Ontario Public Health Association
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# Submission to the Population and Public Health Division, Ministry of Health and Long-Term Care on the 2017 Standards for Public Health Programs and Services Consultation Document

**April 21, 2017**

April 21st 2017

Roselle Martino
Assistant Deputy Minister
Population and Public Health Division
Ministry of Health and Long-Term Care
College Park
777 Bay Street, 19th Floor, Suite 1903
Toronto, ON M7A 1S5

**Re: 2017 Standards for Public Health Programs and Services Consultation Document**

Dear Ms. Martino,

I am writing on behalf of the members of The Ontario Public Health Association to provide feedback on the Standards for Public Health Programs and Services. This feedback reflects and integrates the perspectives of our members, including ten volunteer expert workgroups and task groups as well as nine Constituent Societies* (CSs) that represent over 2,000 public and community health professionals. While several of OPHA's Constituent Societies have independently sent you their own submissions, the inclusion of their main themes in this document intends to reaffirm our support for their key messages.

Our members wish to convey their thanks to those who served in various capacities in reviewing the latest evidence and contributing to the creation of this document. We appreciate the challenges inherent in this task and the opportunity to provide feedback. While our members recognize that these standards are a policy document reflecting government priorities, in the document that follows, they have offered suggestions responding to the questions that were posed during the regional consultations.

OPHA was encouraged to see several new areas included in the modernized standards. Our members have responded by expanding on the opportunities offered by these new additions. Areas that were especially well-received included:

- specific reference to Indigenous populations;
- a standard on health equity;
- an increased emphasis on school health, the built and natural environments and climate change;
- the inclusion of mental health promotion and violence prevention;
- commitment to the use of evidence, evaluation and population health assessment, as well as a strengthening of the importance for quality improvement.

The introduction of these and other changes can also create uncertainty and challenges. Consequently, our members are calling for greater clarity in various areas, including new protocols to promote guidance and consistency that will ensure the work they value, especially related to health promotion, is fully supported. Recognizing that there are various other processes in the works, such as developing

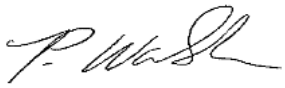
relationships between MOHs, LHINs, PHUs, and Indigenous communities that will be clarified over time, our members have flagged various areas where concerns about capacity have been raised. Specifically, there is apprehension that areas requiring increased emphasis, such as the need for more reliance on Population Health Assessments, will require additional resources.

We have also flagged various concerns about how new standards may be interpreted and have offered recommendations for suggested wording to counter possible unintended consequences. These concerns are raised in a context of pride and passion that our public health colleagues bring to their work in the front lines of service delivery and in various sectors of public health.

OPHA and its CSs, workgroups, and Nutrition Resource Centre, have much expertise to offer and would welcome the opportunity to collaborate with others to provide any needed supports to facilitate implementation. For example, when the Ontario Public Health Standards were last revised in 2008, OPHA partnered with Cancer Care Ontario to manage the creation of the guidance documents for the health promotion standards. This collaborative development process between field and ministry staff resulted in a timely and helpful product. We would be pleased to once again collaborate with others to provide this and other kinds of support. In the last year, for example, we've supported Lean Sigma training, held a Learning Institute on Intersectionality, Anti-Oppression and Collaborative Leadership in Practice, a workshop on cultural humility, launched an on line course and developed a range of webinars and workshops touching on a variety of nutrition and other topics in collaboration with our workgroups, CSs and community partners. As a dynamic organization that strives to respond to emerging needs in public health, OPHA looks forward to discussing ways that we can collaborate in supporting the implementation of these new standards.

Thank you for your consideration of our feedback.

Sincerely,



Pegeen Walsh
Executive Director

**OPHA is proud to represent our Constituent Societies including:*
*Association of Ontario Health Centres (AOHC)*
*Association of Public Health Epidemiologists in Ontario (APHEO)*
*Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO)*
*Canadian Institute of Public Health Inspectors (Ontario Branch) (CIPHIO)*
*Health Promotion Ontario (HPO)*
*Registered Nurses' Association of Ontario-Community Health Nurses' Initiatives Group (RNAO-CHNIG)*
*Ontario Society of Nutrition Professionals in Public Health (OSNPPH)*
*Ontario Association of Public Health Dentistry (OAPHD)*
*Ontario Association of Public Health Nursing Leaders (OPHNL)*

# Table of Contents

# A. Overview

OPHA is pleased to share with the ministry the perspectives of its members, various expert workgroups and constituent societies on the Standards for Public Health Programs and Services Consultation Document. This submission includes a summary of recommendations in response to specific discussion questions as presented by the ministry during recently held regional consultations. As such, we have positioned our recommendations, which are summarized in ***Section B: Summary of Recommendations***, to answer:

- Are there areas that require further clarification of context?
- What are the operational considerations to support successful implementation of the modernized standards?
- What implementation supports are needed?
- What other tools or supports would assist in the modernized approach to the delivery of public health programs and services?

***Section B*** also provides detailed comments about issues for consideration. These comments are organized as they relate specifically to each individual standard.

In addition to the structured discussion of the above-listed topics, our members offer a wealth of thoughtful reflections which are captured in ***Section C: Areas for Opportunity***. Under this section, there are detailed comments about the opportunities presented by the new additions within the modernized standards.

By providing our response to the *Standards for Public Health Programs and Services Consultation Document,* OPHA is optimistic that these recommendations demonstrate our commitment to providing leadership on issues relating to work in public health, and our enthusiasm as a partner in the transformation of public health systems.

# B. Summary of Recommendations

## i. Response to the Ministry of Health and Long-Term Care's Consultation Document

The following summary provides key messages in response to specific areas of discussion sought by the ministry. Additional details are provided in the identified appendices.

### Areas Requiring Further Context

OPHA members have identified a number of areas, described below, where more context is needed to strengthen the effectiveness of these standards. Comments providing more detail on these key points are provided in ***Appendix A***.

- Promote Consistency Across the Standards
- Further Engage Indigenous Communities
- Provide a More Detailed Description of Health Promotion
- Strengthen Food and Nutrition Screening, Assessment and Monitoring
- Implement Vision Health Screening on a Pilot Basis
- Assess the Impact of Health System Transformations and Provide Support for Seamless Transitions
- Clarify Expectations Related to Sexual Health Clinical Services
- Recognize Capacity Needs to Support the use of Evidence, Evaluation and Population Health Assessment

### Areas that Could Benefit from Greater Clarity

OPHA's members and constituent societies have flagged the following as areas where further clarity is needed to ensure effective implementation. These areas are further expanded upon with specific suggestions related to each of these standards in ***Appendix B***.

- Population Health Assessment
- Healthy Environments
- Healthy Growth and Development
- Chronic Disease and Injury Prevention, Wellness and Substance Misuse.
- Oral Health
- School Health
- Health Equity

### Operational Considerations to Support Successful Implementation

OPHA members flagged the following as considerations to keep in mind to support successful implementation. Additional details on these considerations are provided in ***Appendix C***.

- Strengthen Health Unit Capacity
- Strengthen Collaboration with LHINs
- Promote Models for Effective Coordination of Activities Across Programs
- Include Clear Cross-References Across Program Standards to Promote Coordination Among Teams
- Support Research, Evidence and Data Gathering through Common Indicators
- Assess Local Needs Related to the Environment and Population Health

### Implementation Supports

OPHA members have identified the following as needed to support effective implementation of the new standards. Specific details about these supports can be found in ***Appendix D***.

- Provide Guidance on Health Equity and Indigenous Health

- Provide Guidance and Training to Build Diversity/Inclusion Competencies
- Develop an Inter-Ministerial Agreement with MOHLTC and Education Mandating Collaboration between School Boards, Schools and Public Health
- Provide Centralized Provincial Support by Tapping Into the Expertise of Provincial Organizations
- Identify Resource Centres to Assist with the Implementation
- Ensure Adequate Inter-Ministerial Support for Initiatives that Cross Multiple Agencies
- Promote Funding Certainty
- Develop a Consistent Approach to Public Disclosures of Inspections and Centralizing Data
- Support Access to Relevant, Timely and Consistent and Affordable Local Data

### ii. Feedback and Suggestions on Specific Standards

Outlined below are key messages offering recommendations as they relate to each individual standard. Explanations for each theme and detailed comments are provided in ***Appendix E.***

#### *Introduction*

- Include Preconception Health in Visual Depiction of Life Stages

#### *Population Health Assessment*

- Strengthen Public Health's Mandate on Oral Health
- Include a Definition of the Food Environment
- Provide Further Guidance on Nutritional Screening, Surveillance, Assessment and Monitoring

#### *Health Equity*

- Broaden the Definition of Health Equity and Strengthen the Standard
- Mandate Public Health Units to work with Indigenous populations

#### *Effective Public Health Practice*

- Increase the Involvement of Clients in Planning, Evaluating and Improving services

#### *Chronic Diseases and Injury Prevention, Wellness and Substance Misuse*

- Include Alcohol in the statement about Reducing Youth Access
- Revise Requirement 1.d) - "Healthy Eating" to "Healthy Eating Behaviours and Determinants of Healthy Eating"
- Revise Requirement 1.d) - "Built Environment" to "Built and Food Environment"
- Provide Guidance on Healthy Eating Behaviours and Determinants of Healthy Eating
- Coordinate prevention, cessation and protection policies related to alcohol, tobacco and cannabis

#### *Healthy Environments*

- Include the Food Environment and Provide Guidance on Assessment and Reporting

- Provide Greater Clarity on Healthy Environments Program Standard through the Proposed Healthy Environments Protocol
- Develop Environmental Exposure Indicators Centrally
- Use OPHA's Workgroups and the Nutrition Resource Centre to Support the Development of the Proposed Healthy Environments Protocol
- Support Coordination of Program Delivery when Program Requirements Fall Under the Mandate of Different Teams at the Health Unit
- Recognize the Importance of Access to Housing
- Emphasize the Need for Cross-Ministerial Collaboration Support and Guidance
- Provide Supports to those Less Involved in Climate Change
- Provide Other Operational Supports for Implementing the Healthy Environments Program Goal
- Add Additional Outcomes to Healthy Environments Program Standard
- Identify Municipalities as a Partner to Advance Public Health Interests
- Clarify the Concept of Healthy Communities and Healthy Public Policies
- Recognize Environmental Impacts on Children's Health

***Healthy Growth and Development***

- Provide Clarity and Guidance to Support Nutritional Health through the Lifespan
- Include Reference to Oral Health
- Include Reference to Fetal Alcohol Spectrum Disorder and Preconception Health
- Expand Program Outcomes to Include a Broader Lens and Stakeholders beyond the Local Level
- Recognize the Importance of Paternal Health
- Include Reference to Priority Populations
- Include Reference to the Topic of Informed Decision-Making for Labour and Birth
- Use Inclusive Language
- Consider Renaming the Standard *"Healthy Growth and Development and Reproductive Health"*

***School Health***

- Include Determinants of Healthy Eating and Nutritional Health through the Lifespan
- Develop a Protocol/Guidance Document to Screen Child Nutritional Health using NutriSTEP ©
- Recognize the Importance of Oral Health for Youth Not in School
- Refine the Definition of Preconception Health
- Define Emerging Adult

### iii. Other Comments and Suggestions

Throughout the process of our member consultations, additional topics relating to public health issues have been included as they pertain to the Standards for Public Health Programs and Services. Additional explanations and context are provided in ***Appendix F***.

