date actuals and forecasts will change accordingly.

2- Instructions

Provides an overview of the intent of the template and instructions on how to complete the worksheets.

3- Financial Worksheets

Includes a set of worksheets to report on year-to-date (YTD) and forecasted expenditures for programs identified in the 2023 Annual Service Plan and to report on any YTD and forecasted expenditures for any funding approved by the ministry.

All expenditure amounts should be reported at **100%** (including provincial and municipal portions).

2023 Standards Activity Reports

Instructions

The tabs are similar to the COVID-19 budget tabs in the 2023 Annual Service Plan, including the requirements to complete them. Refer to the 2023 Annual Service Plan instructions to complete these tabs in the 2023 Q4 Standards Activity Report.

Boards of health are required to report on YTD and forecasted expenditures at 100% (provincial and municipal portions) for both programs on each tab. The tabs have been pre-populated with budget data reported by the board of health in the 2023 Annual Service Plan. Similar to the 2023 Annual Service Plan, boards of health are required to complete the following for the period of January 1, 2023 to December 31, 2023 for both COVID-19 Programs: program description, forecast assumptions, staffing section (program and administrative staff), YTD and forecasted expenditures in the cost per category section, program costs to be managed within the budget (for mandatory programs, and for municipal contributions over 30% and unorganized territories, if applicable).

Data inputted in these worksheets will automatically populate COVID-19 costs to be managed within mandatory programs, within the municipal contribution over 30% and unorganized territories (if applicable) on both the base funding tab and the summary by funding source tab.

As with the 2023 Annual Service Plan, once the above data is inputted, an extraordinary cost amount will be calculated in both COVID-19 Program tabs of the Q4 Standards Activity Report.

It is recommended that boards of health complete tab 3.1 Base Funding prior to completing both COVID-19 Program tabs in the Q4 Standards Activity Report. This will assist boards of health in accurately reflecting YTD and forecasted expenditures based on board approved budgets for mandatory programs and unorganized territories (if applicable) and therefore, will more accurately reflect the COVID-19 costs that can be managed within those budgets.

Boards of health are required to fully utilize their approved board of health budgets for mandatory programs before requesting additional funds from the province to cover COVID-19 extraordinary costs.

Validation Errors:

- **Salaries**: total salaries in the cost per category section (Cell O67 in the COVID-Gen tab and cell O68 in the COVID-Vacc tab) are linked to the total salaries forecasted in the staffing section. If total salaries do not equal YTD plus Forecast, there will be a validation error.
- **Travel and Accommodation:** Total staff travel in the cost per category section (Cell O78 in the COVID-Gen tab and cell O79 in the COVID-Vacc tab) are calculated by multiplying the number of kilometers travelled by the rate per kilometer. If the total staff travel forecast does not equal the YTD plus the Forecast, there will be a validation error.
- **COVID-19 General Program and COVID-19 Vaccine Program Extraordinary Costs:** If amounts calculated in these sections are lower than zero (0), there will be a validation error.

3.1 Base Funding

The purpose of this worksheet is for boards of health to report back on program budgets included in the 2023 Annual Service Plans submitted to the ministry on April 1, 2023, or revised board approved budgets submitted through the Q3 Standards Activity Report.

Similar to the 2023 Annual Service Plan, direct costs are to be reported by program/standard/standard-section/funding source and indirect costs are to be entered as a lump-sum at the bottom of the worksheet.

If a program is listed multiple times under a Standard due to multiple funding sources, please ensure to allocate expenditures accordingly.

If a new program needs to be added under a Program Standard in order to report YTD and forecasted expenditures for the 2023 calendar year, boards of health can manually add a program under the applicable Standard and select the relevant ministry funding source(s) from the drop down list provided.

No data input is required for both the COVID-19 General Program and the COVID-19 Vaccine Program on worksheet 3.1 under the Immunization and Infectious and Communicable Diseases Prevention and Control Program Standards. Budgeted expenditures and YTD actuals will be pre-populated with program costs to be managed within the board of health budget that were inputted on the COVID-19 General Program and COVID-19 Vaccine Program tabs of the Q4 Standards Activity Report.

Instructions

There are eight columns in this worksheet: the 1st three columns have been pre-populated with information from the 2023 Annual Service Plans, the YTD and Forecast columns (yellow cells) require data input (with the exception of the COVID-19 Programs), and the last three columns include formulas that automatically calculate the total and variance.

Pre-populated Columns

1. Standard - Section / Program (Column A)
2. Funding Source (Column B)
3. Budget at 100% Jan 1 to Dec 31 (Column C)

Input Columns

4. YTD Actual at 100% (Column D)
5. Forecast at 100% (Column E)

Calculated Columns

6. Total at 100% Jan 1 to Dec 31 (Column F)
7. $ Variance Under / (Over) (Column G)
8. % Variance Under / (Over) (Column H)

3.2 One-Time Funding

The purpose of this worksheet is for boards of health to report back on one-time funding approved during a given fiscal year. Similar to worksheet 3.1 (Base Funding), there are eight columns in this worksheet: three columns have been pre-populated, two columns require input (yellow data input cells), and the last three columns are calculated.

Pre-populated Columns

1. Project / Initiative Name (Column A)
2. Funding Source (Column B)
3. Budget at 100% Jan 1 to Dec 31 or Apr 1 to Mar 31 (Column C)

Input Columns

4. YTD Actual at 100% (Column D)
5. Forecast at 100% (Column E)

Calculated Columns

6. Total at 100% Jan 1 to Dec 31 or Apr 1 to Mar 31 (Column F)
7. $ Variance Under / (Over) (Column G)
8. % Variance Under / (Over) (Column H)

Similar to prior years, boards of health are not required to report expenditures related to the approved one-time cost-sharing mitigation funding (if applicable) as the expectation is this one-time funding will automatically offset any increased costs to municipalities as a result of the 2020 cost-sharing change. Therefore, no data input is required in the one-time mitigation funding section in this worksheet. The "one-time mitigation before COVID-19" will automatically update, applying one-time cost-sharing mitigation funding to any variance reported in worksheet 3.3 Summary by Funding Source. The "one-time mitigation after COVID-19" will automatically update based on any COVID-19 costs absorbed by mandatory programs.

Please also note that data input is not required for either the COVID-19 General or COVID-19 Vaccine Program one-time funding. YTD and forecasted expenditures are linked to calculated extraordinary costs on both COVID-19 tabs in the Q4 Standards Activity Report.

Validation Error:

- **Total Forecast for COVID-19 Extraordinary Programs:** There will be validation errors in cells I18 and I19 if the total forecasted expenditures at 100% for mandatory programs including COVID-19 Programs (F17) in tab 3.3. Summary by Funding Source do not equal the total budgeted expenditures at 100% for mandatory programs including COVID-19 Programs (E17) in the Summary by Funding Source.

New for the 2024 Q4 Standards Activity Report, boards of health are required to provide explanations for any variance reported for one-time funding, with the exception of cost-sharing mitigation funding and COVID-19 extraordinary costs.

2023 Standards Activity Reports

Instructions

3.3 Summary by Funding Source Worksheet

This worksheet summarizes by funding source the information entered in worksheets 3.1 (Base Funding) and 3.2 (One-Time Funding) and compares it against the budget and current approval. Note that total budgeted expenditures at 100% for mandatory programs (cell E14) and total forecasted expenditures at 100% (cell F14) do not include budgets and expenditures for either the COVID-19 General or COVID-19 Vaccine Programs from workheet 3.1 Base Funding for the purposes of calculating costs that can be managed within the cost-shared base budget for mandatory programs.

All columns in this worksheet are formula driven. There is no data input required.

Validation Errors:

- **Forecasted expenditures at 100% for COVID-19 Program Costs to be Managed within Mandatory Programs (provincial and municipal portions):** There will be a validation error in cell F15 if this cell does not equal the calculated surplus (cell K14) divided by 70%.
- **Forecasted expenditures at 100% for COVID-19 Program Costs to be Managed within Mandatory Programs (municipal contribution over 30%):** There will be a validation error in cell F16 if forecasted expenditures at 100% for Total Mandatory Programs (Cost-Shared) (including COVID-19 Program Costs to be Managed within Mandatory Programs) (cell F17) does not equal budgeted expenditures at 100% for Total Mandatory Programs (Cost-Shared) (including COVID-19 Program Costs to be Managed within Mandatory Programs) (cell E17)
- **Forecasted expenditures at 100% for Total Mandatory Programs (Cost-Shared) (including COVID-19 Program Costs to be Managed within Mandatory Programs):** There will be a validation error in cell F17 if forecasted expenditures at 100% for Total Mandatory Programs (Cost-Shared) (including COVID-19 Program Costs to be Managed within Mandatory Programs) (cell F17) does not equal budgeted expenditures at 100% for Total Mandatory Programs (Cost-Shared) (including COVID-19 Program Costs to be Managed within Mandatory Programs) (cell E17)

3.4 Variance Explanation

The purpose of this worksheet is for boards of health to provide an explanation for forecasted expenditures which are over/under the budget for base funding included in the Annual Service Plan by greater than 3%.

Municipal Contribution Over 30%

This worksheet calculates the difference between the municipal contribution over 30% included in the 2023 Annual Service Plan and the municipal contribution over 30% reported in the Q4 Standard Activity Report.
Please note that there will be a validation error in cell J15 if the municipal contribution over 30% included in the budget is different to the one included in the Q4 Standards Activity Report.

Reminder: Boards of health are required to utilize their approved budgets for mandatory programs before requesting funds from the province to cover COVID-19 extraordinary costs.

4- Program Data

2023 Standards Activity Reports

Instructions

The purpose of this set of worksheets is for boards of health to report on the program activity information (process level indicators) and, new for the 2023 quarterly reporting process, some Program Outcome Indicators. Program activity information and program outcome information included in the Standards Activity Reports entail output/process-level measures and information collected to support monitoring of program activities and interventions.

The 2023 Program Activity and Program Outcome Indicators Reporting Instructions document provides instructions for the completion of all required program activity and program outcome reporting information for the indicator year 2023.

Boards of health will still be required to report on program outcome indicators not reflected in the quarterly reports as part of the Annual Report and Attestation Template, which measure impact and progress on outcomes.

Beginning with the Q3 Standards Activity Report, boards of health were required to complete the 4.1 Program Data Q3 tab for specific program activity indicators under the Immunization and School Health Program Standards, given the reporting periods are to August 31, 2023.

All other program activity information should be reported as part of the 2023 Q4 Standards Activity Report, in the 4.2 Program Data Q4 tab, and is required to be completed as part of the Q4 Standards Activity Report.

5- Risk Management

The purpose of the Risk Management worksheet is for boards of health to report, in a standardized manner, the **high risks** that are currently being managed at each board of health.
There are eight columns in this worksheet defined as follows:

1. **Ref. #**: Enter a number for each risk. This number will be used for easy referencing (Column A).

2. **Description**: Include what the risk is and a detailed description of the risk, including cause, event, and potential impacts (Column B).

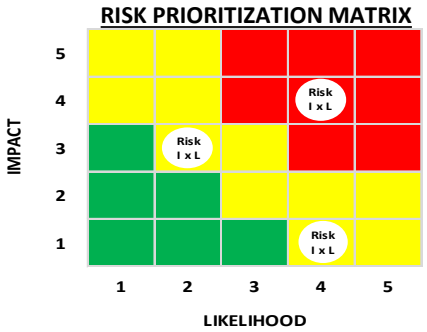
3. **Category**: Select from the drop-down list the category that is the best fit for the risk (Column C). For the list of risk categories and their definitions please see **Table 1 - Risk Categories** at the bottom of the Risk Management worksheet.

4. **Impact (I)**: Select from the drop-down list a rating for the impact of the risk, if it occurred, on meeting your objectives (Column D). The ratings are defined as follows:
   - **1** = Negligible impact;
   - **2** = Minor impact on time, cost or quality;
   - **3** = Notable impact on time, cost or quality;
   - **4** = Substantial impact on time, cost or quality; or,
   - **5** = Threatens the success of the objective.

5. **Likelihood (L)**: Select from the drop-down list a rating for the likelihood of the risk occurring (Column E). The ratings are defined as follows:
   - **1** = Unlikely to occur;
   - **2** = May occur occasionally;
   - **3** = Is as likely to occur as not to occur;
   - **4** = Is likely to occur; or,
   - **5** = Is almost certain to occur.

6. **Overall Risk Rating (R)**: This column is automatically calculated based on the inputted values for impact (Column D) and likelihood (Column E). It describes the overall ranking of the risk in terms of high, medium, and low (R = I x L) (Column F)**. Please note that only high risks are to be reported to the ministry**.
   - **Low** = Risks that do not exist or are of minor importance and not likely to significantly affect the achievement of objectives;
   - **Medium** = Risks that are moderate threat to the achievement of objectives; or,
   - **High** = Risks that are significant threat to the achievement of objectives.

Instructions



7. Key Risk Mitigations: State the risk control method(s) and process(es) that are in place (or will be implemented) to minimize the risk identified (Column G).

8. Date reported to the Board: State the date the public health unit reported the high risk and the key risk mitigations to the board of health as required by the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Column H).

6- Vaccines

Boards of health are required to report the number of doses administered in each quarter for each of the Vaccine Programs (Universal Influenza Immunization Program (UIIP), Meningococcal Quadrivalent (Men-C-ACYW) vaccine, and Human Papillomavirus (HPV) vaccine). Please do not include any doses administered in prior years.

The reimbursable amount will automatically be calculated based on the reported number of doses at the applicable rate per dose. The ministry will reimburse based on this information.

As part of the Standards Activity Report submission, boards of health are also required to submit the PEAR Reports/PR1043 for Men-C-ACYW and HPV for the 2023 Q4 period and the Reimbursement Forms for UIIP for each month within the reporting period (Q4). Vaccine doses reported in the Q4 Standards Activity Report must match vaccine doses submitted to the ministry through the UIIP reimbursement forms or the PEAR reports. Please ensure you speak with the person responsible for the vaccine program within your board of health to collect and coordinate the submission of matching reports and invoices with the Quarterly Standards Activity Report.

In order to improve the timeliness of issuing payments based on doses reported, a separate certification section has been included on the Vaccine Reimbursement tab, requiring the signature of the Medical Officer of Health/Chief Executive Officer and the Chief Financial Officer/Business Administrator.

Refer to Schedule B of the current Public Health Funding and Accountability Agreement for requirements for reporting doses under the vaccine programs.

7- Certification

This worksheet requires that the Medical Officer of Health/Chief Executive Officer and the Chief Financial Officer/Business Administrator certify that: all costs and information submitted in this document are accurate and conform with the categories specified as eligible, copies of all relevant invoices/back-up documentation are available for review at the board of health, and the submitted Excel and scanned/signed copies are identical.

2023 Standards Activity Reports as of December 31, 2023

2023 COVID-19 General Program

Program Description

Please describe how the COVID-19 General Program is being delivered in the public health unit area including unique local considerations.

The COVID-19 General Program is aimed at decreasing Haldimand and Norfolk's rates of COVID-19 and reducing the spread of this infectious disease though appropriate case, contact, and outbreak management.
Screening, Assessment and Case Management: The COVID-19 Response Team conducts case and contact management for COVID-19 through investigation of sources of infection and contact tracing as applicable.
Investigation and Response: The COVID-19 Response Team investigates all reported outbreaks of COVID-19 in highest risk settings (LTCH/RH/CLS/Farms) by working with the infection control and/or administrative staff to recommend and implement outbreak control measures.
Promotion, Awareness, Education and Knowledge Translation: The COVID-19 Response Team utilizes the HNHU website and media accounts to broadcast messaging and provide public education on COVID-19. The HNHU has also developed and maintains a COVID-19 online dashboard with risk assessment tool to provide the public a snapshot of the local COVID-19 risk. The dashboard is updated weekly and includes a number of epidemiological surveillance parameters to support the public in making an informed decision of their COVID-19 risk at present. The COVID-19 Response Team also communicates with internal and external partners to improve service coordination and enhance evidence-based practices. For example; Health Care Provider memos on COVID-19 topics.

