MEDIA RELEASE: Friday, March 4, 2011, 4:30 p.m.

REGIONAL MUNICIPALITY OF WATERLOO
COMMUNITY SERVICES COMMITTEE
AGENDA

Tuesday, March 8, 2011
1:00 p.m.
Regional Council Chambers
150 Frederick Street, Kitchener, Ontario

1. DECLARATIONS OF PECUNIARY INTEREST UNDER THE MUNICIPAL CONFLICT OF INTEREST ACT

2. PRESENTATIONS
   b) Planning, Housing and Community Services – Overview of Major Issues and Priorities related to Community Services and Housing (Staff Presentation)

3. REPORTS – Planning, Housing and Community Services
   a) P-11-031, Proposed ‘Place of Employment’ Survey 1
   b) P-11-032, Raising Awareness of the 2011 Census 4

4. INTERDEPARTMENTAL REPORTS
   a) PH-11-012/P-11-030, 2010 ECOFest Overview and Planning for 2011 7
   b) SS-11-013/CA-11-004, Waterloo Region Immigration Partnership 12

5. REPORTS – Social Services
   a) SS-11-012, Homelessness Partnering Strategy 24
   b) SS-11-014, Homeless Individuals and Families Information System Local Coordination Project (2011-2012) 32

6. REPORTS – Public Health
   a) PH-11-008, Smoke-Free Policy For New Leases and Transfers in Regionally Owned Community Housing: Report of Evaluation Findings (Staff Presentation) 35
   b) PH-11-009, Fluoride Varnish Program in Selected Elementary Schools and Enhanced Surveillance 97
   c) PH-11-010, Ontario Public Health Organizational Standards 101
   d) PH-11-011, Mutual Aid Agreement 127
e) PH-11-013, EMS Master Plan Update *(Staff Presentation)*

7. INFORMATION/CORRESPONDENCE

a) Memo: Online Application

b) Memo: Ontario Works Caseload February 2011 *(To be distributed at meeting)*

c) Correspondence: Minister of Human Resources and Skills Development
Re: Homelessness Partnering Strategy

d) Correspondence: Ministry of Children and Youth Services Re: Best Start Child
and Family Centres in Ontario

8. OTHER BUSINESS

a) Council Enquiries and Requests for Information *Tracking List*

9. NEXT MEETING – Tuesday, April 12, 2011

10. ADJOURN
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: March 8, 2011

FILE CODE: D15-70

SUBJECT: PROPOSED ‘PLACE OF EMPLOYMENT’ SURVEY

RECOMMENDATION:

THAT the Regional Municipality of Waterloo receive Report P-11-031, Proposed ‘Place of Employment’ Survey, dated March 8, 2011 for information;

AND THAT this report be distributed to interested parties, including the Area Municipalities and the Canada’s Technology Triangle (CTT), to advise of the initiation of this project, and to request their support in raising awareness.

SUMMARY:

To effectively plan for business and other employment workplaces, the Region of Waterloo will join several other Ontario municipalities in 2011, who are undertaking a door-to-door enumeration of workplaces within their jurisdictions. From May to August, a count of each business, location, size and type of business activity will be undertaken in order to collect useful data for planning purposes. The amount of information collected from each business will be limited in order to keep short the amount of time for each survey. The data will be valuable for developing detailed estimates and forecasts of employment which are used to plan and size infrastructure, to ensure availability of appropriate land for employment uses, and to understand the changing structure of the local economy in areas such as manufacturing.

There is no current source of detailed workplace data available to the Region to meet these needs. Data from the Municipal Property Assessment Corporation (MPAC), Canadian Business Patterns, and the Census of Canada have been eliminated or marginalized, or are available only at a municipal or other large-scale level. Significant effort is spent by staff to compile employment data from a variety of data sources such as census, building permits, aerial photography, private sector business directories, assessment data, media coverage of business news, and an anecdotal sense of changes in business and employment activity within our community.

Significant benefits have been achieved by similar surveys in other Ontario jurisdictions, including York Region, the City of Toronto, the City of Mississauga, and Halton Region.

REPORT:

The Region of Waterloo requires accurate and comprehensive data on places of employment for estimates and growth forecasts for numerous purposes such as:

- transportation planning
- water and servicing plans, and water protection
- development charges studies, and budget analysis
- input to local area planning studies
- evaluation of development applications
- monitoring trends in the economy and urban structure, and
o to help formulate planning policy.

There is no current source of detailed workplace data available to the Region to meet these needs. Data from the Municipal Property Assessment Corporation (MPAC), Canadian Business Patterns, and the Census of Canada have been eliminated or marginalized, or are available only at a municipal or other large-scale level. Significant effort is spent by staff to compile employment data from a variety of data sources such as census, building permits, aerial photography, private sector business directories, assessment data, media coverage of business news, and an anecdotal sense of changes in business and employment activity within our community.

As a result, municipalities wishing to collect and maintain business and employment data have been left searching for cost-effective alternatives. To meet this growing need for accurate and consistent employment data, several municipalities in Ontario have undertaken an employment survey. Significant benefits have been achieved by such surveys in other Ontario jurisdictions, including York Region, the City of Toronto, the City of Mississauga, and Halton Region.

To acquire the data required for accurate planning and monitoring purposes, the Region of Waterloo will be undertaking a count of businesses and other places of employment in the Region. All workplaces in Kitchener, Waterloo, Cambridge and the Township Settlement Areas will be contacted. Home-based and on-farm businesses are not being included, primarily due to their dispersed locations. Estimates of this type of “work-at-home” employment will continue to rely on Statistics Canada (formerly the long-form Census, now the voluntary National Household Survey) and other data sources.

The survey is scheduled to begin on May 9, 2011 and run until the end of August. Prior to the door-to-door, a mail-out will be completed for larger employers in the Region, such as the School Boards. These workplaces will be asked to complete a written questionnaire and return by mail or fax.

This data will be used for:

- Identifying the location and size of all types of workplaces in the Region, including schools, and other population-related employment;
- Calculating employee – space ratios that are used to forecast the number of employees;
- Capturing a snapshot of the employment in various sectors of the local economy, including high tech;
- Calculating the number of employees in business parks and other land uses that are dedicated to employment;
- Understanding the existing and available square footage in the region in various employment sectors, such as manufacturing.

If this count is repeated in future years (annually or otherwise), the data will also support:

- Monitoring of the change in employment by small levels of geography (sub municipal);
- Analysis of trends in the types of employment in the Region;
- Monitoring for Places to Grow employment targets.

Data collection is being coordinated with the CTT (Canada’s Technology Triangle) and the Area Municipalities. Economic Development staff in the Area Municipalities and CTT use business and employment data to develop business directories, perform sector analyses and promotion of specific sectors of the economy such as tourism or high-tech and knowledge-based sectors, recruitment of new businesses, and as a tool to assist in targeting economic development programming such as export development. An advisory group has been convened to provide input into the project methodology, and to coordinate on communication and data collection. Coordination
with other departments and agencies includes the Region of Waterloo’s Source Water Protection census (2009), and the Workforce Planning Board’s surveys. Hiring is underway for approximately eight students who will work from May to August to collect and collate this data. Each student will receive training on conducting the survey. The students will travel door-to-door to visit business locations, and gather basic data.

Staff will develop a communication strategy, including an official project name, branding of the project, identification of students (through t-shirts and badges) and ways to raise awareness with the business community.

Upon completion of the count, staff will prepare a report to Community Services Committee to highlight the learnings and implications from this survey.

Area Municipal Consultation/Coordination

A consultation meeting was hosted for representatives from Area Municipalities’ planning and economic development staff in January to share a detailed project charter. Area Municipal staff has been invited to participate in an advisory capacity through monthly meetings with the project team.

This report can also be used by Area Municipal staff to inform their Councils of the initiation and purpose of this project, and to request Area Municipal staff support with activities such as communication of the project to local business associations.

CORPORATE STRATEGIC PLAN:

Tracking and monitoring employment information contributes to Strategic Focus Area 1: Manage Regional Growth to Enhance Quality of Life.

FINANCIAL IMPLICATIONS:

The costs associated with undertaking the 2011 ‘Place of Employment’ Survey for this year are included within the council-approved capital budget for Growth Management, and are estimated at $125,000. In order to repeat the count in future years, funding partnerships with Area Municipalities and other interested organizations will be investigated; however, the Region of Waterloo can play an important role initiating the first survey.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Transportation & Environmental Services, Information Technology, and through the Data Networking Group, Social Services and Public Health have been consulted in initiating this project.

ATTACHMENTS:

NIL

PREPARED BY: Margaret Parkin, Manager, Planning Information & Research

APPROVED BY: Rob Horne, Commissioner of Planning, Housing and Community Services
TO: Chair Sean Strickland and Members of the Community Services Committee  
DATE: March 8, 2011   
FILE CODE: D15-80  
SUBJECT: RAISING AWARENESS OF THE 2011 CENSUS  

RECOMMENDATION:  

THAT The Regional Municipality of Waterloo take the following actions to raise awareness of the 2011 Census as described in P-11-032, dated March 8, 2011:  

a) Encourage all residents of the Region of Waterloo to provide a complete response to the 2011 Census Form during May, 2011; and  
b) Use available channels, such as the Region of Waterloo website, to direct residents to information about the Census.  

SUMMARY:  
The 2011 Census will be conducted in early May. The 2011 Census will consist of the same eight questions that appeared on the 2006 Census short-form questionnaire, with the addition of two questions on language. While completing the census is mandatory for all Canadians, raising public awareness of the importance of completing the census form, and how to obtain assistance, should assist in achieving more accurate data on which to base population and household estimates and forecasts. The Region of Waterloo has the ability to provide information through its networks.  

Subsequent to the Census, the National Household Survey (NHS) will be distributed to 1 in 3 Canadian households. The NHS will collect the data (such as income and place of work) that had been mandatory on the Census Long Form, previously distributed to one in five households. Statistics Canada currently has not provided communications material for the NHS. Households will be requested to respond to the survey, and follow-up procedures may include mail-out reminders and telephone contact.  

REPORT:  
Census Background and Importance  
Every five years, Statistics Canada conducts a census of residents to provide a statistical portrait of the people of Canada. The last census was undertaken in 2006. May 10, 2011 is official date of the next census, when 34.25 million people across Canada are required to complete and submit the Census form.  

The 2011 Census will collect data on a smaller number of topic areas than in previous censuses. All households will be required to complete a short questionnaire on number of people, age, sex, marital status, and language. Dwelling information will also be collected in this process. This information is critical for governments, as decisions are based on analysis made possible by Census data. Examples include:  

- Estimates of current population and number of households;
- Population and household forecasts developed by Regional staff; these are used to estimate land use, plan infrastructure, set development charges, assess housing needs, and interpret health and social service trends;
- Age-specific data, which are used in planning new schools and other facilities;
- Population distribution and basic demographic characteristics, which are used to plan and locate services and programs.

All of these needs are best served if the Census data is as complete and accurate as possible.

Data Collection Changes and Challenges

Across Canada, starting May 3rd, Canada Post will deliver a letter to 60% of dwellings across the country. This letter replaces the traditional paper questionnaire and provides information that enables respondents to complete the questionnaire on-line. The letter also contains a toll-free number respondents can call to request a paper questionnaire, or to provide their information over the telephone. Another 20% of Canadian dwellings will receive a questionnaire package by mail. The remaining 20% of dwellings will have questionnaires dropped off by enumerators. At a small number of Canadian dwellings, enumerators will conduct personal interviews. Personal interviews are normally conducted in remote and northern areas of the country and on most Aboriginal reserves. They are also conducted in large urban downtown areas where many residents are transient.

For most dwellings, one respondent will complete the questionnaire for the entire household using either the on-line or paper questionnaire. For residents who understand the process, this approach is convenient and increases the confidentiality of their data.

However, since the Census document is written only in English/French, there is concern that some residents will not understand what it is, or how to seek help, and it may be inadvertently discarded. As a result, it is possible that a significant portion of the recent immigrant population may not get counted. In 2006, about 7,000 Regional residents reported no knowledge of either English or French.

Statistics Canada will operate a Census Help Line from 8 a.m. to 8 p.m., starting May 2nd. The line will be staffed by operators who can provide assistance with completing the questionnaire. In addition, the Census website, www.census2011.ca, provides translations of the census questions into 62 languages, although the actual Census form must be completed in English or French. These tools will only be useful if residents are aware of their availability.

Raising Awareness of the Census

To obtain the best possible response rates, it is important that all residents understand what the Census envelope looks like, why a timely response is important, and how to respond. The Census form will arrive in a yellow envelope which says “Canada – Census”. Raising awareness of the significance of the yellow envelope will help to encourage a strong response.

Statistics Canada has available for order posters, bookmarks and other promotional material, free of charge. Information sheets which provide answers to questions about the census are available in multiple languages. Statistics Canada communications staff have contacted media and other groups to request assistance in distributing the Census messages.

Regional staff recommend taking some additional steps to raise awareness of the Census. These include:
ordering Census promotional material such as posters and bookmarks for display and
distribution through Regional offices and the Region of Waterloo Library;
- contacting Area Municipal and library staff to encourage distribution of Census information;
- working with Citizen Service staff to post Census links on the Region’s website, and to
ensure Citizen Service Associates are able to provide appropriate information to residents;
and,
- working with Statistics Canada and the local multicultural community to determine if
information in additional languages appropriate to this community is needed.

Subsequent to the Census, the National Household Survey (NHS) will be distributed to 1 in 3
Canadian households. The voluntary NHS will collect the data that had been mandatory on the
Census Long Form, previously distributed to one in five households. The data to be collected
through the NHS includes income, ethnic origin, language spoken at home, place of work and mode
of travel. Statistics Canada currently has not provided communications material for the NHS.
Households will be requested to respond to the survey, and follow-up procedures may include mail-
out reminders and telephone contact.

Area Municipal Consultation/Coordination

Area Municipal staff will be circulated a copy of this report.

CORPORATE STRATEGIC PLAN:

Raising awareness of the 2006 Census will help to ensure collection of accurate data which is used
to support Focus Area 1, Manage Regional Growth to Enhance Quality of Life.

FINANCIAL IMPLICATIONS:

Materials for promoting the 2011 Census are available at no cost to the Region of Waterloo by
Statistics Canada.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Staff from Public Health, Social Services and Community Crime Prevention have been consulted in
the writing of this report, through the Data Networking Group.

ATTACHMENTS:

Nil

PREPARED BY:  Margaret Parkin, Manager, Planning Information and Research

APPROVED BY:  Rob Horne, Commissioner of Planning, Housing and Community Services
TO: Chair Sean Strickland and Members of the Community Services Committee
DATE: March 8, 2011 FILE CODE: A02-40

SUBJECT: 2010 ECOFEST OVERVIEW AND PLANNING FOR 2011

RECOMMENDATION:

For information

SUMMARY:

The 2010 ECOFest event took place on June 4 and 5 at the Waterloo Region Museum. ECOFest was comprised of two full-day components, a program for local schools and an event for the general public. Approximately 250 local ‘Eco School’ representatives participated on June 4, while approximately 1,000 members of the general public attended the main ECOFest event on June 5. The entire event was the product of a collaborative planning effort between Regional staff and many external partners. Feedback from ECOFest attendees indicates that the goal of the event – to educate the public about environmentally sustainable actions and issues – was achieved. An evaluation report clearly showed that the event was a success and that the Waterloo Region Museum is an ideal venue. One attendee commented that ECOFest was a “fun, interactive, and educational event”. The majority of participants, which were families with young children, reported that they were willing to take actions to lessen their impact on the environment as a result of attending this event.

The ECOFest event continues to change and evolve since the event proposal was first endorsed by Council in 2007. Public Health has provided planning committee leadership, organization, administration and coordination for 3 years. Staff from Planning, Housing and Community Services will be leading the 2011 ECOFest event. ECOFest will continue to build community awareness, recognition, and support for environmentally sustainable actions. This year’s event will be held on Saturday June 4 at the Waterloo Region Museum, following the week-long Waterloo-Wellington Children’s Groundwater Festival.

REPORT:

Background

In 2007, Regional Council endorsed the development of an “eco- home and garden show” event under the Environmental Sustainability Focus Area of the Corporate Strategic Plan. The overall goal of this event was to educate the public about environmentally sustainable actions related to air quality, climate change, children’s health, transportation, waste management, and water resources. A multi-departmental planning group, coordinated by Public Health, was formed within the Region to prepare and deliver the event.
See the brief summary of past ECOFest events below:

2008 – March 13-15, event titled “ECO Show” was hosted by the Children’s Museum in downtown Kitchener

2009 – June 5 & 6, event titled “EcoFest” was hosted by uptown Waterloo’s Centre for International Governance Innovation (CIGI)

2010 – June 4 & 5, event titled “ECOFest” was hosted by the Waterloo Region Museum

2010 ECOFest Event Overview

The 2010 ECOFest event took place on Friday, June 4 and Saturday, June 5 at the newly opened Waterloo Region Museum building and Doon Heritage Village. This event was comprised of two distinct components:

1. Eco Schools (Friday, June 4) – this full-day program consisted of interactive workshops, entertainment, and an EcoSchool award ceremony for approximately 250 school representatives from 36 local Ontario EcoSchools¹.

2. Free Public Event – “ECOFest” (Saturday, June 5) – similar in format to the public EcoFest event in 2009, this full-day program consisted of hands-on activities, interactive workshops, educational exhibits, presentations, demonstrations, live music, crafts, face-painting, horse-drawn wagon rides, games, food, and more. The event ran from 10 am to 4 pm. Admission was free to the general public. Approximately 1,000 people attended.

The 2010 event was planned, coordinated, and carried out in collaboration with many local partners including the Region of Waterloo, Waterloo-Wellington Children’s Groundwater Festival, Waterloo Region District School Board, Area Municipalities, local community groups, local businesses, and not-for-profit groups.

Planning Committee membership consisted of staff representatives from participating Region of Waterloo departments: Public Health; Planning, Housing and Community Services; Transportation and Environmental Services; and Corporate Resources. The Planning Committee was chaired by a Public Health representative and Public Health also managed general event administration and coordination.

Evaluation Overview

An evaluation of the 2010 ECOFest event was conducted by Public Health staff. Exit interviews for attendees, exhibitor interviews, and a facilitated focus group with Planning Committee members were used to evaluate the event. A brief summary of the evaluation report can be found in Appendix A. Overall, Planning Committee members agreed that the 2010 event reached its target population and “brought people who we do not normally speak to” to this event. The majority of participants reported that they were willing to take actions to lessen their impact on the environment as a result of attending this event.

Evaluation Highlights

- **Attendees** – Approximately 1,000 people attended the free public event on Saturday, June 5. The majority of attendees were families with young children. Sixty-one people volunteered their time to help. Approximately 75 people staffed various exhibits.

¹ Ontario EcoSchools is a provincially coordinated environmental education program for grades K-12 that is developed and run by local school boards. This program is intended to help students develop both ecological literacy and environmental practices to become environmentally responsible citizens.
• **Regional staff involvement** – Twenty-three Region of Waterloo employees were involved in the event in some capacity.

• **Marketing** – The majority of surveyed attendees indicated they heard about ECOFest through the newspaper, a friend, word of mouth, or radio.

• **Exhibitors** – One-fifth of exhibitors indicated they had attended two of the three ECOFest events, including 2010. More than half of the exhibitors indicated they participated in the event to “educate, promote their activities, and increase awareness of environmental issues”.

• **Overall Feedback of Event** – the majority of feedback from respondents was positive. However, there were a few suggestions for improvement provided by respondents.
  - **Successes** – overall, all survey respondents felt positive about the organization of the event, venue, program, marketing and promotion, and the exhibitors, noting:
    - “well organized”; “great location”; “great event especially for kids”; and “fun, interactive, educational event”
  - **Areas for Improvement** – 1) needed better directional signs; 2) getting transportation to venue; 3) parking was insufficient at times; 4) food – more options, cheaper; 5) needed greater corporate and/or political support

**Planning for 2011 ECOFest**

The ECOFest planning committee participated in a focus group after the 2010 event took place. This focus group served two purposes: reflecting on the event from an evaluation perspective and identifying some of the lessons learned that could benefit future events. Below are some comments from planning committee representatives that frame where the event has come from and where they see it going in the future:

- “All past ECOFest events, including the 2010 event, have demonstrated that this event educates the public on environmental issues”
- “This event fulfills many different departmental mandates and corporate plans”
- “There are significant collaborations, partnerships, and dialogue that happen during the planning for this event – both internally & externally”
- “It finally feels like the event has a ‘home’ at the Waterloo Region Museum”
- “Public events take several years of consistency before they penetrate the greater community’s awareness…and I think there is an awareness of ECOFest that’s growing”

With the momentum gained over three successful years, and the good fit established with the Waterloo Region Museum as a venue, it was decided that ECOFest would continue with the same location and objectives in 2011. Responsibility for coordinating the event has been shifted from Public Health to Planning, Housing and Community Services.

ECOFest 2011 will be held on Saturday June 4, from 9:30 to 4:30 at the Waterloo Region Museum. It is a free public event, targeted towards showing families with young children how to reduce their household environmental footprint. Environmentally-themed entertainment, interactive programming, and exhibitors including many Regional departments will be featured. Promotion will occur through print, radio, the Waterloo Region Museum website (www.waterlooregionmuseum.com), and Facebook. The selected date falls at the end of the week-long (May30-June3) Waterloo-Wellington Children’s Groundwater Festival and enables ECOFest to take advantage of many exhibits developed for the Groundwater Festival.

The EcoSchools event will be held on Tuesday June 14, 2011, also at the Waterloo Region Museum. This event is a collaboration between the Waterloo Region Museum and the School Boards, and the date has been selected to better suit all groups.
CORPORATE STRATEGIC PLAN:

Supports Focus Area 1 – Environmental Sustainability: Protect and Enhance the Environment.

FINANCIAL IMPLICATIONS:

The event’s budget has been $20,000 for the last 3 years and has been jointly funded, $5,000 each, from existing budgets of the participating departments: Public Health; Planning, Housing and Community Services; Transportation and Environmental Services; and Corporate Resources.

It is anticipated that similar funding sources will be used for the 2011 event, with the final budget to be established at a minimum level needed to present and promote the event. Coordination and planning are being undertaken through existing staff responsibilities.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Correspondence and consultation with the 2011 ECOFest Planning Committee representatives have been made in the preparation of this report.

ATTACHMENTS:

Appendix A – 2010 ECOFest Evaluation Summary

PREPARED BY:  
Peter Ellis, Public Health Planner  
Dave Young, Manager, Health Protection and Investigation  
Lucille Bish, Director, Community Services

APPROVED BY:  
Dr. Liana Nolan, Commissioner/ Medical Officer of Health  
Rob Horne, Commissioner of Planning, Housing and Community Services
APPENDIX A – 2010 ECOFest Evaluation Summary

2010 ECOFest Public Event – Date: Saturday, June 5, 2010.
Feedback was obtained from event attendees, exhibitors, and the planning group. Summary below:

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
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<tbody>
<tr>
<td><strong>Attendees:</strong></td>
<td><strong>Attendees:</strong></td>
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<tr>
<td>• 92% plan to do something different at home as a result of attending ECOFest</td>
<td>• 77% said to offer greater variety of interactive activities</td>
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<td>• 78% rated the quality of the event as ‘excellent’</td>
<td>• 37% suggested to focus the theme of the event, as there was a lot to see</td>
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<td>• 53% liked the exhibits and displays</td>
<td>• 27% suggested that there should be a greater variety of affordable and healthy food choices</td>
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<td>• 37% said that it was a ‘great event, especially for kids’</td>
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<td>• 35% reported they enjoyed the venue</td>
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<td>• 25% said the event was ‘well organized’</td>
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<td>• 19% liked everything and said that there was nothing to improve on</td>
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<td>• 10% liked the live entertainment</td>
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<td><strong>Exhibitors:</strong></td>
<td><strong>Exhibitors:</strong></td>
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<tr>
<td>• 100% felt it was well organized</td>
<td>• 17% wanted more signage directing to exhibits</td>
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<tr>
<td>• 100% said they were provided with enough space and resources for their exhibit</td>
<td>• Some wanted to be able to ‘take orders for their products and services’</td>
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<td>• 97% felt that the Waterloo Region Museum was a good location</td>
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<td>• 90% felt that their exhibit generated a lot of interest</td>
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<td>• 70% felt that the promotion of the event was adequate</td>
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<td><strong>Planning Group:</strong></td>
<td><strong>Planning Group:</strong></td>
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<tr>
<td>• Great activities: music, snow cones, bracelet game, wagon rides, face painting, Chief Topleaf, animals, and snow plough</td>
<td>• Needed more directional signs</td>
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<td>• Radio, TV, and newspaper coverage was better this year</td>
<td>• Some of the Waterloo Region Museum equipment wasn’t functional</td>
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<tr>
<td>• Good attendance</td>
<td>• Some activities and workshops weren’t attractive or well attended</td>
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<td>• Draw for door prizes worked well</td>
<td>• Need healthier and affordable food options</td>
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<td>• Bracelet game well-received</td>
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<td>• Hybrid bus exhibit was engaging</td>
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<tr>
<td>• Partnership with the Waterloo-Wellington Children’s Groundwater Festival and EcoSchool staff was invaluable</td>
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<tr>
<td>• Good working relationship between all committee members</td>
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<tr>
<td>• Good venue and location</td>
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</tbody>
</table>

PLANNING GROUP – GENERAL COMMENTS:

Planning Process
- Great partnership with the Waterloo-Wellington Children’s Groundwater Festival and Waterloo Region Museum staff, key to event’s success
- New organizational structure worked well – balanced workload between committee members
- Better promotion and marketing of the event than in past years

Recommendations for Next Year
- Ensure that event details and strategies are finalized sooner
- Need to establish specific criteria for ‘event sponsors’
- Ensure that the event is better coordinated with the integrated environmental promotion and education plan
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: March 8, 2011

FILE CODE: A26-50

SUBJECT: WATERLOO REGION IMMIGRATION PARTNERSHIP

RECOMMENDATION:

THAT the Regional Municipality of Waterloo continue to serve as host for the Waterloo Region Immigration Partnership Council and, in its capacity as such, enter into agreements with the Federal Government of Canada or Ministry or agency there of, under the Local Immigration Partnership for the period April 1, 2011 to March 31, 2013, upon terms and conditions acceptable to the Regional Solicitor and the Commissioner of Social Services for the purpose of funding the Local Immigration Partnership;

AND THAT the Regional Municipality of Waterloo approve entering into agreements with agencies or consultants, as determined by the Commissioner of Social Services from time to time, to support the implementation of the Waterloo Region Immigration Partnership Strategic Plan for the period April 1 2011 to March 31, 2013, subject to receipt of Federal Government funding;

AND FURTHER THAT the Operating Budget for Social Planning, Policy and Program Administration be increased by $600,000 gross and $0 net for the period April 1, 2011 to March 31, 2013 as outlined in report SS-11-013/CA-11-004 dated March 8, 2011.

SUMMARY:

The Waterloo Region Immigration Partnership is a comprehensive collaboration with local community stakeholders and the Region of Waterloo. This Partnership is responsible for developing and implementing strategies that facilitate successful settlement and integration of immigrants and refugees in Waterloo Region. The initiative is moving from a planning phase to implementation of a Partnership Action Strategy. The Region of Waterloo has been asked to continue to host the community initiative, which is to be funded through a contribution agreement with the Federal Government - Citizenship and Immigration Canada. As host, the Region is responsible for housing and supervising staff in addition to all legal and financial aspects. Current funding for the planning phase under the CIC ends March 31, 2011. Subject to execution of the contribution agreement, the Federal Government has committed funding for an additional two years, for the period April 1, 2011 – March 31, 2013, in the amount of $300,000 per annum.
1.0 Development of the Local Immigration Partnership

Waterloo Region is a community that has always welcomed and benefited from immigration. Presently, approximately one in four Waterloo Region residents are immigrants from diverse regions of the world, and this is expected to increase to nearly one in three by 2031. Our region is one of the top seven communities in Canada in terms of the proportion of immigrants and recent immigrants in our community.

The challenges and barriers faced by new citizens are varied and complex including: understanding the Canadian health system and accessing needed services; finding employment in chosen field with recognition of foreign credentials; learning a new language; learning how to integrate with local cultures and how to adapt family or personal ways with a new environment; and/or facing discrimination. There have been various initiatives over the past several years to address challenges and systemic barriers faced by new immigrants including the establishment of the Waterloo Region Immigrant Employment Network (WRIEN) which facilitated the creation of several programs to assist with immigrant employment. More recently the community in collaboration with the Region of Waterloo has undertaken some specific activities related to the establishment of a local immigration partnership.

In 2009, a funding agreement with Citizenship and Immigration Canada was approved and the Planning Phase of the Immigration Partnership began under the leadership of an Interim Local Immigration Partnership Council and with support from the Centre for Community Based Research (CCBR). This one year process focused on community input and research through organized community strategy sessions, community task group meetings and various focus groups. Input was gathered from a wide variety of immigrants, service providers, employers, community organizations, governments, and individuals. The result was an Action Strategy which was subsequently presented to a community forum in the spring of 2010. The Action Strategy is to address the following three goals:

- Improve access to and coordination of effective, strategic and comprehensive services/programs that facilitate immigrant settlement and integration;
- Improve equitable access to the labour market for immigrants; and
- Strengthen awareness and the capacity of Waterloo Region to successfully integrate increasing numbers of immigrants in the coming decades.