***Update the monitoring and enforcement of provincial liquor laws.***

- As part of its modernisation of alcohol retailing in Ontario, the government should consider updating the monitoring and enforcement of provincial liquor control laws, including the potential for a greater municipal role.

## C. Areas of Opportunity

OPHA members applaud the ministry and its advisory committees for the various additions and revisions to these standards and recognize that they create new opportunities to strengthen and expand the work of public health. Areas where OPHA members see new opportunities are highlighted below.

**Increased Emphasis on Health Equity:**

- We are pleased to see the inclusion of a new Health Equity Standard, and one that is based on the National Collaborating Centre for the Determinants of Health's Four Roles of Public Health to take action on the Determinants of Health.
- Having Health Equity as a Foundational Standard provides opportunities to address health inequities, including embedding it into all public health work. This increased emphasis on health equity will support the work of health units in addressing important health disadvantages within their communities.

**Greater Flexibility:**

- The focus on local priorities (variability/flexibility) allows public health units to tailor their programs and services to meet the local context and the needs of priority populations within their jurisdictions. This increased flexibility at the local level to determine program and interventions based on a more comprehensive assessment of evidence is welcomed.

**Inclusion of Mental health:**

- The inclusion of mental health promotion is an important addition and reflects the increased emphasis that governments, schools, communities and other agencies are placing on this topic.

**Addition of a Separate Standard on School Health:**

- The addition of the School Health Standard provides a number of opportunities to support the following additional areas of health promotion:
    - Cancer prevention
    - Diabetes prevention
    - Injury prevention
    - Supporting newcomers
    - Supporting children and youth throughout the education system
    - Nutritional health through the lifespan

**Inclusion of Healthy Natural and Built Environments:**

- OPHA members welcome the inclusion of explicit language for healthy natural and built environments within the 2017 Standards as it provides a more explicit mandate than in the 2008 version. This is achieved by making Healthy Environments a standalone standard, and by adding language for natural and built environments to the goal, program outcomes and topics for consideration in the requirements.

- As identified in the *2016 Ontario Public Health Association (OPHA) Recommendations to Modernize the Built Environment Language in the Ontario Public Health Standards*, evidence from research is consistent in showing that natural, built and food environments profoundly impact the health risks, behaviours and outcomes of the population. Public Health outcomes range from respiratory illnesses, injuries, physical activity, access to affordable healthy food, exposure to environmental contaminants and chronic diseases. The public health sector has an increasingly critical role in advancing healthy public policies that influence the built environment. [1]

**Integration of Foundational Standards**:

- Opportunities exist to strengthen public health action in Ontario. For instance, there is an increased consistency across program standards, with particular attention to the integration of Foundational Standards across different program areas (whether you are delivering chronic disease prevention programs, infectious disease prevention or environmental health programs.)
- This provides a consistent framework for health equity, evidence-informed decision making and research quality.

**Expanded Partnerships**:

- New emphasis on partnerships with First Nations and the healthcare sector through the Local Health Integration Networks (LHINs) can also leverage new resources and opportunities for action. Emphasis on partnerships with other stakeholders (e.g. School Boards through School Health Programs) creates new opportunities, but also points to additional supports needed to work across sectors.

**Strengthening the Use of Evidence, Evaluation and Population Health Assessment:**

- The emphasis on continuous quality improvement, evaluation and communications creates new opportunities to further engage in these areas. These standards could help formalize program evaluation processes and strengthen them across the work of public health.
- The Standards could be further strengthened by adding language within each Standard that emphasizes evidence-informed program planning, practice and decision making.

[1] Ontario Public Health Association. (2016, December 16). Opportunities to Modernize the Built Environment Language in the Ontario Public Health Standards. Recommendations from OPHA's Built Environment & Environmental Health Working Groups to MOHLTC. Retrieved March 27, 2017, from http://www.opha.on.ca/getmedia/0372d57d-4b18-4695-a2aa-8dee73d2758c/Opportunities-to-Modernize-the-Built-Environment-Language-in-the-Ontario-Public-Health-Standards.pdf.aspx?ext=.pdf

**Defining Core Competencies for Public Health:**

- The previous standards made specific mention of core competencies for public health professionals, however, there is no reference in these new Standards, thus far. This provides an opportunity to further define these but it could also lead to inconsistencies.

# D. CONCLUSION

OPHA is pleased to provide to the Ministry of Health and Long-Term Care our submission in response to the Standards for Public Health Programs and Services Consultation Document (2017). Through our consultations, OPHA was enthused to compile a wealth of insight from our members and constituent societies. Comments received from our members were numerous and thoughtful, demonstrating an engaged membership that is eager to contribute in a constructive way to the process of modernizing the Ontario Public Health Standards.

The OPHA membership is far-reaching and uniquely encompasses a vast array of colleagues working in a variety of public health roles. These roles range from academics, to professionals involved in public health units, healthcare agencies, non-profit and private sector organizations, to community partners, and constituent societies. Through our diverse membership, OPHA is able to provide a platform where professionals spanning several public health disciplines and sectors can network and collaborate on issues of importance. As an example, OPHA facilitates collaboration through our workgroups who have been productive on several fronts:

- The Environmental Health Workgroup partnered with other sectors through Ecohealth Ontario, prepared submissions to do with food, air, and water quality and safety, and surveyed health units across the province on their initiatives related to climate change.
- The Built Environment Workgroup has been working with various sectors to create an online learning course on building healthy communities. They have also been working with transportation engineers and provincial and municipal planning experts on community design, in an effort to reduce chronic disease and improve the environment.
- The Reproductive Health Workgroup has been busy collating evidence on preconception, and developing action plans to strengthen preconception health and informed decision making for labour and birth.
- The Cannabis Taskforce is currently looking at the repercussions of the legalization of cannabis in Canada.
- The Joint alPHa-OPHA Health Equity Workgroup has created Health Equity Indicators.
- The Breastfeeding Network engages a variety of professionals to focus on increased breastfeeding rates and the promotion of The Baby Friendly Initiative.
- The Chronic Disease Workgroup is looking at issues of tobacco, healthy eating and nutrition.
- Our Persons with Disabilities Taskforce is identifying ways to promote inclusion and reduce barriers.
- Our Alcohol Workgroup advocates for strategies that bring forward the latest evidence on actions needed.
- Our New Professionals Network works to support the next generation of talent in public health.

As a result of our unique potential to bring together a range of expertise, OPHA is well positioned to be a strong partner. We are pleased to articulate our ongoing interest and expertise in assisting the ministry as a partner be it to develop protocol and guidance documents, resources, training activities, supporting networks or other activities that can support the public health sector and the implementation of these new standards.

# APPENDIX A: Areas Requiring Further Context

OPHA members have identified a number of areas, described below, where more context is needed to strengthen the effectiveness of these standards. Some general comments are provided and then some specific suggestions related to each standard.

**Promote Consistency Across the Standards:**

- As different terminology is being used across the standards, we suggest modifying some wording to ensure consistent language is used throughout the program standards/sections. We offer these examples:
  - The Foundational Standards requirements are reiterated in some standards and not others.
  - The term "priority populations" is used throughout the document except in the Healthy Environments Standard where the term "priority issues" is used. (The current OPHS uses "priority populations" in the Health Hazard Prevention and Management program).
  - Health Equity is a Foundational Standard, so it is recognized that it cuts across all program standards. However, some program standards emphasize it again (e.g. monitor health inequities), while others do not. Emphasis should be consistent to illustrate that it is an important component of all standards.
  - The requirement to implement "public health interventions" is explicit in some standards (CDIP, Healthy Growth and Development, School Health) but not others (Healthy Environments, Food Safety, Safe Water). These latter standards require "public health interventions" (e.g. develop strategies to promote health environments; review drinking water quality reports, increase public awareness of food-borne illness).

- The requirement for an Annual Service Plan and Budget Submission is mentioned in the Foundational Standards and some program standards (i.e. Chronic Diseases and Injury Prevention, Wellness and Substance Misuse, Healthy Growth and Development, School Health) but not others (Healthy Environments, Food Safety, Safe Water, Infectious Disease Control). This inconsistency could have implications on how health units prioritize different standards and program areas based on the need for budget submissions. This may have an unintended impact on the resources going into various program areas. Clarification and standardized language can help avoid this interpretation, which assigns priorities without a proper assessment of local needs on healthy environments and other standard areas.

- Anywhere "healthy eating" is listed as a topic to assess and monitor, we recommend that it be revised to state "healthy eating behaviors and determinants of healthy eating." This provides direction to include key factors contributing to nutritional health, including food insecurity, food literacy and the food environment and can be built into protocols and guidance documents.

- The Population Health Assessment Foundational Standard (requirement #3) lists what boards of health should assess, including health status, health behaviours, and preventive health

practices. It is important to add a requirement to assess risk factors, as these have a significant influence on population health (e.g. proximity to traffic-related air pollution).

**Further Engage Indigenous Communities**

- OPHA is pleased to see the importance of building and/or further developing relationships with Indigenous communities and organizations. This presents new opportunities to promote health equity and responds to the need expressed by PHUs for more guidance on providing services to Indigenous communities.

- While a future Guidance Document will provide further guidance, there is an opportunity to further incorporate Indigenous views. It would be helpful to have more guidance from Indigenous communities to ensure that their knowledge, culture, and perspectives are embedded within the standards. For example, the Population Health Approach wheel (Figure 1 on page 3) could reflect the Aboriginal medicine wheel, which has some similarities.