Forecast Assumptions

Please describe assumptions used to forecast costs.

No forecasts have been included, actuals are as at January 29, 2024.

Staffing Section - for the period of January 1, 2023 to December 31, 2023

Program Staff

#	Position Title	Activities	# F.T.E. (based on regular and overtime hours)				# of Regular Hours	Salary Regular Hours ($)	# of Overtime Hours	Salary Overtime Hours ($)	Total # of Hours	Total Salaries Jan 1-Dec 31 ($)
			# P	# T	# R	# Total						
1	Associate Medical Officer of Health					-					-	$ -
2	Program Director					-					-	$ -
3	Program Manager/Supervisor					-					-	$ -
4	Case and Contact Management Manager					-					-	$ -
5	Team Leads					-					-	$ -
6	Program Assistants					-					-	$ -
7	Health Promoter					-					-	$ -
8	Public Health Inspectors					-					-	$ -
9	Call Centre Staff (not including Nurses)					-					-	$ -
10	Public Health Physicians					-					-	$ -
11	PHNs/RPNs/NPs/RNs					-					-	$ -
12	Community Liaison					-					-	$ -
13	Epidemiologists					-					-	$ -
14	Other Program Staff	*Breakdown currently not available, an update will be provided at a later date*	6.80			6.80		$ 739,780			-	$ 739,780
15	Program Evaluator					-					-	$ -
16						-					-	$ -
17						-					-	$ -
18						-					-	$ -
19						-					-	$ -
20						-					-	$ -

2023 Standards Activity Reports as of December 31, 2023

2023 COVID-19 General Program

Total Program Staff	**6.80**	**-**	**-**	**6.80**	**-**	**$ 739,780**	**-**	**$ -**	**-**	**$**	**739,780**

Administrative Staff

#	Position Title	Activities	# F.T.E. (based on regular and overtime hours) # P	# T	# R	# Total	# of Regular Hours	Salary Regular Hours ($)	# of Overtime Hours	Salary Overtime Hours ($)	Total # of Hours	Total Salaries Jan 1-Dec 31 ($)
21	Medical Officer of Health					-					-	$ -
22	Chief Executive Officer					-					-	$ -
23	Director/Business Administrator					-					-	$ -
24	Manager/Supervisor					-					-	$ -
25	Secretarial/Admin Staff					-					-	$ -
26	Financial Staff					-					-	$ -
27	I & IT Staff					-					-	$ -
28	Communications Manager/Media Coordinator					-					-	$ -
29	Volunteer Coordinator					-					-	$ -
30	Human Resources Staff/Coordinator					-					-	$ -
31	Maintenance/Custodian/Security					-					-	$ -
32	Other Administrative Staff	*Please identify each position title, activities, and cost per position title.*				-					-	$ -
Total Administrative Staff			**-**	**-**	**-**	**-**	**-**	**$ -**	**-**	**$ -**	**-**	**$ -**
Total January 1, 2023 to December 31, 2023			**#### ###**	**-**	**-**	**6.80**	**-**	**$ 739,780**	**-**	**$ -**	**-**	**$ 739,780**

Cost per Category - for the period of January 1, 2023 to December 31, 2023

1. Staffing

Cost Item	Description (Please provide details not already included in the staffing section)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Salaries		639,900	739,780		739,780	(99,880)	-16%
Minus: Revenue from Other Funding Sources			-		-	-	0%
Sub-total Salaries		639,900	739,780	-	739,780	(99,880)	-16%
Benefits	Estimated at 30% for temporary positions	274,200	196,478		196,478	77,722	28%
Minus: Revenue from Other Funding Sources			-		-	-	0%
Sub-total Benefits		274,200	196,478	-	196,478	77,722	28%
Total Staffing Expenses		**914,100**	**936,258**	**-**	**936,258**	**(22,158)**	**-2%**

2. Travel and Accommodation

2023 Standards Activity Reports as of December 31, 2023

2023 COVID-19 General Program

Cost Item	Description (Please identify each item and the cost per item)	# of KM	$ per KM	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
				Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Staff Travel	Policy is equal to the CRA mileage rate	1882	$ 0.61	15,000	1,148		1,148	13,852	92%
Other Travel					-		-	-	0%
Staff Accommodation					-		-	-	0%
Other Accommodation	Accommodations for offsite training & development of staff			1,000	-		-	1,000	100%
Minus: Revenue from Other Funding Sources					-		-	-	0%
Total Travel and Accommodation Expenses				**16,000**	**1,148**	**-**	**1,148**	**14,852**	**93%**

3. Supplies and Equipment

Cost Item	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Personal Protective Equipment	Lower budget than 2022 actuals based on current inventory, which is expected to be used first	10,000	-		-	10,000	100%
Office Supplies			-		-	-	0%
Medical Supplies	Emergency/first aid kits	1,000	-		-	1,000	100%
Cleaning Supplies			-		-	-	0%
I&IT equipment			-		-	-	0%
Telephone Equipment			-		-	-	0%
Furnishings			-		-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
Minus: Revenue from Other Funding Sources					-	-	0%
Total Supplies and Equipment		**11,000**	**-**	**-**	**-**	**11,000**	**100%**

4. Purchased Services

Cost Item	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Leasing/Rental Costs	*Please include important terms of the lease/rental agreement including lease period and termination clause.*		-		-	-	0%
Security Services			-		-	-	0%
Maintenance & Cleaning Services	Enhanced and additional cleaning of all staff facilities	80,000	10,066		10,066	69,934	87%
					-	-	0%
					-	-	0%

2023 Standards Activity Reports
as of December 31, 2023

2023 COVID-19 General Program

					-	-	0%
					-	-	0%
					-	-	0%
Minus: Revenue from Other Funding Sources					-	-	0%
Total Purchased Services		**80,000**	**10,066**	**-**	**10,066**	**69,934**	**87%**

5. Communications

Cost Item	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Media Campaign	Costs for newsprint or online releases	1,000	-		-	1,000	100%
Translation	Low-German, one client who required the service		298		298	(298)	0%
Printing	External use for any professionally created and printed documents	5,000	-		-	5,000	100%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
Minus: Revenue from Other Funding Sources					-	-	0%
Total Communications		**6,000**	**298**	**-**	**298**	**5,702**	**95%**

6. Other Operating (please specify)

Cost Item	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Cellphones	Monthly data charges for staff who have a phone	6,000	4,611		4,611	1,389	23%
Legal			-		-	-	0%
Courier Services	Test runs to a Hamilton lab	2,000	1,018		1,018	982	49%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
Minus: Revenue from Other Funding Sources					-	-	0%
Total Other Operating		**8,000**	**5,629**	**-**	**5,629**	**2,371**	**30%**

Total 100% COVID-19 General Program Forecast	**1,035,100**	**953,399**	**-**	**953,399**	**81,701**	**8%**

2023 Standards Activity Reports as of December 31, 2023

2023 COVID-19 General Program

COVID-19 General Program Costs to be Managed Within the Budget

Within Mandatory Programs (provincial and municipal portions)

Cost Category	Description (Please identify each item and the cost per item)	# F.T.E.	Budget (at 100%) Jan 1 - Dec 31	YTD Actual (at 100%) Jan 1 - Dec 31	Forecast (at 100%) N/A	Total (at 100%) Jan 1 - Dec 31	Variance Under / (Over) $	Variance Under / (Over) %
Salaries						-	-	0%
Benefits						-	-	0%
Travel and Accommodation						-	-	0%
Supplies and Equipment						-	-	0%
Purchased Services						-	-	0%
Communications						-	-	0%
Other Operating (please specify)						-	-	0%
COVID-19 General Program Costs to be Managed within Mandatory Programs (provincial and municipal portions)			**-**	**-**	**-**	**-**	**-**	**0%**

Within Mandatory Programs (municipal contribution over 30%, if applicable)

Cost Category	Description (Please identify each item and the cost per item)	# F.T.E.	Budget (at 100%) Jan 1 - Dec 31	YTD Actual (at 100%) Jan 1 - Dec 31	Forecast (at 100%) N/A	Total (at 100%) Jan 1 - Dec 31	Variance Under / (Over) $	Variance Under / (Over) %
Salaries						-	-	0%
Benefits						-	-	0%
Travel and Accommodation						-	-	0%
Supplies and Equipment						-	-	0%
Purchased Services						-	-	0%
Communications						-	-	0%
Other Operating (please specify)						-	-	0%
COVID-19 General Program Costs to be Managed Within Mandatory Programs (municipal contribution over 30%, if applicable)			**-**	**-**	**-**	**-**	**-**	**0%**

Within Unorganized Territories

Cost Category	Description (Please identify each item and the cost per item)	# F.T.E.	Budget (at 100%) Jan 1 - Dec 31	YTD Actual (at 100%) Jan 1 - Dec 31	Forecast (at 100%) N/A	Total (at 100%) Jan 1 - Dec 31	Variance Under / (Over) $	Variance Under / (Over) %
Salaries						-	-	0%
Benefits						-	-	0%
Travel and Accommodation						-	-	0%
Supplies and Equipment						-	-	0%
Purchased Services						-	-	0%
Communications						-	-	0%
Other Operating (please specify)						-	-	0%

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2023 COVID-19 General Program

COVID-19 General Program Costs to be Managed Within Unorganized Territories	-	-	-	-	-	0%

COVID-19 General Program Costs to be Managed Within the Budget

Cost Category	# FTE	Budget (at 100%) Jan 1 - Dec 31	YTD Actual (at 100%) Jan 1 - Dec 31	Forecast (at 100%) N/A	Total (at 100%) Jan 1 - Dec 31	Variance Under / (Over) $	Variance Under / (Over) %
Salaries	-	-	-	-	-	-	0%
Benefits		-	-	-	-	-	0%
Travel and Accommodation		-	-	-	-	-	0%
Supplies and Equipment		-	-	-	-	-	0%
Purchased Services		-	-	-	-	-	0%
Communications		-	-	-	-	-	0%
Other Operating (please specify)		-	-	-	-	-	0%
COVID-19 General Program Costs to be Managed Within the Budget		-	-	-	-	-	0%

COVID-19 General Program Extraordinary Costs

Cost Category	Description (Please identify each item and the cost per item)	# FTE	Budget (at 100%) Jan 1 - Dec 31	YTD Actual (at 100%) Jan 1 - Dec 31	Forecast (at 100%) N/A	Total (at 100%) Jan 1 - Dec 31	Variance Under / (Over) $	Variance Under / (Over) %
Salaries		6.80	639,900	739,780	-	739,780	(99,880)	-16%
Benefits			274,200	196,478	-	196,478	77,722	28%
Travel and Accommodation			16,000	1,148	-	1,148	14,852	93%
Supplies and Equipment			11,000	-	-	-	11,000	100%
Purchased Services			80,000	10,066	-	10,066	69,934	87%
Communications			6,000	298	-	298	5,702	95%
Other Operating (please specify)			8,000	5,629	-	5,629	2,371	30%
COVID-19 General Program Extraordinary Costs			1,035,100	953,399	-	953,399	81,701	8%

2023 Standards Activity Reports as of December 31, 2023

2023 COVID-19 Vaccine Program

Program Description

Please describe how the COVID-19 Vaccine Program is being delivered in the public health unit area including unique local considerations.

The COVID-19 Vaccine Program is aimed at decreasing Haldimand and Norfolk's rates of COVID-19 and reducing the spread of this infectious disease through the access to and provision of approved COVID-19 vaccines. During the period from January 1 - December 31, 2023 there were 25,145 doses of COVID-19 vaccines provided to individuals of Haldimand and Norfolk. The community needs assessment (CNA) conducted in 2022, noted that the majority of survey respondents were familiar with COVID-19 programming. Similarly, respondents also reported that the most commonly used programs in the past 12-months were all COVID-19 related programming.

COVID-19 Vaccine Clinics:

The Haldimand Norfolk Health Unit's COVID-19 Vaccine team operates clinics in various communities in its jurisdiction. To increase access to the vaccine(s) for the populations we serve, clinic start and end times vary throughout the week, as well as the locations we service.

COVID-19 Vaccine Storage and Delivery:

The COVID-19 Vaccine team coordinates the ordering and delivery of COVID-19 Vaccines to service partners (health care providers, long term care homes, and retirement homes) twice per week, as requested. Our team manages the COVID-19 vaccine inventory received from the Ministry at our facility, utilizing ULT freezers.

Promotion, Awareness, Education and Knowledge Translation:

The COVID-19 Vaccine Team utilizes the HNHU website and media accounts to broadcast messaging and provide public education on approved and available COVID-19 vaccines. The team regularly communicates with internal and external

Forecast Assumptions

Please describe assumptions used to forecast costs.

No forecasts have been included, actuals are as at January 29, 2024.

Staffing Section - for the period of January 1, 2023 to December 31, 2023

Program Staff

#	Position Title	Activities	# F.T.E. (based on regular and overtime hours)				# of Regular Hours	Salary Regular Hours ($)	# of Overtime Hours	Salary Overtime Hours ($)	Total # of Hours	Total Salaries Jan 1-Dec 31 ($)
			# P	# T	# R	# Total						
1	Associate Medical Officer of Health					-					-	$ -
2	Clinic Supervisor / Manager					-					-	$ -
3	Clinical Practice Lead					-					-	$ -
4	Non-clinical Practice Lead					-					-	$ -
5	Vaccinator/ Immunizers					-					-	$ -
6	Preload Staff					-					-	$ -
7	Screener Staff					-					-	$ -
8	Vaccine Runner					-					-	$ -
9	Client Flow Monitor					-					-	$ -
10	Pre-Reg Administration					-					-	$ -
11	Pre-Reg Client Support					-					-	$ -
12	Pre-Reg Nurse					-					-	$ -
13	Post Registration Administration					-					-	$ -
14	Post-Vaccination Monitor					-					-	$ -
15	Cold-Chain / Inventory Management					-					-	$ -
16	Paramedics					-					-	$ -

2023 Standards Activity Reports as of December 31, 2023

2023 COVID-19 Vaccine Program

17	Other Program Staff	*Breakdown currently not available, an update will be provided at a later date*	4.17	4.50		8.67		$ 525,005			-	$ 525,005
18	Vaccine Planning					-					-	$ -
19						-					-	$ -
20						-					-	$ -
21						-					-	$ -
Total Program Staff			**4.17**	**4.50**	**-**	**8.67**	**-**	**$ 525,005**	**-**	**$ -**	**-**	**$ 525,005**

Administrative Staff

#	Position Title	Activities	# F.T.E. (based on regular and overtime hours) # P	# T	# R	# Total	# of Regular Hours	Salary Regular Hours ($)	# of Overtime Hours	Salary Overtime Hours ($)	Total # of Hours	Total Salaries Jan 1-Dec 31 ($)
22	Medical Officer of Health					-					-	$ -
23	Chief Executive Officer					-					-	$ -
24	Director/ Business Administrator					-					-	$ -
25	Manager/Supervisor					-					-	$ -
26	Secretarial/Admin Staff					-					-	$ -
27	Financial Staff					-					-	$ -
28	I & IT Staff					-					-	$ -
29	Communications Manager/Media Coordinator					-					-	$ -
30	Volunteer Coordinator					-					-	$ -
31	Human Resources Staff/Coordinator					-					-	$ -
32	Maintenance/Custodian/Security					-					-	$ -
33	Other Administrative Staff	*Please identify each position title, activities, and cost per position title.*				-					-	$ -
Total Administrative Staff			**-**	**-**	**-**	**-**	**-**	**$ -**	**-**	**$ -**	**-**	**$ -**
Total January 1, 2023 to December 31, 2023			**#### ### #### ###**		**-**	**8.67**	**-**	**$ 525,005**	**-**	**$ -**	**-**	**$ 525,005**

