REGIONAL MUNICIPALITY OF OTTAWA-CARLETON
MUNICIPALITÉ RÉGIONALE D'OTTAWA-CARLETON

MEMORANDUM
NOTE DE SERVICE

Our File/N/Réf. RC
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Information Previously Distributed
To Be Listed on Community Services
Committee Agenda 15 May 97

DATE 29 April 1997

TO/DEST. Chair and Members of Council

FROM/EXP. Medical Officer of Health

SUBJECT/OBJET **RESPONSE TO DRAFT MANDATORY GUIDELINES**

BACKGROUND

The Health Protection and Promotion Act has Mandatory Guidelines which define the public health programs required to be delivered by all health units across Ontario. These Guidelines were last revised in April 1989.

The Health Protection and Promotion Act will be amended this year to implement the changes in funding of public health services announced during Megaweek. At the same time the Ministry proposes to amend the Mandatory Guidelines (Annex A). Staff has provided a response to these draft guidelines (Annex B).

DISCUSSION

The intent of the draft Guidelines is as follows:

- To update the programs and tie them more directly to measurable health outcomes and the reduction of health care costs.
- to make the requirements more concrete, measurable and enforceable.
- to reduce the core requirements and make provide the municipalities with more flexibility in the delivery of the rest of the programs.

The position of the government is that the overall content and resources devoted to public health should not change as a result of the change in funding source from the province to the municipalities. The role of the Public Health Branch will change to one of monitoring and enforcement of compliance with the guidelines.

Approved by
Robert Cushman

Attach. (2)

ANNEX B

Feedback on Draft Mandatory Program Guidelines
Ottawa-Carleton Health Department

Overall Comments

We agree with the proposed program structure. It is a considerable improvement over the existing structure where the overlap between Healthy Growth and Development and Health Lifestyle Programs as well as their lack of clear outcomes has led to considerable confusion and variability in application across the province. Disease prevention goals and objectives make sense to the public and decision makers and are readily linked to direct health care costs.

We agree with the effort to achieve specificity in the requirements. In our comments on the programs we have made a number of suggestions to improve the relevance and applicability of certain requirements. The risk of specificity is that it is difficult to be both highly specific and have interventions appropriate for all Health Units. We suggest that there be some provision for equivalency with the guidelines. To invoke equivalency, the onus would be on the Board of Health to provide a rationale as to why that requirement was not appropriate for their particular situation and to demonstrate that the proposed alternative was equivalent in results and effort.

Requirements are currently restricted to Health Education interventions for the understandable reasons that these elnd themselves best to specificity and are the easiest to anchor resource requiqrements to. However, it is important that environmental and community partnership interventions also be specifically mentioned in the requirements. In particularl, some of the elements detaialed on page 4 under “Implementation” should be moved into the Requirements section even if the programs and associated resources are less clearly defined. We have made some specific suggestions in this regard.

The application of the Equal Access Standard remains problematic in the draft. To date, this standard has not been well implemented across the province. This is due, in large part, to the lack of specificity and the broad scope of the existing standard. We suggest adding a requirement that each year the Health Unit identify a subgroup e.g., a particular ethnic group, or group with specific physical socioeconomic or mental disabilities and analyze the barriers to access to public health programs and develop a specific plan to address these on an ongoing basis. This will engender a more systematic approach and will provide the Ministry with a concrete mechanism for accountability for the standard while providing the Board of Health with considerable latitude to tailor a local approach.

The approach of identifying channels, e.g., schools, workplaces etc. and recognizing that programs should be delivered within them in a multifactorial approach is a great improvement on the existing guidelines and correspond much better to the realities of program delivery and the current understanding of the need for synergy among different health promotion programs.

We support the increased emphasis in the guidelines on the use of volunteers as a Health Promotion strategy. We have had considerable experience and success with this approach in Ottawa-Carleton. However, implementation of such a program requires careful attention and resources devoted to training, coordination and support. It also requires a period of time to achieve understanding and respect for the role of the volunteer by the professional staff.

Standards should clearly define the relationship of the volunteers to the Board of Health. In some instances, volunteers are used as the channel for program delivery (as with server intervention training IP R&S 2.b) In other areas, the reference seems to be to more generic volunteer resources in the community (as with training volunteers about the prevention of motor vehicle injury - IP R&S 1.a).