In 2010, the Region of Waterloo submitted and was funded to continue the work of the Interim Local Immigration Partnership Council in preparation for the implementation of the Action Strategy. One key piece of this interim phase has been the establishment of the Waterloo Region Immigration Partnership Council in January 2011. The Terms of Reference and the members of the Council are included in Appendix A. The Council will develop a communications plan, and pursue continued financial sustainability for the partnership. To support their work the Council will launch three action groups in the areas of settling, working and belonging. The Waterloo Region Immigrant Employment Network (WRIEN) has been working collaboratively for five years to promote immigrant employment and to improve and strengthen how employers attract, hire, integrate and retain internationally trained individuals and has been involved in the Immigration Partnership initiative from its inception. The WRIEN Steering Committee and the Immigration Partnership Council are exploring how to more fully integrate the immigrant employment and employer engagement work into the broader Immigration Partnership initiative.

The Waterloo Region Immigration Partnership Council is accountable, through the Region, to the Federal Government for the funds contributed to the initiative, and to the Region of Waterloo as the host and signatory to those agreements. The role of the Council is to:
- Facilitate collaborative and strategic relationships among stakeholders and across the community
- Set strategic priorities and monitor action-plan implementation
- Provide advice or direction on key initiatives (in collaboration with action groups)
- Provide strategic guidance to the Immigration Partnership Manager
- Seek out and strategically allocate resources for the Immigration Partnership and initiatives
- Seek input from community-at-large and educate community about immigrant issues
- Share information back to community
- Identify and conduct advocacy (within the Region and potentially beyond Waterloo Region together with other Local Immigration Partnerships)

The direct costs for office space, staff, and overhead will be funded through the CIC grant over the next two years and the Region will provide some in-kind contributions. As host for the initiative, the Region will manage all legal and financial aspects of the initiative. The Region’s role is to:
- Manage all legal and financial aspects of the project with Citizenship and Immigration Canada
- Hire staff to support the Immigration Partnership Council and action groups.
- Participate as a voting member of the Immigration Partnership Council.

During the planning and interim phases of the Immigration Partnership initiative, the Chief Administrator’s Office has been the primary contact with the project responsible. Subject to continued funding, and as this initiative moves into an ongoing planning and implementation phase, it will be relocated administratively to Social Services, specifically Social Planning, Policy and Program Administration.

CORPORATE STRATEGIC PLAN:

The need to successfully embrace diverse practices and culturally appropriate programs and services was identified through the Region’s 2007-2010 strategic planning process. Related objectives and actions specific to this initiative are in the Region’s previously approved Strategic Plan (Focus Area 4: Human Services) and include: improve programs and services to support immigrants; support and actively participate in the Waterloo Region Immigrant Employer Network (WRIEN); and develop a strategy to improve access to regional programs and services for citizens from diverse backgrounds.

FINANCIAL IMPLICATIONS:

Funding for the Immigration Partnership initiative is 100% federal funds. The allocation to Waterloo Region from April 1, 2011 to March 31, 2013 is $600,000. In addition, the Region is considering one-time funds of $50,000 (2011 budget process) as well as in-kind costs to support the initial implementation of the WRIP. These funds will support temporary staffing to establish and maintain the Waterloo Region Immigration Partnership Council and action groups and to implement the Immigration Partnership Action Strategy.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Legal Services has been consulted regarding the development of the contribution agreement. Finance provides support in reviewing project financial reporting requirements. Human Resources provides support regarding staffing requirements.
ATTACHMENTS

Appendix A: Waterloo Region Immigration Partnership Council Terms of Reference

PREPARED BY: Lynn Randall, Director, Social Planning, Policy and Program Administration
Dan Vandebelt, Project Manager, Waterloo Region Local Immigration Partnership
Lorie Fioze, Manager, Strategic Planning and Strategic Initiatives

APPROVED BY: Michael Schuster, Commissioner, Social Services
Mike Murray, Chief Administrative Officer
Appendix A – Terms of Reference Waterloo Region Immigration Partnership Council

Waterloo Region Immigration Partnership Council Terms of Reference

(Approved in Principle on February 15th 2011)
Preface

The Waterloo Region Immigration Partnership is a community-wide commitment to support and integrate immigrants in Waterloo Region. The Immigration Partnership is premised on the conviction that successful settlement and integration is a mutually-beneficial process that involves both immigrants and the broader community engaging in a process of mutual learning and inter-relatedness. The Immigration Partnership is both an ethical and economic call to create a better and stronger community together.

As an immigrant-focused and collaborative community endeavour, the Immigration Partnership is rooted in the following values and principles: flexibility and responsiveness, inclusivity, consensus, consultation, collaboration, purpose driven, best practices, respect, non judgmental, transparency, preparation, community driven, results focused, and action oriented.

Our vision is that Waterloo Region will be a community where immigrants and refugees can settle, work, and belong.

As such, our mandate is to help facilitate successful settlement and integration of immigrants and refugees in Waterloo Region. We do this by creating and enhancing partnerships in a comprehensive local Immigration Partnership and implementing collaborative strategies – specifically through:

1. **Coordination and information sharing** (This includes promoting and building partnerships; planning and strategically setting priorities; providing advice and direction on key initiatives; seeking input from various groups/sectors and immigrants; sharing between groups; communicating to the broader community; speaking with a unified community voice; etc.)

2. **Problem solving and implementing strategies for change**: (This includes problem solving about local immigrant issues; being a catalyst for collective and coordinated action; working for policy change; seeking out resources; public education; etc.)

Our purpose is therefore to create and enhance partnerships in a comprehensive local Immigration Partnership and to implement collaborative strategies in order to help facilitate successful settlement and integration of immigrants and refugees in Waterloo Region.

Additional detail regarding the vision, outcomes, specific action strategies, and community input are included in the *Waterloo Region Local Immigration Partnership Council Final Report* resulting from the April 2010 community forum.

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1 “Immigrants” includes people who immigrated a long time ago or more recently, refugees and refugee claimants, immigrants who are and are not Canadian citizens and all newcomers to Canada, who are living in Waterloo Region.
Governance Structure

The Immigration Partnership Council is the umbrella coordinating group for the Immigration Partnership, with three action groups or “pillars” (Settling, Working, and Belonging).

**Immigration Partnership Council**

The Working Action Group may have various focused teams. The current vision is that the Waterloo Region Immigrant Employment Network (WRIEN) initially plays the role of an Employer Focus Team within the Working Action Group and that over the course of the first year, WRIEN’s employer engagement activities will be integrated into the Immigration Partnership structure. A joint task group of the WRIEN Steering Committee and the Immigration Partnership Council will review the Working Action Group structure and integration details and bring a proposal to the WRIEN Steering Committee and the Immigration Partnership Council.

**Immigration Partnership Council**

An Immigration Partnership Council of not more than 25 members, including action group chairs, will provide strategic leadership to the Waterloo Region Immigration Partnership. The Council will be responsible for the strategic priorities, communication and coordination of the Immigration Partnership. This group will meet approximately 6-10 times a year with some work in between meetings. Task groups of the Council will be developed as needed.

The Council will be responsible to:

- Facilitate collaborative and strategic relationships among stakeholders and across the community
- Set strategic priorities and monitor action-plan implementation
- Provide advice or direction on key initiatives (in collaboration with action groups)
- Provide strategic guidance to the Immigration Partnership Manager
- Seek out and strategically allocate resources for the Immigration Partnership and initiatives
- Seek input from community-at-large and educate community about immigrant issues
- Share information back to community
- Identify and conduct advocacy (within the Region and potentially beyond Waterloo Region together with other Local Immigration Partnerships)

The Council will be made up of a cross-section of the community, including: immigrants,
immigrant service providers, community/sector representatives, employers/business associations, and local funders/municipalities. Immigrants will make up approximately one third of the Council. Immigrants will bring their own experience and perspective as an immigrant and will preferably represent broader ethno-cultural or immigrant groups and bring forward those perspectives.

**Council Roles**

The Council will elect a **Council Executive** made up of at least one of the Council co-chairs and 2 to 5 other members of Council. The Executive will have two key roles:

1. Provide strategic guidance to the Immigration Partnership Manager in between Council meetings, and
2. Help to set the agenda for WRIP Council meetings.

The Council will elect two **Council Co-chairs** who will have three key roles:

1. Leaders, facilitators, and team builders for the Immigration Partnership Council, including chairing Council and Council Executive meetings;
2. Provide strategic direction to staff between Council or Executive meetings; and,
3. Chief spokespersons in representing the Partnership Council to partners, stakeholders, and the public.

Co-chairs will determine together how to share chair responsibilities.

The Council can invite individuals or groups to regularly or occasionally attend Council meetings (e.g. Ministry representatives or other funders, researchers, etc.). These individuals would not be voting members.

**Council Member Selection**

Council members will have a term of two years, renewable for one additional term. The Council Executive and Chairs will generally be elected for a two year term. In the initial term of Council, the Council may decide to stagger appointments to ensure a balance of continuity and refreshed Council membership.

Each year when there are anticipated to be Council vacancies, expressions of interest will be sought from the Immigration Partnership stakeholders, mailing list, and broader community. The Council will form a recommendation committee to review the expressions of interest in light of specific vacancies and to recommend candidates to the existing Council for approval.

Council candidates will be selected based on specific sectors and skills required on the Council, and will fit the Council member characteristics and composition criteria:

- represent specific sectors/perspectives (immigrants; immigrant service providers; community/sector representatives – such as education, health, justice; employers; municipalities; local funders),
- bringing a community-wide focus,
- commitment to partnerships and collaboration,
- commitment to the Immigration Partnership and its mandate, values and principles,
- responsible and respected community leaders and change agents who are connected across the community,
- are passionate about the Waterloo Region community and embrace the many benefits of a vibrant diverse population, and
- ability to commit to meetings and Council responsibilities.
The Council will strive for diverse representation of members on the Council. This includes diverse sectors, geographic representation, diverse immigrant representation, diverse opinions, etc.

Some members may have multiple connections to various groups involved in the Immigration Partnership – an individual could be connected to a community organization, work for a local funder and also be an employer of immigrants. Individuals would be asked to sit on the Council in one of those roles, though they would bring experience from multiple places to the discussions. In their role, members on the Council would be expected to bring forward the broader perspectives of the group they represent in Waterloo Region (i.e. immigrant service providers, employers, municipalities, funders, etc.) and connect with that group beyond Council meetings.

Council members are expected to promptly respond to Council meeting invitations, review all pre-circulated documents and information, and attend Council meetings.

**Action Groups**

The three action groups - Settling, Working, and Belonging – (i.e. “work groups”) will be responsible for working in collaboration with community partners to carry out the strategic activities established by the LIP Council. The action groups will be catalysts for broader community action. Action group members and partners will carry out action group initiatives, supported where appropriate by Immigration Partnership staff.

It is anticipated that these action groups will meet approximately 4-8 times a year with some work in between meetings. Meetings of each action group will be inclusive and typically open to anyone with an interest in the area.

The members will be committed to the focus of that action group and bring valuable, diverse, and relevant experience/perspectives to the group. Action groups will strive to have one third of their members being immigrants. There will be overlap between the Immigration Partnership Council and the action groups to facilitate sharing and coordinating priorities and work. The action groups will have approximately 20 members with similar characteristics to the members of the Council. Action group members will be selected by Council, generally for 2 year renewable terms. Action groups will choose their own chairs who will sit as members of the Immigration Partnership Council.

The action groups will have the following key roles:

- Carry out activities related to Council strategic priorities within their domain
- Seek input from community-at-large and educate community about immigrant issues
- Strengthen cross-sector partnerships and inter-action group collaboration
- Implement special projects of Council in keeping with Council strategic priorities
- Provide input to Council regarding priorities and issues
- Present periodic progress reports to Council
- Identify and conduct region-wide advocacy (in collaboration with the Council)

**Accountability**

The Waterloo Region Immigration Partnership is accountable to the broader Waterloo Region community, partners and stakeholders for the directions and actions which seek to fulfill the purpose of the Immigration Partnership. As such, the Immigration Partnership will regularly seek
input and report back to the community (including immigrant community) on priorities and actions.

The Immigration Partnership is accountable, through the Region, to its funders for the funds contributed to the initiative, and to the Region of Waterloo as the host and signatory to those agreements. The Immigration Partnership is responsible to the Region of Waterloo, in its role as host, for the financial, legal, and administrative requirements of the funding and the project.

**Project Host**
The Regional Municipality of Waterloo will host the Immigration Partnership and, in partnership with the Immigration Partnership Council, will provide office space, staff supervision, back office support and administrative logistics. A letter of understanding will be developed to detail roles and responsibilities of all partners. As the signatory to the contribution agreements with funders, the Region of Waterloo will be responsible for any matters related to the contract. The host of the Immigration Partnership will be represented as a voting member of the Council.

**Staff Support**
Immigration Partnership staff will provide project management, community engagement and administrative support, and will support the Immigration Partnership Council, Council Executive and task groups, and the action groups. The Immigration Partnership manager will report to the Immigration Partnership Council for all activities of the Immigration Partnership. The Council, through the chairperson, will provide guidance to the manager regarding Immigration Partnership activities. The Immigration Partnership manager will have an administrative link to Region of Waterloo and for administrative matters will connect with the Director of Social Planning at the Social Services Department, and provide regular updates as necessary.

The Immigration Partnership manager will have the following key roles:
- Support Council and action groups in planning, implementing, monitoring, and evaluating the Immigration Partnership strategic directions and initiatives
- Ensure communication and information flow across Council/action groups and with partners
- Liaise with funders and seek funding
- Hire and supervise administrative and project staff, and contract outside consultants as needed

The job description for the Immigration Partnership Manager provides finer details on these responsibilities.

**Decision making**
All members of Council are equal voting partners for decision-making and all members should have their perspectives heard. The chair will seek consensus decisions. In the event that consensus cannot be reached, a vote will take place with the final decision made by majority rule. For an Immigration Partnership Council meeting quorum to be achieved, at least 50% of voting Council members (including a Co-chair or their alternate) must be present.

The Council will speak with one voice. Once a Council decision has been made, if a member has a dissenting opinion, the member should state Council's position on the issue and re-direct inquiries to the Chair or Manager. Should a member find him/herself with a dissenting opinion that cannot be resolved, he/she has the option of resigning from the Council.
This Terms of Reference is a living document. It will be refined as necessary by the Council and will be reviewed at least annually.

**Code of Conduct**

Members are expected to declare any conflict of interest for any agenda item in which they, or an organization/group that they may represent, would have a direct financial or vested interest in a specific outcome. (For example, discussing a marketing proposal on which an employer member’s firm would be bidding.) In the event of a declaration of a conflict of interest, the member will not actively take part in the discussion or the final decision for that agenda item and, at the chair’s discretion, may be asked to leave the room for the discussion.

Members of the Immigration Partnership will commit themselves to the following:

- Work for the well being of all immigrants and all citizens of Waterloo Region.
- Not use their membership for personal advantage, or the advantage of other individuals or organizations.
- Work with other members in a spirit of respect, openness, co-operation and proper decorum in spite of differences that may arise during discussion.
- Not divulge confidential information that they may obtain in their capacity as a Immigration Partnership member.

In the event that there is a failure to comply with Code of Conduct guidelines, or if a member cannot otherwise fulfill their commitment to the Council, the co-chairs will be responsible for addressing the issue with the member, and may request their resignation.

**Meeting Schedule**

Council meetings will normally be held bi-monthly. The Council Executive will meet between Council meetings or as needed. Action groups and task groups of Council will meet as needed.

One meeting per year will be held as an opportunity for broader input and will be intentionally open to the public. At this meeting, the Council will provide an update to the community, and receive input from the community.

All Council minutes will be recorded and circulated to members normally one week prior to the next meeting. Draft Council meeting agendas will also be circulated to members normally one week prior to the meeting.
**Immigration Partnership Council Members (updated January 2011)**

<table>
<thead>
<tr>
<th>Sector or Representation</th>
<th>Member</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immigrants</td>
<td>Fanis Juma Radstake</td>
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<tr>
<td>Immigrants</td>
<td>Fauzia Mahzar</td>
<td></td>
</tr>
<tr>
<td>Immigrants</td>
<td>Maria Alvarez</td>
<td></td>
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<tr>
<td>Immigrants</td>
<td>Yuexin Wang</td>
<td></td>
</tr>
<tr>
<td>Immigrant service providers</td>
<td>Christine Buuck</td>
<td>Conestoga College</td>
</tr>
<tr>
<td>Immigrant service providers</td>
<td>Eunice Valenzuela</td>
<td>Mennonite Coalition for Refugee Support</td>
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<tr>
<td>Immigrant service providers</td>
<td>John Haddock</td>
<td>YMCA of Cambridge, Kitchener and Waterloo</td>
</tr>
<tr>
<td>Immigrant service providers</td>
<td>Lucia Harrison</td>
<td>KW Multicultural Centre</td>
</tr>
<tr>
<td>Community/sector representatives</td>
<td>Anne Kirocos</td>
<td>CTV</td>
</tr>
<tr>
<td>Community/sector representatives</td>
<td>Cathy Brothers</td>
<td>Capacity Waterloo Region</td>
</tr>
<tr>
<td>Community/sector representatives</td>
<td>David Bishop</td>
<td>Waterloo Regional Police Service</td>
</tr>
<tr>
<td>Community/sector representatives</td>
<td>Linda Terry</td>
<td>Social Planning Council of Cambridge and North Dumfries</td>
</tr>
<tr>
<td>Community/sector representatives</td>
<td>Patrick Gaskin</td>
<td>Cambridge Memorial Hospital</td>
</tr>
<tr>
<td>Community/sector representatives</td>
<td>Peter Donahue</td>
<td>Laurier International, Wilfrid Laurier University</td>
</tr>
<tr>
<td>Community/sector representatives</td>
<td>TBD</td>
<td>School board representative</td>
</tr>
<tr>
<td>Employers/business associations</td>
<td>Ann Lillepold</td>
<td>Grand River Hospital</td>
</tr>
<tr>
<td>Employers/business associations</td>
<td>Karen Gallant</td>
<td>Communitech</td>
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<tr>
<td>Employers/business associations</td>
<td>Karen Hiltz</td>
<td>Christie Digital</td>
</tr>
<tr>
<td>Employers/business associations</td>
<td>Rob Jones</td>
<td>Scotia Bank</td>
</tr>
<tr>
<td>Local funders/municipalities</td>
<td>Jan Varner</td>
<td>United Way of Kitchener Waterloo and Area</td>
</tr>
<tr>
<td>Local funders/municipalities</td>
<td>Lynn Randall</td>
<td>Region of Waterloo (as host)</td>
</tr>
<tr>
<td>Local funders/municipalities</td>
<td>Shelley Adams</td>
<td>City of Kitchener</td>
</tr>
<tr>
<td>Action group Chair</td>
<td>TBD</td>
<td>Settling action group chair</td>
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<tr>
<td>Action group Chair</td>
<td>TBD</td>
<td>Working action group chair</td>
</tr>
<tr>
<td>Action group Chair</td>
<td>TBD</td>
<td>Belonging action group chair</td>
</tr>
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TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: March 8, 2011

FILE CODE: S13-80

SUBJECT: HOMELESSNESS PARTNERING STRATEGY

RECOMMENDATION:

THAT the Regional Municipality of Waterloo continue to serve in the role of Community Entity and, in its capacity as such, enter into agreements with the Federal Government of Canada or a Ministry or agency thereof, under the Homelessness Partnering Strategy for the period April 1, 2011 to March 31, 2014, upon terms and conditions acceptable to Legal Services, for the purposes of providing funding to projects based on the priorities identified in the Homelessness Partnering Strategy Community Plan 2011-2014;

AND THAT the Regional Municipality of Waterloo approve the Homelessness Partnering Strategy Community Plan 2011-2014;

AND THAT the Regional Municipality of Waterloo approve entering into agreements with the following agencies for the maximum amount identified for the period April 1, 2011 to March 31, 2014, subject to receipt of Federal Government funding;

<table>
<thead>
<tr>
<th>Agency</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
<td>Lutherwood</td>
<td>$302,314</td>
</tr>
<tr>
<td>K-W Working Centre for the Unemployed</td>
<td>$375,000</td>
</tr>
<tr>
<td>Young Women’s Christian Association of KW</td>
<td>$180,000</td>
</tr>
<tr>
<td>Cambridge Shelter Corporation</td>
<td>$180,000</td>
</tr>
</tbody>
</table>

AND THAT the Regional Municipality of Waterloo approve entering into agreements with agencies or consultants, as determined by the Commissioner of Social Services from time to time, subject to receipt of Federal Government funding, to support implementation of the following:

- Homelessness Individual and Family Information System to a maximum of $25,389 for the period April 1, 2011 to March 31, 2014;
- An Aboriginal specific project(s) to a maximum of $33,900 for the period April 1, 2011 to March 31, 2014;
- STEP Home program evaluation to a maximum of $30,000 for the period April 1, 2011 to March 31, 2014; and
- Supportive Housing of Waterloo (SHOW) to a maximum $35,000 for the period January 1, 2011 to March 31, 2011 utilizing any unexpended funding under the current Homelessness Partnering Strategy ending March 31, 2011;

AND FURTHER THAT the Operating Budget for Social Planning, Policy and Program Administration be increased by $331,354 gross and $0 net, for the year 2011 as outlined in Report SS-11-012, dated March 8, 2011.
SUMMARY:

Current funding under the Federal Homelessness Partnering Strategy (HPS) ends March 31, 2011. The Federal Government has renewed the HPS for an additional three years, for the period April 1, 2011 to March 31, 2014.

The report seeks approval for the Regional Municipality of Waterloo to complete allocations of HPS funding for 2009-2011, approve the Waterloo Region HPS Community Plan for 2011-2014 (distributed separately), continue to serve as the Community Entity for HPS funding and, in its capacity as such, enter into agreements with the Federal Government of Canada and local community projects for the period April 1, 2011 to March 31, 2014. Recommended community projects are based on the priorities identified in the Waterloo Region HPS Community Plan (2011-2014), the local Homelessness to Housing Stability Strategy and recommendations from the Community Advisory Board (CAB).

REPORT:

1.0 Background


In December 2006, the Federal Government announced $526 million for a new Homelessness Partnering Strategy (HPS). The HPS was established for two years beginning April 1, 2007 and ending March 31, 2009. The HPS resembles the former National Homelessness Initiative and the former SCPI with the same amount of funding allocated to Waterloo Region ($441,805 in each year). Council approved the Region’s continued participation as the Community Entity for the HPS (SS-07-008), funding for community projects during the transition year (April 1 – December 31, 2007) (SS-07-008), as well as the Waterloo Region’s HPS Community Plan 2007-2009 (SS-07-034).

In January 2009, the Federal Government confirmed the extension of HPS at the same levels for two years, from April 1, 2009 to March 31, 2011 ($441,805 in each year for Waterloo Region), with the ability to carry over any unspent funds from the previous allocation (for Waterloo Region, the total amount re-profiled to March 2011 was $107,296). Council approved the Region’s continued participation as the Community Entity for HPS and funding for community projects for 2009-2011 (SS-09-013). A summary of National Homelessness Initiative and HPS funding to the Regional Municipality of Waterloo is included in Appendix A.

Since its initiation, it has been a requirement of Federal Government homelessness funding that a Community Advisory Board (CAB) be established to provide input and recommendations regarding local implementation. The CAB is comprised of various sector representatives from across Waterloo Region involved in the area of homelessness to housing stability. A list of current CAB members is included in Appendix B.

2.0 Homelessness Partnering Strategy for 2011-2014

Announcement and Application

In November 2010, the Federal Government announced the renewal of HPS for three years for the period April 1, 2011 to March 31, 2014 at the current funding level ($441,805 in each year for Waterloo Region) (Memorandum to Community Services Committee, November 16, 2010) (official confirmation via e-mail dated November 12, 2010 attached as Appendix C). On November 22-23, 2010, Region Staff attended a two day HPS Community Forum in Toronto to review forms,
requirements and expectations related to the new HPS funding. In December 2010 Region Staff submitted the required application materials to the Federal Government along with a recommendation from the CAB that the Region continue as the Community Entity for HPS funding. The final application requirements include submission of a new HPS Community Plan in early 2011.

HPS Community Plan
The HPS Community Plan consists of a template provided by the Federal Government. The document seeks information on local data, programs, partnerships and priorities for homelessness and housing stability. The community was consulted regarding the HPS Community Plan priorities at an open community forum held February 17, 2011. On February 23, 2011 CAB members met and confirmed Waterloo Region’s HPS Community Plan 2011-2014 and recommended HPS funding for projects.

The HPS Community Plan (2011-2014) identifies the following three priorities and estimated percentage of HPS funding for each:

1. End and prevent persistent homelessness (92% of funding);
2. Increase the capacity of the housing stability system to meet the need for longer term housing stability programs (3% of funding); and
3. Increase the capacity of the housing stability system to close gaps through system-level analysis (5%).

In addition, the Community Plan also officially requests that the name of the designated community be changed from “Kitchener” to “Waterloo Region” to better reflect the existing geographic boundaries of the designated community (i.e., a name change but the boundaries and population served remain the same). This issue was initially raised in a staff report in September 2010 (SS-10-050). Minister Finlay’s response received February 2011 suggests that the Region include this request as part of the Community Plan for 2011-14.

Further, the HPS Community Plan recognizes that for the new HPS allocation, communities must identify a population-based allocation for Aboriginal homelessness project(s). For Waterloo Region this amounts to 3% of the allocation available for community projects or $33,900 over the three year period (2011-2014).

HPS Allocations (wrap-up for 2009-2011 and 2011-2014)
Unlike previous HPS allocations, there is no ability to carry-over any unspent funds from the current allocation (2009-2011). As such, any unspent funds from the current allocation will be lost to the community if not spent by March 31, 2011. Staff reviewed immediate needs in the region with the CAB who supported a recommendation for any unspent HPS funds to be allocated to SHOW support services costs for the period January 1, 2011 to March 31, 2011 (see Appendix D for project description).

Based on the HPS Community Plan 2011-2014 priorities, the CAB recommended HPS funding for the following projects, up to the maximum amounts identified for the period April 1, 2011 to March 31, 2014 (see Appendix D for project descriptions), subject to Federal Government funding:

- Lutherwood – Whatever It Takes Service Resolution: $302,314
- K-W Working Centre – Street Outreach: $195,000
- K-W Working Centre – Streets to Housing Stability: $180,000
- Young Women’s Christian Association – Streets to Housing Stability: $180,000
- Cambridge Shelter Corporation – Streets to Housing Stability: $180,000
- Aboriginal Project(s) (to be determined): $33,900
- STEP Home Evaluation: $30,000
- Homeless Individuals and Families Information System (HIFIS): $25,389
- Total: $1,126,603
As with all HPS funded projects, agencies are required to submit full proposals, which are reviewed and recommended by the CAB to Regional Staff and then to Council (or designate) for approval. A call for proposals for Aboriginal Project(s) will be held between the spring and fall 2011.

**CORPORATE STRATEGIC PLAN:**

Serving as the Community Entity to administer federal funding for programs that address homelessness is consistent with the Region’s Corporate Strategic Plan, Focus Area 4: Human Services: to “promote quality of life and create opportunities for residents to develop to their full potential”; and specifically, Strategic Objective 4.2 to “enhance services to people experiencing or at-risk of homelessness”.

**FINANCIAL IMPLICATIONS:**

Programs under the HPS are 100% federally funded. The new allocation to Waterloo Region from April 1, 2011 to March 31, 2014 is $1,325,415. A total of 15% or $198,812 over three years is available for administration and $1,126,603 is available for community projects. Administrative funding will provide support for .83 FTE staffing to administer the HPS and comply with all reporting requirements.

**OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:**

Legal Services will be consulted regarding the execution of project agreements. Finance provides support in reviewing project financial reports, conducting required audits and financial reporting.

**ATTACHMENTS**

- Appendix A: Summary of NHI/HPS Funding to the Regional Municipality of Waterloo
- Appendix B: CAB Membership List
- Appendix C: E-mail Confirmation of HPS Funding (2011-2014)
- Appendix D: Description of Community Projects

**PREPARED BY:**

- Van Vilaysinh, Social Planning Associate
- Marie Morrison, Manager, Social Planning
- Lynn Randall, Director, Social Planning, Policy, and Program Administration

**APPROVED BY:**

- Michael Schuster, Commissioner, Social Services
## APPENDIX A
### SUMMARY OF NHI/HPS FUNDING TO THE REGIONAL MUNICIPALITY OF WATERLOO
#### 2002 - 2014

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<tr>
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<td>$921,117</td>
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<td><strong>SCPI II Program</strong>&lt;br&gt;April 5, 2004 to March 31, 2006</td>
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<td><strong>SCPI Extension Year</strong>&lt;br&gt;April 1, 2006 to March 31, 2007</td>
<td>$441,805</td>
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<td><strong>HPS Program Transition Year</strong>&lt;br&gt;April 1, 2007 – December 31, 2007</td>
<td>$331,352</td>
</tr>
<tr>
<td><strong>HPS Program</strong>&lt;br&gt;January 1, 2008 – March 31, 2009</td>
<td>$552,258</td>
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<td>$883,610</td>
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<tr>
<td><strong>HPS Program</strong>&lt;br&gt;April 1, 2011 – March 31, 2014</td>
<td>$1,325,415</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$6,011,746</strong></td>
</tr>
<tr>
<td>NAME</td>
<td>TITLE / ORGANIZATION</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Anne Tinker</td>
<td>Executive Director, Cambridge Shelter Corporation</td>
</tr>
<tr>
<td>Charles Nichols</td>
<td>Lived homelessness experience</td>
</tr>
<tr>
<td>Ed Dubas</td>
<td>Program Supervisor, Ministry of Community and Social Services</td>
</tr>
<tr>
<td>Eric Goldberg</td>
<td>Executive Director, Kitchener Downtown Community Health Centre</td>
</tr>
<tr>
<td>Joe Mancini</td>
<td>Director, The Working Centre</td>
</tr>
<tr>
<td>Kathy Payette</td>
<td>Manager, Lutherwood</td>
</tr>
<tr>
<td>Lee Fitzpatrick</td>
<td>Director, Community Resources, Waterloo Regional Police Service</td>
</tr>
<tr>
<td>Linda Terry</td>
<td>Executive Director, Social Planning Council of Cambridge and North Dumfries</td>
</tr>
<tr>
<td>Pauline Moon</td>
<td>K-W Urban Native Wigwam Project</td>
</tr>
<tr>
<td>Rebecca Roy (CAB co-chair)</td>
<td>Program Manager, Lutherwood</td>
</tr>
<tr>
<td>Van Vilaysinh (CAB co-chair)</td>
<td>Social Planning Associate, Region of Waterloo Social Services</td>
</tr>
<tr>
<td>Wendy Czarny</td>
<td>Executive Director, Waterloo Regional Homes for Mental Health</td>
</tr>
</tbody>
</table>
Good afternoon everyone,

I am writing to follow-up on the conference call we held for Community Advisory Boards (CABs) and Community Entities (CEs) on Thursday, November 4, 2010. As mentioned on the call and on the national website for the Homelessness Partnering Strategy (HPS) (http://www.hrsdc.gc.ca/eng/homelessness/index.shtml), HPS has been renewed at current levels for another three years, from April 1, 2011 to March 31, 2014. The continuation of the HPS will ensure the continuity of services for clients who are homeless or at-risk of homelessness, and allow us to build upon ten years of federal government investments to address homelessness in Canadian communities.