Cost per Category - for the period of January 1, 2023 to December 31, 2023

1. Staffing

Cost Item	Description (Please provide details not already included in the staffing section)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Salaries		769,900	525,005		525,005	244,895	32%
Minus: Revenue from Other Funding Sources			-		-	-	0%
Sub-total Salaries		769,900	525,005	-	525,005	244,895	32%
Benefits	Estimated at 30% for temporary staff	330,100	135,405		135,405	194,695	59%

2023 Standards Activity Reports as of December 31, 2023

2023 COVID-19 Vaccine Program

Minus: Revenue from Other Funding Sources					-		-	-	0%
Sub-total Benefits				330,100	135,405	-	135,405	194,695	59%
Total Staffing Expenses				**1,100,000**	**660,410**	**-**	**660,410**	**439,590**	**40%**

2. Travel and Accommodation

Cost Item	Description (Please identify each item and the cost per item)	# of KM	$ per KM	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
				Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Staff Travel	CRA prescribed rate	11351	$ 0.61	2,000	6,924		6,924	(4,925)	-246%
Other Travel					-		-	-	0%
Staff Accommodation					-		-	-	0%
Other Accommodation					-		-	-	0%
Minus: Revenue from Other Funding Sources					-		-	-	0%
Total Travel and Accommodation Expenses				**2,000**	**6,924**	**-**	**6,924**	**(4,925)**	**-246%**

3. Supplies and Equipment

Cost Item	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Personal Protective Equipment			-		-	-	0%
Office Supplies	Includes supplies for the Administrative staff as well as clinics	4,000	1,221		1,221	2,779	69%
Medical Supplies	Includes first aid kits, sharps containers	2,000	707		707	1,293	65%
Cleaning Supplies			-		-	-	0%
I&IT equipment			-		-	-	0%
Telephone Equipment			-		-	-	0%
Furnishings			-		-	-	0%
Vaccine Fridges	Please include the number (#) of vaccine fridges/freezers purchased, as well as the model number and size for each		-		-	-	0%
Pediatric Clinic Supplies	Toys, treats, games for 0-12 clinics	5,000	-		-	5,000	100%
					-	-	0%
					-	-	0%
					-	-	0%
Minus: Revenue from Other Funding Sources					-	-	0%
Total Supplies and Equipment		**11,000**	**1,928**	**-**	**1,928**	**9,072**	**82%**

4. Purchased Services

Cost Item	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%

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2023 COVID-19 Vaccine Program

Leasing/Rental Costs	*Approximately once a week a clinic is held in a location that charges a fee (i.e. not at the Health Unit). Also includes a vehicle rental for clinic staff used to transport supplies/vaccine.*	32,000	2,843		2,843	29,157	91%
Security Services			-		-	-	0%
Maintenance & Cleaning Services	Deep clean of the PHU office building		2,552		2,552	(2,552)	0%
Partnerships			-		-	-	0%
Hazardous Waste Disposal	Contract with a shaps disposal company who delivers to Hamilton.	10,000	-		-	10,000	100%
Transportation clients to/from vaccine clinics			-		-	-	0%
Consulting Services	Budget for any external resource required for bringing the program into base operations (i.e. with the established VPD program)	2,000	-		-	2,000	100%
					-	-	0%
Minus: Revenue from Other Funding Sources					-	-	0%
Total Purchased Services		**44,000**	**5,395**	**-**	**5,395**	**38,605**	**88%**

5. Communications

Cost Item	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Media Campaign			-		-	-	0%
Translation			-		-	-	0%
Printing	External use for posters, signs, etc.	1,000	-		-	1,000	100%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
Minus: Revenue from Other Funding Sources					-	-	0%
Total Communications		**1,000**	**-**	**-**	**-**	**1,000**	**100%**

6. Other Operating (please specify)

Cost Item	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Cellphones	Data charges for staff with a phone	2,000	1,455		1,455	545	27%
Legal			-		-	-	0%
Courier Services	Delivery to Hamilton lab services	5,000	-		-	5,000	100%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%
					-	-	0%

2023 Standards Activity Reports as of December 31, 2023

2023 COVID-19 Vaccine Program

					-	-	0%
					-	-	0%
					-	-	0%
Minus: Revenue from Other Funding Sources					-	-	0%
Total Other Operating		**7,000**	**1,455**	**-**	**1,455**	**5,545**	**79%**
Total 100% COVID-19 Vaccine Program Forecast		**1,165,000**	**676,112**	**-**	**676,112**	**488,887**	**42%**

COVID-19 Vaccine Program Costs to be Managed Within the Budget

Within Mandatory Programs (provincial and municipal portions)

Cost Category	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
	# F.T.E.	Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Salaries					-	-	0%
Benefits					-	-	0%
Travel and Accommodation					-	-	0%
Supplies and Equipment					-	-	0%
Purchased Services					-	-	0%
Communications					-	-	0%
Other Operating (please specify)					-	-	0%
COVID-19 Vaccine Program Costs to be Managed within Mandatory Programs (provincial and municipal portions)		**-**	**-**	**-**	**-**	**-**	**0%**

Within Mandatory Programs (municipal contribution over 30%, if applicable)

Cost Category	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
	# F.T.E.	Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
Salaries					-	-	0%
Benefits					-	-	0%
Travel and Accommodation					-	-	0%
Supplies and Equipment					-	-	0%
Purchased Services					-	-	0%
Communications					-	-	0%
Other Operating (please specify)					-	-	0%
COVID-19 Vaccine Program Costs to be Managed Within Mandatory Programs (municipal contribution over 30%, if applicable)		**-**	**-**	**-**	**-**	**-**	**0%**

Within Unorganized Territories

Cost Category	Description (Please identify each item and the cost per item)	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
	# F.T.E.	Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%

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2023 COVID-19 Vaccine Program

Salaries				-	-	0%
Benefits				-	-	0%
Travel and Accommodation				-	-	0%
Supplies and Equipment				-	-	0%
Purchased Services				-	-	0%
Communications				-	-	0%
Other Operating (please specify)				-	-	0%
COVID-19 Vaccine Program Costs to be Managed Within Unorganized Territories	**-**	**-**	**-**	**-**	**-**	**0%**

COVID-19 Vaccine Program Costs to be Managed Within the Budget

Cost Category	# FTE	Budget (at 100%) Jan 1 - Dec 31	YTD Actual (at 100%) Jan 1 - Dec 31	Forecast (at 100%) N/A	Total (at 100%) Jan 1 - Dec 31	Variance Under / (Over) $	Variance Under / (Over) %
Salaries	-	-	-	-	-	-	0%
Benefits		-	-	-	-	-	0%
Travel and Accommodation		-	-	-	-	-	0%
Supplies and Equipment		-	-	-	-	-	0%
Purchased Services		-	-	-	-	-	0%
Communications		-	-	-	-	-	0%
Other Operating (please specify)		-	-	-	-	-	0%
COVID-19 Vaccine Program Costs to be Managed Within the Budget		**-**	**-**	**-**	**-**	**-**	**0%**

COVID-19 Vaccine Program Extraordinary Costs

Cost Category	Description (Please identify each item and the cost per item)	# FTE	Budget (at 100%) Jan 1 - Dec 31	YTD Actual (at 100%) Jan 1 - Dec 31	Forecast (at 100%) N/A	Total (at 100%) Jan 1 - Dec 31	Variance Under / (Over) $	Variance Under / (Over) %
Salaries		**8.67**	**769,900**	**525,005**	**-**	**525,005**	**244,895**	**32%**
Benefits			**330,100**	**135,405**	**-**	**135,405**	**194,695**	**59%**
Travel and Accommodation			**2,000**	**6,924**	**-**	**6,924**	**(4,924)**	**-246%**
Supplies and Equipment			**11,000**	**1,928**	**-**	**1,928**	**9,072**	**82%**
Purchased Services			**44,000**	**5,395**	**-**	**5,395**	**38,605**	**88%**
Communications			**1,000**	**-**	**-**	**-**	**1,000**	**100%**
Other Operating (please specify)			**7,000**	**1,455**	**-**	**1,455**	**5,545**	**79%**
COVID-19 Vaccine Program Extraordinary Costs			**1,165,000**	**676,112**	**-**	**676,112**	**488,888**	**42%**

2023 Standards Activity Reports
as of December 31, 2023

2023 Base Funding

Standard - Section / Program	Funding Source	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
A	B	C	D	E	F = D + E	G = C - F	H = G / C
Direct Costs							
Foundational Standards							
Effective Public Health Practice	Mandatory Programs (Cost-Shared)	375,100	387,060		387,060	(11,960)	-3.2%
Emergency Management	Mandatory Programs (Cost-Shared)	48,800	50,406		50,406	(1,606)	-3.3%
Health Equity	Mandatory Programs (Cost-Shared)	202,500	208,960		208,960	(6,460)	-3.2%
Population Health Assessment	Mandatory Programs (Cost-Shared)	198,800	205,158		205,158	(6,358)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
Foundational Standards Total		**825,200**	**851,584**	**-**	**851,584**	**(26,384)**	**-3.2%**
Chronic Disease Prevention and Well-Being							
Built Environment	Mandatory Programs (Cost-Shared)	52,800	54,479		54,479	(1,679)	-3.2%
Healthy Eating	Mandatory Programs (Cost-Shared)	69,000	71,221		71,221	(2,221)	-3.2%
Menu Labelling	Mandatory Programs (Cost-Shared)	29,700	30,678		30,678	(978)	-3.3%
Non-Mandatory Oral Health Programs	Mandatory Programs (Cost-Shared)	18,600	19,185		19,185	(585)	-3.1%
Ontario Seniors Dental Care Program	Ontario Seniors Dental Care Program (100%)	633,300	1,146,458		1,146,458	(513,158)	-81.0%
Ontario Seniors Dental Care Program	Mandatory Programs (Cost-Shared)	23,700	24,435		24,435	(735)	-3.1%
Tanning Beds	Mandatory Programs (Cost-Shared)	12,300	12,670		12,670	(370)	-3.0%
Chronic Disease Prevention Strategy	Mandatory Programs (Cost-Shared)	93,100	96,109		96,109	(3,009)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
Chronic Disease Prevention and Well-Being Total		**932,500**	**1,455,235**	**-**	**1,455,235**	**(522,735)**	**-56.1%**
Food Safety							
Food Safety Program	Mandatory Programs (Cost-Shared)	391,600	404,165		404,165	(12,565)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
Food Safety Total		**391,600**	**404,165**	**-**	**404,165**	**(12,565)**	**-3.2%**
Healthy Environments							
Health Hazards Program	Mandatory Programs (Cost-Shared)	97,400	100,544		100,544	(3,144)	-3.2%
Healthy Environments and Climate Change Program	Mandatory Programs (Cost-Shared)	281,200	290,228		290,228	(9,028)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
Healthy Environments Total		**378,600**	**390,772**	**-**	**390,772**	**(12,172)**	**-3.2%**

2023 Standards Activity Reports as of December 31, 2023

2023 Base Funding

Standard - Section / Program	Funding Source	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
A	B	C	D	E	F = D + E	G = C - F	H = G / C
Healthy Growth and Development							
Healthy Growth & Development	Mandatory Programs (Cost-Shared)	519,900	536,564		536,564	(16,664)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
Healthy Growth and Development Total		**519,900**	**536,564**	**-**	**536,564**	**(16,664)**	**-3.2%**
Immunization							
Community Based Immunization Outreach (excluding vaccine administration)	Mandatory Programs (Cost-Shared)	64,500	66,516		66,516	(2,016)	-3.1%
Immunization Monitoring and Surveillance	Mandatory Programs (Cost-Shared)	347,300	358,464		358,464	(11,164)	-3.2%
Vaccine Administration	Mandatory Programs (Cost-Shared)	25,900	26,697		26,697	(797)	-3.1%
Vaccine Management	Mandatory Programs (Cost-Shared)	63,500	65,521		65,521	(2,021)	-3.2%
COVID-19 Vaccine Program	COVID-19 Program Costs to be Managed within Mandatory Programs (provincial and municipal portions)	-	-	-	-	-	0.0%
COVID-19 Vaccine Program	COVID-19 Program Costs to be Managed within Mandatory Programs (municipal contribution over 30%)	-	-	-	-	-	0.0%
COVID-19 Vaccine Program	COVID-19 Program Costs to be Managed within Unorganized Territories / Indigenous Public Health Programs (100%)	-	-	-	-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
Immunization Total		**501,200**	**517,198**	**-**	**517,198**	**(15,998)**	**-3.2%**
Infectious and Communicable Diseases Prevention and Control							
Infectious Disease Program	Mandatory Programs (Cost-Shared)	874,800	902,811		902,811	(28,011)	-3.2%
Rabies Program	Mandatory Programs (Cost-Shared)	258,400	266,699		266,699	(8,299)	-3.2%
Sexual Health Program	Mandatory Programs (Cost-Shared)	61,100	63,078		63,078	(1,978)	-3.2%
Vector-Borne Diseases Program	Mandatory Programs (Cost-Shared)	50,100	51,675		51,675	(1,575)	-3.1%
Zoonotic Disease Reporting Program	Mandatory Programs (Cost-Shared)	60,400	62,353		62,353	(1,953)	-3.2%
COVID-19 General Program	COVID-19 Program Costs to be Managed within Mandatory Programs (provincial and municipal portions)	-	-	-	-	-	0.0%
COVID-19 General Program	COVID-19 Program Costs to be Managed within Mandatory Programs (municipal contribution over 30%)	-	-	-	-	-	0.0%
COVID-19 General Program	COVID-19 Program Costs to be Managed within Unorganized Territories / Indigenous Public Health Programs (100%)	-	-	-	-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
Infectious and Communicable Diseases Prevention and Control Total		**1,304,800**	**1,346,616**	**-**	**1,346,616**	**(41,816)**	**-3.2%**

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2023 Base Funding

Standard - Section / Program	Funding Source	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
A	B	C	D	E	F = D + E	G = C - F	H = G / C
Safe Water							
Drinking Water Program	Mandatory Programs (Cost-Shared)	208,000	214,662		214,662	(6,662)	-3.2%
Recreational Water Program	Mandatory Programs (Cost-Shared)	162,700	167,965		167,965	(5,265)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
Safe Water Total		**370,700**	**382,627**	**-**	**382,627**	**(11,927)**	**-3.2%**
School Health - Oral Health							
Healthy Smiles Ontario Program	Mandatory Programs (Cost-Shared)	231,800	239,278		239,278	(7,478)	-3.2%
Oral Health Assessment and Surveillance	Mandatory Programs (Cost-Shared)	292,200	301,540		301,540	(9,340)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
School Health - Oral Health Total		**524,000**	**540,818**	**-**	**540,818**	**(16,818)**	**-3.2%**
School Health - Vision							
Child Visual Health and Vision Screening	Mandatory Programs (Cost-Shared)	159,900	165,069		165,069	(5,169)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
School Health - Vision Total		**159,900**	**165,069**	**-**	**165,069**	**(5,169)**	**-3.2%**
School Health - Immunization							
Immunizations for Children in Schools and Licensed Child Care Settings	Mandatory Programs (Cost-Shared)	353,300	364,618		364,618	(11,318)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
School Health - Immunization Total		**353,300**	**364,618**	**-**	**364,618**	**(11,318)**	**-3.2%**
School Health - Other							
Comprehensive School Health	Mandatory Programs (Cost-Shared)	614,200	633,940		633,940	(19,740)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
School Health - Other Total		**614,200**	**633,940**	**-**	**633,940**	**(19,740)**	**-3.2%**
Substance Use and Injury Prevention							
Alcohol	Mandatory Programs (Cost-Shared)	145,500	150,136		150,136	(4,636)	-3.2%
Cannabis	Mandatory Programs (Cost-Shared)	43,800	45,159		45,159	(1,359)	-3.1%
Harm Reduction Program Enhancement	Mandatory Programs (Cost-Shared)	217,700	224,707		224,707	(7,007)	-3.2%
Needle Syringe Program	Mandatory Programs (Cost-Shared)	74,800	77,195		77,195	(2,395)	-3.2%

