South East Health Unit

formerly

HASTINGS PRINCE EDWARD Public Health

KFL&A Public Health

Leeds, Grenville & Lanark District HEALTH UNIT
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BOARD OF HEALTH MEETING

INFORMATION ITEMS

Wednesday, September 24, 2025

Hastings Prince Edward Public Health
179 North Park St.
Belleville, Ontario K8P 4P1
613-966-5500 | 1-800-267-2803
Fax: 613-966-9418

Kingston, Frontenac and Lennox & Addington Public Health
221 Portsmouth Ave.
Kingston, Ontario K7M 1V5
613-549-1232 | 1-800-267-7875
Fax: 613-549-7896

Leeds, Grenville & Lanark District Health Unit
458 Laurier Blvd.
Brockville, Ontario K6V 7A3
613-345-5685 | 1-800-660-5853
Fax: 613-345-2879

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Listing of Information Items
Board of Health Meeting – September 24, 2025

1. South East Health Unit – Preschool Speech and Language 2025-26 "Leading Innovation for Transformation" (LIFT) Action Plan for the Ministry of Children, Community, and Social Services (MCCSS) – dated September 24, 2025.
2. Simcoe Muskoka District Health Unit – 2024 Annual Report – dated September 18, 2025.
3. Algoma Public Health – Board of Health resolution to address food insecurity as an income-based problem that requires income-based solutions – dated September 12, 2025.
4. Windsor-Essex County Health Unit – Board of Health resolution to address the escalating opioid crisis in Windsor-Essex County – dated August 26, 2025.
5. Simcoe Muskoka District Health Unit – Organizational Structure Changes – dated August 6, 2025:
    - Carolyn Shoreman, Vice President of the Community and Family Health Department, is now fulfilling the duties of the Chief Nursing Officer (CNO).
    - Dr. Steve Rebellato, Vice President of the Environmental Health Department, has taken on the new role of Chief Innovation Officer (CINO). This role is accountable for advancing public health outcomes through the ethical and strategic application of advanced analytics, data systems, and innovative public health practices solutions through the use of artificial intelligence (AI).
6. Association of Local Public Health Agencies (alPHa) – InfoBreak Summer 2025.
7. Middlesex-London Health Unit – Board of Health resolution for Household Food Insecurity: A primer for municipalities report – dated July 24, 2025.
8. City of Belleville support for City of Pickering resolution – raising income amounts for Ontario Works and Ontario Disability Support Program recipients – dated June 6, 2025 (mentioned at the July 23, 2025 meeting by Councillor S. Kelly).

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Board of Health Briefing Note

To:	South East Health Unit Board of Health
Prepared by:	Catherine Robinson, Preschool Speech and Language (PSL) Manager
Approved by:	Dr. Piotr Oglaza, Medical Officer of Health and CEO
Date:	Wednesday, September 24, 2025
Subject:	**Preschool Speech and Language 2025-26 "Leading Innovation for Transformation" (LIFT) Action Plan for MCCSS**
Nature of Board Engagement	☒ **For Information** ☐ Strategic Discussion ☐ Board approval and motion required ☐ Compliance with Accountability Framework ☐ Compliance with Program Standards
Action Required:	No action required.
Background and Current Status	The Ministry of Children, Community, and Social Services (MCCSS) requires that all Preschool Speech and Language (PSL) programs submit a LIFT Action Plan annually. The purpose of the plan is to set out the actions and associated monitoring activities in order to to make progress towards implementation of the *Preschool Speech and Language and Children's Rehabilitation Guidelines (2023).* The goals include reduced wait-times, and "expanded service that is innovative, evidence-based, tiered, equitable, [and] within seamless pathways." An Implementation Tracker is completed and submitted at year-end to report on progress. The attached LIFT Action Plan for Language Express has been developed by the PSL manager in consultation with the Language Express System Committee and program staff. MCCSS requires that plans be reviewed by the lead agency "board of directors" and signed by the appropriate signing authority. Suzette Taggart, Director of Corporate Services has signed on behalf of the Health Unit; this submission is for Board of Health information only.

PRESCHOOL SPEECH AND LANGUAGE AND CHILDREN'S REHABILITATION

LIFT ACTION PLAN

2025-26

PREAMBLE

Leading Innovation for Transformation (LIFT) is a multi-year ministry strategy for Preschool Speech and Language and Children's Rehabilitation aimed at achieving the following goals:

- Timely access to pre/post-surgical services,
- Reduced wait-times, and
- Expanded service that is innovative, evidence-based, tiered, and equitable, within seamless pathways.

The LIFT strategy follows an annual cycle, and involves collaboration between staff from the Ministry of Children, Community and Social Services and service-delivery agencies.

Agencies identify actions for change and set goals each fiscal year by creating a LIFT Action Plan, and report on progress by completing an Implementation Tracker. Data gathered from this process is collected and analyzed to provide ongoing feedback to agencies.

Leading Innovation for Transformation (LIFT)

Through this exchange of action goals and output measures, the LIFT strategy supports improved service delivery in the children's rehabilitation sector.

INSTRUCTIONS

The *Leading Innovation for Transformation (LIFT) Action Plan* template asks agencies to specify actions supporting LIFT implementation for fiscal year 2025/26.

Section 1 provides a list of requirements and considerations that will guide agencies in their discussions with MCCSS Regional Office Program Supervisors, and in developing their Action Plans.

Section 2 provides the template where agencies must identify the actions they will undertake during the 2025/26 fiscal year to make progress towards implementation of the *Preschool Speech and Language and Children's Rehabilitation Guidelines (2023),* and the strategy goals described above.

The template should be completed by agencies in discussion with their Regional Office Program Supervisors. It should then be reviewed by the agency's board of directors, signed by authorized executive staff, and submitted via TPON as part of year-end reporting prior to **July 31st, 2025**.

SECTION 1 – ACTION PLAN REQUIREMENTS AND CONSIDERATIONS

All agencies must include **a minimum of 3-5 new or carried-over actions** in their 2025/26 Action Plans, and are encouraged to include more where appropriate.

Agencies should consider the following when developing their Action Plans:

- The next stage to goal achievement as outlined in their most recently completed Implementation Tracker,
- Current wait times and the trend for each of the services they offer from the LIFT Data Dashboard,
- Their performance relative to provincial averages (current and previous),
- Innovative practices they can undertake to increase tiered intervention and reduce wait times, and
- Barriers that have hindered their progress, and the steps that can be taken to overcome them.

Identifying actions

Actions should relate to the goals of the LIFT strategy as outlined above. Agencies should document new actions, and ongoing actions carried-over from their 2024/25 Action Plans, in the "New and Carried-Over Actions" section below. Where an agency has completed or discontinued a previous action, they should provide an explanation

regarding its outcome, or of the reason it was discontinued, in the "Completed or Discontinued Action(s)" section below.

Equity and cultural safety

During the 2024/25 Action Planning cycle, only 29% of Action Plans contained actions relating to equity and cultural safety. Of these, approximately 50% involved staff training. Equitable and culturally-safe service-delivery is a key goal of the LIFT strategy, and cannot be accomplished through staff training alone. For this reason, all 2025/26 Action Plans will be required to **include at least one new or carried-over action relating to equity and cultural safety** that does not involve staff training.

Wait-time reduction

In addition, all agencies **must consider the best practices for wait-time reduction** listed in "Appendix A" below when developing their Action Plans. In discussions with Program Supervisors, agencies may be asked to include in their Action Plans one or more specific actions grounded in these best practices. These action(s) must include concrete goals for wait-time reduction (i.e., they must aim to reduce wait-times by a target amount within a set period of time).

Agencies can use their preferred data-tracking metrics if they believe TPON-reporting data will not fully capture their progress. However, they should reconcile these metrics with their TPON-reporting data to ensure accurate reporting, especially for wait-time reduction. Refer to "Appendix B" below for key definitions and guidance on TPON data-reporting.

SECTION 2 – ACTION PLAN

Name of Agency:	South East Health Unit (formerly Leeds, Grenville and Lanark District Health Unit)/Language Express PSL
Name of Signing Authority:	Suzette Taggart, Director, Corporate Services
Contact (email/phone number):	suzette.taggart@kflaph.ca | 613-549-1232
Signature:	
Date:	July 29, 2025

Signatory confirms that Action Plan has been reviewed by agency board of directors: ☒

For each new or carried-over action in their Action Plan, agencies should:

- *Include a name for the action, and indicate whether it is new or carried-over,*
- *Include a description of the action, including details regarding status, completed steps, and planned next steps,*
- *Select the applicable focus area(s),*
- *Explain how they will implement the action (using the suggested headings to help organize their explanation),*
- *Explain how they will monitor/measure progress, including the following details:*
  - *the source(s) of their data (e.g., existing KPI data collection, new client survey, clinician reports, etc.), and*
  - *their monitoring and evaluation frequency (e.g., annual, bi-annual, quarterly, etc.), and*
- *Select the existing Key Performance Indicator(s) with which the action aligns.*

For each completed or discontinued action in their Action Plan, agencies should:

- *Include the action's name,*
- *Include a description of the action, including details regarding status and completed steps,*
- *Select the applicable focus area(s),*
- *Provide a detailed explanation of the action's outcome, or of the reason it was discontinued.*

Please duplicate the tables below for every additional action documented in each section.

Completed or Discontinued Action(s)			
Name	**Description**	**Focus Areas**	**Outcome / Reason for Discontinuation**
Prioritize assessments to reduce wait time to assessment.	Increase the number of assessments completed per FTE and per month. Shift more intervention from SLPs to CDAs.	*Funding Goals:* ☐ Paediatric recovery ☒ Reducing wait times ☐ Expanding provision of service *Guideline Elements:* ☒ Tiered services ☐ Equity and cultural safety ☐ Seamless pathways	This initiative was implemented last year when we had a double cohort of children to discharge, staffing vacancies, and a very long wait time to assessment. None of these are true now (although we do have one fewer CDA position due to funding limitations). Our wait time is now significantly reduced.