In the fall of 2009, the federal government engaged provinces, territories and stakeholders on how best to use federal housing and homelessness investments from 2011 to 2014. The recommendations received during these consultations have been taken into account and we will be introducing a number of program and policy enhancements as part of the renewed Strategy, in order to help communities better address homelessness issues.

Some of the key program and policy enhancements will be:

- Enhancing the community-based approach for the government’s homelessness programming;
- Further strengthening the relationships with provinces and territories and building on successful partnerships to date;
- Greater support for rural and remote communities;
- Ensuring culturally relevant programming and services for Aboriginal people who are homeless or at-risk of homelessness;
- Developing linkages on mental health and homelessness;
- Increasing the relevance and dissemination of research;
- Reinforcing accountability for results; and
- Improving data sharing and collection.

We look forward to working with you as we move forward.

Yours sincerely,

Trish Trainor
A/Director,
Community Based Delivery
Labour Market and Social Development Programs,
Service Canada
25 St. Clair E., 4th Floor.
Toronto, ON M4T 1M2
APPENDIX D
DESCRIPTION OF COMMUNITY PROJECTS

Supportive Housing of Waterloo (SHOW)
SHOW is a five story, 30 self contained one bedroom unit apartment building, located in Waterloo and is a component of STEP Home (support to end persistent homelessness). The program provides affordable housing with 24/7 on-site support for people experiencing or at-risk of persistent homelessness. HPS funding will contribute to the cost of support services for January – March 2011.

Lutherwood – Whatever It Takes (WIT) – Service Resolution
WIT-Service Resolution is a component of STEP Home and brings agencies together to find creative solutions for individuals who are experiencing challenges in accessing services. As a component of this model, a flexible fund is provided to address the complex and specialized needs of the individual quickly and creatively. The WIT-Service Resolution program supports people experiencing or at-risk of persistent homelessness along with significant system barriers towards housing stability by providing consultation with service providers, assisting to connect people with primary support (as needed), and supporting coordination meetings, interagency planning tables and system planning meetings (as needed) in order to develop and support implementation of individualized plans.

The Working Centre - Street Outreach
Street Outreach engages with people in Waterloo, Kitchener and Cambridge (in partnership with the Cambridge Self-Help Food Bank) who are street involved and seeks to develop relationships, build trust, meet immediate needs, and ultimately connect them with the supports and services of their choosing that may assist in maintaining and/or improving their health and/or quality of life. In addition, Street Outreach serves as a support to other programs under the STEP Home umbrella.

Cambridge Shelter, the YWCA and the Working Centre - Streets to Housing Stability
The Streets to Housing Stability Program is a component of STEP Home and provides intensive, flexible support to people on the street who are experiencing or at-risk of persistent homelessness. The Program provides assistance to find and maintain housing (support for a minimum of one year) at a ratio of one staff for five to 10 participants.

Aboriginal Project(s)
Project(s) yet to be determined through a call for proposals and review and recommendation by the HPS Community Advisory Board (CAB) to the Commissioner of Social Services.

STEP Home Evaluation
STEP Home (support to end persistent homelessness) is an interrelated set of seven programs, through eight agencies at 13 sites across Waterloo Region aimed to end and prevent persistent homelessness. STEP Home has been operating since 2008 serving approximately 200 people and assisting 150 people experiencing or at-risk of persistent homelessness to find and maintain housing. Over 2011-2012, agencies within STEP Home will engage in a Social Return on Investment (SROI) evaluation to demonstrate the social, economic and environmental value represented through an investment in STEP Home.

Homelessness Individual and Family Information System (HIFIS)
HIFIS is a database program that supports shelter operations and collects information on homelessness. Funding will support implementation of HIFIS 3.7 at YWCA-Mary’s Place, House of Friendship’s Charles Street Men’s Hostel, Argus Residence for Young People, Cambridge Shelter Corporation, Reaching Our Outdoor Friends, Safe Haven, and Marillac Place. HPS funding will be used to support operations (e.g., staff training, computer equipment) and to assist with the development of accurate, meaningful reports for trend analysis across Waterloo Region (e.g., Crystal Reports).
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: March 8, 2011

FILE CODE: S13-80

SUBJECT: HOMELESS INDIVIDUALS AND FAMILIES INFORMATION SYSTEM LOCAL COORDINATION PROJECT (2011-2012)

RECOMMENDATION:

THAT the Regional Municipality of Waterloo approve entering into an extension of the funding Agreement in the additional amount of up to $57,963 with the Federal Government of Canada or a Ministry or agency thereof for continued local coordination of the Homeless Individuals and Families Information System (HIFIS) for the period April 1, 2011 to March 31, 2012;

AND THAT the Regional Municipality of Waterloo enter into an Agreement with the House of Friendship of Kitchener for up to $21,326 for continued delivery of certain aspects of the Homeless Individuals and Families Information System (HIFIS) for the period April 1, 2011 to March 31, 2012;

AND THAT the Regional Municipality of Waterloo enter into an Agreement(s) with consultant(s), as determined by the Commissioner of Social Services from time to time, for up to a maximum of $15,600 collectively for continued delivery of certain aspects of the Homeless Individuals and Families Information System (HIFIS) for the period April 1, 2011 to March 31, 2012;

AND THAT the Regional Municipality of Waterloo, Social Planning, Policy and Program Administration use the remaining $21,037 to offset the Region Staff time contribution to the Homelessness Individuals and Families Information System (HIFIS) and use this funding towards the further implementation of the Homelessness to Housing Stability Strategy as determined by the Commissioner of Social Services from time to time for the period April 1, 2011 to March 31, 2012;

AND FURTHER THAT the 2011 Operating Budget for Social Planning be increased by $43,472 gross and $0 net as outlined in Report SS-11-014, dated March 8, 2011.

SUMMARY:

This report seeks approval to enter into an annual contribution Agreement with the federal government for local coordination of the Homelessness Individual and Family Information System (HIFIS). The Region has been receiving funding for the local coordination of HIFIS since 2006 through annually negotiating contribution Agreements. There are many benefits to HIFIS including the support for innovative social planning with people experiencing or at-risk of homelessness.
REPORT:

1.0 Background to the HIFIS software program
The Homeless Individuals and Families Information System (HIFIS) is an electronic data management system that allows agencies working with people experiencing homelessness to manage their day-to-day operations as well as collect data on homelessness trends. The HIFIS initiative has been funded through Human Resources and Skills Development Canada (HRSDC) since 2006. There is no purchasing or licensing cost for the software, and training and support are offered at no cost to participants.

Locally, all agencies providing emergency shelter services to people experiencing homelessness that either have an emergency shelter Agreement with the Region or who receive funding from the Region use HIFIS. These agencies include: Argus Residence for Young People, the Cambridge Shelter, Charles Street Men’s Hostel, Marillac Place, Reaching Our Outdoor Friends (ROOF), YWCA-Mary’s Place and Lutherwood-Safe Haven. Region staff will continue to explore possible expansion of the HIFIS software program to include other agencies that are interested subject to ongoing funding.

There are several benefits to participating in the HIFIS initiative:
- The ability to collect longitudinal, multi-locational and unduplicated data on service use/trends.
- An enhanced capacity to work with service providers in the area of housing stability research, program and policy development.
- Participation in a national initiative with a long-term strategy for the promotion, continued development and deployment of a data management system that can compare trends across Canada.

The Region was an early adopter and first became involved with the HIFIS software in the fall of 2002. Following attendance at HIFIS Community Coordinator Training in 2002, Region Staff took on the role of the local Community Coordinator, establishing a HIFIS Working Group and assisting in the implementation of HIFIS in three emergency shelters beginning 2003.

A Data Sharing Protocol Agreement was signed between the shelters and the Region in January 2004 and shelters began exporting data to the Region shortly thereafter. Between 2002 and 2006 Regional staff has expanded the HIFIS Working Group to now include six emergency shelter providers. The HIFIS Working Group has spent considerable time working to implement the HIFIS software successfully through providing feedback to HIFIS National regarding desired changes to the software, developing customized report requests and working with the HIFIS Help-Desk.

2.0 History of Funding HIFIS in Waterloo Region
Since September 2006, the Region has been engaged with Human Resources and Social Development Canada (HRSDC) with the HIFIS Coordination project in Waterloo Region. As such, resources have been allocated toward the task of implementing HIFIS 3.0 (released in April 2006). The HIFIS Coordination Project represents unique partnering of an IT technical skill set with an innovative social and community planning approach to design the local HIFIS implementation.

In the fall of 2006, Council approved a HIFIS local coordination demonstration project (SS-06-050) for the period September 1, 2006 to March 31, 2007 with total funding of $50,000 (100% federal funds). Local coordination of HIFIS has since continued through annual allocations of $49,079 in federal funds for 2008/2009 (SS-07-015 and SS-08-29), $55,214 in federal funds for 2009/2010 (SS-09-015), $57,490 in federal funds for 2010/2011 (SS-10-018). Funding for the HIFIS Coordination project has not been continuous and is negotiated annually; the current contribution Agreement is set to expire March 31, 2011.
3.0 Funding for 2011/2012
Region staff has been asked by HRSDC to submit a proposal based on their intention to enter into a new Agreement for one additional year of funding at $57,963 (April 1, 2011 to March 31, 2012). A proposal has been submitted and is currently under review by the Government of Canada. It is planned that current project activities will be very similar to previous years. While Regional staff will directly undertake the roles of coordinator and data analyst while the House of Friendship and consultant(s) will again be contracted to administer other aspects of the project including technical support, training, and some data analysis.

CORPORATE STRATEGIC PLAN:

Working to strengthen the housing stability system and build the community’s capacity to address issues of homelessness is consistent with the Region’s Corporate Strategic Plan, Focus Area 4: Human Services: to “promote quality of life and create opportunities for residents to develop to their full potential”; and specifically, Strategic Objective 4.2 to “enhance services to people experiencing or at-risk of homelessness” through “implementation of the Homelessness to Housing Stability Strategy”.

FINANCIAL IMPLICATIONS:

The HIFIS local coordination project is 100% federally funded. An approximate total of $57,963 will be received from the federal government for the period April 1, 2011 to March 31, 2012. A total of $21,326 will be provided to the House of Friendship of Kitchener and a total of $15,600 will be provided to consultant Glenn Weber to administer technical support and some data analysis aspects of the project. The remaining $21,037 in funding recognizes the Region Staff contribution to support coordination, training and data analysis aspects of the project and will be utilized towards implementation of the Homelessness to Housing Stability Strategy. An estimated total of $43,472 will be spent in 2011 and the remaining $14,491 will be used from January to March 2012.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

Legal Services will be consulted regarding the execution of agreements. Finance provides support in reviewing project financial statements, conducting required audits and financial reporting.

ATTACHMENTS

NIL.

PREPARED BY:  Amber Robertson, Social Planning Associate
Marie Morrison, Manager Social Planning

APPROVED BY:  Michael Schuster, Commissioner, Social Services
RECOMMENDATION:
For information.

SUMMARY:
This report outlines the tenant feedback and air quality results gathered prior to the smoke-free policy implemented by Waterloo Region Housing and Region of Waterloo Community Housing Incorporated on April 1, 2010. These two studies are a part of a multi-year, multi-component, evaluation project designed to measure the effectiveness of the Smoke-free Policy for new leases and transfers in Regionally owned community housing. This report is a follow-up to PH-11-006/P-11-019 presented to Community Services Committee in February 2011. Waterloo Region Housing and Region of Waterloo Public Health have partnered with the University of Waterloo and the Propel Centre for Population Health Impact to form an evaluation committee and implement an evaluation plan. To date, the evaluation has included (1) a survey that was distributed to every household in Waterloo Region Housing (WRH) and Region of Waterloo Community Housing Inc. (ROWCHI) in March 2010 prior to the policy coming into effect, and (2) an air quality study measuring second-hand smoke in common spaces. This report will summarize the key findings of these two evaluation components.

REPORT:
In October, 2009, Region of Waterloo Council approved a smoke-free housing policy. This policy came into effect on April 1, 2010 and made all new leases signed with Waterloo Region Housing (WRH) in all buildings and properties, 100 per cent smoke-free. These restrictions apply to all living spaces included in the lease, as well as patios and balconies. This smoke-free housing policy also restricts smoking outdoors at all properties to a distance of five metres or more away from any window, entrance or exit to the building/unit. These outdoor restrictions apply to all tenants and visitors. Region of Waterloo Community Housing Inc (ROWCHI) Board of Directors adopted the same policy on November 27, 2009.

The Waterloo Region Housing and Region of Waterloo Community Housing Incorporated portfolio includes 2,722 affordable housing units across Waterloo Region. As of December 31, 2010, 10 per cent of Waterloo Region Housing and Region of Waterloo Community Housing Inc. units have the smoke-free clause incorporated into their lease. There has been an average of 1 per cent turn over of units per month. It is predicted that it will take approximately 10 years to have the majority of units smoke free. The following report outlines the pre-policy tenant survey, including methodology, sample and results, and the pre-policy air quality study methodology, sample and results followed by next steps for the evaluation.
Tenant Survey
For a detailed report of the tenant 2010 survey findings see Appendix A. For a summary of results of a 2008 survey of tenants conducted to determine support for a potential policy see PH-09-46/P-09-073.

Methodology:
A survey consisting of 22 questions was delivered to every household (2,722 units) managed by Waterloo Region Housing and Region of Waterloo Community Housing Incorporated in March 2010. (See page 28-29 of Appendix A for a copy of the survey). The survey was completed by 717 households, a response rate of 26 per cent. In total, 480 households indicated that the household had no smokers; 187 indicated that their household had one or more smokers; and 50 households did not indicate the smoking status of their household.

Results:
- 58 per cent of respondents reported that they, or others in their household, are sometimes or often exposed to second-hand smoke in their home.
- 40 per cent of respondents reported someone in their household has health problems that get worse when they breathe second-hand smoke.

The majority of respondents, 72 per cent, reported they support the Region of Waterloo’s smoke-free community housing policy:
- Support was approximately 87 per cent from households with no smokers.
- Support from households with smokers was approximately 39 per cent.
- Approximately 40 per cent of respondents who smoke reported they plan to cut down on the number of cigarettes they smoke after the new policy is in place.

- 28 per cent of households in WRH and ROWCHI reported having a resident who smoked — the provincial average is 25 per cent.
- Most respondents reported they already have households that are 100 per cent smoke-free inside (75 per cent) and on their patio or balcony (61 per cent):
  - 90 per cent of households with no smokers are 100 per cent smoke-free inside.
  - 35 per cent of households with smokers are 100% smoke-free inside.
- 30 per cent of households that permitted smoking inside in March, 2010, reported that they plan to make their home 100 per cent smoke-free in the next 6 months.
- 41 per cent of respondents who smoke reported that they tried to quit in the last year.
- 29 per cent of respondents who smoke reported that after the new policy is in place they will be more likely to go outside to smoke.

Air Quality Study
For a detailed report of air quality findings see Appendix B.

Methodology:
Researchers from the University of Waterloo collected air quality measurements in common spaces (lobbies, hallways, common rooms) in 6 different buildings using established scientific methods to measure and quantify the presence of second-hand smoke. This included measuring respirable particulate matter (PM$_{2.5}$), an established proxy measure for second-hand smoke.$^{1,2}$ Measurements were collected daily for a week during the afternoon and evening. Outdoor readings of PM$_{2.5}$ were also measured to establish a background or ambient reading.

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During the study period outdoor readings of PM$_{2.5}$ were low, generally less than 10 microgram/m$^3$. The Ontario Ministry of Environment considers air with concentrations of PM$_{2.5}$ less than 12 microgram/m$^3$ to be "very good," and higher than 45 micrograms/m$^3$ to be "poor." It is important to note that PM$_{2.5}$ is used as a proxy measure to understand the absence or presence, and relative level of second hand smoke; there is no safe level of second-hand smoke.\(^3\)

**Results:**
- There was evidence of second-hand smoke drift into the common spaces of all properties studied
- Relative levels of second-hand smoke varied by property and time of day
  - Highest average readings in hallways were measured in family low rise apartments
  - Many environments monitored in this study had levels of second-hand smoke drift higher than in similar published studies of multi-unit dwellings and second-hand smoke drift

**Seniors and Adult Housing:**
- Peak PM$_{2.5}$ levels in some locations were in excess of 200 microgram/m$^3$ when background readings were 4 microgram/m$^3$
- One property experienced extended hours where PM$_{2.5}$ readings were in excess of 100 microgram/m$^3$ in the hallway.

**Multi-unit Family housing:**
- Levels of second-hand smoke were consistently high in the hallway of low-rise apartments for Families
- Second-hand smoke levels were highest during weekday evenings and lower on the weekend
- The average weekly evening readings in the common spaces were significantly elevated, with one evening’s average PM$_{2.5}$ hallway reading >100 mg/m$^3$

**Next Steps**

Similar tenant surveys with households in the Waterloo Region Housing and Region of Waterloo Community Housing Incorporated portfolios will be conducted in 2011 and 2012 and air quality data will continue to be monitored in common spaces. With this longitudinal data it will be possible to understand trends in compliance with expected smoking/non-smoking behaviours and support for the smoke-free policy. The results of subsequent surveys and air quality studies will be presented to Regional Council in similar reports. As noted above, it is predicted that it will take approximately 10 years to have the majority of units be smoke-free; therefore, it will take a number of years to measure the full effect of the smoke-free policy. Also, it is anticipated that changes in attitudes and behaviours may take a number of years.

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CORPORATE STRATEGIC PLAN:

Strategic Focus Area 3: Healthy and Safe Communities – Support safe and caring communities that enhance all aspects of health.

Strategic Focus Area 4: Human Services – Promote quality of life and create opportunities for residents to develop to their full potential.

Strategic Focus Area 6: Service Excellence – Foster a culture of citizen/customer service that is responsive to community needs.

FINANCIAL IMPLICATIONS:

NIL

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

This report was co-authored by Ryan Kennedy, PhD., Scientist, Propel Centre for Population Health Impact.

This report was reviewed by staff from Planning Housing and Community Services.

ATTACHMENTS

APPENDIX A: Findings of the 2010 Waterloo Region Housing and Region of Waterloo Community Housing Inc. Household Tenant Survey

APPENDIX B: Findings of the 2010 Waterloo Region Housing and Region of Waterloo Community Housing Inc. Air Quality Study

PREPARED BY: Stephanie Ellens-Clark, Public Health Planner

APPROVED BY: Dr. Liana Nolan, Commissioner/Medical Officer of Health
SMOKE-FREE HOUSING POLICY EVALUATION

Findings of the 2010 Waterloo Region Housing and Region of Waterloo Community Housing Inc. Household Tenant Survey Report to the Region of Waterloo Community Services Committee

Prepared by:
Ryan David Kennedy PhD, Scientist
This report was prepared by Ryan David Kennedy with review by the Region of Waterloo Smoke-free Housing Evaluation Committee which includes employees from Waterloo Region Housing and Region of Waterloo Public Health.

Suggested Citation:

Kennedy RD. Smoke-free Housing Policy Evaluation - Findings of the 2010 Waterloo Region Housing and Region of Waterloo Community Housing Inc. Household Tenant Survey. Waterloo, ON: Propel Centre for Population Health Impact, University of Waterloo.

This report is available online at www.propel.uwaterloo.ca

Propel is a partnership between the Canadian Cancer Society and the University of Waterloo.
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Smoke-free Housing Policy Evaluation –

Highlights of the 2010 Waterloo Region Housing and Region of Waterloo Community Housing Inc. Household Tenant Survey

Below are some key findings from the 2010 survey mailed to every household managed by Waterloo Region Housing in March 2010. The smoke-free policy had been passed by Region of Waterloo Council in October 2009 and was approved by the Region of Waterloo Community Housing Inc. Board of Directors in November 2009. The survey was conducted prior to the policy being enacted on April 1st, 2010. The survey was completed by 717 households: 480 respondents indicated that the household had no smokers; 187 indicated that their household had one or more smokers; and 50 households did not indicate the smoking status of their household.

- 58% of respondents reported that they, or others in their household, are sometimes or often exposed to second-hand smoke (SHS) in their home
- 40% of respondents reported someone in their household has health problems that get worse when they breathe SHS
- The majority of respondents, 72%, reported they support the Region of Waterloo smoke-free housing policy
  - Support was approximately 87% from households with no smokers
  - Support from households with smokers was approximately 39%
  - Approximately 40% of respondents who smoke reported they plan to cut down on the number of cigarettes they smoke after the new policy is in place
- 28% of households in WRH and ROWCHI reported having a resident who smoked — the provincial average is 25%
- Most respondents reported they already have households that are 100% smoke-free inside (75%) and on their patio or balcony (61%)
  - 90% of households with no smokers are 100% smoke-free inside
  - 35% of households with smokers are 100% smoke-free inside
- 30% of households that permitted smoking inside in March, 2010, reported that they plan to make their home 100% smoke-free in the next 6 months
- 41% of respondents who smoke reported that they tried to quit in the last year
- 29% of respondents who smoke reported that after the new policy is in place they will be more likely to go outside to smoke

Future tenant surveys will be conducted in March 2011 and March 2012. Collecting data before and after the policy will enable the smoke-free housing policy evaluation committee to track changes in reported attitudes and behaviour.
BACKGROUND:

Waterloo Regional Housing (WRH) and Region of Waterloo Community Housing Inc. (ROWCHI) Smoke-free Housing Policy Evaluation—Survey 2010

In October, 2009, Region of Waterloo Council approved a smoke-free housing policy. This policy came into effect on April 1, 2010 and made all new leases signed with Waterloo Region Housing in all buildings and properties, 100 per cent smoke-free. These restrictions are applied to all living spaces in the lease, including patios and balconies. This smoke-free housing policy also restricted smoking outdoors at all properties in the portfolio to a distance of five metres away from any window, entrance or exit to the building/unit. These outdoor restrictions applied to all tenants and visitors. Region of Waterloo Community Housing Inc (ROWCHI) Board of Directors voted and passed the same policy on November 27th, 2009.

As per Ontario law, tenants with existing leases were “grandfathered” — meaning tenants who had previously been allowed to smoke in their units, including on the balcony or patio, would still be permitted to do so.

This was the first policy in Ontario to make an entire housing portfolio smoke-free, and one of the first in Canada. Region of Waterloo Council requested that Regional employees support other local community housing providers to implement similar smoke-free policies.

A committee was created to evaluate aspects of the new smoke-free policy. The evaluation committee consists of membership from WRH, Region of Waterloo Public Health, and a scientist from the Propel Centre for Population Health Impact at the University of Waterloo. The policy evaluation consists of an enforcement database, air quality monitoring and a tenant survey.

The annual survey of tenants is being conducted to measure support for the smoke-free policy, and understand how the policy may affect smoking behaviour. Considering the policy permits “grandfathering” — it is expected that impacts from the policy may take several years to influence behaviour.

This report provides the results of the March 2010 survey which was administered to tenants after the policy had been passed by Regional Council in October 2009 and prior to the policy being enacted on April 1st, 2010. A copy of the tenant household questionnaire is included in Appendix A of this report.
SAMPLE

Waterloo Region Housing manages 2722 affordable rental housing units. Building types in the portfolio include low and high-rise apartments, townhouses, semi-detached and single family homes. Housing is provided for different tenant groups including “seniors,” “adult, no dependant, and “families”” Senior units are intended for residents who are 60 years of age or older. Seniors live in low or high rise apartments. “Adult, no dependant” is typically for residents with no children who are younger than 60 years old. This adult housing is in low or high rise apartments. Most of the tenants in “family” units live in townhouses or semi-detached single family dwellings however some family units are also in low-rise apartments.

METHODS

The questionnaire and research methods used in this study received approval from the Region of Waterloo Public Health Research Ethics Board, and the Office of Research Ethics at the University of Waterloo (ORE# 16168).

An envelope containing a cover letter that described the new policy, the survey questionnaire, and letter that provided instructions on how to access language translation support for completing the survey was delivered by a private courier to every household in the portfolio. The envelope was labeled with the tenant’s name and address, and delivered to their mailbox, or in some cases right to the door. These envelopes were delivered in early March 2010, and respondents were asked to return the completed survey by March 26th, 2010. Copies of the cover letter and translation support material are included in Appendix B.

The survey was entitled “Survey – Evaluation March, 2010 – Smoke-free policy for New Leases and Transfers in Waterloo Region Housing.” The survey had 22 questions, 16 of which were for all households to respond to and 6 which were specifically for respondents who smoked.

Respondents were asked to return the completed survey using a prepaid, self-addressed envelope. Alternatively, respondents were invited to drop off the completed survey in person to the WRH office in either Kitchener or Cambridge.

ANALYSIS

Response percentages are reported for each question. Non-responses (missing data) are not included in most response proportions. Some question responses are reported based on household smoking status; households are classified as either not having a resident who smokes, or having a resident who smokes. Response percentages for
questions intended for people who smoke only report from the sample of respondents who identified as a person who smokes.

Analysis was conducted in PASW Statistics 18. Significance tests used an alpha of 0.05.

Although the survey tool did not provide space for remarks, many respondents wrote written comments throughout the surveys. These comments were entered into a spreadsheet along with the question, if any, the comments were associated with.
FINDINGS

Response Rates

The survey was distributed to all 2722 households and completed by 717 respondents, which represents a response rate of 26.3%.

- This is considered a good or very good response rate given no incentive was offered for households to complete the survey.\(^{\text{i}}\)

- This response rate is similar to previous surveys sent to the households across the portfolio by Region of Waterloo Housing.\(^{\text{ii, iii}}\)

Table 1 below details the response rate by tenant group, being seniors, mixed (adults with no dependants) and families.

<table>
<thead>
<tr>
<th>Tenant Group</th>
<th>Response Rate</th>
<th>Returned Surveys</th>
<th>Total Units in portfolio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seniors</td>
<td>36.8%</td>
<td>396</td>
<td>1076</td>
</tr>
<tr>
<td>Adult, no dependants</td>
<td>36.5%</td>
<td>112</td>
<td>307</td>
</tr>
<tr>
<td>Family</td>
<td>15.6%</td>
<td>209</td>
<td>1339</td>
</tr>
</tbody>
</table>

The response rate for seniors and mixed tenants were similar at approximately 37%. The family units had a lower response rate – approximately 16%. These findings are consistent with previous surveys.\(^{\text{iv}}\)
Household and Respondent Descriptions:

Household and respondent descriptions are reported for the entire sample (n=717). Missing responses are included in the tables and reported as a proportion of the sample.

Questions 1 and 2 asked about the age of respondent. Each question had two parts, and the findings are detailed in Tables 2-5 below. Tables 2 and 3 report the percentage of respondents that identified as being 18 years of age or older, and being 65 years old, or older.

Table 2. Question 1a) Are you 18 years old, or older?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing responses</td>
<td>20.2%</td>
<td>145</td>
</tr>
<tr>
<td>Yes</td>
<td>78.8%</td>
<td>565</td>
</tr>
<tr>
<td>No</td>
<td>1.0%</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>717</td>
</tr>
</tbody>
</table>

Most respondents, approximately 79% (n=565) reported that they were 18 years old or older; however more than 20%, (n= 145) of respondents did not answer the question. The research team identified some inconsistencies with these age-related questions; however all responses have been kept in this analysis.

Table 3. Question 1b) If Yes, are you 65 years old, or older?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No or Missing</td>
<td>62.3%</td>
<td>447</td>
</tr>
<tr>
<td>Yes</td>
<td>37.7%</td>
<td>270</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>717</td>
</tr>
</tbody>
</table>

There were 270 respondents that indicated they were 65 years old, or older; this represents approximately 38% of the sample.

Question 2 asked respondents to describe the number of people in the household including the number of adults and children/teens. The results are detailed in Tables 4 and 5 below.
Table 4. Question 2a) Describe the number of people in your household — Number of adults (18 or over)

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing</td>
<td>6.8%</td>
<td>49</td>
</tr>
<tr>
<td>more than one</td>
<td>22.0%</td>
<td>158</td>
</tr>
<tr>
<td>One</td>
<td>71.1%</td>
<td>510</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>717</td>
</tr>
</tbody>
</table>

The majority of respondents reported that their household had only one adult (71%, n=510).