**Provide a More Detailed Description of Health Promotion**

- Population health promotion and policy development are important roles that could benefit from being better described. Coordination by teams, such as the Tobacco Control Area Networks, which increase collaboration among PHUs both regionally and provincially is a great example of how to increase cost effectiveness, collaboration and communication.

**Strengthen Food and Nutrition Screening, Assessment and Monitoring**

- There is a need to establish and collect data on key indicators which screen for, assess and monitor nutritional health, as well as key factors that contribute to nutritional health, including the food environment, food insecurity and food literacy.

- NutriStep©, the Nutritious Food Basket, the food environment (core indicators under current development by APHEO) and food literacy indicators are recommended to be included in the new and/or revised protocols related to healthy eating and nutrition. (See ***Appendix G*** for more detailed suggestions about NutriStep).

**Implement Vision Health Screening on a Pilot Basis**

- Various questions about the evidence for adding this requirement have been raised by our members with the suggestion that phased implementation be considered to assess the most effective approach.

**Support for Implications while Adapting to Health System Transformations**

- Members see the opportunity to expand and strengthen networks across the health system and enhance health unit engagement with the health care sector and LHINs as well as assist with the planning and coordination of health care services delivery. In the absence of more details about these expectations, members are concerned about the implications of health unit capacity and

the communication and cooperation across PHUs that will be needed to respond to LHIN requests.

- As health units adapt to new requirements and modify and align their programs and services, OPHA members are concerned that there is a risk of service continuity and/or clients falling through the cracks during this system transformation.

**Clarify Expectations Related to Sexual Health Clinical Services**

- As there is no specific mention about the provision of sexual health clinics, members are questioning what this might mean for clients and community members who rely on these services.

**Recognize Capacity Needs to Support the use of Evidence, Evaluation and Population Health Assessment**

- Members welcome opportunities to enhance quality and accountability, especially through the increased commitment to the Population Health Assessment, but recognize this area may be constrained by issues related to health unit capacity.

# APPENDIX B: Areas that Could Benefit from Greater Clarity

OPHA's members and constituent societies have flagged the following as areas where further clarity is needed to ensure effective implementation and have provided specific suggestions related to the Program Standards listed below:

**Population Health Assessment**

- Include a definition of the food environment as an important determinant of healthy eating and chronic disease; this is a well-documented concept in the public health nutrition literature, which includes the built environment as one component of the broader food environment.

- In the Population Health Assessment and Surveillance Protocol, 2016, the current definition of the physical and built environment does not make reference to food access, as the "built environment" is traditionally used in reference to physical activity. As such, a definition of the food environment should also be included in the next protocol document.

**Healthy Environments**

- Revise the "built environment" to state the "built and food environment" as a key determinant of nutritional health, chronic disease and an essential topic to address based on the assessment of local needs. Additionally, in the *Population Health Assessment and Surveillance Protocol*, ensure the appendix includes a definition of the food environment, as currently, the definitions for the 'physical environment' or for 'supportive environments' do not acknowledge healthy food access.

**Healthy Growth and Development**

- Add "nutritional health through the lifespan" as a key topic to address; this would include children's nutritional health. Within each of the requirements that speak to the program of public health interventions "nutritional health through the lifespan" should be explicitly stated.

**Chronic Disease and Injury Prevention, Wellness and Substance Misuse:**

- Where "healthy eating" is listed as a topic to assess and monitor, (i.e. requirement 1.d) it should be revised to state "healthy eating behaviors and determinants of healthy eating." This provides direction to include key factors contributing to nutritional health, including food insecurity, food literacy and food environment and can be built into protocols and guidance documents.

- Revise the "built environment" (requirement 1.d) to state the "built and food environment" as a key determinant of nutritional health, chronic disease and essential

topic to address based on the assessment of local needs. Additionally, in the *Population Health Assessment and Surveillance Protocol*, ensure the appendix includes a definition of the food environment, as currently, the definitions for the 'physical environment' or for 'supportive environments' do not acknowledge healthy food access.

- Clarify expectations around the reciprocity of relationships between health units and stakeholders, such LHINs, school boards, and local governments to implement the standards. It is not clear whether there is an expectation for these stakeholders to work with public health as well. Additional work may be needed to understand how Public Health Transformation can enable collaboration between these key partners and health units. Moreover, in an area such as school health, where public health has a mandate but schools do not, public health has faced various challenges. As such, it would be advantageous for inter-ministerial collaboration and support to implement these requirements.

- The role of PHUs related to cannabis will need to be clarified as provincial plans are developed.

**Oral Health**

- There's a need for clarity around the broad public health impacts across the standards, (e.g. healthy growth and development, school health , chronic disease).

**School Health**

- Add "nutritional health through the lifespan" as a key topic to address; this would include children's nutritional health. Within each of the requirements that speak to the program of public health interventions, "healthy eating behaviours and determinants of healthy eating" needs to be explicitly stated as a key area.
- Where "healthy eating" is listed as a topic to assist school boards with implementation of health-related curricula, (i.e. requirement 5.d) should be revised to state "healthy eating behaviors, determinants of healthy eating, and food safety." This provides direction to include key factors contributing to nutritional health, including patterns of dietary intake/nutrition and food insecurity, food literacy and food environment and can be built into protocols and guidance documents.

**Health Equity**

- More clarity could be provided by embedding health equity language throughout the Program Standards. This could be done by having consistent wording of reducing health inequities and "Priority Populations" (or alternative term) for all Program Standards. Use of a health equity lens such as the MOHLTC's Heath Equity Impact Assessment should also be considered for inclusion in all program standards. If this wording cannot be added, a guidance document on use of an HEIA should be developed.

- It is suggested to provide a clearer definition of Priority Populations (page 13). As written, “priority populations” is not tied to social determinants of health. Since 2008, there has been much confusion as to whether “priority populations” is tied to (access to) social determinants of health, or burden of disease (e.g., white middle aged males with higher incomes with higher rates of disease for non-SDOH reasons). The wording should include clarification that this includes individuals whose circumstances make them vulnerable or marginalized and should not be deprived of opportunities for engagement or full participation affecting their health and welfare (e.g., people living with HIV/AIDS, newcomers/refugees, impoverished youth, women who have suffered abuse, persons with dis/abilities, etc.) If the wording for priority populations cannot be modified, we would suggest a guidance document on how to determine priority populations be developed. Similarly on page 15, "Health equity means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, disability, social class, socioeconomic status or other socially determined circumstance.” Ideally, this list should reference the Human Rights Code’s exhaustive list of 17 prohibited grounds of discrimination, with "disability" referred as dis/ability.

- More clarity is requested around the Nutritious Food Basket (NFB). There is confusion over the removal of the Nutritious Food Basket from the program standards. Currently, NFB is a key way PHUs talk about social determinants of health and living affordability in geographic areas. Public health has been able to report and advocate on issues facing low income people in Ontario and the NFB has been a way to assess and report on the health of local populations. If NFB is to be removed, an alternative way of measuring food security and quality of life/affordability in geographic neighbourhoods should be developed.

# APPENDIX C: Operational Considerations to Support Successful Implementation

OPHA members flagged the following as considerations to keep in mind to support successful implementation.

**Strengthening Health Unit Capacity:**

- The Standards provide a stronger mandate to ensure that all programs are informed by evidence and focus on health equity. Health units should be supported in addressing program areas where this capacity is lacking, either because of the gaps in available evidence, or because of the traditional approach in delivery of health promotion programs versus health protection programs. With increased emphasis on evidence informed decision making and using population health information in program planning, it will be difficult to operationalize without increased epidemiologist/analyst resources.

- Without additional funding being provided, limited resources may need to be re-assigned to meet the new requirements; this will be challenging for PHUs, particularly smaller ones. Also, there will be a need to consider support on the data entry side with information coming in from other programs. Population health assessment needs go beyond health status reporting and will require additional data sources that are not necessarily available.

- OPHA's constituent society (APHEO) could help support core methods development for segmentation and core population identification.

- Revised data sharing agreements may be needed in order for health units to collaborate and share data with LHINS.

- Mental and social well-being and quality of life are highlighted in the standard for population health assessment. This will require going beyond some of the traditional indicators used to try to find ways to stratify by social indicators (e.g. income/education/mental and social well-being).

- Indigenous data is complex and requires more work and resources. Some argue that Indigenous health data should be in Indigenous hands with PHUs occupying a role to support our Indigenous agencies to do this work. Additionally, it takes time to build the trust relationships for working in Indigenous Health.

- There are substantial data gaps that need to be filled to meet the new standards that will require more primary data collection. PHUs differ in their ability to collect data to fill those gaps.

- Evidence is worked into every single program and the new budget submissions allow PHUs to prioritize some programs over others. Even if there isn't the local need the population health assessment piece will still be required for each program area to support this assessment.

- With the move from old to new standards and the increased emphasis in using evidence, it is unclear if there is a net revenue gain as there is little that is discontinued under the new standards.

- Time and resources are required to build capacity to implement the Standards utilizing best practices in leadership and change management. This could involve:
    - Restructuring within public health units
    - New Policies & Procedure development & implementation
    - Changing of staff roles, hiring and labour relations
    - Education and training

**Strengthening Collaboration with LHINs:**

- Provide guidance on defining relationships and collaboration with LHINs, particularly if there may be more than one LHIN per health unit. There may be a need for more operational support for communicating and coordinating across public health units with regards to LHIN requests.

**Promote Models for Effective Coordination of Activities**

- The Foundational Standards facilitate a common lens for public health and reaffirm linkages across programs, such as those between chronic disease prevention and environmental health.

- Several health units are already working collaboratively across programs (e.g. Health Protection and Healthy Living) to develop strategies to promote and advocate for healthy built environments. These collaborations ensure that multiple health perspectives are included (e.g. air quality benefits, physical activity benefits etc.) and have participation by environmental health, chronic disease and health promotion specialists.

- Such models should be recognized as an effective way to coordinate activities across public health programs, including the expertise of multiple public health disciplines, and promote the multiple health benefits of multifactorial public health interventions.