New and Carried-Over Actions					
Name	**Description**	**Focus Areas**	**How?**	**Monitoring**	**Related KPI**
Expand Tier 1 Services: phone call at intake ☐ New Action ☒ Carried-Over Action	Phone call by Administrative Assistant to each family at or shortly after referral intake to offer targeted resources and a strategy to try based on parent concerns, as well as suggestions for programs in the family's community that could be helpful (EarlyON, library programs, etc.). Help with making referrals to other programs as appropriate (Smart Start Hub, CTC, HBHC, ICDP, etc.). Goal is to provide families with help that makes a difference / gets them started as soon as possible. Our region is rural, so the phone call supports equitable access for families who don't have internet access and/or can't visit in person, and for families with limited literacy skills.	*Funding Goals:* ☐ Paediatric recovery ☐ Reducing wait times ☒ Expanding provision of service *Guideline Elements:* ☒ Tiered services ☒ Equity and cultural safety ☐ Seamless pathways	*Key Milestones:* Jan. 2025 moved from having a CDA make the calls to having Admin Assistants call. All calls and messages left are followed up with an email. *Timelines:* Quarterly data tracking on an Excel sheet Annual review of script for phone call based on parent survey results and any new info from community partners about their programs and referrals pathways *Resources Required:* Script and resources for sharing with parents have been written and revised a few times. Calls and follow-up emails take about 15 min per client. *Partners Involved:*	Quarterly data tracking: # of families reached, number of VM messages left, # of referrals to other agencies made. Annual monitoring with parent survey (survey asks if a phone call was received, whether it was useful, what was most useful while waiting, what else would you have like to receive while waiting). Edit script for phone call based on survey responses, annually at end of fiscal year.	☒ Earlier age of referral / first intervention ☒ Reduced wait times ☒ Improved experiential outcomes ☒ Improved functional outcomes

New and Carried-Over Actions					
Name	**Description**	**Focus Areas**	**How?**	**Monitoring**	**Related KPI**
Expand Tier 1 services: update website ☐ New Action ☒ Carried-Over Action	Update and reorganize website to make it easier to navigate and to include more tier 1 resources and more links to tier 1 resources created by other PSLs and reputable programs. Continue to ensure that the website is accessible and meets AODA requirements.	*Funding Goals:* ☐ Paediatric recovery ☐ Reducing wait times ☒ Expanding provision of service *Guideline Elements:* ☒ Tiered services ☒ Equity and cultural safety ☐ Seamless pathways	*Key Milestones:* Resources and links are updated regularly based on the needs that come up in calls to parents and on new research and resources that become available. We also create some of our own resources in response to need, e.g. neurodiversity newsletter. *Timelines:* Ongoing; review entire website every 6 months to check links and ensure all information is up to date. Waiting for new SEHU website to be launched and to see whether LE will be part of it or have a separate site. *Resources Required:* Staff time *Partners Involved:* Other PSLs sharing resources, SEHU Communications Team	Semi-annual review. AAs doing the intake calls and SLPs and CDAs providing client service identify when we need a new resource to fill a gap, or when they become aware of new resources they would like to have available on the website. Parent survey feedback. Use answers to the question, “What else would you have liked to receive while you were waiting?” to inform selection of new resources to add to website. Parent survey is distributed to families annually and at discharge, via link/QR code to CheckMarket survey. Parents can also complete the survey in our clinic sites.	☒ Earlier age of referral / first intervention ☒ Reduced wait times ☒ Improved experiential outcomes ☒ Improved functional outcomes

New and Carried-Over Actions					
Name	**Description**	**Focus Areas**	**How?**	**Monitoring**	**Related KPI**
Create or obtain more online/ recorded presentations and webinars and integrate them into pathways ☐ New Action ☒ Carried-Over Action	Use more pre-recorded teaching/information videos so that families can view them when it suits them and clinic time can be used to discuss content, personalize, and coach parents to implement the ideas. This would only be one tool in the box – i.e. an option when the SLP feels it would be beneficial and the family is able to access online resources. Content can always be delivered in person when that is more appropriate, and content would always be discussed with the family and personalized.	*Funding Goals:* ☐ Paediatric recovery ☒ Reducing wait times ☒ Expanding provision of service *Guideline Elements:* ☒ Tiered services ☒ Equity and cultural safety ☒ Seamless pathways	*<u>Key Milestones:</u>* Implementation of new pathways that include curated lists of resources, including webinars, online modules, and recorded presentations from other PSLs. SLPs will recommend specific resources to families. (summer – fall 2025) *<u>Timelines:</u>* Spring 2025 – resources for pathways have been selected Summer 2025 – implement Speech Pathway Fall 2025 – implement Language Pathway *<u>Resources Required:</u>* We had hoped to record some in-house video versions of locally developed “Backpack” resources, but have not had the time or resources to do it.	Collect feedback from staff on parent uptake and whether watching the videos ahead of time results in more effective use of clinic time and better learning outcomes for parents. Track the number of times the online resources are accessed and completed.	☐ Earlier age of referral / first intervention ☐ Reduced wait times ☒ Improved experiential outcomes ☒ Improved functional outcomes

New and Carried-Over Actions					
Name	**Description**	**Focus Areas**	**How?**	**Monitoring**	**Related KPI**
Update Service Pathways ☐ New Action ☒ Carried-Over Action	Review and revise service pathways to include tier 1, tier 2, and tier 3 branches, and criteria for choosing each tier. Also, update service pathways to reflect discharge at school entry. Write new service pathways for KG-aged children who are not attending school. New pathways support equity and access by including many options for types of service and how services are accessed. E.g. in-person, virtual, phone, consultation to other agencies involved with the family, different frequencies, etc.	*Funding Goals:* ☐ Paediatric recovery ☒ Reducing wait times ☒ Expanding provision of service *Guideline Elements:* ☒ Tiered services ☒ Equity and cultural safety ☒ Seamless pathways	Consult research evidence (e.g. late talker research), other PSLs, and in-house staff expertise to inform the process. Default to less intensive/lower tier of service with indicators for when to move to a higher tier. Include details re services to be offered at each tier, frequency/ intensity of service, options to accommodate family capacity and choice, etc. Develop detailed pathway documents for SLPs, and a simplified infographic for clients and community partners. *<u>Key Milestones and timelines:</u>* -Fall 2024 working groups established -Winter 2025 drafts for Speech Pathway and Language Pathway completed -Spring 2025 both pathways reviewed and updated based on feedback from all staff and from steering committee	Revisit quarterly at clinical staff meetings to gather feedback and make revisions as needed. Parent survey – review annually for any parent input that speaks to the pathways and how to make them meet client needs/reduce barriers better. Once implemented, gather data on the number of clients receiving Tier 3 service and compare to before the pathways were updated. Monitor Outcome Measures if possible.	☐ Earlier age of referral / first intervention ☒ Reduced wait times ☒ Improved experiential outcomes ☒ Improved functional outcomes

			-Summer 2025 Speech Pathway implemented; meetings held with other PSLs in the SE IHP region about IHP pathway -Fall 2025 implement Language Pathway; collect feedback on IHP pathway from IHP SLPs; establish a working group for KG pathway for children not attending school. -Winter 2026: Review Speech and Language Pathways with staff and revise based on feedback from early implementation; draft KG pathway; work with other SE IHP regions to finalize IHP pathway *Resources Required:* Time to do research, have meetings, find resources, etc.		

New and Carried-Over Actions					
Name	**Description**	**Focus Areas**	**How?**	**Monitoring**	**Related KPI**
Build community capacity to provide Tier 1 service ☐ New Action ☒ Carried-Over Action	Support staff in front line early years positions to build their knowledge and skills so that they can better provide Tier 1 communication interventions and support families in making appropriate referrals to Language Express.	*Funding Goals:* ☐ Paediatric recovery ☒ Reducing wait times ☒ Expanding provision of service *Guideline Elements:* ☒ Tiered services ☒ Equity and cultural safety ☐ Seamless pathways	Offer PD sessions and other resources and supports to childcare, EarlyON, and other front line professionals in the early years sector on a variety of topics. Ask what is needed/wanted and develop resources, presentations, other learning/sharing opportunities in consultation with leaders in the sector. Develop a sustainability plan to ensure continuous support and PD opportunities. *Key Milestones:* -Meetings have been held with both EarlyON regions and both child care supervisors (Leeds-Grenville, Lanark). -Set up a "visiting SLP/CDA" program with both EarlyON regions. SLP or CDA attends play and learn sessions in each of 6 locations monthly, and some outreach locations as well. The same person always attends so that families get comfortable with her. She models strategies, answers questions and offers general suggestions, provides info and support around referrals and other community	Informal feedback from EarlyON is very positive. EarlyON manager said, "Language Express staff have […] been visiting our programs and that has seen many benefits, such as staff collaboration and knowledge sharing, and giving families access to a professional without a formal referral for those Tier 1 services." LE staff report that many families are asking questions, some families are attending specifically to talk with them (sometimes as a result of recommendation on intake call).	☒ Earlier age of referral / first intervention ☒ Reduced wait times ☒ Improved experiential outcomes ☒ Improved functional outcomes

			supports, and builds facilitator capacity. -Met with childcare supervisors and developed a plan for supporting front line educators, including quarterly lunch-and-learns, monthly infographic-style tips for educators, picture versions of social media posts that can be distributed to parents via daycare apps, milestones poster. *<u>Timelines:</u>* -EarlyON visits started in Jan. 2025 -presentations to two child care centres in May 2025 -milestones poster distributed in April/May 2025 -meetings with child care in May 2025 -lunch-and-learns, infographics, etc. to start in September 2025 -winter 2026 survey EarlyON and child care staff *<u>Resources Required:</u>* Staff time, Communications Team support *<u>Partners Involved:</u>* EarlyON Child Care sector	Plan to do a survey of EarlyON staff, and later of childcare staff. Tracking the number of families in attendance and the number of referrals to LE or other agencies recommended during SLP and CDA visits to EarlyON groups. Staff add this info to a tracking spreadsheet after each visit. Monitor referral source data (April and October) to see if referrals from childcare and EarlyON increase, and/or more parents say that they heard about Language Express from EarlyON or childcare.	

New and Carried-Over Actions					
Name	**Description**	**Focus Areas**	**How?**	**Monitoring**	**Related KPI**
Equity, Diversity, Inclusion and cultural safety training ☐ New Action ☒ Carried-Over Action	- All staff will attend 2 days of "Trauma and Violence-Informed Care Training for PSL" offered by the George Hull Centre, and participate in follow-up consultations to support implementation of changes. -Add a standing item to meeting agendas: time to engage in cultural safety conversations, reflections; could be a discussion of something in the news, a reflection on a question, or discussion of an issue that has come up.	*Funding Goals:* ☐ Paediatric recovery ☐ Reducing wait times ☐ Expanding provision of service *Guideline Elements:* ☐ Tiered services ☒ Equity and cultural safety ☐ Seamless pathways	*Key Milestones:* -Attend TVIC for PSL training -Participate in follow-up consultations and identify and implement changes to provide more culturally safe services *Timelines:* -TVIC workshop Sept. 17, 23, Oct. 7 2025 -consultations to follow -meeting agenda item starting at our next meeting in September *Resources Required:* -time *Partners Involved:* -George Hull Centre	-staff feedback -ideas for change	☐ Earlier age of referral / first intervention ☐ Reduced wait times ☒ Improved experiential outcomes ☒ Improved functional outcomes

New and Carried-Over Actions					
Name	**Description**	**Focus Areas**	**How?**	**Monitoring**	**Related KPI**
Identify and pilot at least one change or new initiative to reduce barriers to service access for families ☒ New Action ☐ Carried-Over Action	Develop and distribute a one-time survey, or add questions to our ongoing parent survey, asking whether parents feel our services are respectful of their culture and identity, and also what the barriers to accessing our services are and what might help. Develop and distribute a similar survey to community partners. Analyze survey results and use the results, together with ideas gathered from staff, steering committee members, and community partners on a similar journey. Choose 1 or more concrete change to implement.	*Funding Goals:* ☐ Paediatric recovery ☐ Reducing wait times ☒ Expanding provision of service *Guideline Elements:* ☐ Tiered services ☒ Equity and cultural safety ☐ Seamless pathways	*<u>Key Milestones and timelines:</u>* Survey parents and community partners Fall 2025 using a Checkmarket online survey with option to complete in clinic. Ask George Hull TVIC consultants for input on questions to ask. Winter 2026: Analyze survey results and obtain input from staff and steering committee. Choose what to pilot and make a plan. Implement spring 2026 (some changes that don't require a lot of resources may be implemented sooner, e.g. updating forms) *<u>Resources Required:</u>* Will depend on the actions identified. Some will just require staff time, e.g. editing forms, reviewing current resources. Others may require communication team time (e.g. revising print and digital resources), money (e.g. new toys or books), HR and corporate services support (e.g. offering	Repeat survey Monitor uptake/response to new service offerings or resources	☐ Earlier age of referral / first intervention ☐ Reduced wait times ☒ Improved experiential outcomes ☒ Improved functional outcomes

			evening/weekend appointments), or funding (transportation supports, interpreter services, etc.). *Partners Involved:* as above, and we may be able to leverage services provided by other agencies such as support for transportation and/or interpreter services.		