Table 5. Question 2b) Describe the number of people in your household — Number of children/teens (under 18)

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing</td>
<td>63.9%</td>
<td>458</td>
</tr>
<tr>
<td>more than one</td>
<td>14.4%</td>
<td>103</td>
</tr>
<tr>
<td>One</td>
<td>6.7%</td>
<td>48</td>
</tr>
<tr>
<td>Zero</td>
<td>15.1%</td>
<td>108</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>717</td>
</tr>
</tbody>
</table>

There were 151 households that reported at least one child or teen (under 18 years of age) lived in their household. This represents 21% of the sample.

Note: Based on responses to questions 1b and 2b, approximately 59% of the households that completed the survey (n=421) have either a senior or child/teen.
Smoking Behaviour in the Household:

The survey included 5 questions for all respondents about smoking behaviour and home-smoking practices (questions 3-6). Question 7 asked about respondent’s anticipated future smoke-free home policies. The responses to these questions are detailed in Tables 6-12 below. Response percentages do not include non-responses; the number of missing responses is reported with each table.

Question 3 and 4 ask about the number of residents in a household that smoke, and if the respondent to this survey smokes. Findings are reported in Tables 6 and 7.

Table 6. Question 3) How many people in your household, including yourself currently smoke, daily or less?

<table>
<thead>
<tr>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>72.0%</td>
</tr>
<tr>
<td>1</td>
<td>20.4%</td>
</tr>
<tr>
<td>2-3</td>
<td>4.5%</td>
</tr>
<tr>
<td>More than 3</td>
<td>3.1%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Missing responses: 50; total sample n=717

Respondents reported that approximately 28% of households have at least one resident who smokes daily or less (n=187), while approximately 72% (n=480) of households reported that there were no residents that smoke in their household.

The responses to this question were used to classify households by smoking status; households that have a smoker (n= 187) or do not have a smoker (n= 480).

NOTE: The proportion of households in Ontario that have at least one resident who smokes is estimated at 24.9%.\textsuperscript{v}

Table 7. Question 4) Do you smoke cigarettes, either daily or less?

<table>
<thead>
<tr>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>75.8%</td>
</tr>
<tr>
<td>Yes</td>
<td>24.2%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Missing responses: 59; total sample n=717

Approximately 24% of respondents indicated that they smoked cigarettes, either daily or less. The proportion of respondents who indicated they were smokers is similar to the proportion of households
that indicated they had a smoker in the home (a comparison of the proportions between the two groups showed that they were not statistically different; z-score 1.545).

Note: Smoking prevalence in Ontario is 16.8%, lower than the national average of 17.9%. The Ontario Tobacco Research Unit (OTRU) has reported that people in Ontario with lower socio-economic status have a smoking prevalence rate of 27%.

Questions 5 and 6 asked about current smoking practices inside respondents’ homes and on their balcony/patio. Results are presented in Tables 8-11 below. Results are reported for both the entire sample and for households where smoking status is known.

Table 8. Question 5) Does anyone smoke inside your home?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>74.8%</td>
<td>505</td>
</tr>
<tr>
<td>Often</td>
<td>10.8%</td>
<td>73</td>
</tr>
<tr>
<td>Sometimes</td>
<td>14.4%</td>
<td>97</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>675</td>
</tr>
</tbody>
</table>

Missing responses: 50; total sample n=717

The majority of respondents, approximately 75%, reported that their homes are 100% smoke-free (n=505). Approximately 25% of households permit smoking at least sometimes.

Table 9 below reports smoking behaviour in homes, reported by the smoking status of the household, as determined by question 3.
Table 9. Question 5) Does anyone smoke inside your home?

Reported by Smoking Status of the Household

<table>
<thead>
<tr>
<th>Does anyone smoke inside your home?</th>
<th>No Smoker in Household</th>
<th>Smoker in the Household</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>89.6% (n=422)</td>
<td>35.2% (n=63)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>10.0% (n=47)</td>
<td>26.3% (n=47)</td>
</tr>
<tr>
<td>Often</td>
<td>0.4% (n=2)</td>
<td>38.5% (n=69)</td>
</tr>
<tr>
<td>Total</td>
<td>100.0% (n=471)</td>
<td>100.0% (n=179)</td>
</tr>
</tbody>
</table>

Missing responses: 17; household smoking status sample n=667

The vast majority of households that do not have a smoker report that smoking never takes place inside their home (approximately 90%, n=422). More than 10% of households that do not have a resident who smokes, report that someone smokes "sometimes" or "often" inside their home.

Approximately 35% of respondents from households that have a person who smokes, reported that their homes are 100% smoke-free.

Note: A nationally representative study of smokers found that 39% of Canadian households with a smoker are 100% smoke-free (36.3-41.8, 95%CI)."
Question 6 asked respondents about smoking on their patio or balcony. Respondents could answer “Never OR Do not have a patio or balcony,” “Often,” or “Sometimes.” The results of this question are reported in tables 10 and 11.

**Table 10. Question 6) Does anyone smoke on your patio or balcony?**

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never or do not have</td>
<td>60.8%</td>
<td>408</td>
</tr>
<tr>
<td>Often</td>
<td>9.5%</td>
<td>64</td>
</tr>
<tr>
<td>Sometimes</td>
<td>29.7%</td>
<td>199</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0%</td>
<td>671</td>
</tr>
</tbody>
</table>

Missing responses: 46; total sample n=717

Approximately 40% of respondents indicated that smoking takes place on their balcony sometimes or often. Table 11 below reports smoking behaviour on patios or balconies, reported by the smoking status of the household, as determined by question 3.

**Table 11. Question 6) Does anyone smoke on your patio or balcony?**

**Reported by Smoking Status of the Household**

<table>
<thead>
<tr>
<th>Does anyone smoke on your patio or balcony?</th>
<th>No Smoker in Household</th>
<th>Smoker in the Household</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never – or do not have a balcony</td>
<td>72.0% (n=334)</td>
<td>30.9% (n=56)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>26.9% (n=125)</td>
<td>37.6% (n=68)</td>
</tr>
<tr>
<td>Often</td>
<td>1.1% (n=5)</td>
<td>31.5% (n=57)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0% (n= 464)</td>
<td>100.0% (n= 181)</td>
</tr>
</tbody>
</table>

Missing responses: 22; household smoking status sample n=667

Most households that do not have a smoker report that smoking never takes place on their balcony (or they do not have balcony, 72%, n=334). Approximately 28% of households with no smokers report that smoking takes place at least sometimes on their patio or balcony.

Approximately 31% of households that have a smoker, reported that no one ever smokes on their patio or balcony (or they do not have one).

Note: Less than 4% of housing units in the portfolio (n=99) have no patio or balcony.\(^x\)
Question 7 asked respondents to report if they anticipated making their home smoke-free in the near future. For Question 7, 433 respondents indicated that their household was already smoke-free. Given that most households are already 100% smoke-free, the percentages reported include only those respondents that answered “yes” or “no.”

Table 12. Question 7) If you allow smoking in your home, do you plan to make your home 100% smoke-free within the next 6 months?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>70.0%</td>
<td>156</td>
</tr>
<tr>
<td>Yes</td>
<td>30.0%</td>
<td>67</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>223</td>
</tr>
</tbody>
</table>

Missing Responses: 61; total sample n=717

NOTE – 433 respondents reported household was already 100% smoke-free and not reported here.

From the remaining sample (n=223), 30% (n=67) reported that they do intend to make their home 100% smoke-free in the next 6 months. This includes both households that have a person who smokes and those households that do not have a person that smokes.

Of the respondents that indicated “yes,” approximately 33% (n=17) were from households with a smoker.
SUPPORT for SMOKE-FREE POLICY

Question 8 asked respondents if they supported the smoke-free housing policy that was to come into effect April 1, 2010.

Table 13. Question 8) Do you support the new policy that will make all new leases in your building 100% smoke-free, including no smoking on patios or balconies, starting on April 1, 2010?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>72.3%</td>
<td>483</td>
</tr>
<tr>
<td>No</td>
<td>27.7%</td>
<td>185</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>668</td>
</tr>
</tbody>
</table>

Missing Responses: 49; total sample n=717

The majority of respondents were supportive of the policy (72%, n=483). Approximately 39% of households with a person who smokes supported the policy (n=70). Households with no smoker reported 87% support for the smoke-free policy (n=394).

Note: A similar measure was reported by OTRU from the Ontario Tobacco Use Survey. OTRU reported that 79% of the adult population agreed smoking should not be allowed indoors in multi-unit dwellings (compared to 63% in 2003).
**Second-hand Smoke Exposure and Health**

Questions 9-12 asked about respondent’s second-hand smoke exposure in their home and how SHS may impact the health of their household. Responses are detailed in tables 14-17 below, reporting from the entire sample (smokers and non-smokers).

**Table 14. Question 9) How often are you exposed to second-hand smoke in your home? This may include smoke coming in from the outside.**

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>41.6%</td>
<td>274</td>
</tr>
<tr>
<td>Often</td>
<td>21.7%</td>
<td>143</td>
</tr>
<tr>
<td>Sometimes</td>
<td>36.7%</td>
<td>242</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>659</td>
</tr>
</tbody>
</table>

Missing Responses: 58; total sample n=717

Most respondents (approximately 58%, n=385), indicated that they are sometimes or often exposed to second-hand smoke in their home.

**Table 15. Question 10) Are you or others bothered by second-hand smoke while in your home?**

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>43.4%</td>
<td>285</td>
</tr>
<tr>
<td>I am/We are never exposed to second-hand smoke in my/our home</td>
<td>25.3%</td>
<td>166</td>
</tr>
<tr>
<td>Yes</td>
<td>31.4%</td>
<td>206</td>
</tr>
<tr>
<td>Total</td>
<td>100.1%</td>
<td>657</td>
</tr>
</tbody>
</table>

Missing Responses: 60; total sample n=717

Almost a third of households, approximately 31%, responded that someone in their household is bothered by second-hand smoke in their home (n=206).
Table 16. Question 11) Do you or others in your home have health problems that get worse when you breathe in second-hand smoke?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>60.0%</td>
<td>395</td>
</tr>
<tr>
<td>Yes</td>
<td>40.0%</td>
<td>263</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>658</td>
</tr>
</tbody>
</table>

Missing Responses: 59; total sample n=717

40% of respondents (n=263) reported that someone in their household has health problems that are made worse when exposed to second-hand smoke.

Table 17. Question 12) Do you smell second-hand smoke in other parts of the building such as hallways, lobby or other common indoor spaces?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>12.2%</td>
<td>79</td>
</tr>
<tr>
<td>Often</td>
<td>11.6%</td>
<td>75</td>
</tr>
<tr>
<td>Sometimes</td>
<td>34.7%</td>
<td>224</td>
</tr>
<tr>
<td>Never</td>
<td>41.4%</td>
<td>267</td>
</tr>
<tr>
<td>Total</td>
<td>99.9%</td>
<td>645</td>
</tr>
</tbody>
</table>

Missing responses: 72; total sample n=717

Over half of respondents reported that they smell second-hand smoke in common indoor spaces at least sometimes (approximately 59%, n=378).
**Cigarette butts**

Question 13 asked respondents to report how often they see cigarette butts around their housing unit. Responses are detailed in Table 18 below, reporting from the entire sample.

**Table 18. Question 13) Do you see cigarette butts lying on the ground on the property where you live?**

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>16.7%</td>
<td>107</td>
</tr>
<tr>
<td>Often</td>
<td>13.1%</td>
<td>84</td>
</tr>
<tr>
<td>Sometimes</td>
<td>44.2%</td>
<td>283</td>
</tr>
<tr>
<td>Never</td>
<td>26.0%</td>
<td>166</td>
</tr>
</tbody>
</table>

Missing responses: 77; total sample n=717.

Almost three quarters of respondents indicated they see cigarette butt litter at least sometimes (74%, n=474).

**Perceived problems between neighbours**

Question 14 asked respondents to report how often, if at all, smoking has caused problems between households. Responses are described in table 19 for the entire sample.

**Table 19. Question 14) Has smoking caused problems between you/someone in your home and your neighbour(s)?**

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>73.4%</td>
<td>452</td>
</tr>
<tr>
<td>Just a little</td>
<td>14.6%</td>
<td>90</td>
</tr>
<tr>
<td>A fair amount</td>
<td>5.7%</td>
<td>35</td>
</tr>
<tr>
<td>A great deal</td>
<td>6.3%</td>
<td>39</td>
</tr>
</tbody>
</table>

Missing responses: 101; total sample n=717

More than a quarter of respondents reported that smoking has caused problems between neighbours (approximately 27%, n=164). 12% of respondents reported that smoking had caused a fair amount or a great deal of problems (n=74).
**Perceived social norms**
Question 15 asked respondents to report how often they think their neighbours go outside to smoke. This question was asked to help inform health promotion strategies that may focus on social norms. Responses are detailed in table 20 below, reporting from the entire sample.

**Table 20. Question 15) How often do you think your neighbours go outside to smoke?**

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>9.2%</td>
<td>58</td>
</tr>
<tr>
<td>Sometimes</td>
<td>21.4%</td>
<td>135</td>
</tr>
<tr>
<td>Often</td>
<td>16.0%</td>
<td>101</td>
</tr>
<tr>
<td>Always</td>
<td>8.5%</td>
<td>54</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>44.9%</td>
<td>284</td>
</tr>
</tbody>
</table>

Missing Responses: 85; total sample n=717

Almost half of respondents reported they do not know how often their neighbours go outside to smoke (approximately 45%, n=285). Approximately 9% of respondents reported they think their neighbours “never” go outside (n=58).
Self-reported Health

It is common in public health surveys to ask respondents to report their general health status. Question 16 asks respondents to report how they generally felt during the past month. This question is also used in the Canadian Community Health Survey and will make it possible to compare the current study population to a nationally representative sample. Responses are reported in table 21 below for the entire sample.

Table 21 Question 16) During the past month you felt healthy....

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almost Always</td>
<td>36.4%</td>
<td>221</td>
</tr>
<tr>
<td>Most of the Time</td>
<td>37.7%</td>
<td>229</td>
</tr>
<tr>
<td>Half of the Time</td>
<td>16.3%</td>
<td>99</td>
</tr>
<tr>
<td>Rarely</td>
<td>5.6%</td>
<td>34</td>
</tr>
<tr>
<td>Never</td>
<td>4.0%</td>
<td>24</td>
</tr>
</tbody>
</table>

Missing Responses: 110; total sample 717.

Most respondents reported that they felt healthy most of the time or almost always (approximately 74%, n=450). Approximately 10% of the respondents to this survey (n=58) reported that they rarely or never felt healthy.
QUESTIONS FOR PEOPLE WHO SMOKE:
The survey included 6 questions (questions 17-22) for respondents who smoke. The section of the survey included the following statement: “If you smoke, please respond to the following questions or statements.”

Note: Some respondents completed this section that did not indicate in Question 4 that they were a smoker. Tables 22-27 only report responses from respondents that indicated in Question 4 that they smoked “either daily or less.” This included 159 respondents.

Quitting Intentions and Smoking Behaviours

Question 17 and 20 ask respondents to report their recent quit attempts and anticipated quit attempts. Questions 18 and 19 ask about respondents’ intentions to smoke outdoors more often or reduce the number of cigarettes smoked per day.

Table 22. Question 17) At anytime during the past year, did you try to quit smoking?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>58.8%</td>
<td>87</td>
</tr>
<tr>
<td>Yes</td>
<td>41.2%</td>
<td>61</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>148</td>
</tr>
</tbody>
</table>

Approximately 41% (n=61) of respondents indicated that they have tried to quit smoking in the last year.

NOTE: An international study of smokers from Canada, US, UK and Australia reported that smokers with lower incomes were more likely than others to have an interest in quitting but were less likely to have made a quit attempt.¹
Table 23: Question 18) After the new policy starts on April 1, 2010, which will make all new leases in your building 100% smoke-free, including no smoking on patios or balconies, will you be more likely to smoke outside?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>29.1%</td>
<td>32</td>
</tr>
<tr>
<td>No</td>
<td>70.9%</td>
<td>78</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>110</td>
</tr>
</tbody>
</table>

Missing Responses: 16; “smoker” sample n=159. Note – 33 respondents reported they already go outside 100% of the time; proportions reported did not include those respondents.

There were 33 respondents to question 18 that reported that they already go outside to smoke 100% of the time. Of the remaining sample, approximately 29% (n=32) reported that they will be more likely to go outside to smoke after the new smoke-free policy is in place.

Table 24. Question 19) Do you plan to cut down on the number of cigarettes you smoke after the new policy is in place?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>39.4%</td>
<td>56</td>
</tr>
<tr>
<td>No</td>
<td>60.6%</td>
<td>86</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>142</td>
</tr>
</tbody>
</table>

Missing responses: 17; “smoker” sample n=159

Approximately 40% of respondents plan to cut down on the number of cigarettes they smoke after the new policy is in place.

Table 25. Question 20) Do you plan to quit smoking in the next 6 months?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>23.7%</td>
<td>32</td>
</tr>
<tr>
<td>No</td>
<td>76.3%</td>
<td>103</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>135</td>
</tr>
</tbody>
</table>

Missing responses: 24; “smoker” sample n=159

Almost a quarter of smokers reported that they plan to quit smoking in the next six months (approximately 24%, n=32).
Social De-normalization of Smoking Behaviour

Evaluations of smoke-free policies have shown that increases in smoke-free spaces are associated with reductions in the perception of the social acceptability of smoking.60 Question 21 asked respondents to report if they agree or disagree with the statement “there are fewer and fewer places you feel comfortable smoking”.

Table 26. Question 21) There are fewer and fewer places you feel comfortable smoking.

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>29.2%</td>
<td>42</td>
</tr>
<tr>
<td>Agree</td>
<td>38.9%</td>
<td>56</td>
</tr>
<tr>
<td>Disagree</td>
<td>17.4%</td>
<td>25</td>
</tr>
<tr>
<td>Strongly Disagree</td>
<td>14.6%</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>100.1%</td>
<td>144</td>
</tr>
</tbody>
</table>

*Missing responses: 15; “smoker” sample n=159*

Of those that responded to this question, approximately 68% (n=98) reported that they agree or strongly agree that there are fewer and fewer places they feel comfortable smoking.

Interest in Cessation Support

Region of Waterloo Public Health (ROWPH) provides help to tenants to access smoking cessation supports. Question 22 asked respondents about their interest in accessing a smoking cessation program provided by ROWPH.

Table 27. Question 22) Would you consider using one of the Region of Waterloo Public Health quit-smoking programs to help you quit smoking?

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>12.0%</td>
<td>17</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>45.1%</td>
<td>64</td>
</tr>
<tr>
<td>No</td>
<td>42.9%</td>
<td>61</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>142</td>
</tr>
</tbody>
</table>

*Missing Responses: 17; “smoker” sample n=159*

Of those who responded to this question, 12% (n=17) said “yes”, they would consider using one of the ROWPH quit-smoking programs to assist in smoking cessation. Almost half of respondents (45%, n=64) reported they “don’t know.”
ADDITIONAL COMMENTS THAT WERE HAND WRITTEN ON THE SURVEYS

This survey did not include spaces for respondents to add open-ended comments but many did – 124 different respondents wrote at least one comment on their survey. Many comments asked for policy makers to make the smoke-free policy more stringent while others suggested it was going too far.

Comments were tracked by the anonymous respondent ID and according to where the comment was written on the survey; most comments were associated with a specific question.

Here is a sample of the range of comments that were received related to the survey questions:

Following question 8, “Do you support the new policy that will make all new leases 100% smoke-free...”

“I think it should be for all tenants — not just the new ones!”

“My opinion: Should go further! ... no smoking on patios or balconies, for all (new and longtime residents) plus guests”

“Thank you!”

“I hope all old leases will be 100% smoke free too!”

“I feel it's a violation of personal rights”

“Where is right of freedom?”

Following question 9, “How often are you or others exposed to second-hand smoke in your home...”

“All the time. My apartment stinks from smoke and I get sick to my stomach.”

“It comes in my bathroom, from ceiling fans — interconnected.”

“If on balcony — or in elevator — or building entrance”

“More in the summer time and I don't like it”
After question 10: Are you or others bothered by second-hand smoke while in your home?

“I and my friends that visit me in summer, if we sit on balcony, we have to go inside and close door and put air conditioner on. Please make area for balcony free of smoke. Please! Smokers should have smoking bench ten meters from their door.”

General comments at the end:

“I believe current tenants should not be allowed to smoke indoors where connected to other units — especially if children and pets are present!!”

“What has to be done is stop people smoking on their patios which causes problems for upstairs neighbours. We can’t go out on our balcony if someone down below is smoking also we have to close our windows. The smoke comes up from downstairs around the pipes and electrical outlets in the kitchen making it very bad for us.

“Smoking is not illegal according to the Government. Did you stop to think you may add people to the homeless by enforcing these rules.”
NEXT STEPS

The evaluation committee will conduct similar surveys with households in the Waterloo Region Housing and Region of Waterloo Community Housing Inc. portfolios in 2011 and 2012. With this longitudinal cross sectional data it will be possible to understand trends in policy support and smoking behaviour. The results of subsequent surveys will also be presented to Regional Council in similar reports.
INSTRUCTIONS: Please shade the circles below using a dark blue or black ink pen (not pencil) to show your answers to the following questions.

1. Are you 18 years old, or older?  ○ Yes  ○ No  If yes, are you 65 years old, or older?  ○ Yes  ○ No

2. Describe the number of people in your household:
   Number of adults (18 or over)                Number of children/teens (under 18)
   ○ 1 adult                                  ○ 0 children/teens
   ○ More than 1 adult                         ○ 1 child/teen
                                                ○ More than 1 child/teen

3. How many people in your household, including yourself, currently smoke, daily or less?
   ○ 0  ○ 1  ○ 2-3  ○ More than 3

4. Do you smoke cigarettes, either daily or less?  ○ Yes  ○ No

5. Does anyone smoke inside your home?  ○ Never  ○ Sometimes  ○ Often

6. Does anyone smoke on your patio or balcony?
   ○ Never OR Do not have patio or balcony  ○ Sometimes  ○ Often

7. If you allow smoking in your home, do you plan to make your home 100% smoke-free within the next 6 months?  ○ Yes  ○ No  ○ My home is already 100% smoke-free

8. Do you support the new policy that will make all new leases in your building 100% smoke-free, including no smoking on patios or balconies, starting on April 1, 2010?  ○ Yes  ○ No

9. How often are you or others exposed to second-hand smoke* in your home? This may include smoke coming in from the outside.
   ○ Never  ○ Sometimes  ○ Often

   *Second-hand smoke comes from the burning end of a lit cigarette, cigar or pipe and from the smoke blown into the air by the person smoking

10. Are you or others bothered by second-hand smoke while in your home?
    ○ Yes  ○ No  ○ I am/We are never exposed to second-hand smoke in my/our home

11. Do you or others in your home have health problems that get worse when you breathe in second-hand smoke?  ○ Yes  ○ No
12. Do you smell second-hand smoke in other parts of the building such as hallways, lobby or other common indoor spaces?  ○ Never  ○ Sometimes  ○ Often  ○ Always

13. Do you see cigarette butts lying on the ground on the property where you live?  ○ Never  ○ Sometimes  ○ Often  ○ Always

14. Has smoking caused problems between you/someone in your home and your neighbour(s)?  ○ Not at all  ○ Just a little  ○ A fair amount  ○ A great deal

15. How often do you think your neighbours go outside to smoke?  ○ Never  ○ Sometimes  ○ Often  ○ Always  ○ Don’t know

16. During the past month you felt healthy....  ○ Almost always  ○ Most of the time  ○ Half of the time  ○ Rarely  ○ Never

If you smoke, please respond to the following questions or statements:

17. At anytime during the past year did you try to quit smoking?  ○ No  ○ Yes

18. After the new policy starts on April 1, 2010, which will make all new leases in your building 100% smoke-free, including no smoking on patios or balconies, will you be more likely to smoke outside?  ○ No  ○ Yes  ○ I already go outside 100% of the time

19. Do you plan to cut down on the number of cigarettes you smoke after the new policy is in place April 1, 2010?  ○ No  ○ Yes

20. Do you plan to quit smoking in the next 6 months?  ○ No  ○ Yes

21. There are fewer and fewer places where I feel comfortable smoking.  ○ Strongly disagree  ○ Disagree  ○ Agree  ○ Strongly agree

22. Would you consider using one of the Region of Waterloo Public Health quit-smoking programs to help you quit smoking?  ○ No  ○ Yes  ○ Don’t know

THANK YOU! Please return the completed survey using the prepaid, self addressed envelope by March 26, 2010, by mail or in person to:

Waterloo Region Housing
235 King Street East, 6th floor in Kitchener
or
150 Main Street in Cambridge
End Notes and References

1 In an experimental study by Larson and Chow (2002), researchers found that mail-back survey response rates with no incentive, were 13%. When researchers included a person cover letter, response rates were 14%. This matches the lowest response rate experienced with the households in “family” housing, and is lower than the overall average response rate for the housing portfolio.

Full reference:

ii Region of Waterloo, Community Services Committee Report PH-08-034
Available from:


iv Ibid

v Calculated using cycle 1, 2008 of CTUMS (Canadian Tobacco Use Monitoring Survey) – weighted results for Ontario. The proportion of households in Canada that have a smoker is 25.2%.


vii OTRU – Reporting CAMH Monitor Data – in Evaluation News


x Ontario Tobacco Research Unit. Toward a Smoke-Free Ontario: Progress and Implications for Future Developments [Special Reports: Monitoring and Evaluation Series (Volume 13, No. 3)]. Toronto, ON: Ontario Tobacco Research Unit, February 2009.

xi Siahpush M, Yong HH, Borland R, Reid JL, Hammond D. Smokers with financial stress are more likely to want to quit but less likely to try or succeed: findings from the International Tobacco Control (ITC) Four Country Survey. Addiction 2009; 104(8): 1382–1390.

SECOND-HAND SMOKE IN COMMON SPACES OF MULTI-UNIT DWELLINGS

Findings of the 2010 Waterloo Region Housing and Region of Waterloo Community Housing Inc. Air Quality Study

Report to the Region of Waterloo Community Services Committee

Prepared by:
Ryan David Kennedy PhD, Scientist

University of Waterloo | Waterloo, Ontario
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This report was prepared by Ryan David Kennedy and Claire Munhall with review from the Smoke-free Housing Evaluation Committee which includes employees from Waterloo Region Housing and Region of Waterloo Public Health.

Suggested Citation:

Kennedy RD, Munhall C. Second-hand Smoke in Common Spaces of Multi-Unit Dwellings — Findings of the 2010 Waterloo Region Housing and Region of Waterloo Community Housing Inc. Household Air Quality Study. Waterloo, ON: Propel Centre for Population Health Impact, University of Waterloo.

This report is available online at www.propel.uwaterloo.ca

Propel is a partnership between the Canadian Cancer Society and the University of Waterloo.
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Second-hand Smoke in Common Spaces of Multi-Unit Dwellings –

Highlights of the 2010 Air Quality Study
Part of the Waterloo Regional Housing (WRH) and Region of Waterloo Community Housing Inc. (ROWCHI) Smoke-free Housing Policy Evaluation:

Researchers from the University of Waterloo collected air quality measurements in common spaces (lobbies, hallways, common rooms) in 6 different buildings using established scientific methods to measure and quantify the presence of second-hand smoke (SHS). This included measuring respirable particulate matter (PM$_{2.5}$), an established proxy measure for SHS. Measurements were collected daily for a week during the afternoon and evening. Outdoor readings of PM$_{2.5}$ were also measured to establish a background or ambient reading.

During the study period outdoor readings of PM$_{2.5}$ were low, generally less than 10 μg/m$^3$. The Ontario Ministry of Environment considers air with concentrations of PM$_{2.5}$ less than 12 μg/m$^3$ to be “very good,” and higher than 45 μg/m$^3$ to be “poor”. It is important to note that PM$_{2.5}$ is used as a proxy measure to understand the absence or presence, and relative level of SHS; there is no safe level of second-hand smoke.

Key Findings:
- There was evidence of second-hand smoke drift into the common spaces of all properties studied
- Relative levels of SHS vary by property and time of day
  - Highest average readings in hallways were measured in family low rise apartments
  - Many environments monitored in this study had levels of SHS drift higher than in similar published studies of multi-unit dwellings and SHS drift
- Seniors and Adult Housing:
  - Peak PM$_{2.5}$ levels in some locations were in excess of 200 μg/m$^3$ when background readings were 4 μg/m$^3$
  - One property experienced extended hours where PM$_{2.5}$ readings were in excess of 100 μg/m$^3$ in the hallway.
- Multi-unit Family housing:
  - Levels of SHS were consistently high in the hallway of low-rise apartments for Families
  - SHS levels were highest during weekday evenings and lower on the weekend
  - The average weekly evening readings in the common spaces were significantly elevated, with one evening’s average PM$_{2.5}$ hallway reading >100 μg/m$^3$

Future air quality studies will enable the smoke-free housing policy evaluation committee to track changes in second-hand smoke levels in common spaces of the housing portfolio to try and understand the effectiveness of the policy to alter smoking behaviour.
BACKGROUND:
Waterloo Region Housing (WRH) and Region of Waterloo Community Housing Inc. (ROWCHI) Air Quality Study 2010

In October, 2009, Region of Waterloo Council approved a smoke-free housing policy. This policy came into effect on April 1, 2010 and made all new leases signed with Waterloo Region Housing (WRH,) in all buildings and properties, 100 per cent smoke-free. These restrictions are applied to all living spaces in the lease, including patios and balconies. This smoke-free housing policy also restricted smoking outdoors at all properties in the portfolio to a distance of five metres away from any window, entrance or exit to the building/unit. These outdoor restrictions applied to all tenants and visitors. Region of Waterloo Community Housing Inc (ROWCHI) Board of Directors voted and passed the same policy in November, 2009.