We are concerned at the lack of emphasis on senior's programming outside of fall prevention in the draft guidelines. We continue to believe that the fostering of independence and the postponement of institutionalization are valid roles for public health using the MPAC criteria and are readily justified in reduction of direct helath care costs.

OBJECTIVES

Nutrition

Add p. 6 Objective 1 and 2 insert between g and h

> "decreasing to 20 % the proportion of the adult population aged 35- 64 with a Body Mass Index greater than 27" (Baseline 1990: Males 35.4% and females 24.5%)
>
> *Rationale: healthy weight component needs strengthening given that obesity is a risk factor for CAD, hypertension, hyperlipidemia and diabetes. Elimination of obesity could result in a 21.7 % reduction in cardiovascular mortality (aged 35 - 79) - OHS Paper 1990)*

Add

> "increasing to 50% the proportion of the population aged 4 and older consuming 5 or more servings of grain products (Baseline: 1990 21% aged 12 years plus)
>
> *Rationale: Carbohydrate is the preferred replacement for fat as a source of energy since protein intake already exceeds requirements Diets high in complex carbohydrates have been associated with a lower incidence of heart disease and cancer , and are sources o dietary fibre and of B-carotene.*

Smoking

Replace smokers with daily smokers in sub-objectives a and b

> p. 6 Objective 1 and 2 - insert between d and e:
> **"**increasing the proportion of smoke free workplaces to 100%"
> "increasing the promotion of smoke free public places to 100%"
>
> *Rationale: should be consistent with Ontario Tobacco Strategy*

Injury

The goal for injury prevention should include direction on reducing the major impact of injury-related morbidity on the health of Ontarians**.**

Rationale: Injuries are responsible for over 500,000 acute care hospital days annually and over 600,000 hospital days for falls sustained by persons over 65.

Objective 1- This objective is addressing two separate issues.

> "To reduce the rate of injuries caused by motor vehicle collisions and to reduce the rate of injuries caused by cycling that lead to hospitalisation or death by 20% by the year 2010
> by increasing the use of infant car seats by X% by the year 2010
> by increasing the correct use of seat belts up to 95% by the year 2010
> by increasing the correct use of bicycle helmets by X% by the year 2010.

Objective 2 - there is an inconsistency between the objective and the baseline measure. The baseline should be the rate of alcohol related injuries rather than the rate of consumption of alcohol.

> " To reduce the number of people exceeding the recommended daily drinking limits and to reduce the overall rate of alcohol-related injuries and deaths by 20% by the year 2010".

Objective 3

"To reduce the incidence of falls and reduce morbidity and mortality related to the rate of falls

Rationale: Falls in the elderly do not only lead to hospitalisation and death; ***40%*** *of admissions to nursing homes are related to falls. Baseline data is incomplete. 1/3 of seniors fall every year (Baseline from Ottawa Carleton Falls Research Program ; Sattin, R.W. et al. AJE, 131, 1990; Kellogg International Work Group, Danish Medical Bulletin, 1987) and 40% of all nursing home admissions are related to falls (Magellan, M., Geriatric Consultant, 1983).*

Delete Objective 4 unless it specifies reducing drowning

Breast Cancer

Pg. 14 objective 1 - add morbidity to objective as morbidity rates directly impact mortality rates with early detection practices

Reproductive Health

Add a third objective

To decrease the prevalence of Fetal Alcohol syndrome (FAS) and Fetal Alcohol Effects (FAE) -(Estimated Baseline: FAS 5-10/10,000 births; FAE 15-30/10,000 births

REQUIREMENTS AND STANDARDS

Non-Communicable Disease Prevention

Note- the Requirements in this section should be reviewed for consistency with the requirements for the Heart Health Enrichment funding

1. Change of Requirement 2 (p.7) to:

"The board of health shall involve community lay volunteers to augment and deliver community-wide non-communicable disease prevention by promoting tobacco-free living, healthy eating and regular physical activity. This shall include as a minimum:

