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Kenora, ON  P9N 2K4  

April 21, 2017  

Ms. Roselle Martino  
Assistant Deputy Minister  
Population and Public Health Division  
Ministry of Health and Long-Term Care  
10th Floor, 80 Grosvenor Street  
Toronto, ON  M7A 2C4  

Dear Ms. Martino:  

Re: Public Health Programs and Services Consultation  

On April 21st, 2017, the Board of Health of Northwestern Health Unit passed resolutions supporting two attached documents:  
- the letter from the Association of Local Public Health Agencies dated March 17th (attached)  

Thank you for the opportunity to provide feedback on the operations and implementation of the Modernized OPHS. Overall we view the changes in the OPHS positively and consistent with the 2017-2020 Strategic Plan of Northwestern Health Unit.  

Sincerely,  

Paul Ryan, Board Chair  
Northwestern Health Unit Board of Health  

cc: Dr. David Williams, Chief Medical Officer of Health, MOH&LTC  
Linda Stewart, Executive Director, alPHA
Background

The Ministry of Health and Long-Term Care (MOHLTC) has released the Standards for Public Health Programs and Services: Consultation Document (SPHP&S) and has asked for feedback from public health units and other key stakeholders by April 21, 2017 in the following areas:

- What clarification is required on the draft standards?
- What operational matters should MOHLTC consider?
- What implementation supports are required (e.g., protocols, guidance documents, training supports)?

The Leadership Council of the Northwestern Health Unit has reviewed the draft SPHP&S and has prepared this document for the Population and Public Health Division of the Ontario MOHLTC to be considered as part of the consultation process for the modernized Ontario public health standards.

General considerations

Overall, the tone and direction of the modernized OPHS is consistent with the direction of Northwestern Health Unit and our new Strategic Plan (NWHU Strategic Plan 2017-2020). The new components of mental health promotion and strengthened health equity are areas that required increased attention as indicated by the health assessment statistics for the region. The new standards also emphasize the importance of quality, accountability and following public health principles of planning and evaluation. These are areas that will strengthen our work and increase the effectiveness of public health practice.

It is noted that there are a number of new or revised protocols, guidelines, reference documents and ministry policies pending. As the details are unknown at this time, we cannot fully comment on the impact of the proposed changes to the Northwestern Health Unit at this time. We strongly recommend that the development of these documents allow meaningful input from local public health units throughout the development process.

Resources / funding

A main concern is related to the increased workload with the new standards. There is increased work/emphasis related to the Local Health Integration Networks (LHINs), Indigenous organizations and communities, mental health promotion, and health equity. Without increases in funding, finding capacity to do this work will require a reallocation of resources.

As the standards have weakened the requirements with respect to sexual health clinics, travel clinics, harm reduction and outreach to priority populations, there appears to be an implicit provincial direction to reduce such activities. For Northwestern Health Unit, reductions in these activities (i.e., sexual health clinics, travel clinics, harm reduction, outreach) may lead to substantial harms to population health. The catchment area is comprised of many small rural communities (the largest municipality has a population
of approx. 17,000) and there are no other service providers for travel clinics, minimal or no options for sexual health clinics, and minimal or no options for harm reduction and outreach activities. Sexual health clinics, harm reduction and outreach activities target generally vulnerable / high needs populations and reductions in these services will also have a negative impact on health equity.

The new standards have added increased variability to respond to local needs, suggesting that perhaps resources can be reallocated from reductions in some activities. While increased flexibility for programming can be beneficial, it may also weaken or reduce activities on topic areas that are particularly important for Northwestern Health Unit. Population health assessment indicates that strong efforts are required to address chronic diseases, and mental health and addictions in the region. This requires strong programming in these areas as well as in Healthy Growth and Development and School Health. Therefore although there is increased flexibility to allow reduced programming to reallocate resources, the health statistics of the community indicate that reallocation of resources from these areas may be counteractive to improving the health of the population.

Overall, while the reallocate of existing resources could lead to improved efficiencies, there is likely not enough capacity to take on the new work without reducing other important public health activities in our region.

### Standardization versus variability

The standards have sections that are more standardized (e.g., Food Safety, Infectious and Communicable Diseases Prevention and Control, and Safe Water) while other sections allow more variability / flexibility (e.g. Chronic Diseases, Injury Prevention, Wellness and Substance Misuse, Healthy Growth and Development, School Health). If funding does not increase over time to keep up with inflation, then eventually, the sections where there is more variability are likely to be weakened or eroded to adjust for increasing financial constrictions. We would recommend that funding be increased appropriately to prevent this from occurring over time. As mentioned above, population health assessments indicate that stronger emphasis is required for those public health components related to chronic disease prevention, mental health and addictions.