As per Ontario law, tenants with existing leases were “grandfathered” — meaning tenants who had previously been allowed to smoke in their units, including on the balcony or patio, would still be permitted to do so.

This was the first policy in Ontario to make an entire housing portfolio smoke-free, and one of the first in Canada. Region of Waterloo Council requested that Regional employees support other local community housing providers to implement similar smoke-free policies.

A committee was created to evaluate aspects of the new smoke-free policy. The evaluation committee consists of membership from WRH, Region of Waterloo Public Health (ROWPH), and a scientist from the Propel Centre for Population Health Impact at the University of Waterloo. The policy evaluation consists of an enforcement database, tenant survey and air quality monitoring.

Air quality monitoring is being conducted to understand levels of second-hand smoke in common spaces of the housing portfolio. Considering the policy permits “grandfathering,” it is expected that impacts from the policy may take several years to influence behaviour and therefore, influence levels of second-hand smoke.

This report provides the results of the March 2010 air quality studies which were conducted after the policy had been passed by Regional Council in October 2009 and prior to the policy being enacted on April 1st, 2010. This study will be a “baseline” and future air quality and second-hand smoke studies will compare levels in the future.
SAMPLE

The evaluation committee selected 6 buildings from across the portfolio to conduct air quality measurements in. A description of each location and the environments sampled are outlined in Table 1 below. An effort was made to select buildings with different tenant communities (family, adult, and senior), and a range of building design (low or high rise apartments). For the purposes of this sample, low-rise buildings are classified as having 3 or fewer stories. High-rise buildings had 4 or more stories. At each location a researcher collected air quality readings outside the building away from traffic (background), in a lobby or common room, and in a hallway adjacent to private units where it was known that at least one tenant smoked cigarettes, at least sometimes, in their unit. In the family unit (location A) readings were also collected in the back stairwell.

The sample is outlined in Table 1 below.

Table 1. Sample Venues

<table>
<thead>
<tr>
<th>Location</th>
<th>Tenant Type</th>
<th>Building Type</th>
<th>City</th>
<th>Environments Sampled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location A</td>
<td>Family</td>
<td>Low-rise</td>
<td>Waterloo</td>
<td>Lobby, Hallway and Back Stairwell</td>
</tr>
<tr>
<td>Location B</td>
<td>Senior</td>
<td>High-rise</td>
<td>Kitchener</td>
<td>Lobby, Hallway</td>
</tr>
<tr>
<td>Location C</td>
<td>Senior</td>
<td>Low-rise</td>
<td>Kitchener</td>
<td>Lobby, Hallway</td>
</tr>
<tr>
<td>Location D</td>
<td>Adult</td>
<td>Low Rise A</td>
<td>Kitchener</td>
<td>Common Room, Hallway</td>
</tr>
<tr>
<td>Location E</td>
<td>Adult</td>
<td>Low Rise B</td>
<td>Cambridge</td>
<td>Common Room, Hallway</td>
</tr>
<tr>
<td>Location F</td>
<td>Senior</td>
<td>High-rise</td>
<td>Cambridge</td>
<td>Common Room, Hallway</td>
</tr>
</tbody>
</table>
METHODS

Respirable particulate matter (PM$_{2.5}$), an established proxy measure for second-hand smoke$^{xv}$, was assessed in 6 different buildings managed by Waterloo Region Housing. Researchers used standard air quality monitoring equipment and research methods to measure and analyze PM$_{2.5}$ concentrations in the common spaces of these multi-unit dwellings.$^{xvii, xviii, xix, xx, xxi}$

Researchers collected air quality samples between March 8 and 31, 2010. Two different data collection protocols were followed in this study based on tenant type: one for buildings that housed families, and another for buildings that housed seniors and adults with no dependents (adults).

For the family unit included in the sample, researchers collected air quality samples in the afternoon and evening daily for 7 consecutive days. The sampling schedule for the family unit is outlined in Table 2 below.

Table 2: Air Quality Sampling Schedule for Family Building

<table>
<thead>
<tr>
<th>Family Unit</th>
<th>Location</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Afternoon</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approximately 3:30pm-5:30pm</td>
<td>Outside</td>
<td>10 minutes</td>
</tr>
<tr>
<td></td>
<td>Lobby</td>
<td>30 minutes</td>
</tr>
<tr>
<td></td>
<td>Back Stairwell</td>
<td>30 minutes</td>
</tr>
<tr>
<td></td>
<td>Hallway</td>
<td>30 minutes</td>
</tr>
<tr>
<td><strong>Evening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approximately 7:00pm-9:00pm</td>
<td>Outside</td>
<td>10 minutes</td>
</tr>
<tr>
<td></td>
<td>Lobby</td>
<td>30 minutes</td>
</tr>
<tr>
<td></td>
<td>Back Stairwell</td>
<td>30 minutes</td>
</tr>
<tr>
<td></td>
<td>Hallway</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

For the senior and adult housing venues in the sample, researchers collected air quality samples in the afternoon and then left a device in the hallway to monitor the air continuously from the afternoon, overnight and into the morning. The sampling schedule for the senior and adult housing units is outlined in Table 3 below. The overnight sample typically collected data until the batteries could no longer provide a charge to the device. This ensured a collection period of at least 8 hours in duration, and often up to 12 hours.
### Table 3: Air Quality Sampling Schedule for Senior and Adult Buildings

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afternoon</td>
<td>Outside</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Approximately 12:30pm-5:30pm</td>
<td>Lobby or Common Room</td>
<td>30 minutes</td>
</tr>
<tr>
<td></td>
<td>Hallway</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Afternoon - Overnight</td>
<td>Hallway</td>
<td>8-12 hour sample</td>
</tr>
<tr>
<td>Approximately 2:30pm-12:00am</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Air quality was monitored using a TSI SidePak AM510 personal air quality monitor. Daily records were kept of ambient temperature from Environment Canada’s weather website, and ambient PM$_{2.5}$ (background) levels for the Kitchener region were recorded from the Ontario Ministry of Environment. During the afternoon, sampling research assistants also made note of all possible variables which could affect PM$_{2.5}$ values, such as active smoking (inside and outside), the smell of marijuana smoke, rain, and the opening and closing of unit doors.

### ANALYSIS

Air quality readings from the SidePaks were uploaded using the TrakPro Data Analysis Software and were analyzed in Microsoft Excel 2007. The means (arithmetic and geometric) PM$_{2.5}$ concentrations are reported, as well as the maximum and minimum values. This is reported for each session and location. Paired-sample two-tailed t-tests were conducted in PASW Statistics 18 to compare the mean PM$_{2.5}$ readings collected inside to the mean PM$_{2.5}$ values collected outside. A significance of 0.05 was used for all t-tests.
FINDINGS

The air quality readings are reported based on the location where they were studied. The findings are presented first for the family unit and then for the adult and senior units studies.

FAMILY UNIT (LOW RISE)

Below are the findings from the air quality monitoring that was conducted in the family unit. This low-rise building is part of an apartment block that included 12 units that were open to each other through common hallways and stairwells. There was a closed doorway between the hallway and the back stairwell. Many apartment units were known to be smoke-free in the block studied.

The mean concentrations (arithmetic and geometric) of PM$_{2.5}$ are reported for the lobby, hallway and back stairwell of this unit in Tables 4 and 5 below. The readings collected during the Tuesday evening are then presented as time series graphs in figures 1-4 below.

Table 4. LOCATION A – PM$_{2.5}$ Readings collected in the afternoons, Low Rise Family Unit

<table>
<thead>
<tr>
<th>Location</th>
<th>PM$_{2.5}$ (µg /m$^3$)</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mon</td>
<td>Tues</td>
<td>Wed</td>
<td>Thurs</td>
<td>Fri</td>
<td>Sat</td>
<td>Sun</td>
<td></td>
</tr>
<tr>
<td><strong>Outside</strong></td>
<td>mean</td>
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<td>10 min samples</td>
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<td>11.52</td>
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<td>0.1</td>
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<tr>
<td><strong>Lobby</strong></td>
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<td>63.56</td>
<td>66.82</td>
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<td>37.28</td>
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<td>352.00</td>
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<td>221.76</td>
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<td>21.76</td>
<td>9.92</td>
<td>0.96</td>
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<td>89.46</td>
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<td>58.07</td>
<td>24.44</td>
<td>22.28</td>
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<td>45.53</td>
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<td>27.52</td>
<td>27.84</td>
<td>19.2</td>
<td>16.96</td>
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</tbody>
</table>

During the earlier part of this week, outdoor air quality readings were higher than later in the week. These background concentrations of PM$_{2.5}$ would be classified as “good”, or “moderate” air quality.
according to the Ministry of the Environment. Ambient PM$_{2.5}$ levels reported by the provincial Ministry of the Environment were consistent with what the research team collected.

The common spaces measured at the family low rise all showed evidence of SHS. The back stairwell in particular showed highly elevated levels of PM$_{2.5}$. Of interest is the minimum values recorded indoors which are almost all higher than the average outdoor readings. The findings were similar in the evening sample, detailed in Table 5 below. The lobby area is generally lower than the hallway readings; these two spaces were relatively close to each other, with open space between them.

**Table 5. LOCATION A – PM$_{2.5}$ Readings collected in the evening, Low-rise Family Unit**

<table>
<thead>
<tr>
<th>Location</th>
<th>Location</th>
<th>PM$_{2.5}$ (µg/m$^3$)</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outside</strong></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>10 min samples</td>
<td>Outside</td>
<td>mean</td>
<td>16.07</td>
<td>19.48</td>
<td>24.57</td>
<td>13.53</td>
<td>5.42</td>
<td>2.55</td>
<td>2.86</td>
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<td>geomean</td>
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<td>19.00</td>
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<td>13.12</td>
<td>4.75</td>
<td>2.05</td>
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<tr>
<td></td>
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<td>max</td>
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<td>51.52</td>
<td>96.00</td>
<td>37.44</td>
<td>116.16</td>
<td>47.04</td>
<td>19.52</td>
</tr>
<tr>
<td></td>
<td></td>
<td>min</td>
<td>8.32</td>
<td>8.64</td>
<td>14.72</td>
<td>7.68</td>
<td>1.92</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td><strong>Lobby</strong></td>
<td></td>
<td>mean</td>
<td>44.65</td>
<td>85.97</td>
<td>39.19</td>
<td>36.68</td>
<td>84.41</td>
<td>35.14</td>
<td>20.78</td>
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<tr>
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<td>81.58</td>
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<td>83.20</td>
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<td>3502.08</td>
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<td>343.04</td>
<td>172.16</td>
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<tr>
<td></td>
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<td>18.56</td>
<td>47.36</td>
<td>23.36</td>
<td>18.56</td>
<td>42.88</td>
<td>21.44</td>
<td>9.28</td>
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<tr>
<td><strong>COMMON Spaces Indoors</strong></td>
<td>Back Stair</td>
<td>mean</td>
<td>142.63</td>
<td>115.85</td>
<td>120.42</td>
<td>45.75</td>
<td>63.82</td>
<td>19.97</td>
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<td>128.38</td>
<td>114.89</td>
<td>115.71</td>
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<td>62.95</td>
<td>19.29</td>
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<td>max</td>
<td>510.08</td>
<td>253.76</td>
<td>291.20</td>
<td>276.16</td>
<td>259.84</td>
<td>151.36</td>
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<td>41.28</td>
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<td><strong>Hallway</strong></td>
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<td>101.14</td>
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<td>49.00</td>
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<td>70.65</td>
<td>20.54</td>
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<td>294.08</td>
<td>74.24</td>
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<td>34.24</td>
<td>35.20</td>
<td>10.88</td>
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</table>

In general, the evening concentrations of PM$_{2.5}$ were higher than the afternoon concentrations although both time periods were elevated well above background concentrations. The stairwell area had the highest concentrations. The hallway and lobby had similar levels, with the hallway generally having higher concentrations than the lobby.
PM$_{2.5}$ CONCENTRATIONS IN TIME SERIES

The air quality was monitored in sequence, meaning researchers started on the sidewalk outside measuring ambient (background) PM$_{2.5}$ concentrations and then measured the lobby, the stairwell and the hallway. One evening’s set of data are presented in Figures 1-4 below.

Figure 1. Outside (background) Concentrations of PM$_{2.5}$, Evening Sample, Family Low-rise Unit

![Graph showing PM$_{2.5}$ concentrations over time.

Figure 1 shows that the outdoor concentrations of PM$_{2.5}$ were remarkably consistent, with minimal variation. The average PM$_{2.5}$ concentration during this time period was 19.48 $\mu$g/$m^3$. 


Figure 2. Concentrations of PM$_{2.5}$ in the Lobby of Family Low-rise Unit, Evening Sample

Figure 2 shows that the concentrations of PM$_{2.5}$ were never lower than 47 $\mu$g /m$^3$ during the evening sample. The average PM$_{2.5}$ concentration during this time period was approximately 86 $\mu$g /m$^3$, with some peaks in excess of 200 $\mu$g /m$^3$. 
Figure 3. Concentrations of PM$_{2.5}$ in the Stairwell of Family Low-rise Unit, Evening Sample

Figure 3 shows that the concentrations of PM$_{2.5}$ were never lower than 76 $\mu$g/m$^3$ during the evening sample. The average PM$_{2.5}$ concentration during this time period was approximately 116 $\mu$g/m$^3$. This environment had the highest mean concentrations recorded.
Figure 4. Concentrations of PM$_{2.5}$ in the Hallway of Family Low-rise Unit, Evening Sample

Figure 4 shows that the concentrations of PM$_{2.5}$ were very consistent, with an average PM$_{2.5}$ concentration during this time period of approximately 101 $\mu$g /m$^3$. The hallway reading is perhaps the most important to understand since this environment is closest to where people live.

**OBSERVATIONS FROM THE RESEARCH TEAM**

In this housing unit, during some sampling sessions, smoke was seen drifting into the lobby from people smoking immediately outside the front door (closer than 5m away). Therefore, one source of SHS could be from outdoor smoke drifting in. During the entire week of sampling there was a strong smell of cigarette smoke in the hallway, which was more prominent near certain units. This suggests that another possible source of SHS in the common spaces drifts from private units into the hallway and lobby area. At different times during the week, researchers also witnessed evidence of cigarette smoking inside in the back stairwell. This evidence included discarded cigarette butts and ash. This suggests that in this housing unit some people may be smoking inside in environments they are not permitted to smoke in.

On the final night of monitoring, one resident told the researchers that their presence that week had likely deterred some visitors to the cluster; the tenant explained it had been quieter than usual.
STATISTICAL TESTS

Statistical tests were conducted to determine if the mean PM$_{2.5}$ concentrations recorded inside were significantly different from the readings outside. The three indoor readings (lobby, stairwell and hallway) were combined and paired with the outside/background readings (each outside reading was listed three times so that it could be paired with the lobby, stairwell and hallway reading on that day).

A paired-sample two-tailed t-test was conducted to evaluate the difference between PM$_{2.5}$ concentrations outside compared to PM$_{2.5}$ concentrations inside. Afternoon and evening concentrations were paired with outside readings. The test showed that PM$_{2.5}$ concentrations inside were statistically higher than the PM$_{2.5}$ readings outside (mean = 60.03 μg/m$^3$, SD = 31.8, t(41) = 11.4 (p<.0005).
SENIOR AND ADULT HOUSING UNITS (LOW AND HIGH RISE)

Below are the findings from the air quality monitoring that was conducted in the senior and adult housing units. The mean concentrations of PM$_{2.5}$ are reported for the afternoon sampling in the lobby and hallway Tables 6-10 below. For each location an overnight time series graph is also presented to show how concentrations of PM$_{2.5}$ change throughout an evening.

Table 6. Location B – Senior High Rise – Weekly Afternoon Concentrations of PM$_{2.5}$

<table>
<thead>
<tr>
<th>Outside</th>
<th>Sidewalk 10 min samples</th>
<th>PM$_{2.5}$ (µg/m$^3$)</th>
<th>PM$_{2.5}$ (µg/m$^3$)</th>
<th>PM$_{2.5}$ (µg/m$^3$)</th>
<th>PM$_{2.5}$ (µg/m$^3$)</th>
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<td>27.43</td>
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<tr>
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<td>59.52</td>
<td>58.88</td>
<td>24.32</td>
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<td>22.08</td>
<td>7.04</td>
<td>15.36</td>
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<td>21.00</td>
<td>27.43</td>
<td>2.91</td>
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<td>59.52</td>
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<table>
<thead>
<tr>
<th>Indoors</th>
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<th>PM$_{2.5}$ (µg/m$^3$)</th>
<th>PM$_{2.5}$ (µg/m$^3$)</th>
<th>PM$_{2.5}$ (µg/m$^3$)</th>
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<td>3.84</td>
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<td>58.88</td>
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</tr>
<tr>
<td></td>
<td>Hallway 30 min samples</td>
<td>PM$_{2.5}$ (µg/m$^3$)</td>
<td>PM$_{2.5}$ (µg/m$^3$)</td>
<td>PM$_{2.5}$ (µg/m$^3$)</td>
<td>PM$_{2.5}$ (µg/m$^3$)</td>
<td>PM$_{2.5}$ (µg/m$^3$)</td>
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<td>58.88</td>
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<td>22.08</td>
<td>7.04</td>
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<td>64.00</td>
<td>59.52</td>
<td>58.88</td>
<td>24.32</td>
</tr>
</tbody>
</table>

Ambient background readings during the first part of the week were relatively high. These readings were consistent with what the provincial Ministry of the Environment reported for those days. Ambient readings on Wednesday and Friday were in the “moderate” air quality range; indoor readings those days were better than outside.

During some of the afternoons in this senior high rise there is evidence of SHS drift in the hallways. During the sampling period at this property there is no evidence of SHS in the lobby. In this building the lobby was separated physically from living areas and there was no smoking taking place near the entrance/exit adjacent to the lobby.

SHS drift was evident in some of the overnight samples. Figure 5 below graphs the indoor levels of PM$_{2.5}$ (µg/m$^3$) plotted over time on the Monday evening. The outside PM$_{2.5}$ concentrations are also plotted in Figure 5, based on the Ontario Ministry of Environment reported readings of PM$_{2.5}$ (µg/m$^3$) for the ambient air quality monitoring station in Kitchener. xxvii
The air quality monitoring device was placed in the hallway after the afternoon sample was collected. In the early afternoon, indoor and outdoor levels were very similar in the hallway of the Seniors High-rise unit. SHS began to drift into the hallway at approximately 4:00 p.m. and remained elevated at 8:00 p.m.. The average (arithmetic mean) concentration of PM$_{2.5}$ between 4:00 p.m. and 8:00 p.m. was approximately 65 µg/m$^3$. During this time the outdoor concentration of outdoor PM$_{2.5}$ was 10 µg/m$^3$ or less.
In Location C the average afternoon concentrations of PM$_{2.5}$ were higher than ambient or outdoor concentrations in both the lobby and hallway environment. Figure 6 below graphs the indoor levels of PM$_{2.5}$ (µg/m$^3$) plotted over time on the Monday evening. The outside levels plotted are based on the Ontario Ministry of Environment reported readings of PM$_{2.5}$ (µg/m$^3$) for Kitchener.
Figure 6. Afternoon-Evening Hallway measurements in Senior High Rise, Weekday March 2010

In Figure 6 we can see that levels are elevated at the start of the afternoon-evening collection period and climb until about 10:30 p.m., they dip and then climb again towards 1:00 a.m.. The average PM$_{2.5}$ concentration between 6:00 p.m. and midnight was approximately 36 µg /m$^3$; during this period outdoor concentrations were less than 10 µg /m$^3$.

Levels drop to almost background levels until approximately 6:00 a.m. and then rise again to several times background levels.
Table 8. Location D – Adult Low Rise A – Weekly Afternoon Concentrations of PM$_{2.5}$

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In Location D the average afternoon concentrations of PM$_{2.5}$ were higher than ambient or outdoor concentrations in both the common room and hallway environments. Recorded concentrations are very similar thoughout the week with little difference between week day and weekend concentrations. Figure 7 graphs the indoor levels of PM$_{2.5}$ (µg /m$^3$) plotted over time on the Monday evening. The outside levels plotted are based on the Ontario Ministry of Environment reported readings of PM$_{2.5}$ (µg /m$^3$) for Kitchener.
Figure 7. Afternoon-Evening Hallway measurements in Adult Low Rise (A), Weekday March 2010

In Figure 7 we can see that indoor concentrations of PM$_{2.5}$ were much higher than ambient background levels. Between 7:00 p.m. and 1:00 a.m. the average concentration of PM$_{2.5}$ was approximately 56 µg /m$^3$; during this period outdoor concentrations were less than 10 µg /m$^3$. 
Table 9. Location E – Adult Low Rise B – Weekly Afternoon Concentrations of PM$_{2.5}$

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</table>

In Location E the average afternoon concentrations of PM$_{2.5}$ were similar to ambient readings in both the common room and hallway. There is evidence of SHS intrusion into the hallway during the overnight monitoring. Figure 8 below graphs the indoor levels of PM$_{2.5}$ (µg/m$^3$) plotted over time on the Monday afternoon-evening sample. The outside levels plotted are based on the Ontario Ministry of Environment reported readings of PM$_{2.5}$ (µg/m$^3$) for Kitchener.
Figure 8. Afternoon-Evening Hallway measurements in Adult Low Rise (B), Weekday March 2010

In Figure 8 we can see that at several times during the collection period, indoor concentrations of PM$_{2.5}$ were much higher than ambient background levels; at several points in the early morning levels peaked above 40 μg /m$^3$. 
In Location F the average afternoon concentrations of PM$_{2.5}$ were similar to ambient readings in both the common room and hallway, although on some days the average readings were elevated. There is evidence of SHS intrusion into the hallway during the overnight monitoring. Figure 9 below graphs the indoor levels of PM$_{2.5}$ ($\mu$g/m$^3$) plotted over time on the weeknight (Monday) afternoon-evening sample. The outside levels plotted are based on the Ontario Ministry of Environment reported readings of PM$_{2.5}$ ($\mu$g/m$^3$) for Kitchener.
In Figure 9 we can see that at several times during the collection period indoor concentrations of PM$_{2.5}$ were much higher than ambient background levels, at several points in the early morning levels peaked above 100 µg /m$^3$. These peaks took place in the afternoon and early evening. After midnight until 8:00 a.m. the indoor concentrations of PM$_{2.5}$ were similar to the reported ambient (outdoor) readings.
STATISTICAL TESTS

Statistical tests were conducted to determine if the geometric mean PM$_{2.5}$ concentrations recorded inside were significantly different from the PM$_{2.5}$ concentrations recorded outside. A paired-sample t-test was conducted with the daily afternoon geometric means of PM$_{2.5}$ concentrations in the 5 adult/senior hallways, and outdoor ambient readings. A second paired sample t-test was conducted with the daily afternoon geometric means of PM2.5 concentrations in the 5 adult/senior common rooms or lobbies, paired with outdoor ambient readings. Finally, lobby/common room PM$_{2.5}$ geometric mean concentrations were compared to hallway concentrations.

FINDINGS

The paired-sample two-tailed t-test showed that:

PM$_{2.5}$ average concentrations in the lobby or common rooms were statistically higher than the PM$_{2.5}$ readings outside (mean =12.68 $\mu$g /m$^3$, SD = 20.17, t(35) =3.47 (p=.001).

PM$_{2.5}$ average concentrations in the hallways were statistically higher than the PM$_{2.5}$ readings outside (mean =18.78 $\mu$g /m$^3$, SD = 11.82, t(35) =3.82 (p=.001).

PM$_{2.5}$ average concentrations in the hallways were statistically higher than the PM$_{2.5}$ readings in the lobby or common room (mean =18.78 $\mu$g /m$^3$, SD = 11.82, t(35) =3.82 (p=.001).

OBSERVATIONS FROM THE RESEARCH TEAM

There was no visible evidence that anyone had smoked in any of the common spaces.

The ambient air quality readings from the Ministry of Environment website were consistent with what this research team measured in the field.
DISCUSSION
In general, concentrations of PM$_{2.5}$ recorded in some of the housing units’ common spaces were high; the levels recorded in the family unit, for example, are much higher than have been published in other similar studies (such as King et al. 2010).

Although some properties had average readings that were similar to background levels, there were times during the sampling where SHS was drifting into common spaces.

This study is not designed to measure health hazard or attempt to calculate relative risks, however this study does reveal that it is likely that residents living in multi-unit dwellings where people smoke inside could be exposed to SHS in common spaces. There is no safe level of SHS.

It is possible that the new smoke-free policy will influence where people smoke, in their units or outside. Further these policies may help shift practices to make it more likely that people will not break other rules (like smoking in stairwells).

NEXT STEPS

Air quality data will continue to be monitored in common spaces in the Waterloo Region Housing and Region of Waterloo Community Housing Inc. portfolios in 2011 and 2012. With this longitudinal data it will be possible to understand trends in smoking behaviour. The results of subsequent air quality studies will also be presented to Regional Council in similar reports.
End Notes and References


xxii TSI SidePak product specifics sheet can be viewed here: http://www.tsi.com/en-1033/products/2112/sidepak%E2%84%A2_am510_personal_aerosol_monitor.aspx


End Notes and References


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TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: March 8, 2011

FILE CODE: P04-80

SUBJECT: FLUORIDE VARNISH PROGRAM IN SELECTED ELEMENTARY SCHOOLS AND ENHANCED SURVEILLANCE

RECOMMENDATION:

For information only.

SUMMARY:

This report describes activities under development, pending budget approval, which were devised to address dental decay in selected high risk schools across the Region. This follows the decision to discontinue the addition of fluoride to the water supply of the City of Waterloo and takes a Regional perspective on oral health. These include a Fluoride Varnish Program for four selected elementary schools across Waterloo region; and a related evaluation process and enhanced surveillance. This program will not replace community water fluoridation which is a universal public health measure, but rather will provide a targeted intervention to a smaller number of children at higher risk.

Fluoride varnish is recognized by dental health organizations as an effective and safe intervention for reducing the risk of dental decay. It is applied directly to tooth surfaces by Dental Health staff using a small brush with a disposable tip. The procedure is well tolerated by young children. Since February 2010 Public Health has been conducting a pilot project at a public elementary school in Kitchener. The goals of a Fluoride Varnish Program are to improve the oral health of high-risk children in Waterloo region and to reduce the need for invasive and costly emergency dental health services for children and youth. If the budget request is approved, the program will be implemented beginning in October 2011 in a targeted number of high risk schools.

Public Health has been in contact with the Ontario Agency of Health Protection and Promotion (OAHPP) regarding participation in the enhanced surveillance program which will include the monitoring of the long-term effect of the removal of added water fluoride and adding the targeted fluoride varnish program on the decay rates in the targeted schools.

REPORT:

Fluoride Varnish Program in Selected Elementary Schools

Background

Although the prevalence of dental decay has declined significantly since the 1950s, dental decay is still common among high-risk groups, including low-income families and minority groups. Surveys of children from Waterloo Region have found that 22-37% of 5-year-olds and 48-49% of 7-year-olds have experienced dental decay (Source: Public Health Perspectives, April 2007). The increased use of financial assistance programs, such as Children in Need of Treatment (CINOT), also reflects the continued prevalence of dental decay among high-risk children and the difficulty in affording dental care.
Dental decay is a disease that is preventable with appropriate daily oral hygiene, nutrition and regular preventive care. For many years, professionally applied topical fluorides have been used to reduce the risk of dental decay in private practices and public health settings, especially among children. Fluoride varnish is a type of professionally applied topical fluorides that has the advantage of adhering to tooth surfaces for several hours. This prolongs the contact time between fluoride and enamel and improves the uptake of fluoride into enamel. Fluoride acts to protect tooth surfaces from decay by making the tooth stronger or more resistant to acid attacks in the mouth.

The preventive effect of fluoride varnish has been confirmed in a number of clinical trials. Systematic reviews show about a 38% reduction in tooth decay for treated groups compared to control groups when used among high-risk children over at least two years. Evidence indicates that fluoride varnish is as effective as other forms of professionally applied topical fluorides, for example gels and foams. This intervention has been reviewed in 2002 by the Cochrane Library, which provides independent assessments of randomized studies for different interventions: “Fluoride varnishes applied professionally two to four times a year would substantially reduce tooth decay in children”. No common or serious side effects have been reported in the scientific literature. This procedure is well tolerated by children and youth, including young children. As a precaution, it is contraindicated in children with asthma due to possible allergic reactions; and in children who are allergic to postage stamp glue, which is similar to a component of fluoride varnish.

Fluoride varnish is brushed on children’s teeth by Dental Health staff using a small brush with a disposable tip. The treatment takes no more than 1-5 minutes per child depending on the number of teeth in the mouth and the child’s level of cooperation. Applications are repeated at approximately 3-4 month intervals.

Fluoride varnish programs in school settings are not part of the Ontario Public Health Standards and would need to be covered 100% by the Region.

**Fluoride Varnish Pilot Project**

Since February 2010 Public Health has been conducting a pilot project at a public elementary school in Kitchener. This school was selected based on comparisons of results from the oral health screenings that are conducted each year in elementary schools as part of the Ontario Public Health Standards. This Kitchener public school was found to have a higher proportion of students with two or more decayed teeth as compared to other schools in Waterloo region.