- establishing volunteer management guidelines and policies

- allocating staff resources and related budget required for volunteer management
- supporting the role of volunteers associated with local agencies and partners
- recruiting volunteers to work in the community with a variety of groups in a variety of settings such as schools, workplaces, restaurants, supermarkets, farms markets and community centres
- providing appropriate initial training and orientation (min. of 20 hours per volunteer) and ongoing training and updating (min of 7 hours annually per volunteer)
- providing technical consultation and support for volunteers on an on going basis via regular updates, training sessions, telephone contacts and on site visits
- providing ongoing co-ordination of volunteer activities
- providing ongoing support for volunteers via recognition programs and opportunities for social networking.
- monitoring program outputs through evaluation conducted with volunteers, staff and client groups

2. Several requirements are too limiting. We feel it is possible to anchor resources while providing local flexibility. For example:

.Pg. 8, requirement 3 b) should read "communicate at least quarterly to inform and update (e.g.. newsletter, media bulletins, internet)"

Pg. 11, requirement #13: instead of just health professionals - should read "health professionals, allied health professional and other professional and lay community leaders"

Pg. 11, requirement 13 c) should read "communicate at least quarterly (e.g.. newsletter, media bulletins, internet)

Pg.11, requirement #14 on healthy eating needs broadening to include flexibility in programming and partner groups. Change to:

"The board of health shall promote and provide information for, support skill development activities and improve the physical and social environments for people to adopt healthy eating practices. This shall include as a minimum:

- seeking input and collaboration at least yearly, from food industry partners (e.g. supermarkets, restaurants, educators) to develop and implement strategies to promote healthy eating
- providing information on an ongoing basis about healthy food choices in supermarkets, restaurants and cafeterias using a multi-faceted approach (e.g. displays, posters, point of purchase information, restaurant guides)
- providing information and training opportunities for the public about how to make healthy food choices at least 10 times per year (e.g. supermarket tours, presentations, workshops, volunteer training)

- providing healthy eating education to food industry personnel **at** least once a year (e.g. newsletter inserts, Food Handler Training Course addition, chef training, food demonstrations etc.)
- providing technical consultations to restaurants and cafeterias to enable them to offer and promote healthy food choices to their customers

3. Policy/environmental supports/partner involvement

Either add new requirements to include this such as replacing requirement #1 , pg. 7 with:

"The Board of health shall develop and use a comprehensive plan for non communicable disease prevention that collectively addresses and reinforces the awareness of; support skills for; and improves the social and physical environment for; tobacco-free living, healthy eating, and regular physical activity through their work with schools and other educational facilities, workplaces, health and allied health professionals, community agencies and associations, restaurants and grocery stores, recreational facilities and the community at large.

The board of health shall establish and maintin collaborative partnership with community agencies and groups to support community wide multiple risk factor non communicable disease prevention. This shall include as a minimum:

- input and collaboration with community partners in the development and implementation of the plan at least annually
- at least 2 joint initiatives and projects with community partners (e.g. education campaigns, health fairs, contests, policy implementation)

The board of health shall provide information to the public about the prevention of heart disease, lung cancer and other preventable non-communicable diseases through tobacco-free living, healthy eating, and regular physical activity. This shall include as a minimum:

- providing at least once a year, a community -wide media campaign which includes television, radio, pamphlets, posters and presentations
- participating in community wide events at least twice a year to promote non communicable disease prevention (e.g. NNSW, Nutrition Month, Heart Month)
- providing public access to health information/advice and community and board of health programs on tobacco-free living, health eating and regular physical activity on an ongoing basis in a manner appropriate to the community (e.g.. telephone lines, resource libraries, volunteers, resource guides, information sessions, electronic mail, internet pages, media releases etc.)"

5. Pg.10, #11 intro.- change to:

> "The board of health shall provide information, consultation and support to workplaces to increase the awareness of the importance of health issues in the workplace and of the effects of the workplace physical and social environment on risk for non-communicable disease; promote tobacco-free living, healthy eating and regular physical activity; and increase access to health resources in the community. This shall include as a minimum (a-d)"

6. Other Necessary Adjustments:

> Pg. 7 requirement #1(c) - Canada's Fit Week no longer exists.
> Pg. 16 Requirement (a) - change to **ensure** the provision of sun safety education to reduce exposure...(many partners such as Cancer Society already doing this in our community).