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2023 Base Funding

Standard - Section / Program	Funding Source	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
A	B	C	D	E	F = D + E	G = C - F	H = G / C
Smoke-Free Ontario	Mandatory Programs (Cost-Shared)	226,000	233,214		233,214	(7,214)	-3.2%
Comprehensive Substance Use Strategy	Mandatory Programs (Cost-Shared)	80,200	82,806		82,806	(2,606)	-3.2%
[Manual Entry]	[Funding Source]				-	-	0.0%
[Manual Entry]	[Funding Source]				-	-	0.0%
Substance Use and Injury Prevention Total		**788,000**	**813,217**	**-**	**813,217**	**(25,217)**	**-3.2%**
Direct Costs Total		**7,663,900**	**8,402,423**	**-**	**8,402,423**	**(738,523)**	**-9.6%**
Indirect Costs							
Indirect	Mandatory Programs (Cost-Shared)	865,800	893,579		893,579	(27,779)	-3.2%
Indirect Costs Total		**865,800**	**893,579**	**-**	**893,579**	**(27,779)**	**-3.2%**
Board of Health for the Haldimand-Norfolk Health Unit Total		**8,529,700**	**9,296,002**	**-**	**9,296,002**	**(766,302)**	**-9.0%**

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2023-24 One-Time Funding

2023-24 One-Time Funding

January 1, 2023 to December 31, 2023

Project / Initiative	Funding Source	Approved Allocation	One-Time Mitigation before Covid-19	One-Time Mitigation after Covid-19 Cost absorbed by Mandatory Programs	Total One-Time Mitigation	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	Jan 1 - Dec 31	Jan 1 - Dec 31	$	%
A	B	C	D	E	F = D + E	G = C - F	H = G / C
One-Time Mitigation	Cost-Sharing Mitigation (100%)	325,400	325,400	-	325,400	-	0.0%

Project / Initiative	Funding Source	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Jan 1 - Dec 31	Jan 1 - Dec 31	N/A	Jan 1 - Dec 31	$	%
A	B	C	D	E	F = D + E	G = C - F	H = G / C
COVID-19 General Program Extraordinary Costs	COVID-19: General Program (100%)	1,035,100	953,399	-	953,399	81,701	7.9%
COVID-19 Vaccine Program Extraordinary Costs	COVID-19: Vaccine Program (100%)	1,165,000	676,112	-	676,112	488,888	42.0%

April 1, 2023 to June 30, 2023

Project / Initiative	Funding Source	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Apr 1 - Jun 30	Apr 1 - June 30	N/A	Apr 1 - Jun 30	$	%
A	B	C	D	E	F = D + E	G = C - F	H = G / C
School-Focused Nurses Initiative	School-Focused Nurses Initiative (100%)	125,000	70,865		70,865	54,135	43.3%

April 1, 2023 to March 31, 2024

Project / Initiative	Funding Source	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Apr 1 - Mar 31	Apr 1 - Dec 31	Jan 1 - Mar 31	Apr 1 - Mar 31	$	%
A	B	C	D	E	F = D + E	G = C - F	H = G / C
Secure Card Swipe Access	Capital: Secure Card Swipe Access (100%)	15,300	-	15,300	15,300	-	0.0%
PHI Inspector Program	Mandatory Programs: Public Health Inspector Practicum Program (100%)	28,700	24,503	-	24,503	4,197	14.6%
Vaccine Refridgerator Upgrade	Mandatory Programs: New Purpose-Built Vaccine Refrigerators (100%)	48,700	-	48,700	48,700	-	0.0%

2022-23 Carry Over (April 1, 2023 to March 31, 2024)

Project / Initiative	Funding Source	Budget (at 100%)	YTD Actual (at 100%)	Forecast (at 100%)	Total (at 100%)	Variance Under / (Over)	
		Apr 1 - Mar 31	Apr 1 - Dec 31	Jan 1 - Mar 31	Apr 1 - Mar 31	$	%
A	B	C	D	E	F = D + E	G = C - F	H = G / C
Mandatory Programs: Strategic Option Analysis	Mandatory Programs: Strategic Option Analysis (100%)	150,000	-	150,000	150,000	-	0.0%

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2023-24 One-Time Funding

Variance Explanations for One-Time Funding

Please provide explanations for any variances reported for one-time funding.

Project / Initiative	Funding Source	Variance Under / (Over)	
		$	%
A	B	C	D
School-Focused Nurses Initiative	**School-Focused Nurses Initiative (100%)**	**54,135**	**43.3%**
Staff mix of temporary hires and permanent moves from mandatory programs. Permanent staff contracts ended on March 31, 2023 (staff moved back to MP), and the HU was unable to fill positions in the SFN program.			
PHI Inspector Program	**Mandatory Programs: Public Health Inspector Practicum Program (100%)**	**4,197**	**14.6%**
Two students hired - budgeted to begin on May 1 however were unable to start until May 15 and could not be extended due to a return to studies.			
[Program / Project / Initiative Name]	**[Funding Source]**	**[$]**	**[%]**
[Program / Project / Initiative Name]	**[Funding Source]**	**[$]**	**[%]**
[Program / Project / Initiative Name]	**[Funding Source]**	**[$]**	**[%]**
[Program / Project / Initiative Name]	**[Funding Source]**	**[$]**	**[%]**
[Program / Project / Initiative Name]	**[Funding Source]**	**[$]**	**[%]**
[Program / Project / Initiative Name]	**[Funding Source]**	**[$]**	**[%]**

2023-24 One-Time Funding

[Program / Project / Initiative Name]	[Funding Source]	[$]	[%]

[Program / Project / Initiative Name]	[Funding Source]	[$]	[%]

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Summary of Expenditures by Funding Source

Funding Source	Expenditures at 100%				Provincial Share			
	Budgeted Expenditures (at 100%)	Forecasted Expenditures (at 100%)	Variance Under / (Over)		Forecasted Expenditures (at provincial share)	Approved Allocation	Variance Surplus / (Deficit)	
			$	(%)			$	(%)
A	B	C	D = B -C	E = D / B	F = C * Prov. Share	G	H = G - F	I = H / G
Base Funding (January 1, 2023 to December 31, 2023)								
Mandatory Programs (Cost-Shared)	7,896,400	8,149,544	(253,144)	-3.2%	5,704,681	5,527,475	(177,206)	-3.2%
COVID-19 Program Costs to be Managed within Mandatory Programs (provincial and municipal portions)	-	-	-	0.0%	-			
COVID-19 Program Costs to be Managed within Mandatory Programs (municipal contribution over 30%)	-	-	-	0.0%				
Total Mandatory Programs (Cost-Shared) (including COVID-19 Program Costs to be Managed within Mandatory Programs)	**7,896,400**	**8,149,544**	**(253,144)**	**-3.2%**	**5,704,681**	**5,527,475**	**(177,206)**	**-3.2%**
Ontario Seniors Dental Care Program (100%)	633,300	1,146,458	(513,158)	-81.0%	1,146,458	633,300	(513,158)	-81.0%
Base Funding Total	**8,529,700**	**9,296,002**	**(766,302)**	**-9.0%**	**6,851,139**	**6,160,775**	**(690,364)**	**-11.2%**
2023-24 One-Time Funding								
January 1, 2023 to December 31, 2023								
COVID-19: General Program (100%)	1,035,100	953,399	81,701	7.9%	953,399		(953,399)	0.0%
COVID-19: Vaccine Program (100%)	1,165,000	676,112	488,888	42.0%	676,112		(676,112)	0.0%
April 1, 2023 to June 30, 2023								
School-Focused Nurses Initiative (100%)	125,000	70,865	54,135	43.3%	70,865	125,000	54,135	43.3%
April 1, 2023 to March 31, 2024								
Capital: Secure Card Swipe Access (100%)	15,300	**15,300**	-	0.0%	15,300	15,300	-	0.0%
Mandatory Programs: Public Health Inspector Practicum Program (100%)	28,700	**24,503**	4,197	14.6%	24,503	20,000	(4,503)	-22.5%
Mandatory Programs: New Purpose-Built Vaccine Refrigerators (100%)	48,700	**48,700**	-	0.0%	48,700	48,700	-	0.0%
2022-23 Carry Over (April 1, 2023 to March 31, 2024)								
Mandatory Programs: Strategic Option Analysis (100%)	150,000	**150,000**	-	0.0%	150,000	150,000	-	0.0%
2023-24 One-Time Funding Total (January 1, 2023 to March 31, 2024)	**2,417,799**	**1,788,879**	**628,920**	**26.0%**	**1,788,879**	**209,000**	**(1,579,879)**	**-755.9%**
Board of Health for the Haldimand-Norfolk Health Unit Total	**10,947,499**	**11,084,881**	**(137,382)**	**-1.3%**	**8,640,018**	**6,369,775**	**(2,270,243)**	**-35.6%**

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Variance Explanation

**** Please provide variance explanations for variances that are greater than 3% (negative or positive).***

Program / Project / Initiative	Funding Source	Variance Under / (Over)	
		$	%
A	B	C	D
Effective Public Health Practice	**Mandatory Programs (Cost-Shared)**	**(11,960)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Emergency Management	**Mandatory Programs (Cost-Shared)**	**(1,606)**	**-3.3%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Health Equity	**Mandatory Programs (Cost-Shared)**	**(6,460)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Population Health Assessment	**Mandatory Programs (Cost-Shared)**	**(6,358)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Built Environment	**Mandatory Programs (Cost-Shared)**	**(1,679)**	**-3.2%**

Variance Explanation

**** Please provide variance explanations for variances that are greater than 3% (negative or positive).***

Program / Project / Initiative	Funding Source	Variance Under / (Over)	
		$	%
A	B	C	D
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Healthy Eating	**Mandatory Programs (Cost-Shared)**	**(2,221)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Menu Labelling	**Mandatory Programs (Cost-Shared)**	**(978)**	**-3.3%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Non-Mandatory Oral Health Programs	**Mandatory Programs (Cost-Shared)**	**(585)**	**-3.1%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Ontario Seniors Dental Care Program	**Ontario Seniors Dental Care Program (100%)**	**(513,158)**	**-81.0%**
Services continue to be provided externally until a Dentist can be hired. This remains a costly venture as contracted dental services have limited competition and use of the program continues to increase. The expectation is once a Dentist is hired costs will reduce, however, due to increased demand for the program, the approved allocation may not be sufficient to successfully run the program.			
Ontario Seniors Dental Care Program	**Mandatory Programs (Cost-Shared)**	**(735)**	**-3.1%**

Variance Explanation

**** Please provide variance explanations for variances that are greater than 3% (negative or positive).***

Program / Project / Initiative	Funding Source	Variance Under / (Over)	
		$	%
A	B	C	D
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Tanning Beds	**Mandatory Programs (Cost-Shared)**	**(370)**	**-3.0%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Chronic Disease Prevention Strategy	**Mandatory Programs (Cost-Shared)**	**(3,009)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Food Safety Program	**Mandatory Programs (Cost-Shared)**	**(12,565)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Health Hazards Program	**Mandatory Programs (Cost-Shared)**	**(3,144)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Healthy Environments and Climate Change Program	**Mandatory Programs (Cost-Shared)**	**(9,028)**	**-3.2%**

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Variance Explanation

**** Please provide variance explanations for variances that are greater than 3% (negative or positive).***

Program / Project / Initiative	Funding Source	Variance Under / (Over)	
		$	%
A	B	C	D
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Healthy Growth & Development	**Mandatory Programs (Cost-Shared)**	**(16,664)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Community Based Immunization Outreach (excluding vaccine administration)	**Mandatory Programs (Cost-Shared)**	**(2,016)**	**-3.1%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Immunization Monitoring and Surveillance	**Mandatory Programs (Cost-Shared)**	**(11,164)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Vaccine Administration	**Mandatory Programs (Cost-Shared)**	**(797)**	**-3.1%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Vaccine Management	**Mandatory Programs (Cost-Shared)**	**(2,021)**	**-3.2%**

Variance Explanation

**** Please provide variance explanations for variances that are greater than 3% (negative or positive).***

Program / Project / Initiative	Funding Source	Variance Under / (Over)	
		$	%
A	B	C	D
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Infectious Disease Program	**Mandatory Programs (Cost-Shared)**	**(28,011)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Rabies Program	**Mandatory Programs (Cost-Shared)**	**(8,299)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Sexual Health Program	**Mandatory Programs (Cost-Shared)**	**(1,978)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Vector-Borne Diseases Program	**Mandatory Programs (Cost-Shared)**	**(1,575)**	**-3.1%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Zoonotic Disease Reporting Program	**Mandatory Programs (Cost-Shared)**	**(1,953)**	**-3.2%**

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Variance Explanation

**** Please provide variance explanations for variances that are greater than 3% (negative or positive).***

Program / Project / Initiative	Funding Source	Variance Under / (Over)	
		$	%
A	B	C	D
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Drinking Water Program	**Mandatory Programs (Cost-Shared)**	**(6,662)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Recreational Water Program	**Mandatory Programs (Cost-Shared)**	**(5,265)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Healthy Smiles Ontario Program	**Mandatory Programs (Cost-Shared)**	**(7,478)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Oral Health Assessment and Surveillance	**Mandatory Programs (Cost-Shared)**	**(9,340)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Child Visual Health and Vision Screening	**Mandatory Programs (Cost-Shared)**	**(5,169)**	**-3.2%**

Variance Explanation

**** Please provide variance explanations for variances that are greater than 3% (negative or positive).***

Program / Project / Initiative	Funding Source	Variance Under / (Over)	
		$	%
A	B	C	D
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Immunizations for Children in Schools and Licensed Child Care Settings	**Mandatory Programs (Cost-Shared)**	**(11,318)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Comprehensive School Health	**Mandatory Programs (Cost-Shared)**	**(19,740)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Alcohol	**Mandatory Programs (Cost-Shared)**	**(4,636)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Cannabis	**Mandatory Programs (Cost-Shared)**	**(1,359)**	**-3.1%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Harm Reduction Program Enhancement	**Mandatory Programs (Cost-Shared)**	**(7,007)**	**-3.2%**

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Variance Explanation

**** Please provide variance explanations for variances that are greater than 3% (negative or positive).***

Program / Project / Initiative	Funding Source	Variance Under / (Over)	
		$	%
A	B	C	D
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Needle Syringe Program	**Mandatory Programs (Cost-Shared)**	**(2,395)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Smoke-Free Ontario	**Mandatory Programs (Cost-Shared)**	**(7,214)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Comprehensive Substance Use Strategy	**Mandatory Programs (Cost-Shared)**	**(2,606)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			
Indirect	**Mandatory Programs (Cost-Shared)**	**(27,779)**	**-3.2%**
As a whole, Mandatory Programs are slightly over the minimum cost share requirement. As staffing vacancies have been filled, this funding deficit will continue as Salary & Benefit increases outpace the 1% increase in Mandatory Programs each year.			