New and Carried-Over Actions					
Name	**Description**	**Focus Areas**	**How?**	**Monitoring**	**Related KPI**
Explore potential uses of AI to reduce administrative burden ☒ New Action ☐ Carried- Over Action	Learn more about AI tools that could save time and reduce administrative burden (for chart notes, reports, creating resources, meeting minutes, etc.) Consult with lead agency IT, Privacy Officer, etc. Investigate cost and training requirements.	*Funding Goals:* ☐ Paediatric recovery ☒ Reducing wait times ☐ Expanding provision of service *Guideline Elements:* ☐ Tiered services ☐ Equity and cultural safety ☐ Seamless pathways	*Key Milestones and Timelines:* Fall 2025 & Winter 2026: -survey other PSLs and partner agencies re their experience with AI -consult with privacy officer and IT dept. re considerations -advocate to MCCSS to support province-wide tool selection and licensing for PSL or provide funding -gather info about AI tools and costs *Resources Required:* Expert consultation	Monitor milestones. If we do decide to start using an AI tool, we will need to add a new action to our LIFT plan with milestones and a monitoring plan that includes staff feedback and productivity indicators (visits/quarter, etc.).	☐ Earlier age of referral / first intervention ☒ Reduced wait times ☐ Improved experiential outcomes ☐ Improved functional outcomes

New and Carried-Over Actions					
Name	**Description**	**Focus Areas**	**How?**	**Monitoring**	**Related KPI**
Improve access for ESL families ☒ New Action ☐ Carried-Over Action	Explore how we can better support families whose first language is not English, especially families who speak very little English. Explore options for leveraging support from community agencies such as the Immigration Partnership. Ask other PSLs what they do, especially small rural PSLs in regions that are primarily English-speaking. Gather information about options and cost for interpretation services.	*Funding Goals:* ☐ Paediatric recovery ☐ Reducing wait times ☒ Expanding provision of service *Guideline Elements:* ☐ Tiered services ☒ Equity and cultural safety ☐ Seamless pathways	*Key Milestones and Timelines:* Bring the question to the provincial PSL Collaborative and the provincial PSL Community of Practice for discussion in Fall 2025. Reach out to both Immigration Partnerships in our area in Fall 2025. Plan to assess the information we have been able to collect by January 2026, discuss with staff and steering committee, and draft a guidance document to go with our service pathways by April 2026. *Resources Required:* Staff time May require funding for interpreter services	Monitor progress on milestones by reporting to steering committee at each meeting and adding to workplan.	☐ Earlier age of referral / first intervention ☐ Reduced wait times ☒ Improved experiential outcomes ☒ Improved functional outcomes

Additional Comments

- We have already implemented tools to reduce administrative burden, including Caredove online referral process and online booking. There is a significant associated cost.
- The TVIC training for PSLs that is being funded by MCCSS is very welcome. It would be so helpful if MCCSS provided and funded other supports such as licensing for technology supports; these cost a lot and would probably be cheaper with large group purchasing. Also, the research and selection process is onerous, especially for small PSLs.
- We plan to advocate through the Provincial PSL Collaborative for MCCSS to host a province-wide PSL resource-sharing site for all PSLs, and a public-facing website for information and resources for parents. PSL websites across the province vary from non-existent to fantastic, which is not equitable. Small PSLs don't have the resources that large ones do. Also, there is a huge duplication of effort.
- Please keep in mind that some of the actions in this plan are driven by funding and staffing pressures, in that they are attempts to continue to provide quality evidence-based service with diminishing resources. However, an effect of these staffing pressures is that we often don't have the staff time to put into working on special projects that may have longer-term benefits but don't contribute right away to improving client outcomes and keeping wait times down. As a result, we may have to prioritize or delay some of the actions, especially if we have staff vacancies or are forced to lay off more staff.

APPENDIX A – BEST PRACTICES FOR WAIT-TIME REDUCTION

The following best practices were identified through an Environmental Scan of evidenced-based practices that measured outcomes of wait-time reduction methodologies across a variety of different health and social sector fields:

1. **Administrative Burden Reduction:** Administrative tasks occupy a considerable amount of clinicians' time. Agencies may benefit from identifying these burdens and developing solutions to reduce the time spent on administrative tasks (e.g., scheduling). Incorporating efficient technological solutions may also be beneficial.
2. **Addressing Access Barriers:** Families encounter multiple obstacles when seeking services, with limited service-hours being a significant factor. Adopting flexible service models, like extended or alternative hours, can reduce wait-times by accommodating more families.
3. **LEAN Management:** LEAN management practices can help agencies eliminate waste and better address the challenges of high patient volumes and resource constraints.
4. **Incorporation of New Technology and Communication Strategies:** Agencies can utilize technology to identify, and implement, labour-saving alternatives to outdated, inefficient, processes. For example, technological tools can support the optimization of patient scheduling, registration, and note taking.

APPENDIX B – TPON DATA-REPORTING: DEFINITIONS AND GUIDANCE

This Appendix aims to assist agencies in reconciling their internal data-tracking metrics with the TPON data-reporting metrics tracked by the ministry. This reconciliation is especially important in relation to actions aimed at reducing client wait-times, as the ministry measures progress on this critical LIFT-strategy goal based solely on the data it receives via TPON. As a result, if an agency is not able to convey its internally-measured progress in reducing wait-times via its TPON data-reporting, it will appear to the ministry to be making no progress.

The following tables list the TPON reporting requirements tracked by the ministry in relation to PSL, CBRS, and SBRS, and provide clarifications that aim to assist agencies in the data-reconciliation process:

Preschool Speech and Language Program		
Service Data Name	**Definition**	**Clarifications (based on the *Guidelines*)**
Preschool Speech and Language: Ministry-funded agency expenditures	Total ministry-funded expenses for the Transfer Payment Recipient to administer and/or deliver the Preschool Speech and Language Program in the Funding Year (cumulative).	N/A
# of individuals served (unique): PSL	The unique number of all referred children who had an initial assessment plus all referred children who received any intervention during the reporting period (cumulative). Report the same value as the total reflected in the IRSS Monitoring Report Question 4.	• In the context of this definition, the phrase “initial assessment” refers to an assessment completed by a regulated health professional that acts as a gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the “Program Elements” section of the *Guidelines* for details regarding the initial assessment. • In the context of this definition, the phrase “any intervention” encompasses interventions at all Tier-levels.
# of individuals waiting for initial assessment: PSL	The total number of all referred children waiting for an initial assessment at the	• In the context of this definition, the phrase “initial assessment” refers to an assessment completed by a

	end of the reporting period (cumulative). Report the same value as the total reflected in Monitoring Report Question 10.	regulated health professional that acts as a gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding the initial assessment.
# of individuals who received initial assessment: PSL	The total number of all referred children who received an initial assessment during the reporting period. Report the same value as the total reflected in IRSS Monitoring Report Question 2.	• In the context of this definition, the phrase "initial assessment" refers to an assessment completed by a regulated health professional that acts as a gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding the initial assessment.
Average wait time from referral to initial assessment (# of weeks): PSL	The average number of weeks waited from the referral date to the initial assessment date (cumulative). Report the same value as the total reflected in the IRSS Monitoring Report Question 7.	• In the context of this definition, the phrase "initial assessment" refers to an assessment completed by a regulated health professional that acts as a gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding the initial assessment.
# of Individuals who Received their First Intervention: PSL	The total number of referred children in the PSL program who received their first intervention in the reporting period. Report the same value as the total reflected in Monitoring Report Question 3b.	• In the context of this definition, the phrase "first intervention" refers to the first intervention a child receives after their assessment by a regulated health professional has been completed. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment first interventions.
Average wait time from initial assessment to first intervention (# of weeks): PSL	The average number of weeks waited from the date of initial assessment to the date of first intervention. Report the same value as the total reflected in Monitoring Report Question 8.	• In the context of this definition, the phrase "initial assessment" refers to an assessment completed by a regulated health professional that acts as a gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding the initial assessment. • In the context of this definition, the phrase "first intervention" refers to the first intervention a child receives after their assessment by a regulated health professional has been completed.

		○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment first interventions.
Average age at referral (months): PSL	Average age (in months) of children at referral during the reporting period. Report the same value as the total reflected in the IRSS Monitoring Report Question 6b.	N/A
Average Age at First Intervention (Months): PSL	The average age (in months) of the children who accessed their first intervention during the reporting period. Report the same value as the total reflected in Monitoring Report Question 3c.	• In the context of this definition, the phrase "first intervention" refers to the first intervention a child receives after their assessment by a regulated health professional has been completed. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment first interventions.

Community Based Rehabilitation Services		
Service Data Name	**Definition**	**Clarifications (based on the *Guidelines*)**
Ministry-funded agency expenditures: CBRS	Total ministry-funded expenses for the Transfer Payment Recipient to administer and/or deliver community-based rehabilitation services in the Funding Year (cumulative)	N/A
# visits (total): CBRS	The total number of CBRS funded visits with a registered client, whether individually or as part of a group, inclusive of interactions that may be in-person, video, telephone or through electronic communication. Services may include Occupational Therapy, Physiotherapy, Speech-	• In the context of this definition, "visits" refer to both assessments completed by a regulated health professional, and to post-assessment service interactions. ○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding initial assessments. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.