**Include Clear Cross-References across Program Standards to Promote Coordination among Teams**

- The requirement to ensure coordination of program delivery across health areas in the 2017 Standards is applauded. Although, it is also anticipated that coordination across program areas in public health units can be maximized in the implementation. For example, the requirement under the Healthy Environments Standard to develop strategies with community partners to promote healthy natural and built environments is supported by work to prevent chronic diseases and injuries. However, in the 2017 Standards, built environments are mentioned within

the Chronic Disease and Injury Prevention, Wellness and Substance Misuses Standard, but currently there is no link to the Healthy Environments Standard within this section.

- To support integrated implementation of programming around healthy built and natural environments, the Healthy Environments Standard and related protocols need to be linked within all other relevant program standards, including the Chronic Disease and Injury Prevention, Wellness and Substance Misuse Standard, the Health Equity Standard, and the School Health Standard.

**Support Research, Evidence and Data Gathering through Common Indicators**

- Establish and require monitoring of common indicators and facilitate access to data sources to support local health unit work to maximize impact of targeted interventions to increase health equity.

- OPHA and the Nutrition Resource Centre have experience collaborating with a number of provincial partners to develop common sets of public health indicators (e.g., Ontario Food and Nutrition Strategy's food access and food literacy indicators, OCDPA's chronic disease risk factors indicators, LDCP Food Literacy indicators) and welcome the opportunity to support further indicator work related to healthy eating and chronic disease prevention.

- For specific recommendations around nutritional health indicators and data gathering refer to the Chronic Disease and Injury Prevention, Wellness and Substance Misuse Standard, the Healthy Environments Standard, and the Healthy Growth and Development Standards.

**Assess Local Needs Related to the Environment and Population Health**

- It is positive that the 2017 Standards have increased emphasis on local assessment, which will provide greater flexibility to reflect programming based on local needs (pg. 27). However, there needs to be greater clarification on how local assessments are to be completed and how local needs are to be identified.

- With regard to local, natural and built environments, in the 2016 Population Health Assessment and Surveillance Protocol, built environments are only referenced in the appendices under the definition of physical environments. Physical environments are only mentioned as one of the many items for which information is to be collected. Together, these do not provide clear guidance on the data sources that are available to support Healthy Environments assessments. Moreover, the current definitions of the physical and built environment, in the 2016 Population Health Assessment and Surveillance Protocol, does not mention food access and do not capture the food environment - a key determinant of nutritional health and contributor to health inequities.

- The Population Health Assessment Foundational Standard lists assessment requirements, such as health status, health behaviours, and preventive health practices. However, it is important to and language about risk factors having a significant influence on population health (e.g. , density and proximity of fast-food outlets, proximity to traffic-related air pollution, pedestrian oriented land use development).

- Beyond the 2016 protocol, in the past, public health unit-led examples of context-specific analysis have helped advance policies and programs supporting areas, such as healthy design, walkability, air quality and environmental health. The OPHA BEWG members' expertise and Nutrition Resource Centre can support the Population Health Assessment and Surveillance Protocol update from a built and natural environment perspective, which includes considerations related to the food environment.

**Develop a Health Equity Framework**

- Provide clear terminology for terms that are referred to such as life course, protective vs risk factors, resiliency, social connectedness, priority populations as well as list of the SDOH including definitions (e.g. PHAC and that of Dennis Raphael)

- Identifying and providing free educational opportunities (e.g. identifying and understanding priority populations, as per recommendations from Priority Populations Project Technical Report (2015), PHO; and to support the Health Equity requirement 2(a) pg. 16.)

- All programs need to have standard Program Outcomes related to health equity and SDOH (e.g. specifically stating programs are to report on health inequities, causes and support action on health inequities).

- Program outcomes and requirements for the most part continue to address behavioural/lifestyle concerns with minimal focus on advocacy, and engaging meaningfully with those experiencing health inequities. The Program requirements do not include socially produced health inequities such as income, housing, education, employment etc. The importance of PHUs role in advocacy needs to be emphasized.

- Due to the broad nature of the health equity goal, a key area required to achieve that goal will be effective relationships with community partners and people of lived experience. The capacity, understanding and desire of health units may be challenged and require the support of a guiding document.

# APPENDIX D: Implementation Supports

OPHA members have identified the following as needed to support effective implementation of the new standards.

**Provide Guidance on the Health Equity and Indigenous Health**

- To implement the Health Equity Standard, OPHA's Health Equity Work Group recommends an accompanying guidance document. As written, the standard leaves room for interpretation. The recent LDCP Health Equity Indicators project and the Public Health Ontario Priority Populations report would be a useful baseline from which to frame the document.

- In development of a protocol/guidance document to promote health equity and Indigenous Health, there is an opportunity to work with Indigenous communities on the proposed Standards and incorporate Indigenous knowledge, culture, and perspectives.

- The protocol/guidance document for the Health Equity Standard should include how to work with urban Indigenous communities, as well as those living in First Nations communities.

- OPHA is pleased that opportunities for cultural safety training approaches will be made available. We suggest that such training include incorporation of the legacy of colonization and residential schools as outlined by the Truth and Reconciliation Calls to Action as well as the Social Determinants of Indigenous health, OCAP principles for research and the understanding of self-determination when working with Indigenous groups. We would suggest that mandatory cultural safety or access and equity training of public health staff be a requirement of boards of health. This would be part of enhancing public health core competency for Diversity and Inclusion and would also include how to best engage priority populations, and conduct ethical research. This would be in addition to training on how to work with and engage with Indigenous populations, and people with dis/abilities.

- It will be helpful to acknowledge the role of cultural inclusion/cultural humility and sensitivity training for all priority populations in addition to Indigenous people in order to provide service in a culturally safe way for all groups.

**Guidance and Training to Build Diversity/Inclusion Competency**

- Develop a protocol and guidance to enhance public health staff core competency on Diversity and Inclusion, specifically related to dis/ability, ableism and weight bias/stigma. The Ministry can leverage OPHA's Task Group on Persons with Disability (via OPHA-alPHa Health Equity Working Group) as well as the Nutrition Resource Centre for guidance on operationalizing this training need.

**Centralized Provincial Support**

- To support local PHUs in implementing the new Standards, it would be valuable to provide centralized provincial level support organizations (e.g. Ontario Public Health Association, Public Health Ontario, the Nutrition Resource Centre, and the Registered Nurses' Association of Ontario) that encompass a network of experts and resources, such as standard tools, best practices and templates.

**Identify Resource Centres to Assist Public Health Units with the Implementation of the Standards**

- It would be helpful to identify "resource" centres that would be available for Public Health Units that can provide the needed supports to implement the 2017 Standards. For example, the Nutrition Resource Centre supports capacity building in relation to food, healthy eating and nutritional health through the lifespan. As such, the NRC could support public health to implement a number of Standards (e.g. Chronic Diseases and Injury Prevention, Wellness, and Substance Misuses, Food Safety, Healthy Environments, Healthy Growth and Development and School Health).Additionally, it would be beneficial to also assess how Ontario's resource centres align with the National Collaborating Centres and to what degree the such support systems are accessed by public health to support OPHS implementation in Ontario

- It is would important for the Ministry to ensure thoughtful alignment of the supportive structures available, such as the resource centres, to assist Public Health Units with the implementation of the Healthy Environments Standard as these are resources frequently accessed by the public health workforce.

**Ensure Adequate Inter-Ministerial Support for Initiatives that Cross Multiple Agencies**

- Program Standard topic areas, such as Healthy Environments, are determined by a number of intersectoral policies and programs that include but also go beyond public health. In recent years, the public health sector, including the OPHA BEWG, has been very successful in promoting collaboration with other non-traditional health stakeholders, such as the Ontario Ministry of Transportation, the Ministry of Municipal Affairs and Housing, the Ministry of Environment and the Ministry of Education, to build healthier environments. For example, the OPHA BEWG has been an active member representing public health interests in provincial consultations for legislation changes to the Provincial Policy Statement (2014), the Ontario Cycling Strategy (CycleON#), the new edition of the Ontario Driver's Manual, among other multiple initiatives. While at the local level, OPHA BEWG members have fostered similar scenarios for collaboration to further the promotion of healthy natural and built environments.

- Through such cross-sector collaborations at various levels, a lesson learned is that the promotion of Healthy Environments is more productive when there are clear integration mechanisms across different sectors. Examples include, coordination tables or cross-reference of functions in policy, regulation and program documents.

- It would be beneficial to ensure adequate inter-ministerial support for Program Standard initiatives that cross multiple agencies.

**Promote Funding Certainty**

- It is difficult to identify implementation challenges and required resources for standards for which a protocol has yet to be drafted or updated, such as the Healthy Environments Standard. However, there are some items that may require consideration so that resources are allocated and maintained in a way that does not affect public health practices. For instance, the definition of the relationship between LHINs, public health units and Medical Officers of Health could potentially impact other work areas if the emphasis is given to health care provision. This is of particular importance for the Healthy Environments Standards because it requires resources that are focused on supporting municipal partners in the development of healthy policies and programs. Another example is the 2016 Population Health Assessment and Surveillance Protocol, whose scope currently **l**eaves little time for analysts and epidemiologists to do more of the context specific analysis needed for assessment of local natural and built environments.

**Provide Guidance on Nutritional Screening, Assessment and Monitoring**

- There are currently few indicators to address the nutrition status of the population. To complete local population health assessment, ensure comprehensive surveillance, and engage in evidence-informed program planning around the Standards, it would be necessary to establish and require monitoring on common indicators related to "healthy eating behaviours and determinants of healthy eating." This must include metrics not only for food intake and healthy eating behaviours but also key determinants; specifically,, food insecurity, food literacy and food environment indicators.

- The new *2017 Population Health Assessment and Surveillance Protocol* should clarify that the analysis of surveillance data in the area of healthy eating include key determinants of healthy eating, specifically, food security, food literacy and the food environment.
- It would be helpful to include methods and recommendations to comprehensively assess population-based nutritional health status and to support consistency and comparison of data across boards of health.

- It is recommended to provide guidance (i.e. new protocols and guidance documents) specific to Healthy Eating Behaviours, Food Insecurity (i.e. the Nutritious Food Basket), Nutrition Screening (i.e. NutriSTEP©) Food Literacy (e.g. LDCP research project "Measuring Food Literacy") and the Food Environment (e.g. based on APHEO's core food environment indicators). *NutriSTEP© is a valid and reliable nutrition screening tool for children 18-35 moths and 3-5 years, could also potentially be embedded in the revised Healthy Babies Healthy Children Guidance Document (see ***Appendix G***).