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Municipal Contribution Over 30%

	Total Expenditures (at 100%)	Provincial Share $	Provincial Share %	Municipal Share $	Municipal Share %	Municipal Contribution over 30% $
A	B	C	D = C / D	E = B - C	F = 1 - C	G = E - (C / 70%) x 30%
Base Funding (January 1, 2023 to December 31, 2023)						
Mandatory Programs (Cost-Share) Budget	7,896,400	5,527,475	70%	2,368,925	30%	7
Mandatory Programs (Cost-Share) Forecast	8,149,544	5,527,475	68%	2,622,069	32%	253,151
Difference	(253,144)	-		**(253,144)**		**- 253,144**

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2023 Program Data

5.0. Immunization

5.1. Number of school immunization clinics held by the board of health for the grade 7 school-based program including hepatitis B (HBV), meningococcal and human papillomavirus (HPV) vaccines

Total number of school immunization clinics, i.e., the count of board of health delivered immunization clinics held in schools for the September 1, 2022 – August 31, 2023 reporting period:	82

Board of health comments (as needed)

5.2. Number and type of catch-up clinical services held by the board of health for students in grades 8 to 12 for HBV, meningococcal and HPV vaccinations

Total number and type of catch-up clinical services for students in grades 8 to 12 for HBV, meningococcal and HPV vaccinations, i.e., the count of catch-up immunization clinical services for students in grades 8 to 12 for September 1, 2022 – August 31, 2023 reporting period:

Access Point	Count	Comments
Catch-up clinic at a school (no routine school-based provided)	9	We offered catch up clinics, without routine school based vaccines to 9 high sch
Routine school-based clinic (catch-up vaccinations are also provided)	91	We provided catch up clinics for school based vaccines (HB, HPV and Men-C-ACYW) to grade 8,9,10,11 and 12 students
Catch-up clinic at BoH office location (specific clinic for school-based program)	0	We offer regular routine immunization clinics at our health unit locations, which school based vaccines are offered in addition to others.

Access Point	Yes/No	Comments
Appointments for catch-up school-based immunizations at BoH office location	Yes	Appointments could be booked at our regularly scheduled health unit clinics.
Doses provided to healthcare providers upon request	Yes	
Other (please specify)	Yes	In addition to the appointment based clinics, we also operationalized walk-in clinics at our Health Unit locations in Haldimand and Norfolk.

Board of health comments (as needed)

5.3. Number of HBV, meningococcal and HPV vaccine doses administered to students

a) Total number of doses of HBV vaccine administered to students in grades 7 to 12 for September 1, 2022 – August 31, 2023 reporting period:

Vaccinator / Administration By	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
BoH	1,399	1,250	474	33	9	7
Other (please specify)						

b) Total number of doses of meningococcal vaccine administered to students in grades 7 to 12 for September 1, 2022 – August 31, 2023 reporting period:

2023 Program Data

Vaccinator / Administration By	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
BoH	767	677	515	30	22	93
Other (please specify)						

c) Total number of doses of HPV vaccine administered to eligible students in grades 7 to 12 for September 1, 2022 – August 31, 2023 reporting period:

Vaccinator / Administration By	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
BoH	1,399	1,183	464	33	15	18
Other (please specify)						

Board of health comments (as needed)

8.0. School Health

8.1. Narrative Statement – Oral Health

List all clinics that were used in the reporting period (2023) for the provision of clinical service delivery to Healthy Smiles Ontario (HSO) clients as per the HSO Schedule of Services and Fees (i.e. service schedule)

Clinic Name	Clinic Location	Clinic Type	Types of activities/treatment provided	Clinic hours of operation
Haldimand-Norfolk Simcoe Prevetnive Dental Clinic	12 Gilbertson Drive, Simcoe ON	HSO Preventive Dental Clinic	Preventive Treatment: New patient exams, OHE, Sealants, Scaling, SDF, Fluoride Varnish, Screenings	5 days per month 9am-4pm
Haldimand-Norfolk Dunnville Prevetnive Dental Clinic	117 Forest St E Dunnville ON	HSO Preventive Dental Clinic	Preventive Treatment: New patient exams, OHE, Sealants, Scaling, SDF, Fluoride Varnish, Screenings	2 days per month 9am - 4pm
Help Center Evening Clinics	Houghton Public School, 505 Fairground Road, Fairground	HSO Preventive screening and FLV clinic - no suction/air water	Screening and Fluoride varnish clinic	1 day per month 4-7pm

2023 Program Data

Number of portable equipment sets	2

8.2. Number and percentage of students screened who were found to have clinical need for preventive services (i.e., clinically eligible for Healthy Smiles Ontario-Preventative Services Only [HSO-PSO]) (HSO-PSO))

Number of students screened by the board of health as clinically eligible for HSO-PSO in the reporting school year	2,360
Total number of students screened by the board of health in the reporting school year excluding the number of children who were absent, excluded from screening by their parents/legal guardians or who refuse to be screened	3,630
Percentage of students screened who were found to have clinical need for preventive services	65.0%

Board of health comments (as needed)

Note: There is a discrepancy with our "students screened" # from the OHISS report. We are investigating this and have shown the correct number here.

8.3. Number and percentage of students screened who were found to have emergency and/or essential needs requiring immediate clinical treatment (i.e., clinically eligible for Healthy Smiles Ontario, Emergency and Essential Services Stream [HSO- EESS])

Number of students screened by the board of health as clinically eligible for HSO-EESS in the most recently completed school year	387
Total number of students screened by the board of health in the most recently completed school year excluding the number of children who were absent, excluded from screening by their parents/legal guardians or who refuse to be screened	3,630
Percentage of students screened who were found to have emergency and/or essential needs requiring immediate clinical treatment	10.7%

Board of health comments (as needed)

Note: There is a discrepancy with our "students screened" # from the OHISS report. We are investigating this and have shown the correct number here.

8.4. Number and percentage of students screened and found to be clinically and financially eligible for Healthy Smiles Ontario-Preventative Services (HSO- PSO) who were then enrolled in HSO-PSO

2023 Program Data

Number of students screened by the board of health as clinically and financially eligible for HSO-PSO in the most recently completed school year and subsequently enrolled in HSO-PSO	-
Total number of students screened by the board of health in the most recently completed school year excluding the number of children who were absent, excluded from screening by their parents/legal guardians or who refuse to be screened	3,630
Percentage of students screened and found to be clinically and financially eligible for HSO-PSO, who were then enrolled in HSO-PSO	0.0%

Board of health comments (as needed)

Note: There is a discrepancy with our "students screened" # from the OHISS report. We are investigating this and have shown the correct number here.

8.5. Number and percentage of students screened and found to be clinically and financially eligible for Healthy Smiles Ontario, Emergency and Essential Services Stream (HSO-EESS) who were then enrolled in HSO-EESS

Number of students screened by the board of health as clinically and financially eligible for HSO-EESS in the most recently completed school year and subsequently enrolled in HSO-EESS	67
Total number of students screened by the board of health in the most recently completed school year excluding the number of children who were absent, excluded from screening by their parents/legal guardians or who refuse to be screened	3,630
Percentage of students screened and found to be clinically and financially eligible for HSO-EESS, who were then enrolled in HSO-EESS	1.8%

Board of health comments (as needed)

Due to a staffing gap school screening was completed near the end of June and some enrollment from that will be captured within the next school year

8.6. Number and percentage of children screened and enrolled by the board of health in the Healthy Smiles Ontario – Emergency and Essential Services Stream (HSO-EESS) who have initiated treatment within 16 weeks of enrolment

Total number of HSO-EESS enrolled clients who have initiated treatment within 16 weeks of enrolment	56
Total number of clients identified through screening to meet program, clinical and financial requirements, and subsequently enrolled in HSO-EESS	67
Percentage of children screened and enrolled by the board of health in the HSO-EESS who have initiated treatment within 16 weeks of enrolment	83.6%

Board of health comments (as needed)

Due to a staffing gap school screening was completed near the end of June, therefore the data for the initiation of treatment may be captured within the next school year

8.7. Number and percentage of students whose parent/guardian received at least one notice/request for immunization information under the *Immunization of School Pupils Act* (ISPA) assessment process

Number of students whose parents/guardians received at least one Request for Information notice by the board of health in the reporting period	
Total number of students assessed by the board of health in the reporting period	
Percentage of students whose parents/guardians received at least one notice	0.0%

Board of health comments (as needed)

We assessed all records for students in Grades 1-12 during the summer of 2023

8.8. Number and percentage of students suspended under the *Immunization of School Pupils Act* (ISPA)

Number of students suspended in the reporting period	
Total number of students assessed by the board of health in the reporting period	
Percentage of students suspended	0.0%

Board of health comments (as needed)

We suspended in May of 2023 - the 2015 and 2005 birth cohorts

8.9. Most requested and/or supported topics of consideration in schools

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2023 Program Data

List the top 3 most requested and/or supported topics of consideration in schools over the reporting period.

	Topics of Consideration in Schools – Most Requested and/or Supported
1	Vaping
2	Social Media Use and Self-Regulation
3	Misc. Health topics: lice, chicken pox & pink eye

Board of health comments (as needed)

Highschool Topics of Consideration: sexual health, mental health, social/emotional regulation

2023 Standards Activity Reports
as of December 31, 2023

2023 Program Data

1.0. Chronic Disease Prevention and Well-Being

1.1. Menu labelling: number and percentage of new regulated food service premises inspected in 2023

Total number of newly opened/identified regulated food service premises inspected in 2023	3	← Cell (L11)
Total number of new regulated food service premises that have opened/been newly identified in the region in 2023	3	
Percentage of new regulated food service premises inspected in 2023	100.0%	

Board of health comments (as needed)

1.2. Menu labelling: number and percentage of 2022 premises that were re-inspected at least one time in 2023

Total number of premises that had been inspected in 2022 and had been identified as requiring a re-inspection that received at least one re-inspection in 2023	1	← Cell (L18)
Total number of premises identified as requiring re-inspections in 2022	1	
Percentage of 2022 premises that were re-inspected at least one time in 2023	100.0%	

Board of health comments (as needed)

1.3. Menu labelling: number of inspected premises (new and re-inspected) deemed in full compliance, in partial compliance and not in compliance, charges laid

(a) Total number of regulated food service premises (new and re-inspected) inspected in 2023 that the inspectors in the board of health deemed in full compliance	4	
(b) Total number of regulated food service premises (new and re-inspected) inspected in 2023 that the inspectors in the board of health deemed in partial compliance or not in compliance	-	
(c) Total number of regulated food service premises (new and re-inspected) inspected in 2023 that the inspectors in the board of health deemed not in compliance and for which charges were laid	-	
Total number of inspected premises (new and re-inspected) deemed in full compliance, in partial compliance and not in compliance, charges laid [(a) + (b) + (c)]	4	← Cell (L28)

Note: Cell (L28) Must Equal To Cell (L11) + Cell (L18)

Board of health comments (as needed)

1.4. Menu labelling: number and percentage of complaints that resulted in an inspection in 2023

Total number of complaints resulting in an inspection received by the board of health in 2023 for regulated food service premises' noncompliance or partial compliance with the Healthy Menu Choices Act (HMCA).	-	
Total number of complaints received in 2023	-	
Percentage of complaints that resulted in an inspection in 2023	0.0%	

Board of health comments (as needed)

1.5. Locally Developed Indicators

2023 Program Data

Provide results associated with the locally developed indicator(s) described in the 2023 Annual Service Plan to monitor success of Chronic Disease Prevention and Well-being Programs. Describe the results associated with each indicator, including if your board of health met the outcome measures associated with each indicator as intended, and explain any variances (over/under), as applicable.

Healthy Eating:
Completion of Monitoring Food Affordability process: data collection and analysis complete, and Board of Health report scheduled for March 2024 (met indicator)
% of participants who reported increased confident due to community food literacy programming: 80% (N=5)

If applicable, please describe any additional locally developed indicators identified throughout 2023 that were not described in the 2023 Annual Service Plan and associated results (i.e., if outcome measures were met as intended and any variances) to monitor the success of Chronic Disease Prevention and Well-being Programs.

Healthy Eating: Additional indicators were not identified during 2023 as a Locally Driven Collaborative Project is working towards indicators for the Chronic Disease Prevention and Well Being Program Standard. HNHU will monitor for the results of this project and make adjustments to current program planning, implementation and evaluation as required.
Built Environment:

Board of health comments (as needed)

2.0 Food Safety

2.1. Total number of all fixed year-round food premises in operation in 2023 537

Board of health comments (as needed)

2.2. Total number of all fixed seasonal food premises in operation in 2023 146

Board of health comments (as needed)

2.3. Percentage of year-round high-risk food premises inspected once every four months while in operation

Total number of year-round high-risk food premises inspected once every four months while in operation in 2023	90
Total number of year-round high-risk food premises in operation in 2023	90
Percentage of year-round high-risk food premises inspected once every four months while in operation	100.0%

Board of health comments (as needed)

2.4. Percentage of year-round moderate-risk food premises inspected once every six months while in operation

Total number of year-round moderate-risk food premises inspected once every six months while in operation in 2023	227
Total number of year-round moderate-risk food premises in operation in 2023	227
Percentage of year-round moderate-risk food premises inspected once every six months while in operation	100.0%

Board of health comments (as needed)

2.5. Total number of re-inspections for fixed year-round food premises 211

Board of health comments (as needed)

2023 Program Data

2.6. Total number of food safety complaints received that triggered an investigation 75

Board of health comments (as needed)

2.7. Total number of tickets issued per section number

Number of Tickets	Section Number	Number of Tickets	Section Number	Number of Tickets	Section Number	Number of Tickets	Section Number
0							

Total Number of Tickets -

Board of health comments (as needed)

2.8. Total number of summonses issued per section number

Number of Summonses	Section Number	Number of Summonses	Section Number	Number of Summonses	Section Number	Number of Summonses	Section Number
0							

Total Number of Summonses -

Board of health comments (as needed)

2023 Program Data

2.9. Total number of written section 13 orders issued under the *Health Promotion and Protection Act* (HPPA) 2

For each section 13 order, describe the action taken (e.g. closure) and the reason (e.g., no potable water, power outage) for the written order

• Fail to provide food premises with an adequate potable water supply.
• Fail to provide food premises with hot and cold running water under pressure in food preparation area and utensil cleaning area. • Fail to protect the food premises from the entry of pests.
• Fail to keep the food premises free from animals.

Board of health comments (as needed)

2.10. Number and percentage of Salmonella and E. Coli food-borne outbreaks investigated for which a probable source was identified

Number of locally acquired Salmonella food-borne outbreaks investigated where a probable source was identified + Number of locally acquired E. coli foodborne outbreaks investigated where a probable source was identified	-
Total number of locally acquired Salmonella + E. Coli outbreaks	-
Percentage of Salmonella and E. Coli food-borne outbreaks investigated for which a probable source was identified	0.0%

Board of health comments (as needed)

3.0. Healthy Environments

3.1. What actions were taken by the board of health to mitigate the health impacts of heat and cold?

We have an Extreme Weather Response policy which includes notification to stakefolders and the public regarding heat, cold and air quality alerts. Our community partners are notified of events to provide access to warming and cooling centers, as well as puclic education through our website and social media blasts about risks and how to mitgate effects of heat/cold/air quality.

3.2. Locally Developed Indicators

Provide locally developed indicators and associated results for 2023 to monitor the success of the Healthy Environment Programs.