The reference in the 2008 standards to comprehensive health promotion has been removed, essentially replaced by the more flexible (in writing) requirement to develop a “program of public health interventions.” There is no explicit mention of health promotion strategies in the updated document (strengthening community action, supportive environments, healthy public policy, skill development and reorienting health services). Evidence shows that health promotion programming is most effective when using all five strategies. Reference to comprehensive health promotion should be put back into the standards document somewhere, or included in accompanying guidelines to ensure that this evidence-based approach guides public health programs and services.

### Annual service plan and budget submission

In principle, having an annual service plan and budget submission would be a useful method of strengthening public health practice, and ensuring transparency and accountability. The template for
this submission should be balanced in demonstrating appropriate decision making, but without being overly detailed, complicated or resource intensive. Parts of the template may be better completed at the level of the province rather than all health units filling in the same information. For example, if there is a section on the evidence base of the effectiveness of programming, this may come directly from guidelines or evidence briefs produced by the MOHLTC or Public Health Ontario (PHO).

As the overall structure and division of the standards have changed, this is likely to change in how we prepare budgets and program planning. The NWHU finance department may need to completely change the internal funding distribution and categorization process based on the new standards. Program planning may have to occur across program portfolios to be in line with the new standards and the annual service plan submission. This will take increased capacity to adjust fully and local public health units should be allocated adequate time or one-time funding in order to make these adjustments.

Data and data analysis requirements

Throughout the standards, there is an increased emphasis on the importance of data, health information and using health information to support planning, delivery and monitoring of health services. This increased need is also reflected in the requirements related to the LHINs, in the allocation of resources to reflect public health priorities, and for the preparation of annual service plan and budget submissions.

There is a lack of data related to a variety of important topic areas including mental health promotion, health hazards, and child and youth health to help direct programming (https://www.wechu.org/childrencount). The MOHLTC and PHO can play a leadership role in ensuring that this data is available. It is also important that lack of local data should not be a barrier to evidence based programming. This is particularly true in rural and remote health units where local data is often difficult to attain. The Ministry should consider increasing system capacity to collect local population health data (e.g., universal funding for the Rapid Risk Factor Surveillance System) and the annual service plans and budget submission process should acknowledge that programming may be indicated despite the lack of local data on a topic area.

If the new requirements under future protocols (e.g. related to the relationship with the LHINs), guidelines, and the Annual Service Plan and Budget submission, require substantially more data analysis, then resource reallocation or increases may be required to increase data analysis capacity. Public Health Ontario currently plays a role in data analysis at the local public health unit level for some public health topics (e.g., infectious diseases). There would be benefit from dedicating resources to allow Public Health Ontario to increase this analysis role for a more comprehensive scope of topics.

Indigenous communities and organizations

NWHU has many Indigenous organizations in the region and 40 First Nation communities in the catchment area. Engaging ALL organizations and/or communities would be a very large undertaking. Given that, we do continuously work on building relationships as the opportunity arises and within the capacity of the organization.
Engagement of First Nation communities would lead to increased work load. If the work load cannot be reasonably absorbed into current resources, then increased funding will be required. Considering that current cost-shared funding is partially from municipalities, we recommend that funding should come directly from MOHLTC and the related should be 100% provincially funded.

The guidance document related to engagement of Indigenous communities should include:

1. Guidance on evidence based cultural safety training for the organization. There are a variety of training programs currently available nationally. The guidance document can outline which have been evaluated to be effective in improving staff practice, and which are appropriate for a public health organization. If there is more than one training program being recommended, it should outline the pros and cons to assist in choosing one. The document should recognize that there may also be local cultural safety training that could be implemented in addition to a national or provincial training program.
2. Guidance on the definition of “meaningful” relationships and engagement with Indigenous organizations and communities.
3. Legal considerations around Section 50 agreements, particularly if there are various models of a Section 50 that the HPPA can allow.
4. An outline of the expectations of the MOHLTC on the extent to which the HPPA, other public health related legislation (e.g., SFOA), the public health standards, and related performance management systems and accountability indicators apply in First Nation communities.

**Relationship with Local Health Integration Networks**

As stated above, local public health units should be provided the opportunity to provide input and feedback during the development of the requirements, protocols and guidelines, and reference documents related to the expectations of the relationship between the LHINs and the Boards of Health, and LHIN CEOs and Medical Officers of Health.