For the pilot project, the 2009-10 Junior and Senior Kindergarten student cohort was selected to receive three applications of fluoride varnish per school year for at least three years. To increase uptake of the program, Public Health staff and interpreters from YMCA Cross Cultural services provided an information session to answer questions, promote the program, and to assist parents with completing medical histories and consent forms.

Findings from this project have been positive with 23 students having participated thus far. The project has been well –supported by the Waterloo Region District School Board, school staff, teachers and principal. Participation is on a voluntary basis and is not intended to replace regular dental care. If children are already receiving fluoride treatments at a dental office there is no risk to receiving fluoride varnish through this program and there may be additional benefits to their oral health.

The cost of supplies and resources to provide three applications per year for 30 children is approximately $1,120.

**Fluoride Varnish Program Implementation**

Public Health will use a similar program delivery model for the expansion of fluoride varnish.
applications to all grades at the Kitchener Public School and all grades at three additional schools (one school in City of Waterloo, Cambridge, and Rural Planning Area). Schools will be selected from oral health screening results that indicate a high-risk status for dental decay.

A request for an annualized budget of $65,000 has been submitted for the expanded program. The amount of $65,000 is an approximate of the former annual operating costs for fluoridation of the City of Waterloo water supply and provides sufficient funds to reach four of the schools in the Region at highest risk of dental decay. Based on the cost figures for the pilot project, it is estimated that about 50 classes (30 students per class) could participate; or about 1,500 children. This should allow the program to expand to a moderate-to-large size school in each the four regional planning areas (Kitchener, City of Waterloo, Cambridge, and Rural). The application of fluoride varnish is not a controlled act and can be applied by any trained staff member. Dental hygienists, assistants and educators will all be part of the team involved in this program. If the budget request is approved, the program will be implemented beginning in October 2011.

Enhanced surveillance related to the fluoride varnish programs will be implemented to determine the impact of the program on dental decay in the targeted schools. Public Health has been in contact with the Ontario Agency of Health Protection and Promotion (OAHPP) to determine interest in the creation and implementation of the evaluation and enhanced surveillance program. The enhanced surveillance program will include the monitoring of the long-term effect of the removal of added water fluoride in the City of Waterloo and adding the targeted fluoride varnish program on the decay rates in the targeted schools across the Region.

**Conclusion**
The goals of Public Health dental programs are to improve the oral health of children in Waterloo Region and to reduce the need for invasive and costly emergency dental health services for children and youth. Given the discontinuation of water fluoridation, the Dental Health program seeks to apply operational funding to a Fluoride Varnish Program and in addition, a one-time budget allocation would be applied to conduct an enhanced evaluation and surveillance of the impact of the secondary prevention strategy. This program will not replace community water fluoridation which is a universal public health measure, but rather will provide a targeted intervention to a smaller number of children at higher risk. The community water fluoridation was only available in the City of Waterloo and a few other communities, and has now been discontinued. The fluoride varnish program is a Regional program for targeted schools.

**CORPORATE STRATEGIC PLAN:**
Focus Area 3 - Healthy and Safe Communities; and Focus Area 6 - Service Excellence.

**FINANCIAL IMPLICATIONS:**
Funding for the expansion of the Fluoride Varnish Program would be 100% regionally funded and is pending budget approval. An annual budget of $65,000 would be allocated for operating costs.

Funding for enhanced surveillance and an evaluation of the fluoride varnish program will be provided by a one-time 100% regional funding allocation of $25,000.

**OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:**
NIL
ATTACHMENTS

NIL

PREPARED BY:  Dr. Robert Hawkins, Dental Consultant

APPROVED BY:  Dr. Liana Nolan, Commissioner/Medical Officer of Health
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: March 8, 2011

FILE CODE: A09-01

SUBJECT: ONTARIO PUBLIC HEALTH ORGANIZATIONAL STANDARDS

RECOMMENDATION:

For information.

SUMMARY:

The Ontario Public Health Organizational Standards (Organizational Standards) were released by the Ministry of Health and Long-Term Care and the Ministry of Health Promotion and Sport on February 18, 2011. The Organizational Standards set expectations for local boards of health at both the governance and administrative levels. The standards apply to all boards of health, regardless of governance model and are a key component of the government’s performance management framework for public health. The Organizational Standards will become effective in 2011 as part of the upcoming accountability agreements which will incorporate performance management indicators and continuous quality improvement tools.

Because it will take some time for boards of health to assess their readiness and plan for full implementation of the standards, 2011 will be treated as a transitional year. The ministries intend to begin monitoring the implementation of the Organizational Standards by boards of health in 2012. Accountability agreements will incorporate performance management indicators and continuous quality improvement tools.

The Organizational Standards will assist boards of health to operate according to principles grouped into the following six categories:

1. Board Structure
2. Board Operations
3. Leadership
4. Trusteeship
5. Community Engagement and Responsiveness
6. Management Operations (financial, information management, communications, human resources, program management)

REPORT:

The Organizational Standards are complementary to the Ontario Public Health Standards which guide boards of health in assessment, planning, delivery, management and evaluation of public health programs and services. The Organizational Standards outline the requirements for Boards of Health and the management practices of each public health unit. The rationale for organizational standards is to support organizational accountability and capacity; the framework is based on a continuous quality improvement model with a goal of improved performance and measurable outcomes. The Organizational Standards contain expectations of both the Board of Health as the governing body and the public health unit as the administrative arm of the organization.
Region of Waterloo Public Health is already doing many of the things required by the new Standards. In some cases it will be a matter of documenting compliance. In other cases, there may be a need to devise new business processes in order to meet the standards.

The principles that guide boards of health outlined in the Ontario Public Health Standards include Capacity and Partnerships & Collaboration; these particular principles are relevant to governance and management. The Organizational Standards will assist boards of health to operate according to these principles and are grouped into the following six categories:

1. Board Structure
2. Board Operations
3. Leadership
4. Trusteeship
5. Community Engagement and Responsiveness
6. Management Operations (financial, information management, communications, human resources, program management)

Next Steps:
Public Health has planned to implement the Organizational Standards project starting this year. Operationally, discreet working groups, by topic area and pertaining to various Corporate Departments, will be coordinated by Public Health. Because the implementation of the Organizational Standards has corporate implications, a Multi Departmental Initiatives proposal has been prepared. Council will be engaged at a later date, once the Standards have been thoroughly reviewed, to approve the implementation plans that specifically affect Council (as the Board of Health), and to provide overall approval to the general implementation plan.

CORPORATE STRATEGIC PLAN:
Public Health addresses a number of Strategic Focus Areas including:
- Environmental Sustainability: Protect and enhance the environment
- Healthy and Safe Communities: Support safe and caring communities that enhance all aspects of health
- Human Services: Promote quality of life and create opportunities for residents to develop to their full potential
- Service Excellence: Foster a culture of citizen/customer service that is responsive to community needs

FINANCIAL IMPLICATIONS:
A one-time budget request for additional resources in 2011 and 2012 is currently included in the 2011 budget process to provide support for the implementation of these Standards.

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:
The Organizational Standards impact Departments beyond Public Health, including Finance, Human Resources, the CAO’s Office and Corporate Resources.

ATTACHMENTS
Appendix A Ontario Public Health Organizational Standards

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Part I: Introduction

Purpose

The Ontario Public Health Organizational Standards (Organizational Standards) establish the management and governance requirements for all boards of health and public health units. Similar to the Ontario Public Health Standards (OPHS) 2008 (or as current), which outline the expectations for providing public health programs and services, the Organizational Standards outline the expectations for the effective governance of boards of health and effective management of public health units. Organizational Standards help promote organizational excellence, establish the foundation for effective and efficient program and service delivery and contribute to a public health sector with a greater focus on performance, accountability and sustainability.

Scope and Accountability

This document specifies requirements that all boards of health are required to implement throughout their organizations. This document contains both new requirements for boards of health as well as requirements related to governance and management from existing sources. The existing obligations within the Health Protection and Promotion Act (HPPA) and its Regulations have been included here so as to provide a single compiled set of governance and management requirements that boards of health are obligated to meet as a board of health.

Outside of these obligations, boards of health have other duties and responsibilities, which relate to their role as employers, holders of personal and personal health information, corporate entities, service providers and so on. The legal obligations of boards of health in these areas are set out in other provincial and federal legislation and regulation. Boards of health may also be subject to local municipal by-laws. This document does not contain an exhaustive list of the legal obligations of boards of health, as these additional obligations are beyond the scope of this document. Boards of health need to be aware of and to meet these additional obligations.

Boards of health are accountable for implementing the requirements established in this document throughout their organizations. The scope of the Organizational Standards includes activities that will assist boards of health in developing strong governance and management practices, which in turn are a support to the planning and delivery of public health programs and services.

The Organizational Standards are complementary to the OPHS and support the Principles outlined in the OPHS that guide boards of health in assessment, planning, delivery, management, and evaluation of public health programs and services. While there may be variations in the internal lines of authority in different boards of health, the expectation is that all boards of health will implement and meet each of the Organizational Standards requirements. Because the Organizational Standards are complementary to the OPHS, there are no program specific requirements, nor have the sections of HPPA which relate to program delivery been repeated here.
The Organizational Standards apply to all boards of health, regardless of the type of board governance model. Any exceptions as required by the HPPA have been noted.

Currently, there are five types of board governance models operating in Ontario’s public health sector as follows:

- **Autonomous**: Separate from any municipal organization but with multi-municipal representation, including citizen representatives appointed by municipalities; potential for provincial appointees.
  - **Autonomous/Integrated (a subset of Autonomous)**: Only one municipality appoints representatives including citizen representatives; potential for provincial appointees; operates within municipal administrative structure.

- **Regional**: Boards are Councils of Regional Government (federations of local municipalities); no citizen representatives; no provincial appointees.

- **Single-Tier**: Boards are Councils of Single-Tier Municipalities (areas with only one level of municipal government); no citizen representatives; no provincial appointees.
  - **Semi-Autonomous (a subset of Single-Tier)**: Single-Tier Council appoints members to a separate “board of health” including citizen representatives; Council approves budget and staffing; no provincial appointees.

Although the language of the requirements may appear to apply primarily to autonomous boards, this is not the intention. Regardless of the governance model, the board of health as the governing body is legally accountable to the government of Ontario, and is the body that has the authority to enter into agreements with ministries.

The strategies that boards of health use to implement the necessary practices to meet the requirements will vary from board to board, in part due to differences in management structures. While in some boards of health, there is a Chief Executive Officer* (CEO) as well as a Medical Officer of Health (MOH), in others, the MOH plays both roles. Another variation is seen in regional boards, where the MOH relates to a Chief Administrative Officer (CAO) to coordinate services provided by the region, such as HR, procurement, and finances. In these requirements, the CEO and CAO roles have not explicitly been acknowledged but this does not preclude the delegation of administrative and management responsibilities to the CEO or CAO, as appropriate for each organization.

Note that for clarity, the requirements refer to these senior management positions as “the administration.” All of the requirements in Section 6: Management Operations reference the board of health as the governing body delegating management tasks to the administration, which is meant to clarify that the board itself is not expected to be involved in undertaking these tasks, but should be ensuring these activities take place through the management team.

In order to respect the board of health as the body that is accountable to the ministries while also respecting the delegation of authority for the day-to-day management and administrative tasks to the MOH (and CEO or

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* Within the body of the document, the term executive officer is meant to include all related titles such as CEO, CAO and COO (Chief Operating Officer).
other executive officers, where applicable), the requirements have been written to make these distinctions explicit. Where the board of health as the governing body is expected to fulfill a requirement directly, the requirement states: “The board of health shall....” In cases where the expectation is that the board would delegate the responsibilities to the management team, the language of the requirement shifts to “The board of health shall ensure that the administration....”.

**Background**

As stated in the OPHS, boards of health have the responsibility for the delivery of local public health programs and services. The effective delivery of required public health programs and services can be supported by a strong organizational structure which includes effective and efficient governance and management practices. The Organizational Standards are one component of a comprehensive public health performance management system currently being developed for the province of Ontario. By addressing structural aspects such as human resources management, administrative policies, board of health functioning, and financial management, it is intended that the Organizational Standards will help establish consistent organizational processes in all boards of health across the province that will in turn facilitate desired program outcomes.

Although there is limited research and evidence available related to the development of organizational standards within the public health sector, the development of the Organizational Standards was based on a consolidation of the relevant themes and ideas from available peer-reviewed and grey literature, resources and organizations.

**How Can the Organizational Standards Help Public Health Units?**

Research indicates that improvements in processes and structures used to make important decisions will lead to improved results. As such, an essential component of performance management, from which targets and goals can be developed, is the establishment of performance standards. As part of a comprehensive public health performance management system, the Organizational Standards can help boards of health achieve their objectives and improve operations by clearly communicating expectations of boards of health and public health units.

The Organizational Standards can help boards of health make managerial decisions to improve the quality and effectiveness of programs and services, prioritize and allocate resources, inform managers about needed changes in operations to improve efficiency, and identify required changes in policy or program directions to meet goals and objectives. The Organizational Standards can be used as a tool for planning and operational assessment by helping boards of health stay on course toward improving outcomes, identifying gaps in training, leadership, and resources, and encouraging collaboration to reach goals.

The Principles that guide boards of health outlined in the OPHS include Capacity and Partnership and Collaboration. The Principle of Capacity includes the areas of organizational structures and processes; workforce planning, development, and maintenance; information and knowledge systems; and financial resources. The Principle of Partnership and Collaboration refers to fostering partnerships and collaborating
with community partners, and creating supportive environments for health through community and citizen engagement. The Organizational Standards will assist boards of health to operate according to the Principles outlined in the OPHS that are relevant to governance and management.

Framework of the Organizational Standards

The Ontario Public Health Organizational Standards document outlines the requirements for boards of health and the management practices of each public health unit.

The Organizational Standards requirements are grouped into the following categories:

- Board Structure
- Board Operations
- Leadership
- Trusteeship
- Community Engagement and Responsiveness
- Management Operations

Within each category, there are varying numbers of requirements. These are either new requirements, which are based on best practice advice from the literature on governance and administration or have been transferred from the HPPA and its regulations. These have been consolidated within this document to assist boards of health to have a complete understanding of the requirements they are obligated to meet in the areas of governance, management and administration. Each requirement identifies whether it is a new requirement or originates from the HPPA or its regulations.

To ensure consistency, the obligations under the HPPA or its regulations are written exactly as they appear in the original source documents, along with the specific section numbers for ease of referencing back to the original source.

Organizational Standards Categories

Following is a description of the concepts that are addressed in the requirements within each category. The first five categories lay out the requirements that apply directly to boards of health governing bodies. The final category, Management Operations, relates to the responsibilities that will be carried out by the administration of each health unit, under the senior executives who report to the governing body.

1. Board Structure

Boards of health operate through a formal structure that supports governance through a set of expectations regarding membership, size, terms of office, reporting relationships, and other structural features.

2. Board Operations

In order to ensure good governance, board of health members must be aware of current and emerging best practices regarding board operations, which include the establishment of by-laws, as well as policies and
practices related to the conduct of meetings. Board of health members must also have an understanding of their duties and responsibilities as individuals and as a group, and must have an understanding of evaluation to improve their effectiveness as a board.

3. Leadership

Leadership functions at the board of health level require that the board of health assess and take action to improve its governance processes to accomplish its objectives of strategic direction setting, promotion of appropriate ethics and values within the organization, effective organizational performance management and accountability, and effective coordination of board of health activities at all levels of the organization.

While the board of health has responsibility for strategic direction setting, the management team has a related responsibility in operational planning to support the board of health’s strategic priorities and objectives. A strong strategic plan will recognize internal and external forces for and against change, incorporate strategies to overcome resistance to change and address gaps, and include a commitment to action steps to adapt to changes.

4. Trusteeship

In carrying out their functions, board of health members must fulfill fiduciary duties of care, loyalty, and good faith. While the board of health as the governing body typically delegates the day-to-day management of the public health unit to the MOH, CEO and other senior management, board members retain responsibility for oversight and monitoring of the organization’s operations and performance.

Carrying out fiduciary duties requires that board members exercise duty of care, which is the duty to exercise appropriate diligence and make decisions that are informed, and the duty of loyalty, which is the duty to put the interests of the organization before those of the individual.

As part of their duty of loyalty, board members also need to act in good faith, which involves acting with honesty of purpose and in accordance with evolving corporate governance best practices.

5. Community Engagement and Responsiveness

Public health units are expected to undertake their operational duties in a way that demonstrates an understanding of the local community’s context, openness to the community and its needs, and innovation to address emerging needs or gaps in services.

Because public health is rooted in community-based practice; partnerships with all types of organizations are a necessary part of the operational practice of a public health unit. The effectiveness of these partnerships will depend on the work involved in engaging local communities, collaborating with community partners, monitoring and evaluating these partnerships, and public health unit involvement in networking and local planning within the community.

This section contains requirements which refer to both community partners and stakeholders. To be clear, community partners include the agencies, organizations and groups which the board of health works directly with, or partners with or consults with in the design or delivery of programs and services. In the OPHS, the list of community partners includes the voluntary sector, non-governmental organizations, local associations, community groups, networks, coalitions, academia, government bodies, the private sector
and others. Stakeholders is a broader category which includes all of the types of community partners noted above as well as clients, the general public, the media and staff. Anyone with an interest in public health could be considered a stakeholder.

6. Management Operations

A strong organization will have administrative practices that support transparency and accountability, and demonstrate organizational effectiveness and due diligence in exercising day-to-day responsibilities.

Strong organizations will also have an operational planning process that describes how the strategic directions, priorities and objectives of the organization will be achieved in concrete terms within a specified timeframe. The resulting operational plan may include several separate documents, such as an HR strategy, an IT strategy, financial projections, program planning framework, and an evaluation framework. Together, this information provides an overall picture of how the public health unit will use available resources to meet objectives.

The requirements within the Management Operations category relate to the administrative functions in terms of:

- Financial management;
- Information management;
- Communication strategies;
- Human resources planning and management; and
- Program management.
Part II: The Ontario Public Health Organizational Requirements

1. Board Structure

Goal/Objective
To ensure that the structure of the board of health facilitates effective governance and respects the required partnership with municipalities as well as the need for local flexibility in board structure.

Requirements

1.1 Definition of a board of health
There shall be a board of health for each public health unit. (HPPA, s.48) A board of health is composed of the members appointed to the board under this Act and the regulations. (HPPA, s.49 (1)) The term of office of a municipal member of a board of health continues during the pleasure of the council that appointed the municipal member but, unless ended sooner, ends with the ending of the term of office of the council. (HPPA, s.49(7)) (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

1.2 Number of members on a board of health
There shall be not fewer than three and not more than thirteen municipal members of each board of health. (HPPA, s.49(2)) (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

1.3 Right to make provincial appointments
The Lieutenant Governor in Council may appoint one or more persons as members of a board of health, but the number of members so appointed shall be less than the number of municipal members of the board of health. (HPPA, s.49(3)) (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

A member of a board of health appointed by the Lieutenant Governor in Council may be appointed for a term of one, two or three years, (HPPA, s.51(1))

1.4 Board of health may provide public health services on reserve
A board of health for a public health unit and the council of the band on a reserve within the public health unit may enter into an agreement in writing under which (a) the board agrees to provide health programs and services to the members of the band; and (b) the council of the band agrees to accept the responsibilities of the council of a municipality within the public health unit. An appointment under this section may be for one, two or three years. (HPPA, s.50 (1) and (4))
The council of the band that has entered into the agreement has the right to appoint a member of the band to be one of the members of the board of health for the public health unit.

The councils of the bands of two or more bands that have entered into agreements under HPPA, s.50(1) have the right to jointly appoint a person to be one of the members of the board of health for the public health unit instead of each appointing a member under HPPA, s.50(2). (HPPA, s. 50(2) and (3))

1.5 Employees may not be board of health members
No person whose services are employed by a board of health is qualified to be a member of the board of health. (HPPA, s.51(3))

1.6 Corporations without share capital
Every board of health is a corporation without share capital (i.e., Corporations Act and Corporations Information Act do not apply). (HPPA, s.52(1) and (2)) (Does not apply to all municipalities – see HPPA s.55 for exceptions)

1.7 Election of the board of health chair
At the first meeting of a board of health in each year, the members of the board shall elect one of the members to be chair and one to be vice-chair of the board for the year. (HPPA, s.57(2)) (Does not apply to all municipalities – see HPPA s.55 for exceptions)

1.8 Municipal membership
The number of municipal members per municipality for specific boards of health is set out. (HPPA, Reg.559)
2. Board Operations

Goal/Objective
To enable boards of health to operate in a manner that promotes an effective board, effective communication and transparency.

Requirements

2.1 Remuneration of board of health members
A board of health shall pay remuneration to each member of the board of health on a daily basis and all members shall be paid at the same rate. A board of health shall pay the reasonable and actual expenses of each member of the board of health. The rate of the remuneration paid by a board of health to a member of the board of health shall not exceed the highest rate of remuneration of a member of a standing committee of a municipality within the public health unit served by the board of health, but where no remuneration is paid to members of such standing committees the rate shall not exceed the rate fixed by the Minister and the Minister has power to fix the rate. (HPPA, s.49(4), (5), and (6)) (Does not apply to all municipalities – see HPPA s.49(9) and (10) for exceptions)

HPPA, s.49(4) and (5) do not authorize payment of remuneration or expenses to a member of a board of health, other than the chair, who is a member of the council of a municipality and is paid annual remuneration or expenses, as the case requires, by the municipality. (HPPA, s.49(11))

2.2 Informing municipalities of financial obligations
A board of health shall give annually to each obligated municipality in the public health unit served by the board of health a written notice that complies with the following requirements:

- The notice shall specify the amount that the board of health estimates will be required to defray the expenses referred to in HPPA, s.72(1) for the year specified in the notice.
- If the obligated municipalities in the public health unit have entered into an agreement under HPPA, s.72(3) respecting the proportion of the expenses referred to in HPPA, s.72(1) to be paid by each of them, the notice shall specify the amount for which the obligated municipality is responsible in accordance with the agreement.
- If the obligated municipalities in the public health unit have not entered into an agreement under HPPA, s.72(3) respecting the proportion of the expenses referred to in HPPA, s.72(1) to be paid by each of them, the notice shall specify the amount for which the obligated municipality is responsible in accordance with the regulations.
- The notice shall specify the times at which the board of health requires payments to be made by the obligated municipality and the amount of each payment required to be made. (HPPA, s.72(5))
2.3 Quorum
A majority of the members of a board of health constitutes a quorum of the board. (exceptions apply) (HPPA, s.54)

2.4 Content of by-laws
A board of health shall pass by-laws respecting, (a) the management of its property; (b) banking and finance; (c) the calling of and proceedings at meetings; and (d) the appointment of an auditor.

A board of health may pass by-laws respecting, (a) the appointment, duties and removal of officers (other than the medical officer of health or an associate medical officer of health) and employees, and the remuneration, pensions and other benefits of officers and employees; and (b) any other matter necessary or advisable for the management of the affairs of the board of health. (HPPA, s.56(1) and (2))

2.5 Minutes, by-laws and policies and procedures
A board of health shall keep or cause to be kept minutes of its proceedings and the text of the by-laws and resolutions passed by it. (HPPA, s.58)

2.6 Appointment of a full-time medical officer of health
Every board of health (a) shall appoint a full-time medical officer of health; and (b) may appoint one or more associate medical officers of health, of the board of health. If the position of medical officer of health of a board of health becomes vacant, the board of health and the Minister, acting in concert, shall work expeditiously towards filling the position with a full-time medical officer of health. (HPPA, s.62(1) and (2))

2.7 Appointment of an acting medical officer of health
Where (a) the office of medical officer of health of a board of health is vacant or the medical officer of health is absent or unable to act; and (b) there is no associate medical officer of health of the board or the associate medical officer of health of the board is also absent or unable to act, the board of health shall appoint forthwith a physician as acting medical officer of health. (HPPA, s.69(1))

2.8 Dismissal of a medical officer of health
A decision by a board of health to dismiss a medical officer of health or an associate medical officer of health from office is not effective unless, (a) the decision is carried by the vote of two-thirds of the members of the board; and (b) the Minister consents in writing to the dismissal. A board of health shall not vote on the dismissal of a medical officer of health unless the board has given to the medical officer of health (a) reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered; (b) a written statement of the reason for the proposal to dismiss the medical officer of health; and (c) an opportunity to attend and to make representations to the board at the meeting. (HPPA, s.66(1) and (2))
2.9 Reporting relationship of the medical officer of health to the board of health

The medical officer of health of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other Act. The medical officer of health of a board of health is responsible to the board for the management of the public health programs and services under this or any other Act. (HPPA, s.67(1) and (3))

The medical officer of health of a board of health is entitled to notice of and to attend each meeting of the board and every committee of the board, but the board may require the medical officer of health to withdraw from any part of a meeting at which the board or a committee of the board intends to consider a matter related to the remuneration or the performance of the duties of the medical officer of health. (HPPA, s.70)

2.10 Board of health policies

The board of health shall develop and implement policies or by-laws as applicable regarding the functioning of the governing body, including:

- Use of sub-committees, which includes a process for establishing sub-committees and the requirement for the development of Terms of Reference (if sub-committees are used);
- Frequency of meetings;
- Rules of order for meeting procedures, including recognizing delegations to meetings and conditions for special meetings of the board;
- Preparation of meeting agenda and materials;
- Preparation of minutes and other record-keeping;
- Selection of officers (i.e., executive committee members);
- Selection of board members based on skills, knowledge, competencies and representativeness of the community, where boards of health are able to recommend the recruitment of members to the appointing body;
- Remuneration and allowable expenses for board members;
- Procurement of external advisors to the board, such as lawyers and auditors (if applicable);
- Conflict of interest;
- Confidentiality;
- MOH and executive officers (where applicable) selection process, remuneration, and performance review; and
- Delegation of the MOH duties during short absences such as during a vacation.

In addition, the board of health shall ensure that board of health by-laws, and policies and procedures are reviewed and revised as necessary, and at least every two years.
3. Leadership

Goal/Objective
To ensure the board of health members develop a shared vision for the organization, use a proactive, problem solving approach to establishing the organization’s strategic directions, and take responsibility for governing the organization to achieve their desired vision.

Requirements

3.1 Board of health stewardship responsibilities
The board of health shall provide governance direction to the administration and ensure that the board remains informed about the activities of the organization on the following:

- The delivery of the OPHS and its Protocols;
- Organizational effectiveness through evaluation of the organization and strategic planning;
- Stakeholder relations and partnership building;
- Research and evaluations, including ethical review;
- Compliance with all applicable legislation and regulations;
- Workforce issues, including recruitment of the MOH and any other senior executives (i.e., CEO where applicable);
- Financial management, including procurement policies and practices; and
- Risk management.

3.2 Strategic plan
The board of health shall have a strategic plan and shall ensure that it:

- Expresses the philosophy/mission, a values statement, and the goals and objectives of the board of health;
- Describes how equity issues will be addressed in the delivery and outcomes of programs and services;
- Describes how the outcomes of the Foundational Standard in the 2008 OPHS (or as current), will be achieved;
- Establishes policy direction regarding a performance management and quality improvement system;
- Considers organizational capacity;
- Establishes strategic priorities for the organization that address local contexts and integrate local community priorities;
- Covers a 3 to 5 year timeframe;
- Includes the advice and input of staff, and community partners; and
- Is reviewed at least every other year and revised as appropriate.
4. Trusteeship

Goal/Objective
To ensure that board of health members have an understanding of their fiduciary roles and responsibilities, that their operations are based on the principles of transparency and accountability, and that board of health decisions reflect the best interests of the public’s health.

Requirements

4.1 Transparency and accountability
The board of health shall operate in a transparent and accountable manner by ensuring that staff and community partners have access to information about board decisions and processes in a timely manner.

The board of health shall develop and implement policies and practices regarding:

- Criteria for holding closed board or committee meetings;
- Public access to key organizational documents including the strategic plan, by-laws, policies and procedures, and minutes of board meetings.

4.2 Board of health member orientation and training
The board of health shall ensure that board of health members are aware of their roles and responsibilities and emerging public health issues and trends by ensuring the development and annual implementation of a comprehensive orientation plan for new board members and a continuing education program for continuing board members.

Orientation and continuing education activities shall occur on an on-going basis and shall include information on the following topics:

- The structure, vision, mission goals and objectives of the public health unit;
- Overview of the strategic plan, the planning process, its relationship to the operational plan, and performance monitoring;
- Community demographics overview, including information on social and cultural diversity;
- Program and service overview, including organizational emergency preparedness planning;
- Provincial government structure and the funding streams of the three ministries;
- The duties and responsibilities of board members, including requirement to attend board meetings, advanced review of meeting materials, understanding of board of health policies and procedures, and understanding of public health issues;
- Board members’ fiduciary responsibilities in terms of trusteeship, due diligence, avoiding conflict of interest, maintaining confidentiality, strategic oversight, ethical and compliance oversight, stakeholder engagement, MOH (and executive officers, where applicable) compensation, risk management oversight and succession planning; and
- Opportunities for board members to participate in conferences or seminars that are sponsored or hosted by other organizations.
4.3 Board of health self-evaluation

The board of health shall have a self-evaluation process of its governance practices and outcomes that is implemented at least every other year and results in recommendations for improvements in board effectiveness and engagement. This may be supplemented by evaluation by key partners and/or stakeholders.

The self-evaluation process shall include consideration of whether:

- Decision-making is based on access to appropriate information with sufficient time for deliberations;
- Compliance with all federal and provincial regulatory requirements is achieved;
- Any material notice of wrongdoing or irregularities is responded to in a timely manner;
- Reporting systems provide the board with information that is timely and complete;
- Members remain abreast of major developments in governance and public health best practices, including emerging practices among peers; and
- The board as a governing body is achieving its strategic outcomes.
5. Community Engagement and Responsiveness

Goal/Objective
To ensure that the board of health is responsive to the needs of the local communities and shows respect for the diversity of perspectives of its communities in the way it directs the administration of the health unit in planning, operating, evaluating and adapting its programs and services.