- All nutrition-related protocols and guidance documents could be supported by the Nutrition Resource Centre and OPHA (including support from OPHA's constituent societies, The Ontario Nutrition Professional's in Public Health and The Association of Public Health Epidemiologists in Ontario) and in partnership with the Dietitians of Canada.

**Develop a Consistent Approach to Public Disclosures of Inspections and Centralizing Data**

- Our members recognize that further discussion will be required with the ministry to ensure a similar approach is used to increase public disclosure of public health inspection results (e.g. safe food, water). The use of different databases will make it challenging to provide centralized data and a consistent approach.

**Support Access to Relevant, Timely and Consistent and Affordable Local Data**

- The new population health assessment requirements as well as those in other program areas will require new sources of health data that allow for analysis of different geographic areas, in particular of smaller than census division or subdivisions throughout the province. Additional funding will also be needed to support oversampling of existing national, provincial and local surveys as well as standardized provincial survey.

# APPENDIX E: Feedback and Suggestions on Specific Standards

Outlined below is more detailed feedback related to the specific standards.

## *Introduction*

**Include Preconception Health in Visual Depiction of Life Stages**

- Evidence demonstrates the importance of health before a pregnancy occurs. To omit preconception health in the figure ignores the impact of preconception health.
- For a comprehensive representation of health through the lifespan, include the term preconception health on Page 3 under the section, *What is Public Health?,*
- In Figure 1, the outer part of the circle would then read **'Preconception** → Prenatal → Infants →Children → Youth → Adults → Older Adults'.

## *Population Health Assessment*

**Strengthen Public Health's Mandate on Oral Health**

- Oral health is referenced in only one Program Outcome but has a much broader public health impact. The current approach defines Oral Health in narrow terms.

- This program outcome statement limits oral health only to those who are income eligible for services and to just one age group. Moreover, there is limited mention of community water fluoridation as population health strategy.

- Clarification is needed regarding what services/activities would be provided and what ages would be eligible.

- The recognition of oral health in the section on Chronic Disease is an important step forward. However, clarification is needed regarding what services/activities would be provided and which ages would be eligible. If adults could be included, it should be explicitly stated.

- Further clarification is needed regarding "local assessment of needs". Examples should be given of how public health units can address this requirement.

**Guidance on Nutritional Screening, Surveillance, Assessment and Monitoring**

- To complete local population health assessment and inform program planning around the Standards, it would be helpful to establish and require monitoring and reporting on common healthy eating behaviours and key determinants of healthy eating, (i.e. food insecurity, food literacy and food environment indicators.

- The new *2017 Population Health Assessment and Surveillance Protocol* should clarify that the analysis of surveillance data in the area of "healthy eating" should include "healthy eating

behaviours and key determinants of healthy eating", specifically, food security, food literacy and the food environment.

- It would be helpful to include methods and recommendations to comprehensively assess population-based nutritional health status and to support consistency and comparison of data across boards of health.

- It would be supportive to provide guidance (i.e. a new protocols and guidance documents) specific to Healthy Eating, Food Insecurity (i.e. the Nutritious Food Basket), Nutrition Screening (e.g. NutriSTEP©), Food Literacy and the Food Environment (e.g. based on APHEO's core food environment indicators). *NutriSTEP© is a valid and reliable nutrition screening tool for children 18-35 moths and 3-5 years, which could potentially be embedded in the revised Healthy Babies Healthy Children Guidance Document (see ***Appendix G***).

- All nutrition-related protocols and guidance documents could be supported by the Nutrition Resource Centre and OPHA (including support from OPHA's constituent societies, The Ontario Nutrition Professional's in Public Health and The Association of Public Health Epidemiologists in Ontario) and in partnership with the Dietitians of Canada.

### *Effective Public Health Practice*

**Increase the Involvement of Clients in Planning, Evaluating and Improving services**

- Under the Quality and Transparency Requirements, the public engagement concepts would benefit from clear delineation in the document. Measuring the client experience is only one portion of citizen engagement. In order to achieve a client and community centred system that is responsive to client needs, the public health system could benefit from increasing the involvement of. Therefore recommend changing page 20, point b) to:
  *b) Involving clients and communities in program planning, evaluation and improvement through implementation of strategies that elicit the voice of the client; explore and measure the client, community and stakeholder/partner experience; and communicate the impact of client feedback*

### *Healthy Equity*

**Broaden the Definition of Health Equity and Strengthen the Standard**

- Include the concept of Disability in the foundational standard on health equity by explicitly stating dis/ability. This could be achieved by inserting dis/ability in the list on page 15 which reads "Health equity means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, dis/ability, social class, socioeconomic status or other socially determined circumstance."

- Additionally, this list should reference the Human Rights Code's exhaustive list of 17 prohibited grounds of discrimination: disability, age, ancestry, colour, race, citizenship, ethnic origin, place of origin, creed, disability, family status, marital status (including single status), gender identity,

gender expression, receipt of public assistance (in housing only), record of offences (in employment only), sex (including pregnancy and breastfeeding) and sexual orientation.

- On page 16, add:
  - a 5th bullet – "Public Health Advocates with the LHINs to improve culturally safe services that are accessible to priority populations"
  - the word public to the statement "increased awareness on the part of the LHIN(s) and other community partners and the public…"
  - "communities with people experiencing health inequities (lived experience)" under "Partners" to be more encompassing.
  - And on page 10 tweak the wording of "Need" statement to state: "Assessing health inequities related to the distribution of the social determinants of health"
  - Add health equity and focus on Indigenous populations as drivers (page 6)

- Expand the focus of public health's role in supporting initiatives that address the health equity issues of older adults.

- Add an additional goal under "Programs and Services": To reduce disease and death due to health inequities using equity focussed public health practice.

- Add "community / citizens we serve" under "Enablers"

- Clearly define "priority population" so there is consistent interpretation and offer list of vulnerable populations.

***Chronic Diseases and Injury Prevention, Wellness and Substance Misuse***

**Alcohol**

- Add alcohol to the statement, "Youth have reduced access to tobacco products, e-cigs and tanning beds" on page 22.

**Revise Requirement 1.d) - "Healthy Eating" to "Healthy Eating Behaviours and Determinants of Healthy Eating"**

- Where "healthy eating" is listed as a topic to assess and monitor, (i.e. requirement 1.d) should be revised to state "healthy eating behaviors and determinants of healthy eating." This provides direction to include key factors contributing to nutritional health, including food insecurity, food literacy and food environment and should be built into protocols and guidance documents.

- Additionally, the new *2017 Population Health Assessment and Surveillance Protocol* should clarify that the analysis of surveillance data in the area of "healthy eating" to include "healthy eating behaviours and determinants of healthy eating", specifically, food literacy, food insecurity and the food environment.

**Revise Requirement 1.d) - "Built Environment" to "Built and Food Environment"**

- Revise the "built environment" (requirement 1.d) to state the "built and food environment" as a key determinant of nutritional health, chronic disease and essential topic to address based on the assessment of local needs. Additionally, in the *Population Health Assessment and Surveillance Protocol*, ensure the appendix includes a definition of the food environment, as currently, the definitions for the 'physical environment' or for 'supportive environments' do not acknowledge healthy food access.

**Provide Guidance on Healthy Eating Behaviours and Determinants of Healthy Eating**

- It is recommended to provide guidance (i.e. new protocols and guidance documents) related to "Healthy Eating Behaviours and Healthy Eating Behaviours." Specifically, it is recommended that guidance documents be developed for key determinants, including, food Insecurity (i.e. the Nutritious Food Basket), Nutrition Screening (i.e. NutriSTEP©) Food Literacy (e.g. using idicators from the LDCP research project "Measuring Food Literacy") and the Food Environment (e.g. based on APHEO's core food environment indicators). *NutriSTEP© is a valid and reliable nutrition screening tool for children 18-35 moths and 3-5 years, could also potentially be embedded in the revised Healthy Babies Healthy Children Guidance Document (see *Appendix G*).

***Healthy Environments***

**Include the Food Environment and Provide Guidance on Assessment and Reporting**

- Revise requirement 4.c) "built environment" to state the "built and food environment" as the food environment is a key determinant of nutritional health, chronic disease and an essential topic to address based on the assessment of local needs.

- As recommended to include the "built and food environment" as a key topic to address based on local assessment, this will require core indicators for assessment, such that boards of health can collect and compare consistent food environment data across the province. APHEO is currently establishing a core set of food environment indicators which could be embedded in the new Healthy Environments protocol.

- In the *Population Health Assessment and Surveillance Protocol, 2016,* the current definition of the physical and built environment does not make reference to food access, as the "built environment" is traditionally used in reference to physical activity.

- It is recommended that the revised protocol document include a definition of the food environment as an important determinant of healthy eating and a well-documented concept in the public health nutrition literature, which includes the built environment as one component of the broader food environment.

- The new *2017 Population Health Assessment and Surveillance Protocol* should clarify that the analysis of surveillance data in the area of healthy eating should include key determinants of healthy eating, specifically, the food environment.

- All food environment-related protocols and guidance documents could be supported by the Nutrition Resource Centre and OPHA (including support from OPHA's constituent societies, The Ontario Nutrition Professional's in Public Health and The Association of Public Health Epidemiologists in Ontario) and in partnership with the Dietitians of Canada.

**Provide Greater Clarity on the Healthy Environments Program Standard for the Proposed Healthy Environment Protocol**

- The goal of the Healthy Environments Program provides a stronger mandate for boards of health to address climate change health impacts and conditions that create healthy natural and built environments, but the details and requirements related to implementation are not clear. While we understand that the details will be provided at a later date in the Healthy Environments Protocol and that it will have a strong focus on climate change, air quality and linkages to land use planning, it is difficult to speak to opportunities and implementation challenges without these details.

- The Healthy Environment Protocol has not yet been released so it is difficult to assess impact of the Healthy Environments Standard without requirements that will be forthcoming in the Protocol.

- There is acknowledgement that traditional environmental health programs (Healthy Environments, Food Safety, Safe Water) are broader than just inspections/investigations (e.g. promoting development of healthy environments) but the Standards do not go far enough in establishing a consistent, evidence-based approach across all public health programs with respect to public health action, population health assessment, health equity and health promotion.