	Language Pathology, Audiology, Rehabilitation Engineering, Social Work, Psychology and Psychometry, and Therapeutic Recreation. A visit is an interaction (greater than 5 minutes) with a client and/or parent/ guardian/ caregiver for the purpose of providing assessment, intervention or consultation. Notes: Interactions for the sole purpose of scheduling is not considered a visit. All visits should be counted regardless of whether it falls on the same calendar day.	
# of visits (total - Occupational Therapy): CBRS	The total number of CBRS-funded occupational therapy visits with a registered client, whether individually or as part of a group, inclusive of interactions that may be in-person, video, telephone or through electronic communication. A visit is an interaction (greater than 5 minutes) with a client and/or parent/ guardian/ caregiver for the purpose of providing assessment, intervention or consultation. Notes: Interactions for the sole purpose of scheduling is not considered a visit. All visits should be counted regardless of whether it falls on the same calendar day.	• In the context of this definition, “visits” refer to both assessments completed by an occupational therapist, and to post-assessment service interactions with an occupational therapist. ○ See pages 53-58 of the “Program Elements” section of the *Guidelines* for details regarding initial assessments. ○ See pages 58-63 of the “Program Elements” section of the *Guidelines* for details regarding post-assessment services.
# of visits (total - Physiotherapy): CBRS	The total number of CBRS -funded physiotherapy visits with a registered client, whether individually or as part of a group, inclusive of interactions	• In the context of this definition, “visits” refer to both assessments completed by a physiotherapist, and to post-assessment service interactions with a physiotherapist.

	that may be in-person, video, telephone or through electronic communication. A visit is an interaction (greater than 5 minutes) with a client and/or parent/ guardian/ caregiver for the purpose of providing assessment, intervention or consultation. Notes: Interactions for the sole purpose of scheduling is not considered a visit. All visits should be counted regardless of whether it falls on the same calendar day. A visit is each occasion when an individual is provided service in a functional centre.	○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding initial assessments. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.
# of visits (total - Speech-Language Pathology): CBRS	The total number of CBRS-funded speech-language pathology visits with a registered client, whether individually or as part of a group, inclusive of interactions that may be in-person, video, telephone or through electronic communication. A visit is an interaction (greater than 5 minutes) with a client and/or parent/ guardian/ caregiver for the purpose of providing assessment, intervention or consultation. Notes: Interactions for the sole purpose of scheduling is not considered a visit. All visits should be counted regardless of whether it falls on the same calendar day.	• In the context of this definition, "visits" refer to both assessments completed by a speech-language pathologist, and to post-assessment service interactions with a speech-language pathologist. ○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding initial assessments. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.
# of individuals served (unique): CBRS	The unique number of children and youth that received community-	• In the context of this definition, "services" refer to post-assessment service interactions.

	based rehabilitation services in the Funding Year. Services may include Occupational Therapy, Physiotherapy, Speech-Language Pathology, Audiology; Rehabilitation Engineering; Social Work; Psychology and Psychometry; and Therapeutic Recreation.	○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.
# of individuals served (Unique - Occupational Therapy): CBRS	The unique number of individuals receiving community-based occupational therapy during the reporting period. If an individual was served in more than one functional centre, they would be counted in each centre.	• In the context of this definition, "community-based occupational therapy" refers to post-assessment service interactions with an occupational therapist. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.
# of individuals served (Unique - Physiotherapy): CBRS	The unique number of individuals receiving community-based physiotherapy during the reporting period If an individual was served in more than one functional centre, then they would be counted in each centre.	• In the context of this definition, "community-based physiotherapy" refers to post-assessment service interactions with a physiotherapist. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.
# of individuals served (Unique - Speech-Language Pathology): CBRS	The unique number of individuals receiving community-based speech-language pathology during the reporting period. If an individual was served in more than one functional centre, they would be counted in each centre.	• In the context of this definition, "community-based speech-language pathology" refers to post-assessment service interactions with a speech-language pathologist. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.
# of individuals waiting for initial assessment: CBRS	The number of children and youth who are waiting for an initial therapy assessment for community-based rehabilitation services (children and youth have a referral date but have not	• In the context of this definition, the phrase "initial therapy assessment" refers to an assessment completed by a regulated health professional that acts as the gateway to Tier 2 and 3 services (if required).

	received an initial therapy assessment).	○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding initial assessments.
# of individuals waiting for service initiation: CBRS	The number of children/youth who are waiting for community-based rehabilitation intervention services to begin (have received an initial therapy assessment, but service has not begun).	• In the context of this definition, the phrase "community-based rehabilitation intervention services" refers to interventions occurring after the child's assessment by a regulated health professional has been completed. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment interventions. • In the context of this definition, the phrase "initial therapy assessment" refers to an assessment completed by a regulated health professional that acts as the gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the "Program Elements" section of the Guidelines for details regarding initial assessments.
Average wait time from referral to initial assessment (# of days): CBRS	The average number of days waited for a community-based rehabilitation services assessment (from the referral date to the initial assessment date). The number of days waited for an assessment divided by the number of children and youth who received an initial therapy assessment will give the average wait time for an assessment (on a year-to-date average).	• In the context of this definition, the phrase "community-based rehabilitation services assessment" refers to the assessment completed by a regulated health professional that acts as the gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding initial assessments.
Average wait time from initial assessment to service initiation (# of days): CBRS	The average number of days waited from initial community-based rehabilitation services assessment to service initiation (date of the actual first visit).	• In the context of this definition, the phrase "initial community-based rehabilitation services assessment" refers to an assessment completed by a regulated health professional that acts as the gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding the initial assessment.

		• In the context of this definition, the phrase “service initiation” refers to the first intervention a child receives after their assessment by a regulated health professional has been completed. ○ See pages 58-63 of the “Program Elements” section of the *Guidelines* for details regarding post-assessment interventions.
# of individuals referred to CTC services (total)	The unique number of individuals referred to the CTC organization for all services during the reporting period. The referral must be received, and date stamped by the CTC. Report the same data as MIS 8562470 "Referrals to the CTC Organization".	N/A

# of intake assessments completed (total): SmartStart Hubs	The unique number of individuals for which an intake assessment was completed (intake assessment refers to the occurrence of an exploratory conversation). Total refers to the total number during the reporting period.	• In the context of this definition, “intake assessment” refers to the exploratory SmartStart Hub client intake process that occurs around the time of referral. 	
		  ○ See pages 46-49 of the “Program Elements” section of the *Guidelines* for details regarding the intake process.
		  ○ See also Part 8 of the *SmartStart Hubs Guidelines.*

Average age at intake assessment (months): SmartStart Hubs	The average age of all individuals at intake assessment (where an exploratory conversation was held) during the reporting period.	• In the context of this definition, “intake assessment” refers to the exploratory SmartStart Hub client intake process that occurs around the time of referral.
		  ○ See pages 46-49 of the “Program Elements” section of the *Guidelines* for details regarding the intake process.
		  ○ See also Part 8 of the *SmartStart Hubs Guidelines.*

# of individuals at intake assessment (ages 0 to 4): SmartStart Hubs	The number of individuals ages 0 to 4 for which an intake assessment was completed (where an exploratory conversation was held) during the reporting period.	• In the context of this definition, “intake assessment” refers to the exploratory SmartStart Hub client intake process that occurs around the time of referral. 	
		  ○ See pages 46-49 of the “Program Elements” section of the *Guidelines* for details regarding the intake process.
		  ○ See also Part 8 of the *SmartStart Hubs Guidelines.*

# of individuals at intake assessment (ages 5 to 12): SmartStart Hubs	The number of individuals ages 5 to 12 for which an intake assessment was completed (where an exploratory conversation was held) during the reporting period.	• In the context of this definition, "intake assessment" refers to the exploratory SmartStart Hub client intake process that occurs around the time of referral. o See pages 46-49 of the "Program Elements" section of the *Guidelines* for details regarding the intake process. o See also Part 8 of the *SmartStart Hubs Guidelines.*
# of individuals at intake assessment (ages 13 to 21): SmartStart Hubs	The number of individuals ages 13 to 21 for which an intake assessment was completed (an exploratory conversation was held) during the reporting period.	• In the context of this definition, "intake assessment" refers to the exploratory SmartStart Hub client intake process that occurs around the time of referral. o See pages 46-49 of the "Program Elements" section of the *Guidelines* for details regarding the intake process. o See also Part 8 of the *SmartStart Hubs Guidelines.*
# of individuals waiting for intake assessment: SmartStart Hubs	The number of individuals who are waiting to have an intake assessment completed with the SmartStart Hubs (individuals have been referred but have not yet had an exploratory meeting) during the reporting period.	• In the context of this definition, "intake assessment" refers to the exploratory SmartStart Hub client intake process that occurs around the time of referral. o See pages 46-49 of the "Program Elements" section of the *Guidelines* for details regarding the intake process. o See also Part 8 of the *SmartStart Hubs Guidelines.*
Average wait time from referral to intake assessment (# of days): SmartStart Hubs	The average number of days waited for SmartStart Hubs intake assessment (from the referral date to the completion of the exploratory conversation meeting) during the reporting period.	• In the context of this definition, "intake assessment" refers to the exploratory SmartStart Hub client intake process that occurs around the time of referral. o See pages 46-49 of the "Program Elements" section of the *Guidelines* for details regarding the intake process. o See also Part 8 of the *SmartStart Hubs Guidelines.*

School Based Rehabilitation Services		
Service Data Name	**Definition**	**Clarifications (based on the *Guidelines*)**
Ministry-funded agency expenditures: SBRS	Total ministry-funded expenses for the Transfer Payment Recipient to administer and/or deliver school-based rehabilitation services in the Funding Year (cumulative).	N/A
# of visits (total - Occupational Therapy): SBRS	The total number of SBRS -funded occupational therapy visits with a registered client, whether individually or as part of a group, inclusive of interactions that may be in-person, video, telephone or through electronic communication. A visit is an interaction (greater than 5 minutes) with a client and/or parent/ guardian/ teacher/ educational assistant/ caregiver for the purpose of providing assessment, intervention or consultation. Notes: Interactions for the sole purpose of scheduling is not considered a visit. All visits should be counted regardless of whether it falls on the same calendar day.	• In the context of this definition, “visits” refer to both assessments completed by an occupational therapist, and to post-assessment service interactions with an occupational therapist. o See pages 53-58 of the “Program Elements” section of the *Guidelines* for details regarding initial assessments. o See pages 58-63 of the “Program Elements” section of the Guidelines for details regarding post-assessment services.
# of visits (total - Physiotherapy): SBRS	The total number of SBRS -funded physiotherapy visits with a registered client, whether individually or as part of a group, inclusive of interactions that may be in-person, video, telephone or through electronic communication.	• In the context of this definition, “visits” refer to both assessments completed by a physiotherapist, and to post-assessment service interactions with a physiotherapist. o See pages 53-58 of the “Program Elements” section of the *Guidelines* for details regarding initial assessments. o See pages 58-63 of the “Program Elements” section of the Guidelines for details regarding post-assessment services.

	A visit is an interaction (greater than 5 minutes) with a client and/or parent/ guardian/ teacher/ educational assistant/ caregiver for the purpose of providing assessment, intervention or consultation. Notes: Interactions for the sole purpose of scheduling is not considered a visit. All visits should be counted regardless of whether it falls on the same calendar day.	
# of visits (total - Speech-Language Pathology): SBRS	The total number of SBRS -funded speech-language pathology visits with a registered client, whether individually or as part of a group, inclusive of interactions that may be in-person, video, telephone or through electronic communication. A visit is an interaction (greater than 5 minutes) with a client and/or parent/ guardian/ teacher/ educational assistant/ caregiver for the purpose of providing assessment, intervention or consultation. Notes: Interactions for the sole purpose of scheduling is not considered a visit. All visits should be counted regardless of whether it falls on the same calendar day.	• In the context of this definition, “visits” refer to both assessments completed by a speech-language pathologist, and to post-assessment service interactions with a speech language pathologist. ○ See pages 53-58 of the “Program Elements” section of the *Guidelines* for details regarding initial assessments. ○ See pages 58-63 of the “Program Elements” section of the Guidelines for details regarding post-assessment services.
# of individuals served (unique): SBRS	The unique number of children and youth that received school- based rehabilitation services in publicly funded schools during the reporting	• In the context of this definition, “services” refer to post-assessment service interactions with a regulated health professional.

	period. Services may include occupational therapy, physiotherapy and/ or speech-language pathology.	○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.
# of individuals served (Occupational Therapy): SBRS	The unique number of individuals receiving school-based occupational therapy in publicly funded schools during the reporting period. If an individual was served in more than one functional centre, then they would be counted in each centre.	• In the context of this definition, "school-based occupational therapy" refers to post-assessment service interactions with an occupational therapist. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.
# of individuals served (Physiotherapy): SBRS	The unique number of individuals receiving school-based physiotherapy in publicly funded schools during the reporting period. If an individual was served in more than one functional centre, then they would be counted in each centre.	• In the context of this definition, "school-based physiotherapy" refers to post-assessment service interactions with a physiotherapist. ○ See pages 58-63 of the "Program Elements" section of the *Guidelines* for details regarding post-assessment services.
# of individuals served (Speech-Language Pathology): SBRS	The unique number of individuals receiving school-based speech-language pathology in publicly funded schools during the reporting period. If an individual was served in more than one functional centre, then they would be counted in each centre.	• In the context of this definition, "school-based speech-language pathology" refers to post-assessment service interactions with a speech-language pathologist. ○ See pages 58-63 of the "Program Elements" section of the Guidelines for details regarding post-assessment services.
# of individuals waiting for initial assessment: SBRS	The number of children and youth who are waiting for an initial therapy assessment for school-based rehabilitation services (have a referral date but have not received an initial therapy assessment).	• In the context of this definition, the phrase "initial therapy assessment" refers to an assessment completed by a regulated health professional that acts as a gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the "Program Elements" section of the *Guidelines* for details regarding initial assessments.