Send out 100% of extreme weather alerts from Environment Canada for our jurisdiction.
Continued coordination with local stakeholders (Norfolk and Haldimand counties, Church Out Serving to ensure services are still offered and information accurate.

4.0. Healthy Growth and Development

4.1. Locally Developed Indicators

Provide locally developed indicators and associated results for 2023, to monitor the success of the Healthy Growth and Development Programs.

All staff are trained in Cognitive Behavioral Therapy strategies and have integrated into their client service plans.
Intention to Breastfeed rates and Infants fed Breast milk only at hospital discharge is higher Haldimand Norfolk compared to the provincial average (BORN, 2023).
Projected prenatal HBHC screen number for 2023 is 10% based on quarterly reports.

5.0. Immunization

5.4. Number and percentage of refrigerators that store publicly funded vaccine that received their routine annual inspection as per the vaccine storage and handling requirements

Total number of refrigerators in operation in the public health unit jurisdiction as of Dec 31st with completed routine cold chain inspection	93
Total number of refrigerators in operation in the public health unit jurisdiction as of Dec 31st	97
Percentage of refrigerators that store publicly funded vaccine with completed cold chain inspection	95.9%

Board of health comments (as needed)

HNR_SI_00009, HNR_SI_00012, HNR_SI_00055 and HNR_SI_00112 were missed for inspection due to staff capacity in 2023. They will be prioritized for inspection in Q1 of 2024 and again in Q3 of 2024.

PR1042 Validation Report has 97 Fridges in Operation, and 93 inspected - this is correct.

6.0. Infectious and Communicable Diseases Prevention and Control

6.1. Number of infection prevention and control (IPAC) complaints received that triggered an investigation

a) Total number of all IPAC complaints received from January 1 – December 31 for the reporting year (2023) | -

b) Total number of all IPAC complaints received that triggered an investigation by the board of health from January 1 – December 31 for the reporting year (2023). | 10

Board of health comments (as needed)

6.2. Number of verbal and written infection prevention and control (IPAC) related section 13 health hazard orders issued under the Health Protection and Promotion Act (HPPA) | -

For each section 13 order, please describe the action taken (e.g., closure), reason (e.g., stop use of sterilizer), and type of setting (e.g., personal service setting, dental clinic).

Board of health comments (as needed)

6.3. Percentage of reported confirmed sexually transmitted and blood-borne infection (STBBI) cases where treatment and follow-up were conducted according to the *Infectious Diseases Protocol, 2018* (or as current), for each of Hepatitis C, Gonorrhea, and Syphilis

	Number of reported cases where follow-up has been listed as closed, follow-up complete according to the protocol	Total number of reported cases	Percentage
Hepatitis C	15	20	75.0%
Gonorrhea	21	23	91.3%
Syphilis	2	14	14.3%
Total	38	57	66.7%

Challenges (e.g. priority populations challenging to follow-up with) and other comments.

As the HNHU has not yet established the priority populations for our community the number's provided are for all cases of Hepatitis C, Gonorrhea, and Syphillis cases managed according to the infectious disease protocol as we are currently treating all populations with a Disease of Public Health Significance as a priority population.

6.4. Number of catch basins treated with larvicide per round | -

In addition to the number of catch basins treated with larvicide per round, the board of health is to also indicate how many rounds done

Board of health comments (as needed)

6.5. Number of mosquito traps set per week | 8

In addition to the number of mosquito traps set per week the board of health is to report on the number of weeks of surveillance conducted

2023 Program Data

We have set 8 traps in HN for 12 weeks.

Board of health comments (as needed)

6.6. Total number of cases with acquired drug-resistance for tuberculosis (TB) identified in the public health unit jurisdiction

Board of health comments (as needed)

6.7. Number of rabies exposures investigated, broken down by species/category of animal and type of exposure (e.g., bite, non-bite, or, bat)

	Bite exposures	Non-bite exposures	Bat exposures	Total number of Investigations
Dog	272	7	0	279
Cat	100	9	0	109
Bat	0	0	17	17
Livestock	1	0	0	1
Wildlife	13	0	0	13
Rodent	11	1	0	12
Other (please specify)				-
Other (please specify)				-
Other (please specify)				-

Board of health comments (as needed)

6.8. Rabies vaccination status data for all dogs, cats, ferrets, horses, cattle and sheep investigated following reported human exposures (i.e., vaccinated, vaccinated non-compliant, unvaccinated, exempt or unknown)

	Vaccinated (as per O. Reg. 567)	Vaccinated, non-compliant	Unvaccinated	Exempt from vaccination	Unknown status	Total number of Investigations
Dog	110	0	39	0	133	282
Cat	26	0	16	0	68	110
Ferret	0	0	0	0	0	-
Horse	0	0	0	0	0	-
Cattle	0	0	0	0	0	-
Sheep	0	0	0	0	0	-

Board of health comments (as needed)

6.9. Rabies post-exposure prophylaxis

The number of individuals (i.e., count), suspected of rabies exposure during 2023 for whom

2023 Program Data

Count of Suspected Rabies Exposures, in 2023	Number
Rabies PEP was not indicated	384
Started rabies PEP but discontinued given rabies testing results	0
Prescribed PEP and were not previously vaccinated	49
Received a shortened course of PEP due to previous PrEP	2
Total	435

6.10. Narrative Statement: Board of health activities related to Latent TB Infections

What actions did the board of health undertake to initiate and complete Latent TB Infections treatment in the reporting year (2023)?

The ID Team provide education on LTBI treatment, and advise that treatment if free of cost. The team also recommend that people follow up with their health care provider to see if treatment for LTBI would be indicated.

6.11. Number of infection prevention and control (IPAC) lapses by setting

Total number of all IPAC lapses from January 1 to December 31: -

For each lapse identified, please describe the setting (e.g., personal service setting, dental clinic, pharmacy) and summary description of the IPAC lapse (e.g., reprocessing).

1	
2	
3	
4	
5	

Board of health comments (as needed)

7.0. Safe Water

7.1. Recreational water: number and percentage of Class A (seasonal and year-round) pools inspected while in operation

Total (number of year-round Class A pools inspected once every three months in 2023) + (number of seasonal Class A pools receiving all required inspections)	7
Total (number of year-round Class A pools in operation in 2023) + (number of seasonal Class A pools in operation in 2023)	7
Percentage of Class A (seasonal and year-round) pools inspected while in operation	100.0%

Board of health comments (as needed)

7.2. Recreational water: number and percentage of Class B (seasonal and year-round) pools inspected while in operation

Total (number of year-round Class B pools inspected once every three months in 2023) + (number of seasonal Class B pools receiving all required inspections)	21
Total (number of year-round Class B pools in operation in 2023) + (number of seasonal Class B pools in operation in 2023)	21

2023 Program Data

Percentage of Class B (seasonal and year-round) pools inspected while in operation	100.0%

Board of health comments (as needed)

7.3. Recreational water: number of Class C facilities

Total number of all Class C recreational facilities in operation in the BoH jurisdiction in the reporting year (2023).	6
Total number of wading pools in operation in the BoH jurisdiction in the reporting year (2023).	-

Board of health comments (as needed)

7.4. Recreational water: number and percentage of spas (seasonal and year-round) inspected while in operation

Total (number of year-round spas receiving all required inspections in 2023) + (number of seasonal spas receiving all required inspections in 2023)	2
Total (number of year-round spas in operation in 2023) + (number of seasonal spas in operation in 2023)	2
Percentage of spas (seasonal and year-round) inspected while in operation	100.0%

Board of health comments (as needed)

7.5. Recreational water: number of re-inspections for Class A, B, C facilities, and spas

Total number of re-inspections for Class A, B, C facilities, and spas in the reporting year (2023).	11

Board of health comments (as needed)

7.6. Recreational water: number and percentage of recreational water facility complaints that triggered an investigation

Total number of all recreational water facility complaints that triggered an investigation by the board of health in the reporting year (2023).	1
Total number of complaints received for all recreational water facilities within the reporting year (2023)	1
Percentage of recreational water facility complaints that triggered an investigation	100.0%

Board of health comments (as needed)

7.7. Recreational water: total number of tickets issued by section number

Number of Tickets	Section Number	Number of Tickets	Section Number	Number of Tickets	Section Number	Number of Tickets	Section Number
0							

2023 Program Data

Total Number of Tickets Issued -

Board of health comments (as needed)

7.8. Recreational Water: Total number of summonses issued by section number

Number of Summonses	Section Number	Number of Summonses	Section Number	Number of Summonses	Section Number	Number of Summonses	Section Number
0							

Total Number of Summonses -

Board of health comments (as needed)

7.9. Drinking water: percentage of adverse water quality incidents (AWQIs) that had an initial response by the board of health within 24 hours

Total number of AWQIs followed up within 24 hours	72
Total number of AWQIs	72
Percentage of AWQIs that had an initial response by the board of health within 24 hours	100.0%

Board of health comments (as needed)

7.10. Drinking water: total number of written section 13 orders under the *Health Protection and Promotion Act* and the reason for the orders 2

Provide a reason for each order issued

Adverse Sample Result- Fail to provide potable water supply to residential facility. X2

Board of health comments (as needed)

8.0. School Health

8.9. Most requested and/or supported topics of consideration in schools

List the top 3 most requested and/or supported topics of consideration in schools over the reporting period.

	Topics of Consideration in Schools – Most Requested and/or Supported
1	Substance Use Prevention (Vaping)
2	Physical Activity (Playground Activity Leaders in Schools)
3	Healthy Nutrition (Crunch the Numbers, You're the Chef)

Board of health comments (as needed)

Mental health promotion was a topic of consideration that was requested for by a number of schools. Where possible, the team supported schools in mental health promotion in collaboration with the school board employed staff.

8.10. Locally Developed Indicators

Provide results associated with the locally developed indicator(s) described in the 2023 Annual Service Plan to monitor success of the School Health Program. Describe the results associated with each indicator, including if your board of health met the outcome measures associated with each indicator as intended, and explain any variances (over/under), as applicable.

2023 saw an increase in the number of meetings between the Health Unit and the school boards. New initiative planned with both school boards, and currently being implemented in schools in collaboration with one school board. The intended outcome was to have established regular meetings with the school boards. While this was not achieved and is a work in progress, multiple ad-hoc meetings did occur with the school boards, which is a step towards achieving the objective, and this will be built on in 2024.

If applicable, please describe any additional locally developed indicators identified throughout 2023 that were not described in the 2023 Annual Service Plan and associated results (i.e., if outcome measures were met as intended and any variances) to monitor the success of the School Health Program.

9.0. Substance Use and Injury Prevention

9.1. Locally Developed Indicators

Please provide results associated with the locally developed indicator(s) described in the 2023 Annual Service Plan to monitor success of Substance Use and Injury Prevention Programs. Describe the results associated with each indicator, including if your board of health met the outcome measures associated with each indicator as intended, and explain any variances (over/under), as applicable.

1) Alcohol:
Number and type of awareness raising/education related to alcohol:
-1 media release regarding Canada's Guidance on alcohol and health

If applicable, please describe any additional locally developed indicators identified throughout 2023 that were not described in the 2023 Annual Service Plan and associated results (i.e., if outcome measures were met as intended and any variances) to monitor the success of Substance Use and Injury Prevention Programs.

Reduced duplication of efforts and increased alignment and consistency between boards of health, as per the Tobacco, Vapour, and Smoke Guidelines, 2021
Ontario TCANs collaborated to establish a provincial collaborative structure to strategically address nicotine dependence and prevention across Ontario
HNHU participated as one of the 31/32 PHUS who participated in the Provincial Collaborative Structure

Board of Health for the Haldimand-Norfolk Health Unit

2023 Standards Activity Reports as of December 31, 2023

Risk Management

Ref. #	Description	Category	Impact	Likelihood	Overall Risk Rating		Key Risk Mitigations	Date reported to the Board
A	B	C	D	E	F = D x E		G	H
1	Handling of personal health information (e.g. receiving, transporting, storing, sharing, etc.)	Compliance Legal	5	2		Not a high risk	Develop loss prevention & mitigation strategies; Need to review relevant policies and processes; Develop policies where necessary; Implement training and education for staff to attempt to mitigate risk of a privacy breach;	Risk Management update presents to Board of Health on July 5, 2023
2	Lack of electron client management system	Operational / Service Delivery	5	2		Not a high risk	Nursing documention procedures being updated; securing client files; lobbying for funding for electronic client management system	Risk Management update presents to Board of Health on July 5, 2023
3	Retention and recruitment of qualified people to fill staffing gaps.	People / Human resources	4	3		High	Continue to recruit for positions needed; Distribute essential tasks to other staff, if they have the knowledge, skills, abilities and capacity to complete them	Risk Management update presents to Board of Health on July 5, 2023
4	Failure to develop a comprehensive succession plan	People / Human resources	3	3		Not a high risk	Continue to work with Human Resources to develop a process to identify staff to be placed on a management track; Provide professional development and progressive leadership opportunities geared towards management	Risk Management update presents to Board of Health on July 5, 2023
5	Uncertainty regarding public health restructuring affecting funding requests and staff morale.	Strategic / Policy	5	5		High	Share information with staff as soon as it is available; Listen to staff concerns and provide support whenever possible; Supprot staff through pychological health and safety strategies	Risk Management update presents to Board of Health on July 5, 2023
6	Lack of comprehensive staff scheduling system to ensure coverage of program needs.	Strategic / Policy	4	3		High	Continue to use various other processes (e.g. Excel spreadsheets and online calendars) to plan staffing needs	Risk Management update presents to Board of Health on July 5, 2023
7	Staffing changes due to new staff orientation and staff moving to other programming area	People / Human resources	2	3		Not a high risk	Continue to recruit for positions needed; Develop a comprehensive orientation plan for new staff; Develop a comprehensive training and development plan for staff to continue to build their knowledge, skills and abilities to perform the needed tasks	Risk Management update presents to Board of Health on July 5, 2023

8	Increasing COVID cases and potential for remobilizing staff again	Strategic / Policy	5	3		**High**	Remobilizaition plans being developed; Potential impact on "regular" programming being assessed	Risk Management update presents to Board of Health on July 5, 2023
9	Lack of emergency preparedness resources to address local environmental health hazards (e.g. gas well leaks of H2S and Methane, etc.)	Environment	4	3		**High**	Continue to monitor and advocate for additional resources at different levels of government (Federal, Provincial and municipal)	Risk Management update presents to Board of Health on July 5, 2023
10	Lack of reliable faxing system	Technology	5	5		**High**	No personal health information being sent via email; Developed new processes to communicate with community partners; Information Technology Department obtaining new service provider and system	Risk Management update presents to Board of Health on July 5, 2023
11	No maintenance of Distribution Group lists	Operational / Service Delivery	4	2		**Not a high risk**	Policy to manage distribution groups; Outbreaks listed on the website	Risk Management update presents to Board of Health on July 5, 2023

Table 1 - Risk Categories	
Risk Category	**Definition**
Compliance Legal	Uncertainty regarding compliance with laws, regulations, standards, policies, directives, and/or contracts. May expose the organization to the risk of fines, penalties, and/or litigation.
Environment	Uncertainty usually due to external risks facing an organization including air, water, earth, and/or forests.
Equity	Uncertainty that policies, programs, and services have an equitable impact on the population.
Financial	Uncertainty of obtaining, using, maintaining economic resources, meeting overall financial budgets/commitments, and/or preventing, detecting, or recovering fraud.
Governance / Organizational	Uncertainty of having appropriate accountability and control mechanisms such as organizational structures and systems processes, systemic issues, culture and values, organizational capacity commitment, and/or learning and management systems,
Information / Knowledge	Uncertainty regarding the access to or use of accurate, complete, relevant and timely information. Uncertainty regarding the reliability of information systems.
Operational / Service Delivery	Uncertainty regarding the performance of activities designed to carry out any of the functions of the organization, including design and implementation.
People / Human resources	Uncertainty as to the organization's ability to attract, develop, and retain the talent needed to meet its objectives.
Political	Uncertainty of the events may arise from or impact any level of the government including the Offices of the Premier or Minister (e.g., a change in government political priorities or policy direction).
Privacy	Uncertainty with regards to the safeguarding of personal information or data, including identity theft or unauthorized access.
Security	Uncertainty relating to physical or logical access to data and locations (offices, warehouses, labs, etc.).
Stakeholder / Public Perception	Uncertainty around the expectations of the public, other governments, media or other stakeholders. Maintaining positive public image; ensuring satisfaction and support of partners.
Strategic / Policy	Uncertainty that strategies and policies will achieve required results or that policies, directives, guidelines, legislation will not be able to adjust necessarily.