- There is a need for a glossary either in the Healthy Environments standard or protocol. The meaning of "environmental health status" is not defined. It is not clear whether this is referring to environmental factors, health outcomes or both. It would be helpful to have this definition. There are also some terms that could be interchangeable such as "exposure to chemical contamination" and "exposure to hazardous environmental contaminants". We also noted the lack of wording around children's environmental health.

- UV exposure is mentioned in the CDIPSM program standard. Exposure to radiation is mentioned in the Healthy Environments program standard. We recommend that the broader term "radiation" be used for consistency, or alternately, that UV exposure be included in the Healthy Environments program standard.

**Use of OPHA's Workgroups and the Nutrition Resource Centre to Support Healthy Environments**

- The Ontario Public Health Association Built Environment Working Group (OPHA BEWG), the Nutrition Resource Centre and OPHA's constituent society, the Association of Public Health Epidemiologists in Ontario, are strategic partners to support the technical quality that the anticipated Healthy Environments Protocol requires to guide public health action in healthy environments; including the local, natural, built and food environment**.**

- It is positive that the 2017 Standards contain a stronger mandate for healthy natural and built environments, including the anticipated development of a much needed protocol to guide public health action. The promotion of healthy natural and built environments requires collaboration across sectors and policy areas to promote health, an approach that is consistent with a Health-In-All-Policies (HiAP) perspective. Also central is the capacity to understand evidence and policy context from a variety of disciplines and apply it to public health practice. Hence, the proposed Healthy Environment Protocol requires clarification surrounding support materials, references and guidance policies for health, land use, transportation, natural environments and the food environment. It would also benefit from the inclusion of tools to support the Standard objectives, providing a 'menu of choices' for health units to embed health equity into this area, which could be supported by OPHA's Health Equity Work Group. Furthermore, the Healthy Environments protocol should cross reference relevant land use planning and transportation legislation that affects local municipal practice.

- The OPHA BEWG builds on years of leadership and experience in promoting healthy built environments in public health units across Ontario. For instance, the OPHA BEWG successfully worked with the Ontario Professional Planners Institute and the Public Health Agency of Canada to develop an online training course entitled 'Public Health and Planning 101'. The course targets public health and planning professionals working on the built environment in Ontario and aims to promote cross-disciplinary knowledge and collaboration among both professions involved in the land use planning process to help inform policy related to healthy built environments. This experience was based on a systematic approach to better understand opportunities for public health to support policies and processes that contribute to healthy built environments, as described in a recent article published in the Health Promotion and Chronic Disease Prevention in Canada Journal.[2] Another example of OPHA BEWG experience and leadership include the 2016 release of a White Paper on the opportunities for collaboration between health and transportation professionals in the promotion of active transportation. This work has been successfully presented in public health and transportation forums and continues to be the bases for engaging other sectors in the development of recommendations for public health practice. Other examples include the successful collaboration with the province and

[2] Mahendra, A., Vo, T., Einstoss, C., Weppler, J., Gillen, P., Ryan, L., & Haley, K. (2017). Status report, The Public Health and Planning 101 project: strengthening collaborations between the public health and planning professions. Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice, 37(1), 24–29.

other sectors in improvements to the Ontario Driver's Manual and numerous participations in scenarios to promote healthy environments at a policy and program level.

- The Nutrition Resource Centre (NRC) has depth of knowledge and expertise related to the food environment and are well-connected to both national and international experts in this area. The food environment has been a key area of focus for the NRC to build capacity among Ontario's public health professionals to create healthier food environments in their respective regions. One example of NRC's work in this area is a series beginning in 2015, Transforming the Food Environment Series, which included multiple webinars, workshops and a provincial forum.

**Develop Environmental Exposure Indicators Centrally**

- The goal of the Healthy Environments Program also changes the focus from reducing *"the burden of illness from health hazards"* to reducing *"exposure to health hazards"*. This presents an opportunity for the public health system to coordinate the development of indicators relating to environmental exposures. **We recommend that environmental exposure indicators be developed centrally with support from Public Health Ontario, the Association of Public Health Epidemiologists of Ontario and local health units.**

**Support Coordination of Program Delivery when Program Requirements Fall Under the Mandate of Different Teams at the Health Unit**

- There is a need to ensure coordination of program delivery when program requirements fall under the mandate of different Public Health Teams at the health unit. For example, the requirement under the Healthy Environments Standard to develop strategies with community partners to promote healthy natural and built environments is something that both Healthy Living (Chronic Disease) and Health Protection (Environmental Health) teams can address through their respective lenses. This is already happening at many health units and may not cause operational issues**.**

**Recognize the Importance of Access to Housing**

- Housing is an important determinant of health. The proposed Healthy Environments standard include indoor air pollutants as a topic for boards of health to address based on an assessment of local needs, but housing is not specifically identified. Given the important linkages of safe, healthy and affordable housing to public health and health equity, we recommend a stronger focus on this issue in the Standards. While this may be addressed in the forthcoming Healthy Environments protocol, a start would be to include it as an area for health units to address based on an assessment of local needs (e.g. under requirement 4 (c) .

**Emphasize the Need for Cross-Ministerial Collaboration Support and Guidance**

- As identified in the Standards, partnerships and collaborations at the local level are key components of public health programs and services. It is also very important to have cross-

- ministerial support and recognition of linkages for initiatives under the mandate of multiple provincial ministries e.g. MOHLTC and MOECC with respect to climate change; MOHLTC and Ministry of Municipal Affairs for built environment etc. While we were happy to see the recognition of climate change in the Premier's 2016 mandate letters to her ministers – "*I ask that you work closely with your Cabinet colleagues to deliver positive results on initiatives that cut across several ministries, such as our Climate Change Action Plan, …"* we noted the omission of a specific mandate for the Minister of Health and Long Term Care when it comes to climate change. While we feel that was an unfortunate oversight, we were pleased that the Premier's mandate letter to the Minister of Health and Long Term Care did include a priority of "Exploring *opportunities to enhance the environmental health of Ontarians, including supporting research and engaging key stakeholders such health care providers, public health partners, and patients on potential areas of action"* .

  [As noted by MOECC staff in their January 2017 presentation to the GTA Clean Air Council *"consideration of [climate change] adaptation is directly relevant to the mandate of various ministries, and cannot be considered a purely environment issue (it is a land-use planning issue, a health issue, and a risk and emergency management issue, etc. While there has been success in integrating future climate considerations in a number of programs and policies, there is still a strong need for guidance and capacity building in this area."]*

**Provide Support to Those Less Involved in Climate Change**

- The Healthy Environments Program Standard have additional requirements/increased expectations that could have resource implications for health units that are not already engaged in these activities e.g. addressing climate change, promoting healthy natural and built environments. We are pleased to see that the importance of addressing climate change is recognized by including it in the Healthy Environments Program goal. As noted by Dr. Margaret Chan, Director-General of the World Health Organization "Climate Change is the defining Issue for Public Health in the 21st Century." That being said, health units that have not already identified this as a priority may have to re-prioritize program delivery given the stronger emphasis to address climate change health impacts. There is a need for guidance/best practice/evidence to promote the development of healthy natural and built environments. This could include checklists, indicators and other tools to measure success of strategies and public health interventions. We recommend that this be incorporated into the Healthy Environments Protocol or related Guidance Documents.

**Other Operational Supports for Implementing the Healthy Environments Program Goal**

- There are a number of specific changes/additions to requirements under the Healthy Environments Program Standard that may have operational or implementation issues for health units. These include:

- Added requirement to use epi surveillance to inform Healthy Environments programs *(current standards require BOH to conduct surveillance and analyze data but did not require this to be used to inform programs & services)*

- Strengthened requirement related to collaborating with community partners i.e. current standards say BOH are to assist community partners to develop healthy policies. Proposed standards say BOH are to develop healthy environment strategies in collaboration with community partners.

- Revised public communication and awareness requirement based on an assessment of local needs. Topics added: chemical contamination, hazardous environmental contaminants and biological agents *(although it is likely that PHUs were already addressing these)*

- Moved vector-borne disease requirements from HHPM to ICDPC *(unlikely to have operational impact)*

- Added/clarified health hazard investigation and response requirement. Rather than "implement control measures", the requirement is to investigation and respond by preventing or reducing exposure.

- Removed requirement to communicate with health care providers and partners about health hazards *(perhaps under Foundational Standard but I did not see it).*

**Add Additional Outcomes to Healthy Environments Program Standard**

- *"There is a reduction in population health inequities related to chronic diseases, injuries and substance misuse"* is a program outcome in the Chronic Disease/Injury/Substance Misuse Program Standard (CDIPSM). There should be a similar outcome in the Healthy Environments Program e.g. *"There is a reduction in population health inequities related to exposure to health hazards and healthy natural and built environment"*. This is significant as we know there are inequities in terms of impacts of climate change, as well as the built environment.

- *There is increased adoption of healthy living behaviours…"* is an outcome in the CDIPSM program. There should be a similar outcome in the Healthy Environments Program e.g. *"There is increased adoption of health protective factors relating to healthy natural and built environments, and climate change."*

- The CDIPSM program outcome states that "There is increased awareness of risk factors and healthy behaviours". The Healthy Environments Program outcome states that there is increased awareness of health protection and prevention activities". There should be more consistency here. It is equally important to increase awareness of "risk factors" and "healthy behaviours" that can reduce exposure to health hazards. For example, limiting time outdoors or finding a cool place during extreme heat events.

- The CDIPSM program standard states that "Community partners, including policy-makers, and the public are meaningfully engaged.." in the planning of programs of relevance to the community. This

is an important outcome for the Healthy Environments program, for example, in planning climate change adaptation plans to protect human health and in developing strategies to promote healthy environments.

- Under Requirement #7: "ensuring 24/7 availability" there should be a similar requirement as per the Food Safety and Safe Water requirements e.g. *"…respond to health hazard issues arising from floods, fires, power outages, environmental incidents and other situations that may affect public health.."*

- To ensure a consistent approach in program delivery across all programs, the following additional requirements are recommended under the Healthy Environments Program:
    - #8: *"The BOH shall assess climate change health impacts"*
    - #9: *"The BOH shall implement a program of public health interventions to reduce exposures to health hazards and promote healthy natural and built environments."*

- Risk factors related to environmental health are missing from the School Health Program. This can be addressed by:
    - Adding "healthy environments" under third program outcome along with "healthy living behaviours" in reference to school-based initiatives. There are several linkages to environmental health in the school curriculum including climate change and air quality, and several schools have environmental clubs or are part of Ecoschools Ontario.
    - Adding "reduction in unhealthy risk factors" along with " increased adoption of healthy living behaviours" under the fourth program outcome. Examples of these risk factors include exposure to indoor and outdoor air pollutants.
    - Adding "Healthy environments" under requirement #5 as an area where BOH shall offer support.