# of individuals waiting for service initiation: SBRS	The number of children and youth who are waiting for school- based rehabilitation intervention services to begin (have received an initial therapy assessment, but service has not begun).	• In the context of this definition, the phrase “school-based rehabilitation intervention services” refers to interventions occurring after the child’s assessment by a regulated health professional has been completed. 	
		  ○ See pages 58-63 of the “Program Elements” section of the *Guidelines* for details regarding post-assessment interventions.
		• In the context of this definition, the phrase “initial therapy assessment” refers to an assessment completed by a regulated health professional that acts as the gateway to Tier 2 and 3 services (if required).
		  ○ See pages 53-58 of the “Program Elements” section of the Guidelines for details regarding initial assessments.

Average wait time from referral to initial assessment (# of days): SBRS	The average number of days waited for a school-based rehabilitation services assessment (from the referral date to the initial assessment date). The number of days waited for an assessment divided by the number of children and youth who received an initial therapy assessment will give the average wait time for an assessment (on a year-to-date average).	• In the context of this definition, the phrase “school-based rehabilitation services assessment” refers to the assessment completed by a regulated health professional that acts as the gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the “Program Elements” section of the *Guidelines* for details regarding initial assessments.
Average wait time from initial assessment to service initiation (# of days): SBRS	The average number of days waited from initial assessment for school-based rehabilitation services to service initiation (date of the actual first visit).	• In the context of this definition, the phrase “initial assessment for school-based rehabilitation services” refers to an assessment completed by a regulated health professional that acts as the gateway to Tier 2 and 3 services (if required). ○ See pages 53-58 of the “Program Elements” section of the *Guidelines* for details regarding the initial assessment. • In the context of this definition, the phrase “service initiation” refers to the first intervention a child receives after their assessment by a regulated health professional has been completed.

		○ See pages 58-63 of the “Program Elements” section of the Guidelines for details regarding post-assessment interventions.
# of Schools Receiving Tier 1 Services: SBRS	Tier 1 supports are accessible and beneficial to all, and registration with the Children's Treatment Centre (CTC) is not required for access. Tier 1/Universal services may involve: Working collaboratively with partners as part of the service system to build reciprocal capacity in education and community settings towards supporting child development, identifying needs, implementing strategies, and connecting families with information and services. SBRS Tier 1 services may include time related to activities associated with the planning or delivery of a universal service, planning or delivering workshops / education sessions with content to support all children, researching or developing tools to support all children, consulting with educators, co-teaching/ classroom programming, participation in team meetings for school-wide interventions etc. Note: Report the number of schools receiving Tier 1 services in the cell and total number of schools in the CTC catchment area in the "variance explanation" section on	N/A

	Tab H at year-end only. Input "0" for interim reporting.	

Please follow the links below for the complete TPON data-reporting requirements for PSL, CBRS, and SBRS:

- Preschool Speech and Language Program
- Community Based Rehabilitation Services
- School Based Rehabilitation Services

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Kathleen Thompson

From: EA <ea-bounces@lists.alphaweb.org> on behalf of Nickason, Melissa <Melissa.Nickason@smdhu.org>
Sent: Thursday, September 18, 2025 1:31 PM
To: loretta@alphaweb.org; ea@lists.alphaweb.org; 'allhealthunits@lists.alphaweb.org'
Subject: [EA] SMDHU 2024 Annual Report
Attachments: ATT00001.txt

Sending on behalf of Ann-Marie Kungl, Chair, Board of Health for Simcoe Muskoka District Health Unit

On behalf of the Board of Health of the Simcoe Muskoka District Health Unit (SMDHU), I am pleased to share our *2024 Annual Report*, highlighting a year of progress in protecting and promoting public health across our region. Throughout 2024, SMDHU remained focused on delivering core public health services that support the health and well-being of those who live in, work in, and visit our communities. With the full resumption of core programming, particular attention was given to immunization and helping school-aged students catch up on vaccines required under the *Immunization of School Pupils Act* (ISPA).

In 2024, SMDHU's senior leadership and members of the Board provided input into the review of the Ontario Public Health Standards (OPHS) that are to be implemented in 2026. To prepare for the upcoming OPHS, the Board extended the 2023–2024 Strategic Plan through 2025, ensuring flexibility and readiness for future provincial directions. The Board also approved an organizational restructuring to strengthen capacity in key areas such as infectious disease and immunization, with implementation beginning in January 2025.

Recognizing the importance of accessible information, we began development of a refreshed Health Professional Resources site and introduced "SAM," a generative AI assistant designed to enhance public access to timely, accurate public health information.

In our commitment to reconciliation, the Board initiated meetings with leadership from First Nations and Métis communities across Simcoe Muskoka late in the year, laying the foundation for respectful and ongoing relationships.

These accomplishments reflect the dedication of our staff, leadership, and Board members and we encourage you to share our 2024 Annual Report with others inside and outside of your organization. If you have any questions, comments or concerns about public health issues or topics in your community, please contact the health unit at 705-721-7520 or 1-877-721-7520 between 8:30 a.m. to 4:30 p.m., Monday to Friday, or through the online contact form on our website.

Sincerely,

Ann-Marie Kungl
Chair, Board of Health

Melissa Nickason
Executive Assistant to the Office of the Medical Officer of Health
t: 705-721-7520 **or** 1-877-721-7520 **x:** 7079
f: 705-725-0335

e: melissa.nickason@smdhu.org

Simcoe Muskoka District Health Unit, 15 Sperling Dr, Barrie, ON L4M 6K9

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Algoma PUBLIC HEALTH
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3.0

September 12, 2025

Via Email

The Honourable Doug Ford
Premier of Ontario

Subject: Working Together to Reduce Food Insecurity in Ontario

Dear Premier Ford,

On behalf of the Board of Health of Algoma Public Health (APH), please accept our appreciation for the provincial government's efforts to support vulnerable Ontarians, including tying ODSP rates to inflation and increases to minimum wage. These steps are positive, and we hope they signal a continued commitment to addressing the root causes of poverty and food insecurity.

At the same time, we are deeply concerned about the rising rates of food insecurity across Ontario. Between 2022 and 2023, the rate of severe household food insecurity rose from 4.8% to 7.8%[1]. This trend has serious implications for public health, as food insecurity is strongly linked to chronic conditions like diabetes, poor mental health, and increased health care use[1].

We know that food insecurity is fundamentally an income issue. While food banks and community programs provide essential short-term relief, long-term solutions require policies that improve a household's financial stability. Research consistently shows that increasing social assistance rates and aligning minimum wage with a living wage can significantly reduce food insecurity[2-4].

In Algoma, our monitoring food affordability data shows that current social assistance rates fall short of covering basic needs like food and housing[5]. We also know that employment alone is not always protective – over half of food-insecure households in Ontario rely primarily on wages or self-employment income[3].

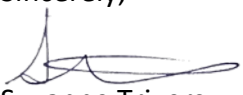
At its meeting on May 28, 2025, the Algoma Board of Health passed the following motion:

> ***That the Board of Health for the District of Algoma Health Unit continue to advocate for income-based responses by calling on the provincial government to:***
>
> 1. ***Recognize and acknowledge food insecurity as an income-based problem that requires income-based solutions;***
> 2. ***Set targets to reduce food insecurity; and***
> 3. ***Engage with all levels of government, private and non-profit sectors, and people with lived and living experiences, to implement progressive economic policies that increase household income (i.e., living wage, indexing all social assistance to inflation, and using monitoring food affordability data to set adequate social assistance rates).***

We believe these actions align with your government's stated goals of building a stronger, more resilient Ontario. By investing in income-based solutions, we can reduce pressure on our healthcare system, improve quality of life, and ensure that all Ontarians have the opportunity to thrive.

We would welcome the opportunity to work with your government on this important issue and would be pleased to provide further data or insights from our region.

Sincerely,



Suzanne Trivers,
Chair, Board of Health,
Algoma Public Health

cc: Dr. K. Moore, Chief Medical Officer of Health
Heather Schramm, Director, Health Promotion and Prevention Policy and Programs Branch, Ministry of Health
Susan Stewart, Chair, Health Promotion Ontario Executive Committee
Dr. Michael Sherar, President and Chief Executive Officer, Public Health Ontario
MPP Chris Scott, Sault Ste. Marie
MPP Bill Rosenberg, Algoma-Manitoulin
David Thompson, Chair, Algoma Food Security Network
All Ontario Boards of Health

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WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | wechu.org |

1005 Ouellette Avenue, Windsor, ON N9A 4J8 | 33 Princess Street, Leamington, ON N8H 5C5

August 26, 2025

The Honourable Marjorie Michel
Minister of Health
House of Commons
Ottawa, ON
K1A 0A6

Dear Minister Michel

The Windsor-Essex County Health Unit's Board of Health has a longstanding history of supporting progressive approaches to system changes. On June 26, 2026, the Board of Health continued this support by passing a resolution to address the escalating opioid crisis in Windsor-Essex County (WEC) through coordinated, comprehensive and innovative client support and substance prevention strategies.

The resolution states:

WHEREAS, the Windsor-Essex County has been consistently ranked among the areas in Ontario with the highest rates of opioid overdoses presenting in Emergency Departments, as well as significantly higher rates of opioid-related deaths.

WHEREAS, new and unrecognizable compounds and substances have entered the drug supply, worsening the substance use crisis.

WHEREAS, Windsor-Essex County's alcohol-related ED visits and hospitalizations are significantly higher than the provincial average, with emergency department visits rising among youth and young adults, particularly those 24 and under.

WHEREAS, the Public Health Agency of Canada's Youth Substance Use Prevention Program has previously opened opportunities for community-based funding program that focuses on implementing upstream prevention models for local community agencies.

NOW THEREFORE BE IT RESOLVED that the Windsor-Essex County Board of Health endorses the prioritization of communities which are experiencing disproportionately high overdose rates like Windsor-Essex for the allocation of funding from all levels of government for both upstream (e.g., youth prevention) and downstream services.

FURTHER, the Windsor-Essex County Board of Health supports work of the Windsor-Essex County Health Unit to explore new partnership opportunities with local agencies to implement novel drug testing solutions to support enhanced data collection, surveillance, and harm reduction services for people who use drugs.

FURTHER, the Windsor-Essex County Board of Health encourages the Public Health Agency of Canada for continued commitment to opening funding streams through one-time grants for Public Health Units and other community agencies in the most impacted regions to support local evidence-based substance use prevention models.