The North West LHIN covers a large geographical area that covers 2 health units (NWHU and Thunder Bay District Health Unit). In the catchment area of NWHU, there are 3 sub-LHINs (integrated district networks is the terminology used by the North West LHIN) which are further broken down into 8 local health hubs. Because of the large geographical spread of the communities and variations in partners, collaborative conversations usually are most effective at the level of the sub-LHIN or local health hub. Working towards effectively applying a public health and health equity perspective to health care services requires purposeful effort at both the local level and the LHIN level. This will require additional staff and management time and capacity.
## Detailed feedback

We also have some specific feedback or questions for clarification for specific standards as included in the table below.

<table>
<thead>
<tr>
<th>Standards</th>
<th>Clarity/context</th>
<th>Operational considerations</th>
<th>Implementation supports</th>
<th>Other tools and supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Health Assessment</td>
<td></td>
<td>Increased local capacity and/or system (provincial) capacity required to collect, analyze, share and support the use of local data in program planning &amp; evaluation</td>
<td>Evidence-based tool or mechanism for allocation of resources related to public health priorities</td>
<td>Continue to provide annual NFB spreadsheet and data collection survey for HU. If not provided this will not be consistent across the province – local HU do not have the capacity to do this.</td>
</tr>
<tr>
<td>Effective Public Health Practice</td>
<td>Disclosure of inspections take time to ensure data accuracy, developing a communication strategy and resources for the public and operators and changes to the website. Disclosure of food safety</td>
<td>guidance document on “improving the quality of programs and services”</td>
<td>Guidance document/protocol on</td>
<td>Some program inspection result databases (e.g., SFOA, ECA, RCAT) are provincial. Can the MOHLTC disclose those provincially instead of at the local health unit level?</td>
</tr>
</tbody>
</table>
**Standards** | **Clarity/context** | **Operational considerations** | **Implementation supports** | **Other tools and supports**  
--- | --- | --- | --- | ---  
Chronic Disease, Injury Prevention, Wellness and Substance Use |  | Information took about 1 year to prepare. | Disclosure of results from inspections |  
Healthy Environments | Definitions of a healthy natural environment | Increased staff time required to dedicate work to new topics. | Guidance documents for mental health promotion, food literacy/food skills and other new topic areas | Provincial supports and/or local funding to access, gather and analyze health information related to health hazards.  
  
  Built environment shows up here and also in Chronic disease prevention. Can you provide clarity on the difference?  
  
There is a lack of data related to health hazards (e.g., lead exposure, mercury, radon). Substantial funding would be required to design and implement a study to determine the unique needs of the community related to these health hazards.  
  
For many health hazards, the cost of remediation falls on the individual (e.g., lead remediation of homes, remediation of homes with high Radon levels) and may involve services that are not available (e.g., contractors who
## Standards

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<td>Healthy Growth and Development</td>
<td></td>
<td>can do remediation). In addition to identifying the problem, there should also be supports/expertise to address the health hazard.</td>
<td>Guidance documents or evidence briefs for healthy sexuality and mental health promotion.</td>
<td>Provincial supports and/or local funding to access, gather and analyze health information related to child and youth health</td>
</tr>
<tr>
<td>Immunization</td>
<td>Increased staff time required to strengthening programming related to school aged children, youth and emerging adults.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Infectious and Communicable Diseases</td>
<td>Do all Health units require a rabies contingency plan?</td>
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### NWHU Report

**Title:** Feedback on the “Standards for Public Health Programs and Services. Consultation Document”

**DATE:** April 21, 2017  
**PREPARED BY:** NWHU Leadership Council  
**PAGE** 8 of 8

**INTENDED AUDIENCE:** Population & Public Health Division of the Ontario MOHLTC

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<td>School Health</td>
<td>Staff training or new staff expertise related to vision screening</td>
<td>Increased staff time required to increase work related to strengthening school health and the new topic areas.</td>
<td>Guidance documents or evidence briefs for addressing new topic areas, particularly mental health promotion, healthy sexuality, violence and bullying</td>
<td>Provincial requirement for school boards to work with public health units, including catholic school boards to address healthy sexuality and sexual health.</td>
</tr>
</tbody>
</table>
March 17, 2017

Roselle Martino
Assistant Deputy Minister
Population and Public Health Division
Ministry of Health and Long-Term Care
10th Floor, 80 Grosvenor Street,
Toronto, Ontario M7A 2C4

Dear Roselle,

Re: Public Health Programs and Services Consultation

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHa), I am writing today to provide our initial feedback on the Standards for Public Health Programs and Services Consultation Document that was released for comment on February 17.