Injury Prevention

Expand range of specific actions to meet standards

In Requirement 1b change the reference to providing demonstrations to all child care centres-not only is this not feasible; it is also not the best way to address the problem. It would be better to provide training to daycare workers so that they may provide accurate information and assistance to parents using car seats incorrectly. Another method is to work with enforcement agencies to enforce the law about car seats.

In Requirement 2, there is nothing addressing the issue of access for minors. It would be unethical to teach low risk drinking to underage drinkers. There is also no mention of imparting to parents their role as models to their children.

A comprehensive, effective intervention to reduce injuries requires inclusion of relevant policies and environmental factors. Add requirement 2 c) working in community coalitions to identify and promote policies for alcohol use in both public and private facilities and 3c) working in community coalitions to promote policies to reduce safety hazards in public buildings, including seniors buildings.

Family Health

Definition of family excludes older children.

Reproductive Health

Suggest that the requirements in this section follow the same format as non-communicable disease (see attached)

Sexual Health

1. The three hours of classroom teaching for grades 7 to 9 needs to be explicitly part of a broader comprehensive school approach. It also needs to fit in with the new provincial education curriculum and be viewed positively by teachers.

2. To requirement 1, add the following requirements which stress a comprehensive approach and involve parents:
   - -provide assistance to school boards and parent councils to review and implement sexual health curriculum at least once a year.
   - -Offer inservice education to teachers from all schools at least every two years
   - -support the implementation on an ongoing basis of a variety of strategies in schools with grades 7 and up including classroom education, student-led school-wide initiatives, peer education, peer discussion groups and annual awareness events.
   - In requirement 2, specify 4 hours/week per 150,00 population.

Child Health

1. There is no mention of post-partum visiting. We understand this will be part of a yet to be announced program. It is important that there be an element of post partum assessment to determine which families are in need of community follow-up
2. There needs to be a requirement for the Health Unit to work with partners to create a supportive environment for parenting.
3. Requirement 4c should include provision of breastfeeding support for women who are experiencing significant difficulty breastfeeding in the community. A volunteer cannot be expected to assess a baby for dehydration and failure to thrive.
4. In Requirement 7, the DIS survey as proposed is far more complex than necessary and would require hygienists to wear gloves, wash their hands between each child that was examined. This is impractical. We are able to identify high risk children based on our own modified survey in high risk schools without the use of this labour intensive survey.
5. Requirement 9 is reasonable only if other socially funded dental programs remain intact. If not, the cost could become very large. The requirement would have to be delivered in a clinical setting. We suggest this is a substantial enrichment for most health units and should be carefully assessed against other options.

Infectious Disease Control

1. Requirement 2b should read investigate cases according to Ministry of Health protocols and additional protocols relevant to local conditions.
2. Requirement 3c should be restricted to public health management as we have limited scope over the clinical management of a non- communicable individual

STD's and AIDS

1. Requirement 1 should specify that clinical and other services should be free. Requirement 1c should specify those at risk for STD's and provide for distribution through community channels.
2. Requirement 2 should address both case and contact management.
3. Requirement 4 should refer to HIV/AIDS. It should include parents and caregivers of school aged children as a target audience
4. Add a requirement on working in partnership with community including interagency councils.
5. Hepatitis B immunization for those at risk should be mentiuoned here or cross referenced to Vaccine Preventable.

Vaccine Preventable Disease

1. Objective 8 should include a target for Hepatitis immunization for those at risk of STD's and recognize involvement of STD services in this.
2. Requirement 8 should specify frequency.

Tuberculosis Control

1. Objective 2 should be to reduce not eliminate progression and include a target.
2. Requirement 1 should be limited to communicable and potentially communicable cases.
3. Replace R2c with 'Promote the screening of persons in high risk groups, and assessment to rule out active Tb in those testing positive, through education of physicians and selective group screening programs e.g. recent immigrants.
4. R2h cannot require completion. Suggest wording 'maximize completion through education, support and followup'.

Infection Control

1. R2g should read selected staff.
2. R3 should give a more prcise definition of boarding home.
3. R4 should specify licensed child care centres.

Food Safety

1. Objective should refer to food borne illness. The draft objectives are in fact requirements.