Given the escalating health impacts of opioids and other substances, it is critical to implement solutions that are sustainable in both the short and long term. In Windsor-Essex County, the severity of the opioid crisis has placed significant strain on local health system resources and has adversely impacted population health outcomes at a rate higher than the provincial average. In 2024, the region saw 519 Emergency Department (ED) visits due to opioid overdoses, more than double the 258 ED visits recorded in 2019. In 2024, WEC's opioid overdose rate was 11.09 per 10,000 residents, significantly higher than the provincial average of 7.76 per 10,000 (Public Health Ontario, 2024). Opioid-related deaths in WEC have also been on the rise, with 127 fatalities reported in 2023, equivalent to a rate of 28.9 deaths per 100,000 residents, significantly higher than the provincial average of 16.8 per 100,000 (Public Health Ontario, 2024). This underscores the need for accessible, well-resourced, and integrated substance use prevention and other strategies that not only address urgent needs but also promote conditions that protect and sustain population health and well-being.

Upstream and downstream prevention efforts are complementary, evidence-based strategies that address the root causes of substance use while supporting individuals who are actively using substances. Innovative drug checking tools help reduce overdose risk by enabling safer choices and ultimately better health outcomes (Vickers-Smith et al., 2025). In contrast, youth prevention programs that take a comprehensive, community-based approach have shown a reduction in adolescent substance use (Kristjansson et al., 2010). Since early substance use is a strong predictor of later addiction, mental health challenges, and risky behaviors, sustained investment in both approaches is essential to improving long-term outcomes in our communities (Clark, 2017).

The Board of Health for Windsor-Essex County commends the Federal government for investing in the Youth Substance Use Prevention Program (YSUPP), which supports efforts to prevent substance use and related harms among youth. However, limited funding availability places communities like Windsor-Essex, where youth substance use and related harms are on the rise, at a disadvantage. With Ontario public health units responsible for prevention activities, the Federal government has a significant opportunity to expand support for both upstream and downstream interventions. This would help mitigate current substance-related harms while fostering environments that support youth health, development, and resilience—especially amid the growing prevalence of vaping (from 28% in 2018 to 39% in 2023; Hammond et al., 2024) and the early onset of alcohol use, with an average initiation age of 13 (Drug Free Kids Canada, 2025).

Hence, continuing forward, we call on the Federal government to expand funding opportunities for public health units and community agencies to deliver sustainable and scalable evidence-based

prevention programs, such as Planet Youth. Without adequate support, communities may lack the capacity to deliver comprehensive strategies, leaving vulnerable youth at greater risk of substance use.

Yous truly,

Joe Bachetti, Chair
Windsor-Essex County Board of Health

Cc: Hon Francois-Philippe Champagne, Minister of Finance
Hon. Sylvia Jones, Ontario Minister of Health
Andrew Dowie, Member of Provincial Parliament
Lisa Gretzky, Member of Provincial Parliament
Anthony Leardi, Member of Provincial Parliament
Kathy Borelli, Member of Parliament
Harb Gill, Member of Parliament
Chris Lewis, Member of Parliament
Steve Vlachodimos, City Clerk, Windsor
Katherine Hebert, County Clerk, Essex

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simcoe muskoka
DISTRICT HEALTH UNIT

5.0

August 6, 2025

To Partner Agencies of the Simcoe Muskoka District Health Unit;

As I have previously communicated, at the beginning of this year, the Simcoe Muskoka District Health Unit commenced with a new organizational structure to meet a number of agency needs. Please be advised that we have made the following additional changes:

Carolyn Shoreman, Vice President of the Community and Family Health Department, is now fulfilling the duties of the Chief Nursing Officer (CNO).

We have also established the role of a Chief Innovation Officer (CINO) which is being fulfilled by Dr. Steve Rebellato, Vice President of the Environmental Health Department. This role is accountable for advancing public health outcomes through the ethical and strategic application of advanced analytics, data systems, and innovative public health practice solutions through the use of artificial intelligence (AI).

These changes are included within the most recent agency organizational chart.

I thank our Vice Presidents for fulfilling these very important leadership roles for our agency.

Sincerely,

ORIGINAL Signed By:

Charles Gardner, MD, CCFP, MHSc, FRCPC
Medical Officer of Health

CG:mn

c. Board of Health, Simcoe Muskoka District Health Unit

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InfoBreak

alPHa's members' portal

alPHa Association of Local PUBLIC HEALTH Agencies

6.0

Key Highlights:

- We're embarking on a new term of strategic actions to strengthen local public health influence with government and system partners.
- alPHa is dedicated to showcasing how local public health achieves population health results, reduces health system burden, and is a key partner in health system transformation.
- We seek examples from member agencies to showcase the effectiveness, efficiency, and innovation in local public health. Please submit contributions for consideration to Loretta Ryan, alPHa's CEO, for inclusion on the upcoming Innovation Resource Page (example digital innovations and/or creative cost savings). This page will resemble the popular Artificial Intelligence (AI) Resource Page used by many Members. Members are also encouraged to view Steven Rebellato's AI presentation from the June 20 alPHa Boards of Health Section meeting, available with other conference slides on the Presentations webpage.

NEW ***Newsletter Refresh: Leader to Leader***

Building on Past Leadership:

- *Leveraging the foundational work of previous alPHa leaders, we're refreshing the Chair's section of the newsletter starting with this summer issue.*

Content Focus:

- *The Chair's update will focus on our strategic trajectory by highlighting:*
  - *What We Want to Achieve: Key objectives and goals.*
  - *Steps We're Taking: Examples of actions and initiatives underway (not meant to be comprehensive).*
  - *LPHA Contributions: How individual local public health agencies can participate in achieving our collective objectives.*

What Do We Want to Achieve?:

- *Strengthening local public health's position:*
  - *Objective: Ensure alPHa is positioned to highlight local public health favourably with key stakeholders, including provincial and municipal governments.*
  - *Importance: This strengthened position is critical for advocacy efforts, particularly in enhancing and equitably allocating funding across health units.*

InfoBreak

alPHa's members' portal

Summer 2025

Outcome & Results Driven:

o Requirement: Address the provincial government's focus on data, outcomes, and results by demonstrating collective impact in resonant language.

Team Player and Leadership Role:

o Approach: Present innovative, cost-efficient solutions instead of employing a "deficit approach," which focuses on asking for more funding by highlighting current shortfalls.

o Role: Showcase local public health as a crucial partner/leader in collaboration, partnership, and innovation.

o Example: Position local public health as a vital partner/leader in digital health innovation.

Steps We're Taking:

- Government Relations Training: Based on member requests, we organized a learning opportunity in July to enhance our engagement strategies with government officials.
- Outcomes and Results Focused: We plan to continue highlighting our contributions to community health through our successful infographics series. We appreciated participation from the Chief Medical Officer of Health and his office, Public Health Ontario, and Ontario Health at our June conference. We aim to explore further collaborations to show how local public health is essential in achieving health system objectives.
- A key partner and system leader: Public health units have a unique opportunity, through our recognized strengths in data and data systems, to play a leadership role in digital health innovation. For this reason, the upcoming Fall Symposium and Workshops will include discussion of this topic. Hold the date and stay tuned for more information on these online events that will be taking place November 5 to 7.

Local Public Health Agency Contributions:

- Items for Showcase: As noted above, alPHa maintains a Resource Page on various topics – Artificial Intelligence, Climate Change, Workplace Health and Wellness, and more.
- Strategic Feedback: Engage with alPHa leadership to provide input on our strategy & its execution, in light of emerging challenges and opportunities. Click here to get to know alPHa's Board of Directors.

2025 alPHa AGM and Conference: Recap

This year's Annual General Meeting and Conference, that took place June 18-20, continued the important conversation on the critical role of local public health in the province's Public Health System. We want to thank everyone who attended and participated as this event would not have been a success without you!

Updates have been made to the Resolutions home page, including the ones for this year. Individual Resolutions can be found here: A25-01: Integrating the Ontario Early Adversity and Resilience Framework into Public Health Practice to Improve Population Health Outcomes and A25-03: Preventing heavy metal exposure from contaminated spices, cosmetics, ceremonial powders and products sold for natural health purposes.

The Annual General Meeting Report, Annual Report, and other conference-related materials can be found on the Conference webpage. On the Presentations webpage: Conference slides (Medicine Shield Workshop and *Public Health and Engagement with Indigenous Communities*), BOH Section Meeting Slides (*BOH Legal Obligations* and *Digital Innovation and Public Health*), and the Distinguished Service Awards booklet are available. Please note, we can only post presentations we receive from the speakers. You must also log into the alPHa website to view most of the files.

Thank you to all the speakers, moderators, and participants. All of you worked extremely hard to make each day a success. Please know the time you took to help plan, speak, moderate, or attend is appreciated.

The winner of the after-event survey gift card is Dr. Kathryn Marsilio, Peel Region Public Health. Congratulations!

2025 alPHa AGM and Conference: Recap

A special shoutout goes to Trudy Sachowski for chairing the event. Much thanks to the alPHa staff who put in many hours into making these events a success: Loretta Ryan, Gordon Fleming, Melanie Dziengo, and Lynne Russell.

We would also like to take a moment to thank Toronto Public Health for co-hosting the AGM and Conference, and acknowledge Platinum Level sponsors: vocalmeet and NaloxOne; Esri Canada as a Gold Level sponsor, and Mosey & Mosey and BrokerLink as Silver Level sponsors. We are thankful to the Pantages Hotel for providing us with an excellent venue.

2025 alPHa AGM and Conference: Distinguished Service Awards (DSAs)

The DSAs, that were presented at the conference, recognize exceptional qualities of leadership, tangible results through lengthy service and/or distinctive acts, and exemplary devotion to public health at the provincial level.

alPHa was pleased to announce this year's recipients: Sue Perras, Boards of Health Section, Northwestern Health Unit; Dr. Hsiu-Li Wang, Council of Ontario Medical Officers of Health Section, Region of Waterloo Public Health and Paramedic Services; Nancy Kennedy, Affiliates, Ontario Association of Public Health Dentistry, and Loretta Ryan, alPHa, Chief Executive Officer. To learn more about these award winners, please click here.

Congratulations to the 2025 DSA recipients!

Association of Local Public Health Agencies

Fall Symposium and Workshops

November 5-7, 2025

Co-hosted by

alPHa Association of Local PUBLIC HEALTH Agencies

SW Southwestern Public Health Oxford · Elgin · St.Thomas

alPHa's Fall Symposium and Workshops will continue the important conversations on the critical role, value, and benefit of Ontario's local public health system.

Participate in engaging online workshops and in-depth plenary sessions with public health leaders.

You must be an alPHa member to participate.
Pre-Symposium Workshops are included when you register for the Fall Symposium: $399 + HST.

Registration will be available mid-September and further information will also be shared in alPHa's newsletter, InfoBreak, as details become available.

The Fall Symposium is generously supported by:

EOHU Eastern Ontario Health Unit | BSEO Bureau de santé de l'est de l'Ontario

Dalla Lana School of Public Health

AMO Conference Resources

Next month, many alPHa members, particularly from the Boards of Health Section, will be attending AMO's 2025 Annual General Meeting and Conference, taking place from August 17-20, in Ottawa.