Requirements

5.1 Community engagement
The board of health shall ensure that the administration develops and implements a community engagement strategy which includes:

- The provision of information to the public on the board of health’s mission, roles, processes, programs and activities to improve the health of its communities;
- The dissemination of results of population health assessments to its communities;
- Providing all information noted above in formats that are accessible to everyone in local communities, and are available through a variety of methods, including a website; and
- The recruitment and engagement of community partners and the public to participate in the development of the strategic and operational plans for the board of health, and in the evaluation of programs and services.

5.2 Stakeholder engagement
The board of health shall ensure that the administration develops and implements a stakeholder engagement strategy which includes:

- Establishing and participating in collaborative partnerships and coalitions which address public health issues with non-health sector partners such as community planning organizations, boards of education, social housing authorities, labour organizations, children and youth services and local chambers of commerce;
- Collaborative relationships with key health sector partners, including but not limited to the chief executive officer(s) of the local health integration network(s) (LHINs), hospital administrators, long-term care facility administrators, community health centre administrators and community care access centre administrators, to identify mechanisms for collaboration and coordination in planning and service delivery;
- Establishing relationships with schools of public health and/or other related academic programs to promote the development of qualified workers for public health; and
- Monitoring and evaluating these partnerships to determine their effectiveness and identify and address gaps.

5.3 Contribute to policy development
The board of health shall contribute to the development and/or modification of healthy public policy, as described in the Ontario Public Health Standards, 2008 (or as current), by facilitating community involvement and engaging in activities that inform the policy development process.
5.4 **Public reporting**  
The board of health shall produce an annual financial and performance report to the general public, with a description of the mission, roles, processes, programs and operation of the public health unit and performance indicators, to ensure transparency and accountability.

5.5 **Client service standards**  
The board of health shall ensure the administration develops and implements a set of client service standards which will articulate the organization's commitment to provide services that are accessible and timely for clients, community partners and the general public. Client service standards shall include:

- Set times for responsiveness to enquiries;
- Accessibility of programs and services in terms of locations, hours of service, and language; and
- Provision of public information in a manner that is timely and accessible, in multiple formats.
6. Management Operations

Goal/Objective
To ensure that the administration of the board of health uses a proactive, problem solving approach to establishing its operational directions, demonstrates its organizational priorities and objectives through its actions on program delivery, and functions in an efficient and effective manner.

Note that the requirements in this section require that the board delegate tasks to the senior staff of the health unit, described here as “the administration.” This is further defined in the introduction, within the Management Structures section.

Requirements

6.1 Operational plan
The board of health shall ensure that the administration establishes an operational plan for the organization which:

- Describes the composition, responsibilities and function of the public health unit;
- Documents the internal processes for managing day-to-day operations of programs and services to achieve the required board of health outcomes as per OPHIS;
- Demonstrates that the operational activities of the public health unit are aligned with the board of health’s goals, objectives and priorities, as described in the strategic plan;
- Includes objectives, activities, timeframes, responsibilities, intended results, monitoring processes, an organizational chart and internal reporting requirements;
- Contains planned activities based on an assessment of its communities’ needs;
- Demonstrates efforts to minimize barriers to access; and
- Describes the monitoring of key performance indicators to support continuous quality improvement and evidence-informed public health practice.

The development of the operational plan shall involve staff at all levels of the organization and include input from community partners and shall be reviewed and updated at least annually, or more often as required by local circumstances, with the date of the most recent revisions noted.

Achievement of the operational plan shall be monitored and reported in status reports on a quarterly basis to board members and staff.

6.2 Risk management
The board of health shall ensure that the administration monitors and responds to emerging issues and potential threats to the organization, from both internal and external sources, in a timely and effective manner. Risk management is expected to include but is not limited to: financial risks, HR succession and surge capacity planning, operational risks, and legal issues.

6.3 Medical officer of health provides direction to staff
The employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the medical officer of health of the board if their duties relate to the delivery of public health programs or services under this or any other Act. (HPPA, s.67(2))
6.4 Eligibility for appointment as a medical officer of health

No person is eligible for appointment as a medical officer of health or an associate medical officer of health unless (a) he or she is a physician; (b) he or she possesses the qualifications and requirements prescribed by the regulations for the position; and (c) the Minister approves the proposed appointment. (HPPA, s.64)

6.5 Educational requirements for public health professionals

The educational and experiential qualifications of boards of health staff are specified for the positions of business administrator, public health dentist, dental hygienist, public health inspector, public health nurse, and public health nutritionist. (HPPA, Reg.566)

6.6 Financial records

The board of health shall keep or cause to be kept (a) books, records and accounts of its financial affairs; (b) the invoices, receipts and other documents in its possession that relate to the financial affairs of the board.

The board of health shall cause to be prepared statements of its financial affairs in each year including but not limited to (a) an annual statement of income and expenses; (b) an annual statement of assets and liabilities; and (c) an annual estimate of expenses for the next year. (HPPA, s.59(1) and (2))

6.7 Financial policies and procedures

The board of health shall ensure that the administration implements appropriate financial management and oversight which ensures that the following are in place:

- A plan for the management of physical and financial resources;
- A process for internal financial controls, which is based on generally accepted accounting principles;
- A process to ensure that areas of variance are addressed and corrected;
- A procedure to ensure that the procurement policy is followed across all programs/services areas;
- A process to ensure the regular evaluation of the quality of service provided by contracted services, in accordance with contract standards;
- A process to inform the board of health regarding resource allocation plans and decisions, both financial and workforce related, that are required to address shifts in need and capacity; and
- A budget forecast for the current fiscal year that does not project a deficit.

6.8 Procurement

The board of health shall comply with Section 270(2) of the Municipal Act, 2001, which requires that the board of health ensures that the administration adopts policies with respect to its procurement of goods and services.

Such policies shall include:

- The types of procurement processes that shall be used;
- The goals to be achieved by using each type of procurement process;
- The circumstances under which each type of procurement process shall be used;
- The circumstances under which a tendering process is not required;
• The circumstances under which in-house bids will be encouraged as part of the tendering process;
• How the integrity of each procurement process will be maintained;
• How the interests of the board, the public and persons participating in the procurement process will be protected; and,
• How and when the procurement processes will be reviewed to evaluate their effectiveness.

The board of health is expected to implement procurement policies and practices that align with those of the relevant municipality as appropriate.

6.9 Capital funding plan

A board of health may acquire and hold real property for the purpose of carrying out the functions of the board and may sell, exchange, lease, mortgage or otherwise charge or dispose of real property owned by it. HPPA, s.52(3) does not apply unless the board of health has first obtained the consent of the councils of the majority of the municipalities within the public health unit served by the board of health. (HPPA, s.52(3) and (4))

The board of health that owns its own building(s) shall maintain a capital funding plan, which includes policies and procedures to ensure that funding for capital projects is appropriately managed and reported.

6.10 Service level agreements

Where a board of health functions as part of a municipal or regional government and is required to contribute financially to the corporate provision of services (e.g., IT, HR, financial management services), the board of health shall ensure that the administration negotiates a service level agreement with its local government which includes a description of the scope, volume and timeliness of services to be provided for a specific cost.

6.11 Communications strategy

The board of health shall ensure that the administration develops an overall communication strategy that is complementary to the program specific communication strategies required in the OPHS and its Protocols, and addresses both external and internal audiences. The communication strategy shall include:

• Guidelines for sharing information with community partners and staff;
• A plan to ensure consistency in messaging at all levels, to all audiences;
• Dissemination plans to disseminate relevant research findings for each approved research project proposal;
• Guidelines for use of relationships with media channels (e.g., print, radio, television, web) to share health information with general public and targeted populations or audiences;
• Plan for use of multiple modalities to ensure accessibility;
• Strategies for educating community partners and the public about key public health issues; and
• An internal communication strategy, including the posting of minutes of senior management team meetings, which informs staff of significant management decisions.
6.12 Information management

The board of health shall ensure that the Medical Officer of Health, as the designated health information custodian under the Personal Health Information Protection Act, maintains information systems that support the organization's mission and workforce by providing infrastructure for data collection/analysis, program management, administration and communications.

The board of health shall ensure that the Medical Officer of Health establishes, maintains and implements policies and procedures related to data collection and records management, which ensure:

• Compliance with all applicable legislation, regulations and policies, including the HPPA, Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), and Personal Health Information Protection Act (PHIPA) to the management of all personal information and personal health information in board of health records;
• Data quality in the creation and collection of data;
• Confidentiality in how records are used and accessed;
• Use of current and appropriate security features, including strong encryption of personal health information during transfers and when stored on mobile devices;
• A records maintenance process that includes remediation of errors;
• Appropriate records retention process that varies by type of record;
• Secure disposal of records; and
• That the purposes and appropriate uses of data being created are communicated to and respected by staff and management who collect, enter, store, analyze, use and/or destroy the data.

This requirement applies to all information that the board of health has in its control, including personal information and personal health information.

6.13 Research ethics

The board of health shall ensure that the administration establishes, maintains and implements policies and procedures related to research ethics that reflect accepted standards of practice.

6.14 Human resources strategy

The board of health shall ensure that the administration establishes a human resources strategy, based on a workforce assessment which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development and leadership development of the public health unit workforce.

The board of health shall ensure that the administration establishes and implements written human resource policies and procedures which are made available to staff, students, and volunteers. All policies and procedures shall be regularly reviewed and revised, and include the date of the last review/revision. Written policies and procedures shall be maintained concerning:

• Orientation of public health unit staff;
• The availability of job standards and position descriptions for staff;
• A process to ensure that staff meet qualifications for their positions, job classifications and licensure (as required);
• Contents of a personnel file and provisions for access; complete personnel files shall be maintained for each staff member, with appropriate policies and practices regarding the confidentiality of personnel information;
• Occupational health and safety policies;
• Recruitment and retention strategies, including workplace health practices;
• A code of conduct;
• Compensation policy;
• Reporting relationships;
• Discipline and labour relation policies;
• Staff performance evaluation processes; and
• Succession planning.

6.15 Staff development
The board of health shall ensure that the administration develops a workforce development plan which identifies the training needs of staff, including discipline specific and management training, and encourages opportunities for the development of core competencies and partnerships with academic institutions.

The board of health shall ensure that the administration provides formal and informal opportunities for leadership development, such as educational programs, membership in professional associations, coaching and mentoring, for staff at all organizational levels and with consideration to equity and fairness.

The board of health shall ensure that the administration fosters an interest in public health practice for future health professionals by supporting student placements.

6.16 Professional practice support
The board of health shall support a culture of excellence in professional practice for all regulated and unregulated health professions that ensures inter-professional collaboration and learning, and that staff are able to comply with professional regulatory body requirements where applicable. A range of models could be used, including the designation of professional practice leads.

Effective January 2013, boards of health are required to designate a Chief Nursing Officer (CNO) to be responsible for nursing quality assurance and nursing practice leadership.*

* Further work will be undertaken during 2011 with the Registered Nurses Association of Ontario (RNAO) and the Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario (ANDSOOHA) to define the role and requirements of the CNO position within a public health context. Implementation expectations and the associated resource implications will be identified and addressed as part of the development of the model.
Part III: References


TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: March 8, 2011

FILE CODE: L04-20

SUBJECT: MUTUAL AID AGREEMENT

RECOMMENDATION:

THAT the Regional Municipality of Waterloo:

(a) enter into a mutual aid agreement with other health units, as attached as Appendix “A”;
(b) provide the Medical Officer of Health and the Associate Medical Officer of Health with all necessary authority to carry out the terms and conditions of the mutual aid agreement; and
(c) enact A By-law to Appoint an Acting Medical Officer of Health, as attached as Appendix “B”, pursuant to Report PH-11-011, dated March 8, 2011.

SUMMARY:

The Region has worked with other health units in Southern Ontario to develop a mutual aid agreement in the event of a public health emergency where a health unit requests assistance in the form of public health staff and/or equipment from another health unit. The Region has also worked with other health units in Southern Ontario, as part of this process, to update its by-law to appoint an Acting Medical Officer of Health in the event that the Region’s Medical Officer of Health and Associate Medical Officer of Health are absent or unable to act.

REPORT:

1) Mutual Aid Between Public Health Units

The Region is the board of health for the Waterloo Health Unit pursuant to the Health Protection and Promotion Act.

From time to time, health units deal with public health emergencies where assistance is requested and granted from other health units in the form of public health staff and/or equipment. In a specific instance, aid was provided by Region of Waterloo to a health unit during the Walkerton outbreak when staff were sent to Grey Bruce Health Unit to assist.

In order to plan for future requests for assistance, the health units for Brant, Haldimand-Norfolk, Halton, Hamilton, Wellington-Dufferin-Guelph, Niagara and Waterloo worked together to develop a mutual aid agreement which is attached as Appendix “A” to this Report. This agreement is to cover important issues such as the process to make a request, liability and paying for the cost of providing assistance. Of importance is that the health unit in need will reimburse the other health unit for its costs to provide assistance. These costs include supplies, equipment, materials, fuel, repairs, parts, lodging, wages, salaries, overtime, shift premium, Canada Pension Plan, Employment Insurance, OMERS contributions, and/or contributions made to life insurance, health, dental and/or disability plans or policies.
2) Acting Medical Officer of Health

The *Health Protection and Promotion Act* allows a board of health to appoint a Medical Officer of Health and an Associate Medical Officer of Health. However, the *Health Protection and Promotion Act* also allows a board of health to appoint an Acting Medical Officer of Health if the Medical Officer of Health and Associate Medical Officer of Health for the health unit are absent or unable to act.

The Region currently has By-law 04-008 that appoints other Medical Officers of Health and Associate Medical Officers of Health as the Acting Medical Officer of Health for the Waterloo Health Unit in the event that the Region’s Medical Officer of Health and Associate Medical Officer of Health are absent or unable to act.

As part of the development of the mutual aid agreement, the participating health units agreed to update their by-laws for Acting Medical Officers of Health. The proposed by-law is attached as Appendix “B” to this Report.

**CORPORATE STRATEGIC PLAN:**

Nil

**FINANCIAL IMPLICATIONS:**

Nil

**OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:**

Corporate Resources Department, Legal Services Division

**ATTACHMENTS**

Appendix “A” – Mutual Aid Agreement
Appendix “B” – Draft By-law to Appoint an Acting Medical Officer of Health

**PREPARED BY:**  
*Dr. Liana Nolan, Commissioner/Medical Officer of Health*

**APPROVED BY:**  
*Dr. Liana Nolan, Commissioner/Medical Officer of Health*
APPENDIX “A”

THIS MUTUAL AID AGREEMENT made this __ day of __, 20__

BETWEEN:

THE REGIONAL MUNICIPALITY OF HALTON

-and-

CITY OF HAMILTON

-and-

THE REGIONAL MUNICIPALITY OF NIAGARA

-and-

THE REGIONAL MUNICIPALITY OF WATERLOO

-and-

BRANT COUNTY HEALTH UNIT

-and-

WELLINGTON-DUFFERIN-GUELPH HEALTH UNIT

-and-

HALDIMAND-NORFOLK HEALTH UNIT

WHEREAS the Parties wish to provide for mutual aid and assistance to each other through the provision of personnel, services, equipment or materials to one or the other in a time of an Emergency or for an Urgent Project or where a medical officer of health needs coverage;

AND WHEREAS each of the Parties is a “health unit” as defined in Ontario Regulation 553 to the Health Protection and Promotion Act, or a “board of health” as defined in Section 1 of the Health Protection and Promotion Act;

NOW THEREFORE in consideration of the mutual covenants herein contained, the Parties agree as follows:
1. Definitions

1.1 In this Agreement,

1.1.1 “Assisted Party” means the Party receiving aid or assistance pursuant to this Agreement;

1.1.2 “Assisting Party” means the Party providing aid or assistance pursuant to this Agreement;

1.1.3 “Emergency” means a situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise (as defined in the Emergency Management and Civil Protection Act);

1.1.4 “Medical Officer of Health” or “MOH” means the person appointed under s. 62(1)(a) of the Health Protection and Promotion Act, an associate medical officer of health appointed under s. 62(1)(b) of that act, or a person or designate authorized by or acting under their direction or control;

1.1.5 “Mutual Aid Agreement” or “Agreement” means this agreement and the attached Schedule “A” which embody the entire agreement between the Parties;

1.1.6 “Party” means any of the parties to this Agreement and “Parties” means all of them;

1.1.7 “Requesting Party” means the Party asking for aid, assistance or both pursuant to this Agreement;

1.1.8 “Urgent Project” means a public health project that is too large for the Requesting Party to handle itself using its own resources in a timely manner.

2. Authorization to Request/Offer Assistance

2.1 Each Party hereby authorizes its MOH to request assistance, accept offers to provide, or to offer to provide assistance pursuant to this Agreement on behalf of that Party.

3. Requests for Assistance

3.1 The Parties agree that:

3.1.1 In the event of an Urgent Project or an Emergency, a Requesting Party may request assistance in the form of qualified personnel, services, equipment, or material from another Party; OR

3.1.2 In the event a Party’s appointed medical officer of health is absent, or unable to act, such Party may request the assistance of another Party’s appointed medical officer of health for a time-limited duration.

3.2 The request for assistance shall be made, in writing, by the MOH of the Requesting Party to the MOH of the other Party. Where the MOH of the Requesting Party is incapacitated or otherwise incapable of acting, a request for assistance may be made by the senior administrative officer of the Requesting Party who is able to submit the request, and the other Party may place reasonable reliance on any request submitted by a person who appears to be the senior administrative officer of the Requesting Party in the circumstances. Any request made hereunder should be given with as much notice as possible.
3.3 The written request shall set out in detail the specific personnel, service, equipment or material that has been requested as assistance. The format in Schedule “A” attached hereto may be used.

3.4 The MOH may make the initial request for assistance orally. However, any request for assistance made orally shall be confirmed in writing by the Requesting Party within 3 (three) days of the initial oral request or as soon as reasonably practicable.

3.5 The Assisting Party may provide assistance to the Requesting Party upon receipt of the oral request.

3.6 Either before or after choosing to provide assistance, a Party may request such reasonable additional information from the Requesting Party as it considers necessary to confirm the existence or other details of the Emergency or Urgent Project and to assess the type, scope, nature and amount of assistance to be provided.

3.7 The Party which has received a request from a Requesting Party shall respond to the request within one (1) day or as soon as reasonably practicable, and may, in its sole discretion,

3.8 The Assisting Party shall confirm in writing the assistance it has agreed to provide.

3.9 The Assisted Party and the Assisting Party may, by mutual agreement at any time as necessary, amend the scope, type, nature or amount of assistance to be provided to the Assisted Party. Such amendments shall be confirmed in writing by the Assisted Party within 3 (three) days of being agreed upon or as soon as reasonably practicable.

4. Limitations on Assistance Provided

4.1 Nothing in this Agreement shall require or obligate, or be construed to require or obligate, a Party to provide assistance, provided that each Party shall in good faith consider providing the assistance requested or some portion thereof if they have the resources to do so. Each Party shall retain the right to refuse the request to provide assistance, and the right to offer alternatives to the assistance that has been requested.

4.2 No liability shall arise against any Party if it fails, for any reason whatsoever, to respond to a request for assistance made under this Agreement.

4.3 When assistance has been offered or provided by the Assisting Party, the Assisting Party shall not be obligated to provide any further assistance or to do anything or take any action beyond that which is specifically agreed to by the acceptance of the request for assistance.

4.4 Nothing in this Agreement shall prevent the Assisting Party, in its sole discretion, from withdrawing any or all assistance it had agreed to provide to the Assisted Party. Any withdrawal of assistance by the Assisting Party shall be made upon at least forty-eight (48) hours’ notice to the Assisted Party, or as soon as reasonably practicable unless the Assisting Party is responding to an actual or pending Emergency within its own geographical boundaries, in which case it may withdraw assistance from the Assisted Party immediately on notice.

4.5 The Assisted Party may determine in its sole discretion, subject to any required approval by governmental authorities, that its requirement for assistance has ceased and shall notify the Assisting Party of this in writing.

4.6 Nothing in this Agreement affects a Party’s statutory responsibilities under the Health Protection and Promotion Act, its regulations, and the Ontario Public Health Standards.

5. Term and Termination
5.1 This Agreement shall be in effect for each Party from the date on which each Party signs the Agreement.

5.2 Despite any other section of this Agreement, any Party may terminate this Agreement upon at least sixty (60) days’ written notice to the other Parties. It is understood that, notwithstanding termination by any Party, the Agreement shall continue in force as between the other Parties.

6. Costs

6.1 Unless otherwise agreed upon, any and all direct and indirect costs of the Assisting Party in providing assistance are to be paid initially by the Assisting Party and shall be reimbursed by the Assisted Party in accordance with this Agreement. The Assisted Party shall be required to reimburse any and all actual costs incurred by or attributable to the Assisting Party in providing the assistance.

6.2 The costs referred to in paragraph 6.1 above shall include, but are not limited to, any and all supplies, equipment, materials, fuel, repairs, parts, lodging, wages, salaries, overtime, shift premium, Canada Pension Plan, Employment Insurance, OMERS contributions, and/or contributions made to life insurance, health, dental and/or disability plans or policies, and similar charges and expenses incurred in or attributable to providing the assistance including those wages, salaries, overtime and shift premium charges incurred resulting from staffing requirements in its home jurisdiction during the period of the assistance that are attributable to the provision of assistance to the Assisted Party.

6.3 The Assisting Party shall remain responsible for making all statutorily required deductions, contributions and/or payments, such as Employment Insurance, Canada Pension Plan, etc., for its employees, but shall be reimbursed for any amount of such payments attributable to the provision of assistance to the Assisted Party.

7. Payment

7.1 Payment by the Assisted Party for costs incurred for the assistance provided shall be made to the Assisting Party upon receipt of an invoice from the Assisting Party, notwithstanding any objection made by the Assisted Party under section 7.2. Such invoice shall set out in sufficient detail the costs actually incurred by or attributable to the provision of assistance by the Assisting Party to the Assisted Party pursuant to this Agreement, and where practically available, receipts for disbursements shall be forwarded in support of the invoice.

7.2 Any discrepancy relating to an invoice shall be discussed between the Parties involved and additional documentation shall be provided. The Parties shall attempt in good faith to reach resolution as expeditiously and amicably as possible. The Parties may agree on a method of third party resolution, if necessary, and shall share the costs of same equally.

8 Employment Relationship

8.1 Despite that the employees, contractors, servants and agents of the Assisting Party may be assigned to perform duties for the Assisted Party, the employees, contractors, servants and agents of the Assisting Party shall retain their employment or contractual relationship with the Assisting Party. The Parties acknowledge and agree that the Assisted Party is not to be deemed the employer or contractor of the Assisting Party’s employees, contractors, servants or agents, under any circumstances or for any purpose whatsoever.

9 Rights and Records

9.1 Unless otherwise specified, the Assisted Party shall afford to the personnel of the Assisting Party, operating within the Assisted Party’s jurisdiction, the same powers and rights as are afforded to like personnel of the Assisted Party.

9.2 Confidentiality and Record Keeping: Any personal (health) information collected, used or disclosed by an Assisting Party while assisting an Assisted Party pursuant to this agreement is subject to the rights, responsibilities, and safeguards provided for in the Municipal Freedom of
Information and Protection of Privacy Act and the Personal Health Information Protection Act, 2004. While the circle of care provisions of the legislation may also assist in the legal disclosure of any personal health information between Parties under this Agreement, the Parties hereby state their intention that the Assisting Party and its employees, contractors, servants and agents are acting as agents of the Assisted Party in the collection, use or disclosure of any personal (health) information, which is at all times the intellectual property of and under the care, custody and control of the Assisted Party. The Assisted Party may direct the Assisting Party how to safeguard and deal with the information to meet the purposes of this Agreement and the Assisting Party shall protect and treat the personal (health) information according to the standards of the applicable legislation and in accordance with the directions of the Assisted Party, acting reasonably.

10 Indemnity

10.1 The Assisted Party shall defend, indemnify and save harmless the Assisting Party, its directors, officers, and employees, from any and all claims, costs, all manner of action or actions, cause and causes of action, accounts, covenants, contracts, demands or other proceedings of every kind or nature whatsoever at law or in equity arising out of this Agreement and out of assistance provided pursuant to this Agreement. The indemnity herein provided shall include all costs, including but not limited to duties, dues accounts, demands, penalties, fines and fees (including, without limitation, all reasonable legal expenses).

10.2 Notwithstanding the foregoing, the Assisted Party shall not be obligated or liable for any injury or death of any person or damage to any property caused by the gross negligence of the Assisting Party.

11 Insurance

11.1 During the term of this Agreement, each Party shall obtain and maintain in full force and effect general liability insurance issued by an insurance company authorized by law to carry on business in the Province of Ontario, providing for, without limitation, coverage for personal injury, public liability and property damage. Such policy shall:

11.1.1 Have inclusive limits of not less than Five Million Dollars ($5,000,000) for injury, loss or damage resulting from any one occurrence;

11.1.2 Contain a cross-liability clause endorsement and severability of interests clause of standard wording;

11.1.3 Name all of the other Parties as an additional insured with respect to any claim arising out of the Assisted Party’s obligations under this Agreement or the Assisting Party’s provision of personnel, services, equipment or material pursuant to this Agreement; and

11.1.4 Include a non-owned automobile endorsement; and

Upon request of any Party, each Party shall provide proof of insurance if so required in a form satisfactory to the requesting Party.

11.2 During the term of this Agreement, each Party is required to ensure the following: Medical Malpractice Liability Insurance in the name of any professional service provider who will provide assistance under this Agreement, providing coverage to the extent of $2,000,000 per claim or alternatively, where applicable, proof of current membership in a medical professional’s association, such as CMPA, that offers corresponding coverage to its members. The Assisted Party may request proof of coverage.

12 Notice
12.1 Written notice under this Agreement may be given to the MOH or designate or, where the MOH is incapacitated or otherwise incapable of acting, then the senior administrative officer referred to in section 3.2, using the contact information below and the most current address information which can be accessed on the Association of Local Public Health Agencies website (http://www.alphaweb.org/ont_health_units.asp). The Parties agree to update their primary and secondary contact by notice in writing when necessary.

In the case of notice to:

Brant County Health Unit
194 Terrace Hill Street
Brantford, ON N3R 1G7
Tel: (519) 753-4937
Fax: (519) 753-2140
Primary Contact: Medical Officer of Health
Secondary Contact: Executive Director

The Corporation of Norfolk County
Haldimand-Norfolk Health Unit
12 Gilbertson Drive, P.O. Box 247
Simcoe, ON N3Y 4L1
Tel: (519) 426-6170
Fax: (519) 426-9974
Primary Contact: Medical Officer of Health
Secondary Contact: General Manager, Health and Social Services

The Regional Municipality of Halton,
Health Department
1151 Bronte Road
Oakville, ON L6M 3L1
Tel: (905) 825-6000
Fax: 905-825-1444
Primary Contact: Medical Officer of Health
Secondary Contact: Associate Medical Officer of Health

City of Hamilton Public Health Services
1 Hughson Street North, 4th Floor
Hamilton, ON L8R 3L5
Tel: (905) 546-2424
Fax: (905) 546-4075
Primary Contact: Medical Officer of Health
Secondary Contact: Mayor of City of Hamilton

Niagara Region Public Health
2201 St. David's Road, Campbell East
P.O. Box 1052, Station Main
Thorold, ON L2V 0A2
Tel: (905) 688-3762 or 1-800-263-7248
Fax: (905) 682-3901
Primary Contact: Medical Officer of Health
Secondary Contact: Associate Medical Officer of Health

Region of Waterloo, Public Health
P.O. Box 1633, 99 Regina Street South
Waterloo, ON N2J 4V3
Tel: (519) 883-2000
Fax: (519) 883-2241
Primary Contact: Medical Officer of Health
Secondary Contact: Associate Medical Officer of Health
12.2 If hand delivered, the notice is effective on the date of delivery; if faxed, the notice is effective on the date and time the fax is sent; and if mailed, the notice is deemed to be effective on the fifth business day following the day of mailing.

12.3 Any notice given shall be sufficiently given if signed by the MOH or by the senior administrative officer referred to in section 3.2.

13 General

13.1 Nothing contained in this Agreement shall be construed as restricting or preventing either Party from relying on any right or remedy otherwise available to it under this Agreement, at law, or in equity in the event of any breach of this Agreement.

13.2 This Agreement shall enure to the benefit of, and be binding upon the Parties and their respective successors and administrators.

13.3 This Agreement shall not be construed as or deemed to be an agreement for the benefit of any third parties, and no third party shall have any right of action arising in any way or manner under this Agreement for any cause whatsoever.

13.4 This Agreement shall not be assigned by any Party.

13.5 This Agreement and the attached Schedule “A” embody the entire Agreement and supersede any other understanding or agreement, collateral, oral or otherwise, existing between the Parties prior to or at the date of execution. If a more specific agreement for a particular Emergency, Urgent Project or unavailability of the appointed medical officer of health or other purpose is made between the Parties, or any two of them, while this Agreement is in place, the parties to the more specific agreement shall enunciate their preferences regarding priority between this Agreement and the other more specific agreement. This Agreement may be signed in counterparts, and if so, each Party shall ensure that a copy of their signed original is sent to the other Parties. For clarity, this Agreement is intended to replace the agreement dated April 13th, 1999, between all the Parties or their predecessors except The Corporation of Norfolk County, Haldimand-Norfolk Health Unit. The Parties acknowledge that other mutual assistance agreements may exist, which are not considered to conflict with this Agreement.