Technology	Uncertainty regarding alignment of IT infrastructure with technology and business requirements. Uncertainty of the availability and reliability of technology.

Board of Health for the Haldimand-Norfolk Health Unit

2023 Standards Activity Reports
as of December 31, 2023

Vaccines Reimbursement

Program	Q4 Oct 1 - Dec 31	
	Doses Administered	Reimbursable Amount
Universal Influenza Immunization Program ($5/dose)	1,138	5,690.00
Meningococcal Quadrivalent Vaccine ($8.50/dose)	155	1,317.50
Human Papillomavirus Program ($8.50/dose)	846	7,191.00
Total	**2,139**	$ 14,198.50

Vaccine doses reported in the Quarterly Standards Activity Reports must match vaccine doses in the PEAR/PR1043 Reports for Men-C-ACYW and HPV and the Reimbursement Forms for UIIP, submitted by the board of health with the Quarterly Standards Activity Report.

Certification

Medical Officer of Health / Chief Executive Officer	
Name	Dr. Joyce Lock
(Signature) (Date)	

Chief Financial Officer / Business Administrator	
Name	Amy Fanning, CPA

(Signature) (Date)	

I certify that the information provided in the 4th Quarter Standards Activity Report is accurate and complete and that the signed/scanned and Excel versions submitted are identical to the scanned version submitted

Board of Health for the Haldimand-Norfolk Health Unit

2023 Standards Activity Reports
as of December 31, 2023

Certification

Medical Officer of Health / Chief Executive Officer	
Name	Dr. Joyce Lock
(Signature) (Date)	

Chief Financial Officer / Business Administrator	
Name	Amy Fanning, CPA
(Signature) (Date)	

We certify that: all costs and information submitted in this document are accurate and conform with categories specified as eligible, copies of all relevant invoices/back-up documentation are available for review at the board of health, and the submitted Excel and scanned/signed copies are identical.

View this email in your browser

PLEASE ROUTE TO:
All Board of Health Members
All Members of Regional Health & Social Service Committees
All Senior Public Health Managers

February 5, 2024

February 2024 InfoBreak

This update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa activities, correspondence, and events. Visit us at alphaweb.org.

Leader to Leader - A Message from alPHa's President - February 2024

Hello and greetings to all as we settle into what the 2024 year has to bring.

I look forward to our lineup in the alPHa Winter Symposium (held virtually) February 14-16. Commencing, we have the *Building Climate Change Resilient*

Health Systems workshop throughout the day on February 14th, on the importance of climate change to local public health, seeking a shared understanding of our roles in mitigation and adaptation, sharing perspectives on the challenges, actions and responses, and developing tools to manage heat-related adaptation. Joining us for this will be speakers from Health Canada, the British Columbia Centre for Disease Control, the National Collaborating Centre for Environmental Health, the Ontario Ministry of Health, and local public health units in Ontario. We intend for this to be an opportunity for mutual learning as we face challenges now and into the future.

On the afternoon of Thursday, February 15th, from 1 p.m. to 3 p.m., we will hold the second workshop: *Thriving in Change: Building Resilience in Turbulent Times* with Tim Arnold from Leaders For Leaders. Tim's message has been well received in the past and continues to be highly relevant in all that we do.

On February 16th throughout the day, we will have a range of speakers and topics including an update from Chief MOH Dr. Kieran Moore, a PHO update from Michael Sherar, progress on the alPHa bylaw (coming into compliance with ONCA), and an overview of the new alPHa Strategic Plan. Also of note will be the opportunity to meet (virtually) with peers and colleagues in our Section meetings.

The province continues its work with us on *Strengthening Public Health*. To this end, it is leading Community of Practice meetings. I do wish to highlight the excellent planning tool provided and maintained by KFL&A, including a map of boards of health that have communicated the possibility of merging.

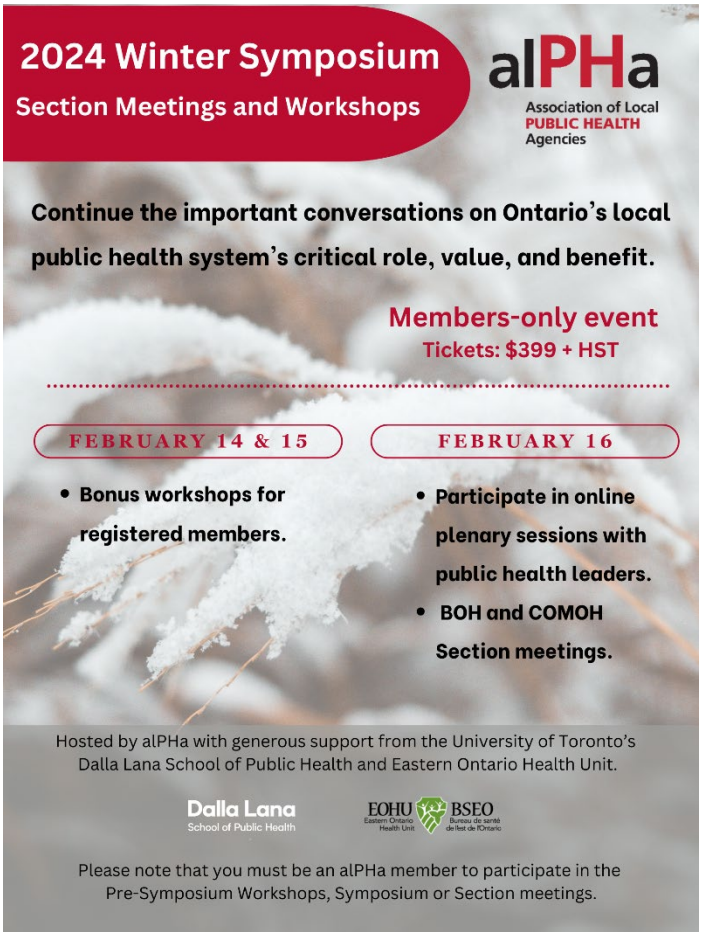
In December 2023, Dr. Moore issued a notice specifying the province's engagement process in the review and revision of the Ontario Public Health Standards (OPHS), citing groups and committees for this work. In this, he reiterated the intention to complete this work within 2024, with the exception of the standards for Infectious and Communicable Diseases Prevention and Control and for Immunizations, which will now be completed in a phased approach extending beyond 2024. Many in local public health have communicated to the province their willingness to participate in the OPHS review, demonstrating our strength of conviction and dedication. I commend all who have come forward with their willingness to make this commitment.

As we navigate through the changes that abound, our daily work continues across the very broad range of our mandate, addressing both acute health challenges and the underlying determinants of health. We continue working in and with our local communities addressing our unique circumstances pursuing better health for all. I look forward to seeing many of you virtually at the alPHa Winter Symposium,

virtually and in-person at TOPHC, and in-person in June at our alPHa Annual Conference.

Dr. Charles Gardner
alPHa President

Registration for the 2024 alPHa Winter Symposium, Section Meetings, and Workshops closes this Wednesday!



Have you registered for the online 2024 Winter Symposium, Section Meetings, and Workshops that are taking place February 14th-16th yet? **If not, registration closes Wednesday, February 7th, 2024.** This event will discuss a variety of issues of key importance to public health leaders and you won't want to miss out.

On Friday, February 16th, from 8:30 a.m. to 4:30 p.m., there is an exciting lineup of Symposium and Boards of Health Section meeting topics, with a focus on

Strengthening Public Health, including revising the Ontario Public Health Standards, voluntary mergers, and long-term funding for local public health.

alPHa is pleased to announce we will have welcoming remarks from the Hon. Doug Ford, Premier of Ontario and Minister of Intergovernmental Affairs; the Hon. Sylvia Jones, Deputy Premier and Minister of Health; Colin Best, President, Association of Municipalities of Ontario; Steini Brown, Dean, Dalla Lana School of Public Health and key speakers: Dr. Kieran Moore, Chief Medical Officer of Health; Dr. Charles Gardner, President, alPHa; Kelly Pender, Chief Administrative Officer, County of Frontenac; Dr. Piotr Oglaza, Medical Officer of Health and CEO, KFL&A and Wess Garrod, Chair, Board of Health, KFL&A; Franger Jimenez; John Allen, Partner, Allen & Malek LLP and Dr. Robert Kyle, Past-Chair, alPHa – ONCA Compliance Working Group; Michael Sherar, President and CEO, Public Health Ontario; and Sabine Matheson, Principal, StrategyCorp.

In conjunction with the Symposium and Section meetings, we are holding two workshops. The first one, *Building Climate Resilient Health Systems*, is on Wednesday, February 14th, from 9 a.m. to 4:30 p.m. On the afternoon of Thursday, February 15th, from 1 p.m. to 3 p.m., we will hold the second workshop: *Thriving in Change: Building Resilience in Turbulent Times* with Tim Arnold from Leaders For Leaders. These workshops are being offered at no additional cost to Symposium registrants and you will be registered automatically when you sign up for the Winter Symposium. Separate registrations are not available for individual events.

The following documents can be accessed by clicking on the links below:

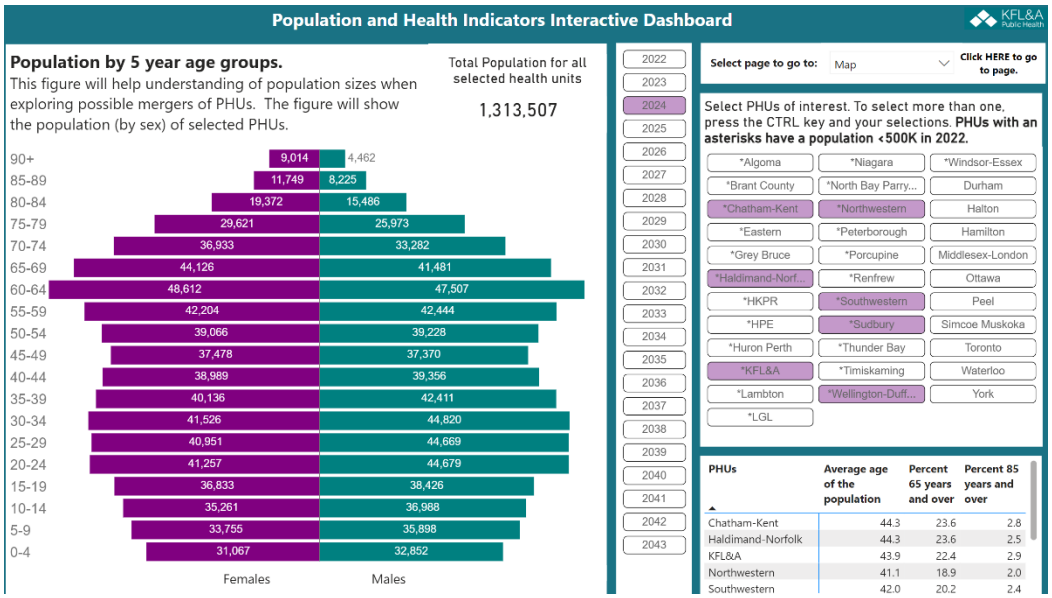
- Event flyer
- Symposium draft program (revised)
- BOH Section Meeting draft agenda (revised)
- Building Climate Resilient Health Systems workshop draft agenda
- Thriving in Change: Building Resilience in Turbulent Times workshop
- Speakers' biographies (new)

Registration is for alPHa members only, (please note, you do not need to create an account on the alPHa website in order to register for the event) and the cost is $399+HST (and is inclusive of the Symposium, Workshops, and Section Meeting and you only need to register once to attend all of the events). Please note, the best way to pay for your registration is via credit card or Electronic Fund Transfer.

Please note, alPHa will collect any presentations shared by the speakerswith the membership and will distribute the presentations as soon as these areavailable.

alPHa would like to thank the University of Toronto's Dalla Lana School of Public Health and Eastern Ontario Health Unit for their generous event support!

Population and Health Indicators Interactive Dashboard



KFL&A would like to share with members the population dashboard they created to facilitate exploratory discussions regarding voluntary mergers between Boards of Health. To view the dashboard, click here. **Please note, this will be featured as part of a session at the Winter Symposium.**

Boards of Health: Shared Resources

A resource page is available on alPHa's website for Board of Health members to facilitate the sharing of and access to information, orientation materials, best practices, case studies, by-laws, resolutions, and other resources. **In particular, alPHa is seeking resources to share regarding the province's Strengthening Public Health Initiative, including but not limited to, voluntary mergers and the need for long-term funding for local public health.** If you have a best practice, by-law or any other resource that you would like to make available via the newsletter and/or the website, please send a file or a link with a brief description to gordon@alphaweb.org and for posting in the appropriate library.

Resources available on the alPHa website include:

- Orientation Manual for Boards of Health (Revised Jan. 2024)
- Review of Board of Health Liability, 2018, (PowerPoint presentation, Feb. 24, 2023)
- Legal Matters: Updates for Boards of Health (Video, June 8, 2021)
- Obligations of a Board of Health under the Municipal Act, 2001 (Revised 2021)
- Governance Toolkit (Revised 2022)
- The Ontario Public Health Standards
- Public Appointee Role and Governance Overview (for Provincial Appointees to BOH)
- Ontario Boards of Health by Region
- List of Units sorted by Municipality
- List of Municipalities sorted by Health Unit
- Map: Boards of Health Types

- Risk Management for Health Units
- Healthy Rural Communities Toolkit
- NCCHPP Report: Profile of Ontario's Public Health System (2021)
- The Municipal Role of Public Health(2022 U of T Report)
- Boards of Health and Ontario Not-for-Profit Corporations Act

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Final call for all Executive Assistants/Administrative Assistants!

Registration for this year's Executive Assistant/Administrative Assistant Workshop is **closing on Wednesday, February 7th, 2024**! This virtual event, which costs $149+HST, will be held on Wednesday, February 14th from 1 p.m.-3 p.m., and is an opportunity to connect with colleagues from across Ontario, share ideas, and enhance your skills.

The workshop, called *Thriving in Change: Building Resilience in Turbulent Times*, will be put on by Tim Arnold from Leaders For Leaders and will "help you navigate the tricky and turbulent moments you face in the workplace. This interactive

session seamlessly integrates change management, emotional intelligence, and resilience, providing you with a holistic toolkit to thrive amidst unprecedented change, tight timelines, and high-stress work environments."

To learn more about this event, you can view the flyer here.

Please note, you do not need to create an account on the alPHa website in order to register for the workshop. However you must be an Executive Assistant/Administrative Assistant to a medical officer of health/board of health at a health unit to participate.

alPHa would also like to thank Melissa Ziebarth from Renfrew County District Health Unit, Kathy Proksch from Region of Waterloo, Public Health, and Loretta Ryan and Melanie Dziengo, alPHa, for being part of the Workshop Planning Committee.