Whether you're an alPHa member attending the conference or participating in a delegation, here are some key alPHa resources:

- alPHa Resolutions and Correspondence including alPHa Letter Budget (2025)
- PH Matters Infographics: *Public Health Matters #4: Keeping Ontarians Healthy and Safe* and *Public Health Matters #3: A Business Case for Local Public Health*
- BOH Shared Resources Page including: BOH Orientation Manual and BOH Governance Toolkit
- *Information Break*. Be sure to check the archive of newsletters. These can be found here.

Diplomacy, Delegations and Avoiding Government Relations Disasters - alPHa Lunch & Learn Thank you!

Thank you to all of the alPHa Members who participated in the lunch and learn session on July 16. It was well attended, and we appreciated each of you for making it interactive and lively.

We would also like to thank presenters, Sabine Matheson, Principal, StrategyCorp, Loretta Ryan, Chief Executive Officer, alPHa, and Monika Turner, Principal, Roving Capacity.

alPHa will post the slides from Sabine Matheson when these become available.

alPHa Workplace Health and Wellness Month: Recap

The *alPHa Workplace Health and Wellness Month* (WHWM) continues to be a success! The response from the Membership has been overwhelmingly positive. We want to thank so many of you for participating during the month of May. We received many pictures of Members walking, biking, canoeing, doing yoga, and taking care of their physical, mental, and social health.

Renfrew County & District Health Unit hit it right out of the park! Thank you for your very active participation. Below is one of four picture collages showing Renfrew's weekly activities during the month. Durham Region Health Department also did an amazing job, with over 200 photos of their staff participating in WHWM. A collage of some of those photos is above. Well done! And a shot out to the Members of the alPHa Board of Directors and Members who also sent in pictures of themselves in action.

We are not done encouraging you to take care of your physical, mental, and social health. alPHa continues to share information via our newsletter. We also have a dedicated webpage with infographics and other resources, including a WHWM infographic on Work Life Balance, that can be found here.

Thank you to the alPHa staff for their work on WHWM and for participating too! Many thanks in particular to Lynne Russell for her ongoing work on this initiative. Thank you again to everyone who participated. New for this year! As promised, we had a draw for a gift card and the winner is Melissa Ziebarth.

Stay healthy and we hope you join us in next year's Workplace Health and Wellness Month!

Ontario Early Adversity and Resilience Framework

The newly released Ontario Early Adversity and Resilience Framework was developed by members of the Public Health Ontario ACEs and Resilience Community of Practice and was endorsed at the June 19th alPHa meeting. This framework is a call for collective action across sectors and aims to inspire and mobilize communities to work together to develop innovative and meaningful solutions that prevent adversity, strengthen protective factors, build resilience, and support healing in families and communities.

A key message of the framework is that “Everyone has a shared responsibility to foster children's potential and build family and community resilience”.

To access the full report, a 2-page graphic summary, and more information about the Community of Practice and why this framework was created, see earlyadversityandresilience.ca.

alPHa Correspondence

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

- alPHa Letter- Tobacco Settlement Investments - July 24, 2025

Board of Health Shared Resources

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

Resources available on the alPHa website include:

- Orientation Manual for Boards of Health (Revised Jan. 2024)
- Review of Board of Health Liability, 2018, (PowerPoint presentation, Feb. 24, 2023)
- Legal Matters: Updates for Boards of Health (Video, June 8, 2021)
- Obligations of a Board of Health under the Municipal Act, 2001 (Revised 2021)
- Governance Toolkit (Revised 2022)
- Risk Management for Health Units
- Healthy Rural Communities Toolkit
- The Canadian Centre on Substance Use and Addiction
- The Ontario Public Health Standards
- Public Appointee Role and Governance Overview (for Provincial Appointees to BOH)
- Ontario Boards of Health by Region
- List of Units sorted by Municipality
- List of Municipalities sorted by Health Unit
- Map: Boards of Health Types NCCHP Report: Profile of Ontario's Public Health System (2021)
- The Municipal Role of Public Health (2022 U of T Report)
- Boards of Health and Ontario Not-For-Profit Corporations Act

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

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

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

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

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

Ontario Public Health Directory: May 2025 update

The *Ontario Public Health Directory* has been updated and is available on the alPHa website. Please ensure you have the latest version, which has been dated as of **May 9, 2025**. To view the file, log into the alPHa website.

Public Health Ontario | Santé publique Ontario

PHO's new Online Water Testing Portal has launched!
This new portal improves how individuals who rely on private water sources submit their information and receive their test results online. It allows users to complete an electronic requisition form online before dropping off their water sample at a designated location. Once the sample is received and tested, clients can return to the portal to securely access and download their test results. This new process offers a more efficient and accessible alternative to the traditional paper-based submission. Visit their PHO News post for more information.

New Course Coming Soon! Infection Prevention and Control for Health Care Workers!
The new Infection Prevention and Control (IPAC) for Health Care Workers (HCWs) will launch on August 12, 2025!

Public Health Ontario

This new interactive, scenario-based course is designed to help HCWs improve their IPAC knowledge and skills by increasing learner knowledge and understanding of key IPAC principles. It will replace the existing IPAC Core Competencies course. Learners who are currently taking the IPAC Core Competencies course must complete their training by August 1, 2025, to obtain a certificate of completion. If the course is not completed by this date, learners will no longer have access to this course and are encouraged to register for the new IPAC for HCWs course. Check out this video to learn more about the upcoming course offering.

Recent Knowledge Products

- Measles in Ontario
- Mpox in Ontario
- SARS-CoV-2 Genomic Surveillance in Ontario
- Ontario Respiratory Virus Tool
- Invasive Group A Streptococcal (iGAS) Disease in Ontario: October 1, 2024 to June 30, 2025

Updated Snapshots

- Injury Mortality
- Chronic Disease Mortality
- Potential Years of Life Lost
- Potentially Avoidable Mortality
- All-Cause Mortality

Events

Be sure to keep an eye on PHO's Events page for their upcoming events.

Recent Presentations

- Supporting Smoking Cessation in Indigenous Communities
- Engaging Policymakers on the Commercial Determinants of Health: Lessons from Global Tobacco Control
- Community Partnerships for Public Health Emergencies: Spotlight on Evacuations
- Maternal Mortality in Ontario – Partnerships for Awareness and Prevention

Dalla Lana School of Public Health

Upcoming DLSPH Events and Webinars

- CIHR Project Grant: Strategies for Success (Jul. 24)
- Drum Circle with Spirit Wind (Aug 6 and Aug. 20)
- New Frontiers in Research Fund (NFRF) Exploration 2025: Strategies for Success (Aug. 27)

News Releases

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

alPHa's mailing address

Please note our mailing address is:

PO Box 73510, RPO Wychwood
Toronto, ON M6C 4A7
For further information, please contact info@alphaweb.org.

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BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

7.0

MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 48-25

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2025 July 24

HOUSEHOLD FOOD INSECURITY: A PRIMER FOR MUNICIPALITIES

Recommendation

It is recommended that the Board of Health:

1) *Receive Report No. 48-25 re: "Household Food Insecurity: A Primer for Municipalities" for information; and*
2) *Direct the Clerk to send Report No. 48-25 (including Appendix A) to the City of London, Middlesex County, lower tier municipalities within the County of Middlesex and all Ontario Boards of Health.*

Report Highlights

- In 2023, 1 in 4 households in Middlesex-London were food insecure. This is a statistically significant increase from 2022.
- Food insecurity has a pervasive impact on health; and there is a need for income-based solutions.
- "Household Food Insecurity: A Primer for Municipalities" (Appendix A) provides a range of income-based strategies that London and Middlesex County can implement to help reduce food insecurity. The primer also includes affordability-based strategies, which can help reduce financial strain and contribute to more inclusive, resilient and healthy communities.

Background

Household food insecurity is defined as inadequate or insecure access to food due to financial constraints[1]. Food insecurity negatively impacts health and community well-being (e.g., increased barriers to employment and increased social isolation)[1-3].

The financial impact of food insecurity is broad and extends across all levels of government. For example, households with food insecurity have 23%-121% higher annual health care costs[4]. While health care funding primarily falls under provincial and federal jurisdictions, municipalities also shoulder significant costs. As reported by the Association of Municipalities in Ontario (AMO), in 2017, Ontario municipal governments contributed $2.1 billion for health care costs[5].

While food programs, such as community gardens and community meals, can offer temporary relief from hunger, they do not address the root cause. Research consistently shows that food insecurity is most effectively reduced through income-based solutions[1,2].

Food Insecurity in Middlesex-London

In 2023, one in four households in Middlesex-London were food insecure[6] - the highest rate reported in Middlesex-London since the Canadian Income Survey started measuring food insecurity in 2019. This marked a statistically significant increase from 2022, with an estimated 151,477 residents living in food insecure households in 2023, compared to 107,835 residents in 2022.[6,7]

As reported to the Board of Health in Q4 2024, the 2024 local Nutritious Food Basket results demonstrate decreased food affordability and inadequate income to afford basic needs for many Middlesex-London residents[8]. A single person receiving Ontario Works needs an additional $522 monthly to afford local rent and food costs, plus additional funds for all other expenses[8]. Report No. 82-24 includes additional household and income scenarios.

Municipal Strategies to Address Food Insecurity

MLHU established and chaired a provincial work group in partnership with the Ontario Dietitians in Public Health to develop resources and messaging aimed at reducing household food insecurity. The resulting municipal primer, adapted by MLHU for local municipalities, outlines strategies to address household food insecurity (Appendix A). Municipal governments are important partners in addressing food insecurity, and the primer provides a range of income-based strategies that London and Middlesex County can implement. The primer also includes affordability-based strategies, which can help reduce financial strain and contribute to more inclusive, resilient and healthy communities.

References are affixed as Appendix B.

Next Steps

It is recommended that the Board of Health direct Health Unit staff to share “Household Food Insecurity: A Primer for Municipalities” (Appendix A) with the City of London, Middlesex County, lower tier municipalities within the County of Middlesex, and Ontario Boards of Health.

The Health Unit will continue to monitor food affordability as mandated by the Ontario Public Health Standards in the Population Health Assessment and Surveillance Protocol, 2018. The 2025 surveillance data will be reported to the Board of Health in Q4 2025.

This report was written by the Municipal and Community Health Promotion Team of the Family and Community Health Division.

Alexander Summers, MD, MPH, CCFP, FRCPC
Medical Officer of Health

Emily Williams, BScN, RN, MBA, CHE
Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Population Health Assessment and Surveillance Protocol, 2018; and the Chronic Disease Prevention and Well-Being and Healthy Growth and Development standards, as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
    - Our public health programs are effective, grounded in evidence and equity

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendations:

Anti-Black Racism Plan Recommendation #37: Lead and/or actively participate in healthy public policy initiatives focused on mitigating and addressing, at an upstream level, the negative and inequitable impacts of the social determinants of health which are priority for local ACB communities and ensure the policy approaches take an anti-Black racism lens.

Taking Action for Reconciliation Supportive Environments: Establish and implement policies to sustain a supportive environment, as required, related to the identified recommendations.

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Household Food Insecurity: A Primer for Municipalities

Household food insecurity refers to inadequate or insecure access to food due to financial constraints.[1] For simplicity, household food insecurity will be referred to as food insecurity in this primer.

While food programs, such as community gardens and community meals, can offer temporary relief from hunger, they do not address the root cause. Research consistently shows that food insecurity is most effectively reduced through income-based solutions.[1]

Food insecurity and poverty are pressing issues that municipalities can help address.