13.6 Sections 4.2, 6, 7, 9, 10, 12, and 13, of this Agreement shall survive termination of this Agreement.

13.7 The Parties agree to be governed by the laws of the Province of Ontario and Canada.

IN WITNESS WHEREOF the Parties have, by their authorized signing officer(s), executed this Agreement.

BRANT COUNTY HEALTH UNIT

Name: 
Title: 

Name:
Title:
I/We have the authority to bind the corporation/health unit.

THE CORPORATION OF NORFOLK COUNTY,
HALDIMAND-NORFOLK HEALTH UNIT

Name: ____________________________
Title: ____________________________

_______________________________
Name: ____________________________
Title: ____________________________
I/We have the authority to bind the corporation/health unit.

THE REGIONAL MUNICIPALITY OF HALTON

Name: ____________________________
Title: ____________________________

_______________________________
Name: ____________________________
Title: ____________________________
I/We have the authority to bind the corporation/health unit.

CITY OF HAMILTON

Name: ____________________________
Title: ____________________________

_______________________________
Name: ____________________________
Title: ____________________________
I/We have the authority to bind the corporation/health unit.

THE REGIONAL MUNICIPALITY OF NIAGARA

Name: ____________________________
Title: ____________________________

_______________________________
Name: ____________________________
Title: ____________________________
I/We have the authority to bind the corporation/health unit.
THE REGIONAL MUNICIPALITY OF WATERLOO

Name: 
Title: 

Name: 
Title: 
I/We have the authority to bind the corporation/health unit.

WELLINGTON-DUFFERN-GUELPH HEALTH UNIT

Name: 
Title: 

Name: 
Title: 
I/We have the authority to bind the corporation/health unit.

SCHEDULE “A”

Mutual Aid Agreement

I, __________________________, Medical Officer of Health of the __________________________, duly authorized to do so by the Board of Health of __________________________, do hereby request of the __________________________, to provide assistance in the form of:

_____ PERSONNEL
_____ SERVICES
_____ EQUIPMENT
_____ MATERIAL

AS IS MORE PARTICULARLY SET OUT IN DETAIL AS FOLLOWS:
The above confirms the assistance verbally requested on ____________________, and which assistance __________________ has agreed to provide.

Dated at __________________ this _______ day of ________________, ______.

_____________________________________ Medical Officer of Health of __________________________
APPENDIX “B”

BY-LAW NUMBER XXXX

OF

THE REGIONAL MUNICIPALITY OF WATERLOO

A By-law to Appoint an Acting Medical Officer of Health When the Medical officer of Health and Associate Medical Officer of Health for the Waterloo Health Unit are Absent or Unable to Act and to repeal By-law 04-008

WHEREAS The Regional Municipality of Waterloo is the Board of Health for the Waterloo Health Unit pursuant to the Health Promotion and Protection Act, R.S.O. 1990, c.H.7. as amended;

AND WHEREAS the Medical Officer of Health and Associate Medical Officer of Health for the Waterloo Health Unit may, from time to time, be absent or unable to act;

AND WHEREAS section 69 of the Health Protection and Promotion Act, R.S.O. 1990, c.H.7., as amended, requires a Board of Health to appoint an Acting Medical Officer of Health when the Medical Officer of Health and Associate Medical Officer of Health are absent or unable to act;

AND WHEREAS the said section 69 further provides that an Acting Medical Officer of Health shall perform the duties and have the authority to exercise the powers of a Medical Officer of Health;

NOW THEREFORE, the Council of The Regional Municipality of Waterloo enacts as follows:

1. The Medical Officer of Health or Associate Medical Officer of Health of the Niagara Regional Area Health Unit, City of Hamilton Health Unit, Halton Regional Health Unit, Brant County Health Unit, Halldimand-Norfolk Health Unit or Wellington-Dufferin-Guelph Health Unit, as the case may be, is hereby appointed as the Acting Medical Officer of Health for the Waterloo Health Unit provided that the Medical Officer of Health and Associate Medical Officer of Health of the Waterloo Health Unit are absent or unable to act pursuant to 69 of the Health Protection and Promotion Act, R.S.O. 1990, c. H. 7, as amended or any successor thereto.

2. That this By-law shall come into force and take effect on the day upon which it is passed.

3. By-law 04-008 of The Regional Municipality of Waterloo shall be repealed effective on the coming into force and effect of this By-law.

By-law read a first, second and third time and finally passed at the Council Chamber at the Regional Municipality of Waterloo this 23rd day of March, 2011.

_________________________________  ____________________________________
REGIONAL CHAIR                        REGIONAL CLERK
TO: Chair Sean Strickland and Members of the Community Services Committee

DATE: March 8, 2011

FILE CODE: P05-80

SUBJECT: EMS MASTER PLAN UPDATE

RECOMMENDATION:

For information

SUMMARY:

This report provides an update of the various EMS Master Plan activities to date, current system performance results (2010), and the impacts of significant operational issues such as hospital offload delays and instances of “Code Red” coverage levels.

REPORT:

On December 7, 2007, Regional Council endorsed various actions with regards to the recommendations contained within Report PH-07-061: Emergency Medical Services (EMS) Master Plan, dated December 4, 2007. These are:

1. Adopt 6 minutes, 90% of the time, as the Region’s community target time for arrival of a defibrillator at the scene of a cardiac arrest call;

2. Adopt 10 minutes 30 seconds, 90% of the time, as the Region’s EMS response time target for Code-4 emergency calls (from time crew notified until arrival at scene);

3. Adopt in principle, the recommended twenty-five year optimized staffing requirements necessary to maintain the 10 minute 30 second response time target, subject to a regular and ongoing review of needs and the annual budget process;

4. Adopt the following baseline recommendations subject to the 2008 Budget process:
   - The addition of 1.25 FTE (full time equivalent) paramedics for an emergency response unit in the rural areas;
   - Investigate adding beneficial medical skills/procedures for area firefighters at the discretion of each area municipality;
   - Enhance the Region’s traffic light pre-emption infrastructure to allow EMS vehicles to change traffic lights during emergency calls;
   - Fund the acquisition of enhanced dispatch technologies to optimize dispatching through the current Ministry of health operated Dispatch Centre;
   - Investigate the efficiency and effectiveness of other dispatch models relative to the current system;
   - Establish a community-wide public First Aid/CPR/ Public Access Defibrillation awareness program;
   - Standardize collection of agency response time date to enable development of a “community response time target” for cardiac arrests;
- Work at the most senior levels with area hospitals and the provincial government to investigate alternate patient care pathways and limit the impact of hospital delays on EMS; and
- Develop a formal advocacy plan to lobby for changes in provincial legislation to allow needed flexibility in local provision of EMS.

5. Adopt changes necessary in the 10 year Capital Plan to accommodate the recommended station construction and Fleet Centre renovation schedule as per Appendix I to Report PH-07-061.


Action areas have been consolidated and summarized below with related system performance results to provide an update of actions and results-to-date:

Response Time Targets:

The response time targets approved in the Master Plan are currently in place. 10 minutes 30 seconds 90% of the time, has been the legislated emergency response time standard in the Region of Waterloo since transition to municipal EMS oversight. The standard was based on the performance achieved in 1996, and was never adjusted to address population and call growth. The Ministry of Health and Long Term Care was unable to meet this standard during provincial control of ambulance service, and similarly, the Region has been unable to maintain this standard in the face of growing call volumes and system issues such as hospital offload delays. Due to significant resources added since transition, 2010 marks the first year where response times have climbed following four successive years of improvement.

<table>
<thead>
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<tr>
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<td>2009</td>
<td>11:45</td>
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Following significant pressure from AMO (Association of Municipalities of Ontario), the Regional Chairs and CAOs’ groups and AMEMSO (Association of Municipal Emergency Medical Services of Ontario), the Ministry agreed to revise the response time standard. The new regulation allows municipalities to establish their own standards based on patient acuity, i.e., there will be a separate standard for cardiac arrest calls, and then for each of four lower acuities as designated by the Canadian Triage Acuity Scale (CTAS). By October 1, 2012, each municipality must establish and report annually on their standards and compliance with them. Standards can be unilaterally changed by municipalities on an annual basis in the future if required.

To ensure appropriate, yet achievable standards are established, the Department of Management Sciences at the University of Waterloo has been engaged to quantify response times possible, given existing call volumes and acuities, station locations and vehicle resources. A report to Council is expected mid-year 2011, containing recommended response time standards.

Dispatch Model Review:

The Dispatch Model Review Working Group was established in 2008 (PH-08-009), and
continues to work towards improvements in the dispersed emergency services dispatch centre model presently in use. Despite the Ministry of Health and Long Term Care’s unwillingness to make available proven technology from the Niagara Pilot Project, there is optimism that a current initiative between the Ministry and the Ontario Fire Marshals’ Office, will result in a means of providing simultaneous dispatch of Fire and EMS vehicles. The project is currently out to tender by the Province, with a project completion date of approximately 12-18 months forward. In the meantime, the working group is making progress with common technological solutions for Waterloo Region Emergency Services, and is also examining any benefits of dispatch co-location not directly related to response times.

Further to the previous update to Council in June of 2010, a meeting was also held with Staff, Councillors and MPPs John Milloy and Leanna Pendergast, to express concern with the Ministry of Health’s hesitancy to participate in the working group’s activities. This resistance is not unique to Waterloo Region. Despite efforts from both the Regional Chairs and CAOs’ groups, the Ministry has similarly refused to participate in a Greater Toronto Area-wide ambulance dispatch review. A further progress report is scheduled for Council in June of this year.

Traffic Signal Pre-Emption:

In September 2010, Council approved the purchase of Traffic Signal Pre-Emption technology (PH-10-042.1/E-10-079.1) to both add pre-emption capabilities for EMS vehicles, and upgrade the existing system capabilities with regards to additional intersections so equipped, as well as adding other Fire, Police and transit vehicles. Finalization of the purchasing contract has been a lengthy process, but Traffic Systems staff expects to begin installation of equipment in the Spring of 2011, with completion by the end of 2012. Installation will be staged municipality by municipality following the completion of a high use priority EMS route for testing. Once fully implemented Region-wide, EMS expects a reduction in emergency response times of between 45 and 60 seconds per call, although improvements will begin immediately as each signal is converted to the new technology.

CARE (Community Awareness and Response to Emergencies) Program:

The CARE program is the outcome of the EMS Master Plan baseline recommendation to establish “a community-wide Public First Aid/CPR/ Public Access Defibrillation awareness program” throughout the Region. CARE is a working partnership between Region of Waterloo EMS and local branches of the Heart and Stroke Foundation of Ontario, the Canadian Red Cross and St. John Ambulance. The program co-ordinates the placement and ongoing maintenance of some 247 Public Access Defibrillators in Regional buildings, select police vehicles, schools, and various public venues across the Region. Defibrillators may be municipally or corporately funded, donated by individuals, or in most cases funded by the Heart and Stroke Foundation of Ontario’s “Restart a Heart, Restart a Life” program. In addition to maintaining the defibrillators, the CARE program also trains and regularly retrains defibrillator operators at all sites and response teams for schools with Public Access Defibrillation units. 1,207 individuals have been certified in this regard.

In the broader community, the CARE program provides free 90 minute public awareness sessions providing a lifesaving overview of CPR, First Aid and Public Access Defibrillation. In addition, a number of mass CPR training events have also been held. These sessions provide basic lifesaving knowledge and encourage participants to take full CPR and First Aid training. To date, some 2,377 individuals have attended these CARE-operated sessions.
In conjunction with funding provided by the ACT Foundation, the CARE program is also responsible for “train the trainer” programs in all of the Region’s high schools, where Physical Education teachers are trained as CPR/ Automated External Defibrillator instructors. The 2010/2011 school year is the first year where all Grade 9 students in both Boards are expected to receive CPR and Automated External Defibrillator training as part of the Provincial education curriculum. To date, 3,472 high school students have received training under this initiative, and this number is expected to reach 5,200 by the end of the school year.

**Cardiac Arrest Community Response Time Target:**

Rapid defibrillation (electric shock) of an ailing heart offers the best chance of survival from sudden cardiac arrest. As survival rates deteriorate by 10% for every minute defibrillation is delayed, a co-ordinated system that ensures the most rapid delivery of a life-saving shock (regardless of from which defibrillator), is essential. Region of Waterloo EMS, Cambridge and Waterloo Fire Departments, as well as all CARE Public Access Defibrillator sites, now co-ordinate data collection through standardized equipment, i.e., data from a municipal arena Public Access Defibrillator unit can be linked with data from a responding Fire Automated External Defibrillator, and ultimately the EMS defibrillator, to provide a complete history of any particular cardiac arrest. This data is forwarded to an international Resuscitation Outcomes Consortium, so that resuscitation techniques can be optimized and survival rates maximized. Efforts are presently underway to incorporate the Kitchener Fire Department in these efforts and thus be able to accurately measure cardiac arrest community response time for upwards of 90% of the Region’s population with regards to the 6 minute target time.

**Rural Emergency Response Units:**

As a further component of the EMS Master Plan, Council approved the addition of 1.25 FTE paramedics to staff a second Rural Emergency Response Unit beginning in 2008. Staffing is now provided from 0600-2400 daily with two single paramedic response units providing advanced life support prior to ambulance arrival at calls in the townships. With ambulances more often delayed at city hospitals, Rural Emergency Response Units have become an essential component of timely rural emergency medical response. Advanced Care Paramedics begin lifesaving care prior to ambulance arrival, yet transportation is rarely delayed beyond the time normal assessment and stabilization would take if performed by the arriving ambulance crew.

**Limiting the Impact of Hospital Delays on EMS:**

Emergency Department overcrowding continues to grow. This impacts on EMS by not allowing ambulances to transfer patients in a timely fashion, resulting in fewer ambulances available to respond to emergency calls in the community. In 2010, there were 4,282 offload delays longer than 30 minutes in duration (mean of 1.35 hours). These totalled 5,790 hours, the equivalent of one ambulance sitting idle 24 hours-a-day for 241 days.

Offload delays now impact EMS ability to guarantee the minimum emergency coverage by Region of Waterloo ambulances in the community 24 hours a day. Note that when an ambulance is not available, one is always dispatched from a more remote community, but the response time to that call will inevitably be more lengthy.
The number of offload delays grew 6.8% and total offload hours increased 20% in 2010 vs. 2009, creating a potential annual cost (due to lost time) approaching $1 million.

For the past six months, the Ministry’s Central Ambulance Communications Centre in Cambridge, has been able to provide a record of “Code Red” coverage instances. These are defined as periods where no ambulances are available locally for any new emergency call received. Until very recently, Code Reds did not exist for all intents and purposes. Historically, the Region would “run out of ambulances” once weekly, for one of two minutes at a time. Since July of this year, Code Red instances have ranged from 6-17 per month, but more importantly, from 1-119 minutes in duration (mean 14-26 minutes).

While a Code Red does not necessarily mean that an emergency call was received during that time frame, with on average just over 4.1 new calls generated every hour, any Code Red longer than 15 minutes would be guaranteed to affect response on at least one emergency call. Processes have been put in place to delay “urgent” calls up to 20 minutes to maintain minimum coverage for the higher priority “emergency” call, and aggressive upstaffing is being used whenever possible. Calling in additional crews has limitations as a solution because a limited number of extra ambulances are available, and there is an inherent delay of up to an hour before a crew can report for work. Unless deteriorated coverage is ongoing for prolonged periods, upstaffing is typically ineffective.
This is an extremely complex health care system-wide problem made more difficult by hospital staffing issues and admission pressures. Regular and detailed discussions are ongoing with Community Care Access Centre and senior leadership at the local hospitals to develop appropriate system wide solutions to this challenge. Offload delay is occurring across the province. There are system issues with provincial implications that won't be entirely solved at the local level alone. However, collaborative work is ongoing and staff is optimistic that a number of suggested local initiatives related to patient flow will help to improve the situation.

Despite Ministry of Health and Long Term Care funding that allows EMS to support a dedicated nurse at both Grand River and St. Mary's hospitals to care for offload delay patients and return ambulances to emergency service, offload delays continue to grow. Locally, staff and partner agencies are collaboratively exploring ways to better utilize the offload nurse staff funding, and have also requested an increase in funding from the province for 2011.

Area hospitals are in the final stages of testing a “Code Yellow” (EMS at minimum coverage levels) and “Code Red” (no EMS coverage) notification system. Once notified of the alert by the Ministry communications centre, hospitals will be required by mutual agreement between agencies to free up ambulances from offload delays. The number of ambulances and from which hospitals will be predetermined by the number of offload delays at each site. The ability of hospitals to consistently free up ambulances for emergency coverage has yet to be confirmed.

**Twenty-Five Year Optimized Staffing Requirements to maintain the 10 minute 30 second Response Time Target:**

Adopted in principle, but subject to ongoing review and the annual budget process, the twenty-five year optimized staffing plan is that additional staffing estimated as necessary to maintain the 10 minute 30 second response time target. As noted earlier in this report, 2010 is the first year in the last five to show 90th percentile response times climbing (14 seconds over 2009).
While traffic signal pre-emption had been anticipated to maintain response times at or near the target, delay in implementation of that program in conjunction with call volume growth and ongoing hospital offload delays, has significantly stretched existing resources.

The Ministry-generated "Potential Patient Carrying Call Volume" data normally used to describe call volume growth is not yet available for 2010. To provide a similar view of EMS workload change, a comparison of patient contact from our internal patient care records is shown below instead. Rather than the usual "number of potential patient carrying calls" (responses), this shows the actual number of "patients contacted" and assessed/transported to hospital. Year-to-year percentage increases are similar between the two measures. As shown, call volume has increased 4.4% 2010 over 2009, representing an increase of 1,318 calls (3.6 per day). With an average call duration of 70 minutes, this represents 1,538 additional hours of work, or one ambulance for 64 24-hour days.

### Annual Patient Contacts

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<tbody>
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</tr>
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<td>29,739</td>
</tr>
<tr>
<td>2010</td>
<td>31,057</td>
</tr>
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</table>

While system performance data indicates significant staffing increases are needed immediately to address deterioration in EMS response performance, much of the deterioration is due to external factors such as health system overcrowding. Given that hospital offload delays continue to increase in duration, adding ambulance staffing to address more than call volume growth, would simply add more ambulances to the queues now common at each emergency department. A 2011 Budget issue paper (Page 9 in the Budget Issue package) requests an additional staffed ambulance 12 hours-a-day to address call volume-related response time deterioration, in the first of five years of Master Plan optimized staffing. Aggressive upstaffing and other efforts in concert with area hospitals will continue to be used to offset hospital offload delays.

### Capital Plan Changes:

Integral to the EMS Master Plan, three new stations, additional ambulances and Emergency Response Units, as well as renovations to EMS Headquarters were required. One of the three stations (Downtown Kitchener - Interim) is complete and functional, while a second (Conestoga College) is currently under construction with a summer 2011 completion expected. The EMS Headquarters expansion planning is well underway with construction expected to begin in the Spring of 2011. With these projects and a replacement station for North Cambridge in progress, the remaining Master Plan station addition (Waterloo), is not expected until 2012-2013. The first additional Emergency Response Unit was acquired in 2008 to achieve the addition of the second Rural Emergency Response Unit noted earlier. Additional ambulances and response units are required as a component of the twenty-five year optimized staffing requirements, the first of which is included in 2011 Budget issue papers (Page 148).

### EMS Master Plan Outstanding Recommendations:

Two recommendations remain essentially outstanding:

- Investigate adding beneficial medical skills/procedures for area firefighters at the discretion of each area municipality; and
- Develop a formal advocacy plan to lobby for changes in provincial legislation to allow needed flexibility in local provision of EMS.

While no local formal advocacy plan exists, the Regional Chairs and CAOs groups have been effective lobbyists in concert with Association of Municipalities of Ontario. They were able to successfully lobby for both the new locally set response time targets, and an extension in the implementation date to ensure appropriate local standards were established. As well, our dispatch issues have been clearly identified to area MPPs.

With regards to added medical skills for firefighters, there have been no requests received to date from area fire departments. This is likely due to their already heavy Fire Service training demands, but we have committed to assisting with training such as EpiPen for severe allergic reactions, if requested. As noted earlier, two city fire departments are already participating in the Resuscitation Outcomes Consortium initiative, which has improved CPR and defibrillation skill sets to state-of-the-art levels. It is hoped that all three city departments will be providing this level of care by year-end.

CORPORATE STRATEGIC PLAN:

This report directly addresses Focus Area 3: Healthy and Safe Communities, and specifically Objective 3.3: Provide effective and efficient emergency medical services. As a component of the Human Services Plan in support of the Regional Growth Management Strategy, the EMS Master Plan also addresses Focus Area 2: Growth Management, Focus Area 4: Human Services, Focus Area 5: Infrastructure, and Focus Area 6: Service Excellence.

FINANCIAL IMPLICATIONS:

Budget Committee of the Whole is currently considering a Budget issue entitled “EMS Master Plan Optimized Staffing Requirements” (pages 9 (staffing) and 148 (vehicle) in the 2011 Budget Issue Package).

OTHER DEPARTMENT CONSULTATIONS/CONCURRENCE:

EMS Master Plan activities have been supported by numerous Regional Departments and external agencies.

ATTACHMENTS

NIL

PREPARED BY: John Prno, Director, Emergency Medical Services

APPROVED BY: Dr. Liana Nolan, Commissioner/Medical Officer of Health
MEMORANDUM

To: Chair Sean Strickland and Members of the Community Services Committee

From: Leslie Perry, Project Manager, Social Services Solutions Modernization Project
Employment and Income Support

Copies: Michael Schuster, Commissioner, Social Services

File No.: S08-20

Subject: ONLINE APPLICATION

As outlined in a memorandum to Committee on September 28, 2010, the Province has undertaken a project to replace the Service Delivery Model Technology (SDMT) that supports the delivery of social assistance (Ontario Works, Ontario Disability Support Program, Assistance for Children with Severe Disabilities). The first phase of this project is the implementation of an Online Application which will allow individuals another avenue to apply for social assistance. Implementation of the Online Application is Spring 2011.

As part of the implementation, service delivery agents, such as the Region of Waterloo, are required to submit a Site Readiness Plan indicating activities that will occur in the months leading to implementation. The objective of the Site Readiness Plan for the Online Application is to ensure delivery agents are prepared and supported to successfully implement the Online Application.

The Site Readiness Plan for the Online Application captures three main areas of focus:
1. changes that may occur as a result of implementing the Online Application;
2. impact on existing processes;
3. preparation for implementation.

Specifically, the Plan looks at:
- change readiness including strategies to manage change;
- staff roles and responsibilities;
- training;
- local site equipment realignment;
- communications (citizens, community agencies, staff);
- technical support;
- operational support from Province.
The expectation is that a detailed plan will be developed for each Ontario Works local office and approved by the Province. The Site Readiness Plan for Waterloo Social Services was submitted on February 16, 2011.

Management of the Online Application will become a function of Intake Services within Employment and Income Support. Staff are now engaged in reviewing business processes to ensure successful implementation in Spring 2011. A follow-up report will be provided to Council prior to implementation.

The delivery of social assistance addresses Focus Area 3: Healthy and Safe Communities; Strategic Objective 1: (to) improve health by reducing or preventing the environmental and social conditions of behaviours that lead to poor health and disparity.

For further information or a copy of the submitted plan, please contact David Dirks, Director, Employment and Income Support at 519 883-2179 or ddirks@regionofwaterloo.ca
Mr. Ken Seiling  
Regional Chair  
Regional Municipality of Waterloo  
150 Frederick Street  
Kitchener, Ontario  
N2G 4J3  

Dear Mr. Seiling:

Thank you for your letter, written on behalf of the Waterloo Regional Council, expressing concern about the renewal of the Homelessness Partnering Strategy (HPS) and its implementation in your community. First, I would like to offer my sincere apologies for this late reply. Departmental officials have been advised to review their procedures to ensure Canadians receive a timely response to their concerns.

As you are aware, the Government of Canada is fulfilling its commitment to help those seeking to break free from the cycles of homelessness and poverty with an investment of more than $1.9 billion in housing and homelessness until March 31, 2014.

Recognizing that homelessness is a shared responsibility, the HPS works to enhance partnerships with provincial and territorial governments and a wide range of community stakeholders to find longer-term solutions to homelessness, strengthen community capacity and build sustainability. Last fall, the Government engaged all the provinces and territories, as well as a number of public and private stakeholders, on how best to use federal housing and homelessness investments from 2011 to 2014, and we are moving forward with our partners.

I am pleased to inform you that the HPS has been renewed until March 31, 2014, at its current funding level of $134.8 million per year. The renewed HPS will continue to invest in and focus on communities, while introducing a number of enhancements to help communities to better address homelessness issues. HPS program enhancements will include increased support for rural and remote communities; greater alignment with the priorities of the provinces and territories; the development of linkages on mental health and homelessness; and improved accountability measures.

.../2
In alignment with the renewal of the HPS at its current funding level, the allocated funding for designated communities will remain the same until 2014. These funding allocations were developed with the aim of addressing community needs across the country in an equitable way.

I have noted the request to change the name of your designated community from “Kitchener” to “Waterloo Region”. If this is an issue that the community agrees upon, the Kitchener HPS Community Advisory Board is directed to put forward the proposed name change in its next community plan. An official name change will be considered provided that the geographic boundaries of the designated community remain the same and the homeless population in Kitchener is not adversely affected.

Additional information on the HPS renewal and enhancements is available on the following Human Resources and Skills Development Canada Web site: http://www.hrsdc.gc.ca/eng/homelessness/index.shtml.

Please rest assured that the federal government is committed to working with all levels of government, local communities and stakeholders to prevent and reduce homelessness in Canada.

Thank you again for taking the time to write.

Yours sincerely,

[Signature]

The Hon. Diane Finley, P.C., M.P.

c.c. The Honourable Gary Goodyear, P.C., M.P.
Cambridge

Mr. Harold Albrecht, M.P.
Kitchener—Conestoga

Mr. Peter Braid, M.P.
Kitchener—Waterloo

Mr. Stephen Woodworth, M.P.
Kitchener Centre
February 11, 2011

Dear Stakeholder,

I wanted to take this opportunity to update you on the progress we are making as we move toward the creation of Best Start Child and Family Centres here in Ontario.

As you know, Dr. Charles Pascal’s report, With our Best Future in Mind: Implementing Early Learning in Ontario, sets out the vision for an integrated system of services for families and children delivered through Best Start Child and Family Centres (BSCFC).

On April 27, 2010, I announced that, with the help of Charles, I would lead the work to design and implement a framework for integration of services for infants, children and families.

As part of the first phase, work is underway to:
- raise awareness about the BSCFC concept—what it is and what it isn’t;
- get a better idea of what is and isn’t working currently for kids and families;
- develop the provincial framework for BSCFCs;
- develop ideas for implementation in communities;
- highlight examples of innovative and promising service delivery practices around the province; and
- identify program and service integration opportunities at the provincial level.

The provincial framework for BSCFCs will be guided by the advice received from internal and external committees as well as community meetings and consultations and will build on the work that is currently underway.

Throughout the Fall, Charles and I enjoyed visiting several communities across the province to listen to and learn from the experiences of local providers and parents.

An Internal Reference Group made up of Assistant Deputy Ministers from across government has been meeting regularly to provide strategic advice and guidance. This committee is focusing on the development of a comprehensive inventory of programs and services that support families and children aged pre-natal to 12 years. The Inventory will be used to develop the BSCFC concept and to identify opportunities to improve integration of programs and services across government.

.../cont’d
An External Reference Group of experts in childhood programs and services has been meeting to help identify best practices and offer advice as we move forward to implement the vision of an integrated system of services for children and families including child care, parenting literacy, and special supports. We are also seeking guidance from Aboriginal providers and practitioners regarding the needs of Aboriginal children and families in relation to the BSCFC concept.

In addition, we will be holding a meeting of relevant provincial associations to help ensure that we capture their important perspectives.

I am pleased that five community engagement tables will be held across the province in the upcoming weeks. The tables will be held in Hamilton (February 11), Toronto (February 24), Sudbury (February 25) and Clinton (March 4) and Casselman (March 7). These sessions are intended to get direct feedback from families and service providers on what's working for children and where the system could be improved. These discussions will help to identify the system gaps in services and supports for children as well as new ideas on how to offer high quality, integrated, and accessible services.

To complement this process, we have created an online feedback tool to ensure that anyone who wants to provide input to the development of the policy framework has an opportunity to do so. The online submission website became active on February 2nd at Ontario.ca/beststart.

Information gathered from the community engagement tables, the online submissions and the guidance and advice from these valuable sources will help us develop the policy framework for the Centres, which we will develop by the summer of this year.

We have embarked on a challenging process of change that will build on best practices and the dedication and ingenuity of the many dedicated children's service providers throughout the province. It will take time, but it's worth it. All children in Ontario deserve the best opportunities to reach their potential. We are working hard to deliver even better services for children and their families so we can make Ontario the best place in the world for kids to grow up.

Yours truly,

Original signed by

Laurel Broten
Minister
## Council Enquiries and Requests for Information

### Community Services Committee

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<th>Request</th>
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<td>07-Sep-10</td>
<td>S. Strickland</td>
<td>Staff report regarding the impact of the Public Health Needle Exchange Program on the incidence of blood-borne infections</td>
<td>Public Health</td>
<td>As part of Harm Reduction program report due in March 2011</td>
</tr>
<tr>
<td>28-Sep-10</td>
<td>Committee</td>
<td>Staff report regarding the impact of revised technology for Delivery of Social Assistance on applicants. Social</td>
<td>Services</td>
<td>early 2011</td>
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