We recognize that a great deal of work went into this review, and appreciate the fact that many of our members were directly involved in the development of the revised Standards for Public Health. We are also pleased with the decision to hold regional consultations and hope that the feedback that you receive from our members as part of these will be carefully considered, as our members will be more likely to provide more detailed operational feedback not covered here. Finally, we are most appreciative of the extension to the original April 3 deadline to accommodate a more thorough consideration of the document.

Our response as an Association is based primarily on what we heard at the 2017 alPHa Winter Symposium and follow-up discussions during meetings of our Council of Ontario Medical Officers of Health (COMOH) and Boards of Health Sections as well as the alPHa Executive Committee and Board of Directors since that time.

We understand that the intent of the present consultation is to gather feedback on operational considerations and implementation requirements and supports. We expect that the most useful feedback on these will be heard as part of the regional consultations that will take place later this month, as staff and managers who are most familiar with the various programs and services are in the best position to provide the required analysis and advice.
Indeed, a recurring theme that we have heard from our members during and following our February symposium is that it will be difficult to fully assess the operational implications of the revised standards before more clarity on the more specific expectations are available. We are given to understand that these will emerge with the development of protocols, guidance documents and annual service plan template, and we would appreciate assurances that the field will be fully involved in this process so that we can answer the operational and implementation questions as they arise.

Similarly, the importance of examining the existing and potential capacity, resource and funding issues cannot be overstated. These have been at the forefront of our discussions of the revised standards so far, and the expectations will need to be more clearly understood before an assessment of the capacity to meet them can be properly carried out.

The above uncertainties notwithstanding, we already have significant concerns about capacity in light of our escalating struggles to meet our existing mandate and respond to local needs with constrained budgets. These struggles will only intensify with the new program and process obligations that are laid out in the revised standards and the continued implementation of the public health funding formula.

We have, for example, communicated on several occasions as part of our feedback on the Patients First initiative that increasing engagement with the health care sector carries with it significant resource implications. Assisting with the planning of health care delivery services is a new application of public health’s expertise in population health assessment, which requires different analytical approaches and is in addition to the applications that we will be expected to continue.

Even if this and the various other added requirements are offset by the subtraction or consolidation of others, there will be resource implications related to adapting our service delivery processes to the shifts in expectations, including retraining staff for new obligations, re-allocating resources and developing outreach and negotiation strategies for programs that we are no longer expected to ensure are available. New administrative requirements such as developing annual public health service plans and individualized programs of public health interventions will also entail significant additional consideration.

We also have some concerns about the much less prescriptive approach to the health promotion standards. Although we are very receptive to the greater latitude to tailor health promotion / chronic disease prevention programs via local public health “intervention plans”, we see a potential risk to their effectiveness and sustainability in the current fiscal climate. If available resources remain static (as they have now for two years in most cases), meeting the more explicit health protection requirements on an ongoing basis will almost certainly erode the resources left over for the delivery of effective tailored health promotion programs and services over time. We recommend that there be mechanisms developed to mitigate this risk and protect our critical work in the more flexible areas of the standards.

As we observed above, there is still much that has not yet been defined within the new standards, and there are additional uncertainties about the outcomes of the correlated health system transformation processes. We do see this as an important opportunity to answer questions and address concerns, and it will be exceedingly important that these processes (including but not limited to the Expert Panel on Public Health, the Public Health-Local Health Integration Network Work Stream, the new Accountability Framework) are appropriately bridged to ensure that we have the information we need to guide us through the transformation process. We would appreciate assurances that we will be full participants in ensuring that these processes and their products serve the best interests for effective health protection and promotion throughout the province.
It is important to note that the above points are reflective of the collective discussions that our members have had in the short time since the release of the consultation document. The emergence of other questions and concerns as the revised Standards are more closely examined are a near-certainty, and we hope that you will remain open to discussing them – including feedback on content - in the months leading to the January 2018 implementation.

In closing, we recognize that having such explicit and comprehensive public health standards is unusual in Canada and we are grateful to have a strong foundation for the practice of public health in Ontario. We thank you for the opportunity to assist in further strengthening Ontario’s public health system to most effectively protect and promote the health of all Ontarians.

Yours sincerely,

Carmen McGregor
alPHa Vice-President

COPY: Dr. David Williams, Chief Medical Officer of Health
     Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation, Ministry of Health and Long-Term Care
     Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Ministry of Health and Long-Term Care