We hope to see you online February 14th!

2024 alPHa Conference and AGM!

Save the date for the alPHa Conference and AGM that will be held in-person June 5-7, 2024 in Toronto. Further details, including accommodation information, will be shared in early March when the AGM package is released.

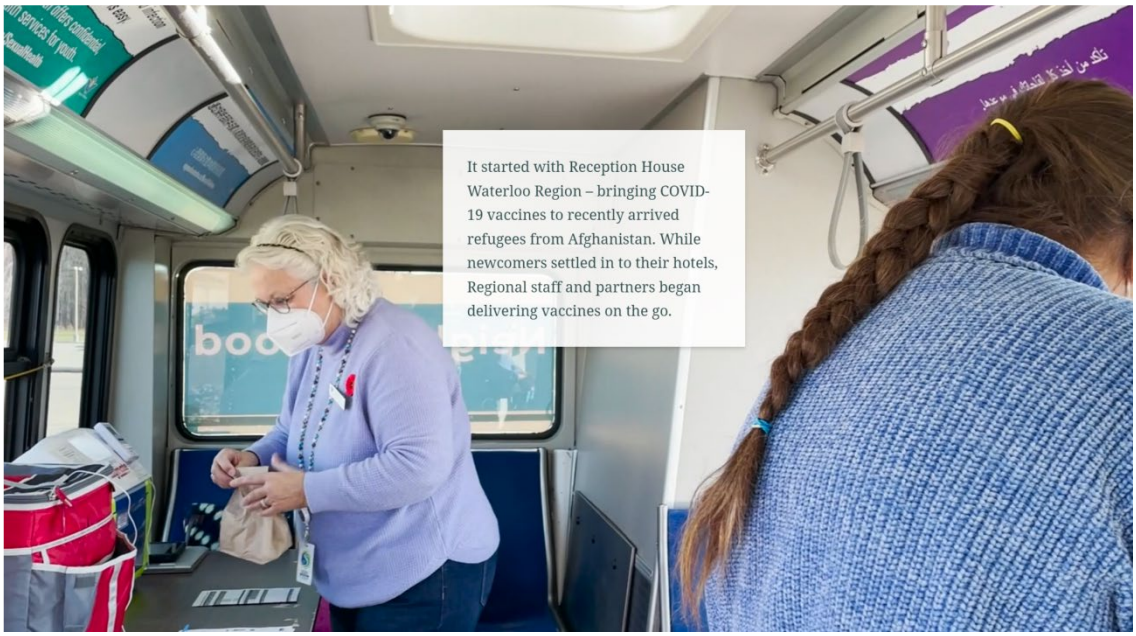
alPHa members are invited to submit resolutions for consideration at the 2024 alPHa Annual General Meeting & Resolutions Session during the Annual Conference in June.

It is important that resolutions are drafted using the "Procedural Guidelines for alPHa Resolutions" found by clicking here. Members are also encouraged to visit alPHa's extensive library of past resolutions to ensure consistency with or to build upon existing positions where appropriate.

Rural Ontario Municipal Association (ROMA) proposal released

At the ROMA Conference that took place January 21-23, *Fill the Gaps Closer to Home - Improving Access to Health Services for Rural Ontario: Proposals from the Rural Ontario Municipal Association*, was released. Public health is noted as being part of the project scope, mentioned a number of times in the document, and included in recommendations. The full report is available here.

Region of Waterloo Vaccine Bus



To address challenges in accessing vaccines at pharmacies and doctor's offices in some neighbourhoods, the Region of Waterloo has been providing vaccines on a Grand River Transit bus. To read more, click here.

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alPHa Workplace Health & Wellness

Do you want to improve your physical and mental health? Head to our website to read more of our infographics to help you improve your health and wellness.

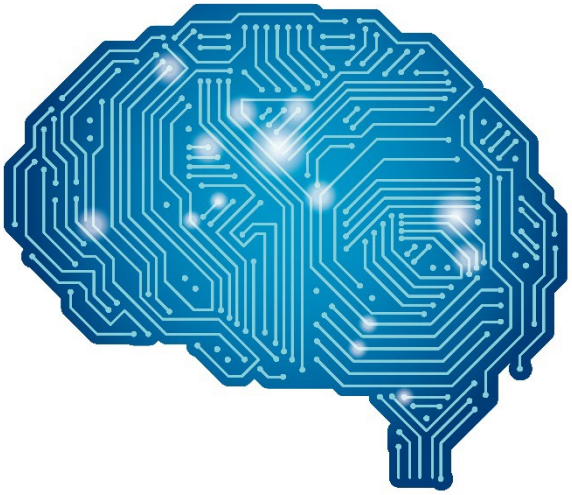
To view this year's Workplace Health & Wellness Month poster, please click here. We encourage all alPHa members to start thinking about participating in May's Workplace Health& Wellness Month.

Climate Change update

With 2023 marked the hottest year on record, the urgency for robust public health action in mitigation and adaptation in LPHAs remains critical. Local impacts including air quality and heat from wildfires is negatively impacting the health of Ontarians. These events underscore the urgency for robust public health action in both climate change adaptation and mitigation activities at the local level. The pursuit of such health and health equity through mitigation and adaptation activities demands strong public health action to address climate change. In keeping with such activities, alPHa's winter symposium on February 14, 2024 will focus on the collective action required of LPHAs. The workshop, *Building Climate Resilient Health Systems*, will include speakers from Health Canada, the BC Centre for Disease Control, Ontario Ministry of Health and numerous health units with a focus on both mitigation and adaptation efforts representing federal, provincial and local efforts.

Read the full article here on our recently revamped Climate Change and Health - Resources page.

Artificial Intelligence (AI) update



In January 2024, the launch of ChatGPT's 'GPT Store' heralded a new era in AI, offering a range of tools leveraging OpenAI's expanding platform and infrastructure. These GPT-based applications, including the release of Microsoft Co-Pilot provides access to technology requiring minimal coding knowledge and spans various sectors in public health including communications, research, education, health protection and health promotion. This innovation contrasts with traditional app development, which required extensive programming expertise. The simplicity of the creation of GPT and similar AI platforms has led to a rapid increase in their number and diversity. LPHAs stand to benefit from such innovation, using tools to enhance operations and collaboration with healthcare partners. This advancement presents a unique opportunity for executives and LPHAs to integrate AI into their existing and future strategies, optimizing public health outcomes and sharing applications to maximize innovation across the sector.

The unveiling of ChatGPT's 'GPT Store' marks a significant milestone in the evolution of artificial intelligence applications. The GPT store, similar to a digital marketplace for apps, offers a wide range of AI-driven tools built on OpenAI's advanced machine learning technology. GPT-based applications extend the functionalities of the ChatGPT platform to encompass specific tasks across diverse domains. Key categories include communications, such as graphic design tools; research, offering sophisticated literature search capabilities; educational aids like tutors and consultants; and health/lifestyle applications, including nutrition, exercise coaching, and infection prevention and control (IPAC) consultants. The development of applications for platforms like Apple or Android requires significant coding expertise, limiting innovation among organizations without such resources or budget. In contrast, GPT-based applications streamline this process, allowing

creation with minimal or no coding experience. This ease of development of GPTs and similar solutions including Microsoft Co-Pilot has led to a rapid expansion in the variety and number of available applications, democratizing access to AI technology.

While this surge in development presents certain risks, such as ensuring the effectiveness and reliability of these applications, it also opens unprecedented opportunities for LPHAs in leveraging AI technology to enhance operational efficiency and program delivery. Furthermore, sharing these applications with public health and partners can foster collaborative innovation and better resource utilization. As LPHAs explore the potential of solution-based applications, risk mitigation through an adequate organizational AI policy (see November 23, 2023, alPHa BN) is required in keeping with privacy and ethical considerations in effective public health practice. This new era of accessible AI applications presents a unique opportunity for public health executives to harness cutting-edge AI technology to advance their mission and improve community health outcomes.

Affiliates Update

Health Promotion Ontario (HPO)

Health Promotion Ontario is once again celebrating excellence in health promotion. Nominations for the Lori Chow Memorial Award are open!

Individual Award

This award is presented annually to someone who demonstrates excellence in health promotion, champions the social determinants of health, and demonstrates leadership and mentorship in health promotion.

Project/Initiative Award

This award acknowledges outstanding health promotion projects or initiatives. This award is presented annually to projects/initiatives that demonstrate teamwork, collaboration, innovation and impact.

Please submit by completing the nomination form for an individual or project/initiative award. Submissions will be accepted until February 28, 2024.

TOPHC 2024

Registration for TOPHC 2024 has launched! Here's what you can expect:

- In-person workshops: March 26, 2024 - (at Beanfield Centre, Toronto); Interactive workshops, with opportunities for in-person networking. The cost to attend in-person workshops is $125.
- Virtual session: April 3, 2024 - An exciting program with a variety of interactive presentations that will inspire ideas and spark conversations with colleagues. The cost to attend the virtual convention is $250, which includes access to the 2024 Virtual Library for six months following the event. Discounts for multiple registrations are available.

There are six confirmed workshops on a variety of topics, including: advancing health equity, avoiding burnout, wildfire season, chronic disease prevention, enteric outbreaks, and rapid review basics. For more info, visit the TOPHC website: tophc.ca

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RRFSS' next Membership opportunity starts in May!

One of the benefits of RRFSS is that PHUs can join three times during the year and the next opportunity is just a few months away.

RRFSS provides much-needed local data to understand local health issues and PHUs have complete control over survey content, with the ability to choose or develop locally-relevant questions (current module questions can be found here).

New Module Development

- RRFSS is known for its response to emerging health issues and there is current interest in developing new modules related to mental health stigma, substance use health stigma and mental health support. The results will be used to measure the impact of public health and community partner interventions on stigma and to better understand where more targeted interventions are needed.

- In 2023, the provincial government announced their plan to provide resources, support, and incentives to facilitate voluntary PHU mergers to better support communities. RRFSS can be used to respond to the unique needs of communities and develop modules related to support for health unit mergers.

- A new Optional – Flex module is being created for a new RRFSS module design that allows for PHU flexibility to pick non-sequential questions from a particular module. This is in response to a change suggested from last year's RRFSS Participation Survey.

The next cycle of RRFSS data collection runs May to August and data is delivered about 2 months following the end of the 4-month data collection cycle. For more information about joining RRFSS for the next cycle starting in May, contact Lynne Russell, RRFSS Coordinator lynnerussell@rrfss.ca

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Calling all Ontario Boards of Health: Level up your expertise with our NEW training courses designed just for you!

Don't miss this unique opportunity to enhance your knowledge and strengthen local public health leadership in Ontario.

BOH Governance training course
Master public health governance and Ontario's Public Health Standards. You'll learn all about public health legislation, funding, accountability, roles, structures, and much more. Gain insights into leadership and services that drive excellence in your unit.

Social Determinants of Health training course
Explore the impact of Social Determinants of Health on public health and municipal governments. Understand the context, explore Maslow's Hierarchy of Needs, and examine various SDOH diagrams to better serve your communities.

Speakers are Monika Turner and Loretta Ryan.

Reserve your spot for in-person or virtual training now! Visit our website to learn more about the costs for Public Health Units (PHUs). Let's shape a healthier future together.

Additionally, thank you to all the public health agencies who have shown interest in our BOH courses. alPHa staff are currently coordinating the bookings and are pleased to see the uptake.

BrokerLink Insurance

In partnership with alPHa, BrokerLink is proud to offer preferred home and auto insurance rates for members. Going on vacation soon? Review travel tips to help keep you safe and stress-free while on holiday here.

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alPHa Correspondence

Through policy analysis, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention, and surveillance services in all of Ontario's communities. A complete online library of submissions is available here. These documents are publicly available and can be shared widely.

- CMOH Response - BOH Leadership & Mergers

Public Health Ontario

Public Health Ontario | Santé publique Ontario

Influenza Genomic Surveillance in Ontario: 2023-24 Early Season

PHO has released the Influenza Genomic Surveillance in Ontario report, which provides surveillance data on early season influenza whole genome sequencing performed at PHO. The report describes the genetic characteristics of influenza strains circulating in the province during the inter-season period (June 1, 2023 to August 26, 2023) and the first part of the 2023/24 respiratory virus season (August 27, 2023 to November 17, 2023).

This report will be updated both in the middle and the end of influenza season. This information can be used to help public health professionals assess whether

antivirals are working against the currently circulating viruses, and advise on vaccine strains for the upcoming seasons.

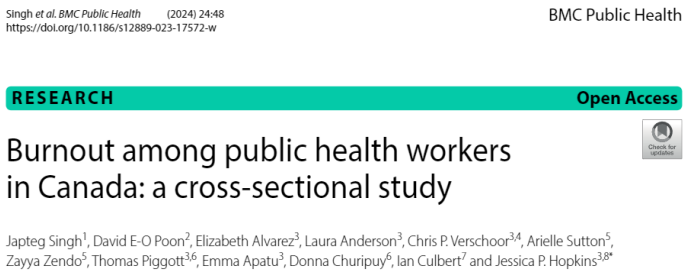
Enhanced Epi Summaries: Chlamydia, Gonorrhea, Syphilis

PHO's suite of enhanced epidemiological summaries include data including; trends over time, age and sex, geography, site of infection and testing for confirmed cases of chlamydia, gonorrhea and syphilis. These reports include the most current information available from Ontario's integrated Public Health Information System (iPHIS) as of September 18, 2023.

Additional Resources

- Ontario Respiratory Virus Tool (updated to include hospital bed occupancy data for COVID-19, influenza and RSV)
- Considerations for Food Safety Investigations at Food Premises during an Outbreak
- Focus On: Alpha-gal Syndrome (AGS)
- Outbreak Preparedness, Prevention and Management in Congregate Living Settings
- Focus On: Salutogenesis and Health Promotion

In case you missed it: Burnout among public health workers in Canada: A cross-sectional study


Singh *et al. BMC Public Health* (2024) 24:48
https://doi.org/10.1186/s12889-023-17572-w

BMC Public Health

RESEARCH Open Access

Burnout among public health workers in Canada: a cross-sectional study

Japteg Singh[1], David E-O Poon[2], Elizabeth Alvarez[3], Laura Anderson[3], Chris P. Verschoor[3,4], Arielle Sutton[5], Zayya Zendo[5], Thomas Piggott[3,6], Emma Apatu[3], Donna Churipuy[6], Ian Culbert[7] and Jessica P. Hopkins[3,8*]

A new study led out of Public Health Ontario and, published in BMC Public Health, finds 79 per cent of public health workers in Canada meet criteria for burnout and 49 per cent of participants reported harassment because of their work during the pandemic. Read more here.

Upcoming DLSPH Events and Webinars

Dalla Lana School of Public Health

- Canadian Centre for Health Economics Friday Seminar Series: Cost Estimate of a Single-Payer Universal Drug Plan (Feb. 9)
- Data Science in Health: A Holistic Perspective - Prof. Rumi Chunara (Feb. 12)
- The Black Health Lecture Series (Feb. 20)

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alPHa's new mailing address

Please note our mailing address has changed to:
PO Box 73510, RPO Wychwood
Toronto, ON M6C 4A7

Please update your records accordingly for correspondence, payments, and other remittances. Our telephone number and e-mail addresses remain the same.

Additionally, if your health unit has not yet moved to credit card or electronic fund transfers (EFTs) for payment, alPHa requests that you do so.

For further information, please contact info@alphaweb.org.

News Releases

The most up to date news releases from the Government of Ontario can be accessed here.

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