**Identify the Municipalities as a Partner to Advance Public Health Interests**

- It is encouraging that the 2017 Standards offer more flexibility for local public health units to define partners that are important for local public health needs. It is also positive that further integration with new partners such as the LHINs and First Nations communities is promoted. However, there is inconsistency in the language used to refer to partners across standards. Currently, while some standards contain a specific list of partners to work with, the Healthy Environments Standard doesn't. This may be a well-intended approach to allow more flexibility for local public health units. However, in the promotion of healthy natural and built environments, partners at the upper and lower tier municipal level are central to advance public health interests. Public health units across Ontario have learnt to work with their municipalities, whose jurisdiction and policies impact the built and natural characteristics that affect health. The importance of working with municipal partners was identified as early as 2011 by an OPHA c-led analysis of examples of how ten health units in Ontario worked in multiple areas to create

healthy and sustainable communities.[3] Since the release of this report, other examples of successful collaboration between public health units and municipal partners have shown the importance of municipal partnerships to promote Healthy Environments. This highlights the importance of clarifying the role of municipal partners in the promotion of Healthy Environments.

**Clarify the Concept of Healthy Communities and Healthy Public Policies**

- It is positive that the 2017 Healthy Environments include explicit language about the promotion of healthy natural and built environments that support health. However, except for climate change and health hazards, the 2017 Standard wording does not contain explicit language to clarify the concept of built environments and the related concept of Healthy Communities that support active living and healthy eating, among other health benefits. Without further clarification, there is a risk of having too much focus on hazard prevention, rather than the full positive health promoting potential of healthy environments.

- There is also a risk of miscommunicating the importance of a broad spectrum of action required to support public health action and health promotion strategies, as identified in the Ottawa Charter. This is because the Standard Requirements only contain a general statement to ensure community partners have information and create communication plans. There is no reference to healthy policies, which are central to the promotion of healthy environments.

- The Policy Framework on Figure 2 (Defining our Work section) is a positive step in the right direction to define Healthy Communities and Healthy Policies. An opportunity exists if this Policy Framework is better articulated, integrated and cross-referenced across the document, with particular attention to the Healthy Environments Standard. In addition, consideration should be given to improving the Policy Framework so that it clearly defines Healthy Communities and Healthy Policies. Currently, it reads like a logic model without clear definitions to guide public health practice. In general, the term Healthy Communities is used in the document with a very positive intention but without a definition. This leaves the local public health practitioner without a clear direction about what a Healthy Community looks like.

- More clarity is also needed about the importance of healthy public policy and health promotion to capture the full potential of the Healthy Environments Standard and the Policy Framework. Currently, explicit language in the requirements is limited to awareness and communication strategies. This can generate confusion about the importance of intersectoral policies, which are central to promoting healthy environments. In many public health units across the province, the work being done surrounding built environment and Healthy Communities is beyond the point of awareness raising and communication surrounding community design. This includes

advancing healthy public policy through informing the policies of other sectors, such as planning and transportation. Built environment best practices need to be recognized. Referring to the Public Health Agency of Canada Core Competencies for Public Health in Canada can illustrate the breadth of skills and capacity within Public Health Units. Building on the Policy Framework, stronger language and cross-references can provide clarification for both public health units and the municipal jurisdiction levels that are central for improving healthy environments at a local level.

**Recognize Environmental Impacts on Children's Health**

- The work of the Canadian Partnership for Children's Health and Environment (CPCHE) needs to be captured here (see page 28) dust, fragrances, cleaners and mold would be captured under indoor air pollutants.

- Evidence is mounting on the impact of plastics; use of micro bacterial products (for example) on health. These critical issues are not being captured in the way the standards are currently laid out.

### *Healthy Growth and Development*

**Provide Clarity by Adding Nutritional Health through the Lifespan**

- The Healthy Growth and Development Standard includes breastfeeding as a key nutritional health topic/stage for local assessment but does not explicitly state the comprehensive range of life stages to which healthy eating is fundamental for nutritional health, growth and development.

- Within each of the requirements that speak to the program of public health interventions, "nutritional health through through the lifespan" needs to be explicitly stated.

- "Nutritional health through the lifespan" needs to be assed as a key topic (listed in requirement 1. d) to inform the program of public health interventions for healthy growth and development; this would include children's nutritional health.

**Provide Clarity and Guidance to Support Nutritional Health through the Lifespan**

- Clarity could further be provided in relation to the relevant data to monitor trends overtime in outcomes, in healthy growth and development and population inequities (requirement 1.) explicitly stating the link between "healthy eating behaviours and determinants of healthy eating" as factors that contributes to nutritional health, growth and development. Specifically, food insecurity, food literacy and the food environment.

- The new *2017 Healthy Babies* Healthy Children Protocol should explicitly state a requirement to screen for "child nutritional health using NutriSTEP ©", as a valid and reliable tool for assessing nutritional risk among preschool children, which is currently part of accountability agreements with boards of health (see *Appendix G*, NutriSTEP©).

- OSNPPH, an OPHA constituent society, The Nutrition Resource Centre at OPHA, and Dietitians of Canada can, in partnership, support the development of protocols and guidance documents related to healthy eating behaviours and determinants of healthy eating.

**Include Reference to Oral Health**

- Oral health should be specifically referenced in the section on Healthy Growth and Development. Oral health is an important part of growing up healthy.

**Include Reference to Fetal Alcohol Spectrum Disorder**

- A reference to fetal alcohol spectrum disorder prevention should be added under Healthy Growth and Development. As alcohol use among women has been increasing, this is an area of increasing public health concern and is a preventable condition.

**Include Reference to Preconception Health**

- The 6th bullet for the program standard outcomes mentions increased awareness among youth and emerging adults about contraception and healthy pregnancies. A reference to preconception health should be added.
- In addition, the following language under Healthy Growth and Development should be added: Program Outcomes; bullet #6; page 29 and School Health – Program Outcomes; bullet #6; page 42 "…among youth and emerging adults about contraception, healthy fertility and health pregnancies."
- It is important to recognize the role preconception health plays in contributing to healthy pregnancy.

**Expand Program Outcomes to Include a Broader Lens and Involvement with Stakeholders beyond the Local Level**

- The current Healthy Growth and Development Standards seem quite inward focused (other standards include a greater sense of the importance to extend beyond the local community). We would suggest including the importance of expanding program outcomes and requirements to include a provincial/national lens.
- As noted in *Patient's First,* collaborating with diverse partners/organizations is important; especially collaborating across the levels as decisions nationally/provincially impact work at the local level.

**Recognize the Importance of Paternal Health**

- The standard focuses on "maternal" health but it should also include "paternal" health and recognize the importance of men. Alternatively, it could refer to "family health" and include a definition of what this entails and ensure the needs of others are recognized. (Refer to *"Making*

*It Better: Gender-Transformative Health Promotion",* Edited by Lorraine Greaves, Ann Pederson, Nancy Poole for more information.

**Include Reference to Priority Populations**

- There is no mention of priority populations. As priority populations have specific needs that need to be addressed to be able to promote maternal, newborn, child, youth and family health.

**Add Informed Decision-Making for Labour and Birth**

- Add "informed decision-making for labour and birth" to the list of topics for consideration in the in requirements (see section 2. d. on page 30).
- "Labour and birth is a physiological process that does not inherently require intervention (2). It begins and progresses via natural biological processes and promotes "fetal readiness for birth and safety during labour, enhancing labour effectiveness, providing physiologic help with labour stress and pain, promoting maternal and newborn transitions and maternal adaptations, and optimizing breastfeeding and maternal-infant attachment, among many processes" (2 p. x). However, rates of medical intervention used for labour and birth vary significantly between hospitals for low-risk women giving birth in similar settings (12). This variation suggests that pregnant individuals and babies are being subjected to risks associated with unnecessary interventions. These unnecessary risks impact downstream health outcomes for mothers and babies. Informed decision-making has emerged as an important component for supporting physiological labour and birth which in turn reduces unnecessary interventions, improves birth outcomes, and increases positive birth experiences (13). (p.7)"

- "As recently as 2015, the Ministry of Health and Long-term Care (MOHLTC) recognized healthy birth practices as a means to healthy birth outcomes for low-risk pregnancies (10). Research study findings released in 2016 also suggest that attending childbirth education classes is associated with an increased likelihood of having a vaginal birth (11). Public health currently provides prenatal education, health promotion and support to expectant individuals and families across Ontario. As a result, public health is well positioned to also provide health education and promotion about informed decision-making and the importance of physiological labour and birth. Through public health advocacy efforts for access to consistent, evidence-based information necessary for informed discussions about labour and birth, the dialogue is shifted from an illness model to one that supports wellness (1). This aligns with the OPHA Reproductive Health Work Group's focus on promotion of wellness. Furthermore, such investments may increase the sustainability of the health care system by reducing costs of maternity care and by improving long-term health outcomes. (p.6)"

- See OPHA's position paper entitled: Informed Decision-Making for Labour & Birth

**Use Inclusive Language**

- Ensure the use of inclusive language (e.g. 'breast or chest feeding') instead of just 'breastfeeding', in the requirements (see section 2. d. on page 30).

**Consider Renaming the Standard Healthy Growth and Development and Reproductive Health**

- Removing "Reproductive Health" from the Standards undermines the importance of the evidence that there are specific and unique public health needs specific to women (as a population i.e. women's health) throughout the lifespan.

- From the revised OPHS document: "What unifies public health action is its focus on prevention, upstream interventions" "focused on upstream efforts to promote health and prevent diseases to improve the health of populations." (p. 3.) RH promotion is globally an upstream prevention strategy "to reduce the burden of chronic diseases…" (Goal for Chronic Diseases and Injury Prevention… program standard). Current RH upstream strategies are at risk of being lost without them being clearly identified in the modernized standards.

**Strengthen the Healthy Growth and Development Standard**

- Comparing **Growth and Development Standard** with the **Immunization Standard**, the language of the Growth & Development standard lacks the level of detail and specific program outcomes which help to provide PHUs with direction and focus.

    1. Recommend changing Bullet 4 on page 30 to:

    *Individuals and families have increased knowledge, skills and access to local resources related to growth and development to effectively foster healthy growth and development at different life stages and progress through the transitions between these stages.*

    2. Recommend increasing level of detail on *page 30 of Growth and Development Standard* to match page 32 of Immunization Standard and harmonize the language:

    The board of health shall implement a program of public health interventions to support healthy growth and development *in the health unit's local population by:*

    - *Assessing the* risk and protective factors that influence healthy growth and development
    - *Utilizing evidence informed interventions*
    - Consulting and collaborating with local *and other appropriate* stakeholders in the health, education, municipal, non-governmental, social, *public* and other relevant sectors with special attention to:
        - *Prenatal educators, families and support networks*
        - School boards, principals, educators, *parents,* parent groups, student leaders and students
        - Child care providers and organizations that provide child care services, such as Community Hubs and Family Centres
        - *Hospitals,* Health care providers and LHINs

- Social service providers
- Municipalities

d.) *Considering the following topics based on an assessment of local needs:*

- *Importance of breastfeeding and ensuring informed infant feeding decisions*
- *Healthy* growth and development
- *Healthy eating and nutrition*
- Healthy pregnancies
- Healthy sexuality *and positive relationships*
- Mental Health promotion *and resiliency*
- *Factors that support* preconception health
- Preparation for parenting
- Positive parenting

### *School Health*

**Revise Requirements to Include Determinants of Healthy Eating and Nutritional Health through the Lifespan**

- Where "healthy eating and food safety " is listed as a topic to assist school boards with implementation of health-related curricula, (i.e. requirement 5.d), it is recommended to be should be revised to state "healthy eating behaviors, determinants of healthy eating, and food safety." This provides direction to include curricula on key factors contributing to nutritional health, including patterns of dietary intake/nutrition, key determinants of healthy eating (i.e. food insecurity, food literacy and food environment) as well as food safety. These topic areas can be built into protocols and guidance documents.

- Add "nutritional health through the lifespan" as a key topic to address (requirement 5. d); this would include children's nutritional health. Within each of the requirements that speak to the

**Develop a Protocol/Guidance Document to Screen Child Nutritional Health using NutriSTEP ©**

- As with oral health, nutritional health is a key risk and protective factor related to chronic diseases and growth and development. When young children have nutrition problems they are not school-ready. Nutrition-related challenges have deep roots that go beyond the health/illness care system. The role of public health is to address these root conditions that create nutritional risk. The NutriSTEP® program has been shown to be effective at changing parent knowledge and skills in the promotion of healthy eating for their young children. (See ***Appendix G***: NutriSTEP ©)

- Boards of Health currently use NutriSTEP © as a valid and reliable tool to assess nutritional risk among preschool children and many have integrated into their school readiness programs.

- Recommend developing its own Protocol/Guidance Document (simply build from and revise the present Accountability Agreement Indicator NutriSTEP® Implementation Toolkit) to further support nutritional risk assessment at this stage of child's physical and cognitive development.

**Oral Health**

- With the Oral Health protocols in school health, there should be a statement that Healthy School Outcomes work is not limited to junior kindergarten (JK) to grade 12 (G12) or even the grades screened (JK to G8). It is for children aged 0-17. Oral health should be view for youth and children not just school aged children.

**Preconception Health**

- Under Program Outcomes, bullet #6, page 42 revise to read "…among youth and emerging adults about contraception, healthy fertility and health pregnancies" to recognize the important role preconception health plays in contributing to healthy pregnancy.

**Define Emerging Adults**

- The Inclusion of 'emerging adults' would indicate partnering with higher education such as universities, colleges, apprenticeship programs for those who continue their education. However 'emerging adults' are not reflected in requirements #3 or #4. Reproductive Life Planning messaging would be of importance with this population.

- The Standards should clearly define 'emerging adults' and set an age range.

- Emerging adults need to be made aware of potential challenges they could face if they delayed pregnancy i.e. infertility (basic fertility info – FSH and AMH values. This could help them plan better and possibly start a family sooner, avoid issues conceiving and less costly interventions.

- Increase messaging of RLP via apps, public service announcements, health education, physician outreach.

**Include Post-Secondary Education**

- Older adolescents continue to need public health support as they individuate from their families in the sometimes unfamiliar new surroundings of a college or university.

# APPENDIX F: Other Comments and Suggestions

OPHA members offer the following additional comments and suggestions for consideration.

**Update the monitoring and enforcement of provincial liquor laws**

- As part of its modernisation of alcohol retailing in Ontario, the government should consider updating the monitoring and enforcement of provincial liquor control laws, including the potential for a greater municipal role. For example, public health inspectors (or tobacco enforcement officers) could be used to monitor grocery stores (authorised to sell alcohol) for compliance.

- We recognize that this recommendation may be is beyond the scope of this consultation and will require consultation with other ministries (including Finance), legislative changes, and allocation of additional funding. However, given the rapid increase in the number of new alcohol retail outlets (involving new alcohol vendors), the government must ensure that all steps are taken to mitigate the potential to increase the public health burden of alcohol use.

# APPENDIX G: Inclusion of NutriStep© in Implementation Requirements and Supports

The NutriSTEP® program has been shown to be effective at changing parent knowledge and skills in the promotion of healthy eating for their young children. The Public Health Ontario LDCP multi-year funded *Beyond BMI* project has demonstrated the effective role of local public health in collaborating with primary care practices to ensure EMR uptake of this screening. Many local health units include NutriSTEP® as part of their school readiness programs.

Thus, **child nutritional health using NutriSTEP®** needs to be explicitly stated (like *oral* health, *visual* health/screening) in the modernized Standards for Public Health Programs and Services, 2017.
Specifically, **child nutritional health using NutriSTEP®** needs to be included in:

1. Three of the program standards (Chronic Diseases, Healthy Growth & Development, and School Health);
    a. Within each of the requirements that speak to the "program of public health interventions" Healthy Eating needs to be explicitly stated;
    b. As a Program Outcome (similar to School Health's "…increase in the number of children screened for *visual* health concerns")
2. The Population Health Assessment Protocol as a key risk and protective factor that influences healthy growth and development and prevents chronic diseases.
3. Its own Protocol/Guidance Document (simply build from and revise the present Accountability Agreement Indicator NutriSTEP® Implementation Toolkit).

**Rationale and Background**
What follows is a summary using the Principles of Need, Impact, Capacity and Partnership, Collaboration and Engagement. There is demonstrated rationale to include explicit language concerning child nutritional health using NutriSTEP®.

Nutrition is vital for support of optimal growth and development. Young children, including toddlers and preschoolers, with nutritional problems are at risk for growth, behavioural and developmental problems, including overweight and obesity, failure to thrive (growth failure), iron deficiency anemia, food allergies/ intolerances, delayed/inadequate acquisition of feeding/eating skills, unhealthy feeding/eating environments, and food insecurity. Delayed, inadequate, or inappropriate intervention and management has both short and long term health consequences.

**How does this align with Ontario's priorities?**

***Ontario's Patients First: Action Plan for Health Care*** priority is to inform: Support people and patients – providing the education, information and transparency they need to make the right decisions about their health. The use of the NutriSTEP® Toddler and Preschool Screens assist public health units in facilitating access and support for families to complete screening tools to monitor nutrition risk behaviours.

***No Time to Wait: The Healthy Kids Strategy*** identified the early years as a critical life stage in preventing childhood obesity and cited NutriSTEP® Screen as an important tool to assess the nutrition-related habits of toddlers and preschoolers and also help to identify individual children who are nutritionally at risk.

As stated in the *Technical Document: Health Promotion Indicators December 2015* the NutriSTEP® Screen can be used to:
- Identify children at risk of poor nutrition early,
- Increase parental nutrition knowledge and awareness,
- Refer to community resources, and
- Monitor nutrition behaviours and evaluate preschool intervention.

**Research indicates that:**
- Completion of the NutriSTEP® Preschool Screen by parents may reduce negative consequences of poor nutrition through improvements in parental nutrition awareness, knowledge and behaviours. Thus, administering the NutriSTEP® Preschool Screen is also an intervention.
- Associations between eating behaviours identified by the NutriSTEP® Preschool Screen and cardiovascular risk appear early in life and may be a potential target for intervention.
- Expanding an EMR-based childhood healthy weights surveillance system to include NutriSTEP® data in primary care practices is feasible and acceptable and there is receptivity to its integration into EMRs. In 2017 phase 3 of the Public Health Ontario LDCP-funded research project is exploring the implementation of NutriSTEP® electronically through its integration into the EMRs of primary care practices.

**The NutriSTEP® Screen Measures Risk and Protective Factors of Chronic Diseases, Growth & Development, and School Readiness:**
- Is a valid and reliable assessment of nutrition risk in children measuring the construct "parental perception of risk for nutrition-related problems" and the attributes in Table 1 below.
- Is completed by the child's parent in less than five minutes.
- Use of all 17 questions generates a low, moderate or high risk score and questions reflect the risk and protective factors associated with chronic diseases, growth & development, and school readiness.

| Question Topic | Question # NutriSTEP® Toddler | Question # NutriSTEP® Preschooler |
|---|---|---|
| Food Intake | 1-5, 7, 12 | 1-6, 7, 10, 13 |
| Beverage Intake | 6, 10, 11 | 9 |
| Eating Environment | 13, 14 | 11, 12 |
| Physical Activity & Sedentary Behaviour | 15 | 14, 15 |
| Physical Growth | 16, 17 | 16, 17 |
| Developmental Capabilities | 8 | 8 |

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## About OPHA

*Created in 1949, the Ontario Public Health Association (OPHA) is a non-partisan, non-profit organization that brings together a broad spectrum of groups and individuals concerned about people's health. OPHA's members come from various backgrounds and sectors - from the various disciplines in public health, health care, academic, non-profit to the private sector. They are united by OPHA's mission of providing leadership on issues affecting the public's health and strengthening the impact of people, who are active in public and community health throughout Ontario. This mission is achieved through professional development, information and analysis on issues effecting community and public health, access to multidisciplinary networks, advocacy on health public policy and the provision of expertise and consultation.*

*OPHA members have been leading change in their communities on a wide range of issues - tobacco control, poverty reduction, diabetes prevention, increased access to oral health care, immunization, supporting children and families, food security, healthy eating and nutrition, climate change and designing walkable communities, among others.*