This resource provides a range of income-based strategies that municipalities can implement to make a meaningful impact in their communities. It also includes affordability-focused strategies, which can help reduce financial strain and contribute to more inclusive, resilient communities.

Adapted from:
"Food Insecurity: A Primer for Municipalities" developed by the Ontario Dietitians in Public Health (ODPH) Food Insecurity Workgroup (www.odph.ca).

Adapted by:
Middlesex-London Health Unit

For more information, contact us:
Middlesex-London Health Unit
Phone: 519-663-5317
Email: health@mlhu.on.ca

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

Food Insecurity: A Primer for Municipalities

Household Food Insecurity in Middlesex-London

Food insecurity means not having enough money for food.[1]

In 2023, 25% of Middlesex-London households were food insecure.[2]

1 in 4

Food Affordability

After rent and food, many don't have enough left for all other monthly expenses.[3]

Single parent of 2 on Ontario Works

$257

Single person on Ontario Works

-$522

Wages

Having a job does not guarantee food security.

In 2022, over half (58.6%) of food-insecure households in Ontario depended on employment income.[1]

Food Insecurity Takes a Toll on our Community

Physical and Mental Health

- risk of diabetes and heart disease [1]
- risk of depression, anxiety, and mood disorders [1]

Health Care Costs

23%-121% higher health care costs [4]

In 2017, Ontario municipal governments contributed **$2.1 billion** for health care costs[5]

Community Well-Being

- barriers to employment[6]
- social isolation[6]

impede people's ability to advance in life[6]

Solutions

Food insecurity is an income problem that requires income solutions.

Municipalities can support policies and initiatives that improve the finances of households with low incomes and advocate for a stronger social safety net.

For information on local data, health impacts, and to work together on strategies to reduce local food insecurity, email Middlesex-London Health Unit at health@mlhu.on.ca.

Income-Based Strategies

1. Support living wage certification

Ontario's minimum wage is less than a living wage. A living wage is the hourly pay a worker must earn to afford their basic needs and engage in their community based on regional living costs.[7] Paying a living wage benefits employers (e.g., employee retention), employees (e.g., afford housing and food), and the community (e.g., money spent locally).[8,9]

The minimal annual employer certification fee helps support the Ontario Living Wage Network to calculate the living wage and advance the living wage movement.

- Become a Living Wage employer and recertify annually (e.g., Township of Blandford-Blenheim, City of Waterloo, Corporation of the City of St. Catharines, The County of Huron, The Municipality of North Perth).
- Encourage local businesses to become Living Wage employers (e.g., provide education and awareness, incentives like public recognition of local Living Wage employers, community engagement and support).
- Provide support for local businesses to become certified (e.g., practical guidance, marketing incentives, and policy support).

Resource: Living Wage Certification Process

2. Support free income tax filing clinics for households with lower incomes

Filing income taxes is essential to be eligible for subsidized housing and receiving federal government benefits and credits. In 2023, nearly $44 million was received in refunds, credits, and benefits entitlements by 11,070 individuals through free tax clinics in London, Ontario through the Community Volunteer Income Tax Program.[10]

- Promote clinics and help to recruit volunteers (e.g., London tax clinics, Strathroy tax clinics).
- Provide subsidized transportation to clinics (e.g., transportation vouchers).
- Provide community spaces for clinics at no cost.
- Support systems navigation at clinics (e.g., promote community resources and governmental benefits, and make referrals to community resources).
- Coordinate existing income tax clinics and improve client support at tax clinics by offering more super clinics in the community.
- Advocate for policies that simplify tax filing for community members living with a low income (e.g., automated system using existing information).
- Explore the promotion of virtual tax-filing in partnership with local organizations and Prosper Canada.

Resource: Guide to Hosting an Enhanced Free Community Volunteer Income Tax Program (CVITP)

3. Work with the provincial and federal governments to advance income-based policies and income support programs

The current income support system in Ontario is not adequate for households to cover their basic needs and live with dignity.[1]

- Support the advocacy work of local partnerships (e.g., endorse advocacy letters sent to the provincial and federal governments by local partnerships) (e.g., United Way Elgin Middlesex).

- Advocate to the provincial government to:
  a. Raise the minimum wage to be on par with the cost of living (living wage).
  b. Increase social assistance rates to reflect the real cost of living (e.g., Middlesex-London Board of Health, 2023; Prince Edward-Lennox & Addington, 2025; Niagara Region, 2024; Prince Edward County, 2024; Simcoe-Muskoka District Health Unit, 2025)
  c. Index Ontario Works (OW) rates to inflation and increase the amount of income exempt from reduction of benefits to better support those working toward leaving the OW program (e.g., Orangeville, 2023; AMO, 2024)
  d. Commit to not reduce or claw back any provincial assistance related to the implementation of the Canada Disability Benefit (e.g., London, 2025).
- Advocate to the federal government to:
  a. Expand the Canada Child Benefit (CCB) by increasing the amount for lowest income households and equalizing the benefit for families with children over 6 years old (e.g., Peterborough Public Health, 2024; PROOF, 2023).
  b. Enhance the Canada Disability Benefit (CDB) by increasing the benefit amount and simplifying the application process by working with provinces and territories to automatically enroll recipients of provincial and territorial disability support programs (e.g., Community Food Centres Canada, 2024).
- Endorse basic income (e.g., Municipality of Chatham-Kent Council, 2024; Ottawa City Council, 2024; numerous Ontario municipalities) and advocate for the provincial and federal governments to collaborate to implement a basic income (e.g., Kitchener City Council, 2024; Region of Waterloo, 2023; Halton Region, 2023; Hamilton City Council, 2023).

Resource: PROOF – Identifying Policy Options to Reduce Household Food Insecurity in Canada

4. Raise awareness within the community about food insecurity and its connection to income

- Utilize reports from public health units to obtain local data on food insecurity and food affordability (e.g., Middlesex-London Health Unit, 2024)
- Engage with community partners to promote the need for long-term solutions to food insecurity (e.g., fund a forum)
- Communicate about food insecurity from a poverty reduction perspective (e.g., need for income-based solutions), and not as an issue of food access or food literacy (e.g., more food banks or food literacy programs)
- Declare food insecurity an emergency (e.g., City of Kingston Council, 2025; Mississauga, 2024; Toronto City Council, 2024; City of Brantford, 2025)

Resource: Position Statement and Recommendations on Responses to Food Insecurity

5. Create and support a municipal poverty reduction strategy

Municipal poverty reduction strategies address specific challenges and action plans tailored to the municipality complementing provincial and federal level strategies (e.g., London (2017); Ottawa (2025-2029); Toronto (2019-2022).[11]

- Provide funds to implement action(s) from a Poverty Reduction Strategy.
- Allocate higher amounts of funding towards food and housing insecurity.
- Actively engage people who have lived and/or have living experience of food insecurity and/or poverty.

Resource: Tamarack Institute Ending Poverty Network for Change

6. Provide leadership and support to local partnerships working to reduce food insecurity and/or poverty (e.g., Age Friendly London Network and Child & Youth Network, Middlesex-London Food Policy Council, Basic Income London)

- Explore forming a local partnership, if not already operating.
- Support the advocacy work of local partnerships (e.g., endorsing advocacy letters).
- Collaborate with community partners to determine local priorities for action to address food insecurity and poverty.
- Become a member of a local partnership.
- Provide funding (e.g., supporting a specific action item).

Resource: Food Systems Planning in Canada: A toolkit of priority practices for planners

Affordability-Based Strategies

7. Support affordable housing

Encouraging an adequate supply of affordable housing is critical to ensuring households can afford other basic necessities, such as food. Municipalities and regional governments play a critical role in shaping housing affordability through land use planning, investment, and policy advocacy.

Affordable housing is a priority for the City of London and Middlesex County (e.g., Health & Homelessness in London, Ontario: A Whole of Community System Response (2023)
The Housing Stability Action Plan for the City of London (2019-2024); Middlesex County's Homeless Prevention and Housing Plan (2019-2024).

8. Improve the affordability and accessibility of local public programs and services

- Invest in accessible and affordable transportation by providing subsidized transportation passes or subsidizing rural transportation services (e.g., London, Toronto, Waterloo).
- Offer childcare subsidies to eligible families, prioritizing individuals who are most financially in need (e.g., London-Middlesex (2024-2028), Middlesex County, London, Kingston).
- Provide discounted and/or subsidized recreation programs at municipal facilities (e.g., Middlesex County, London, Toronto, Hamilton, Kingston).
- Support and promote local financial literacy and counselling programs (e.g., CPA Canada, London, Toronto).
- Implement Community Connector and Community Navigator roles in municipalities, libraries, and other community organizations to support residents with applications to housing programs, social assistance, free income tax clinics, and other necessary supports (e.g., Middlesex County Libraries, London Family Centres, Durham, Huron Perth).

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Sent by Email

June 6, 2025

The Honourable Peter Bethlenfalvy
MPP Pickering-Uxbridge
1550 Kingston Rd., Suite 213
Pickering, ON L1V 1C3
peter.bethlenfalvy@pc.ola.org

Subject: Raising Ontario Works (OW) and Ontario Disability Support Program (ODSP)

The Council of The Corporation of the City of Pickering considered the above matter at a Meeting held on May 26, 2025 and adopted the following resolution:

WHEREAS individuals and families receiving income support through Ontario Works (OW) and the Ontario Disability Support Program (ODSP) are facing increasing challenges in meeting basic needs due to rising costs of living;

And Whereas Statistics Canada notes that people with disabilities have a higher poverty rate and a lower rate of employment than the overall population;

And Whereas the annual income support for Ontario Works is currently $8,796.00 and $16,416.00 for Ontario Disability Support Program. These supports have not increased sufficiently to keep up with inflation and the cost of living. Such costs are anticipated to continue increasing;

And Whereas the low income measure for a single person in Greater Toronto Area is estimated to be approximately $27,343 annually, and the deep income poverty threshold is determined to be $20,508;

And Whereas Food Banks, including our local Food Banks, provide a necessary service with increasing demands in our communities;

And Whereas the Pickering Food Bank served 1,722 adults, and 1,054 children in February 2025;

And Whereas food banks are already reducing their distribution capacity; and it is anticipated that due to developing economic circumstances, such as the current tariff war, there will be increased unemployment, increased food prices, and a heightened demand for food distribution, while donations continue to decline;

And Whereas these economic trends will continue to erode the purchasing power of OW and ODSP recipients, increasing reliance on food banks and placing additional pressure on municipalities and community organizations;

Now therefore it be resolved that the Council of The Corporation of the City of Pickering directs through the Office of the Chief Administrative Officer:

1. That staff send a letter to the Premier of Ontario, Minister of Finance, Minister of Children, Community and Social Services, and the Minister for Seniors and Accessibility, to strongly urge that the Ontario Provincial Government significantly raise the payments of Ontario Works and Ontario Disability Support Program and the increases be reflected in the upcoming Provincial Budget and that the increased amount aligns with inflationary costs and thereby decrease the pressure on food banks and the reliance on municipalities and taxpayers to supplement the gap in financial need; and,

2. That a copy of this resolution be forwarded to all Members of Provincial Parliament (MPPs), the Regional Municipality of Durham, all Municipalities in the Province of Ontario, the Federation of Canadian Municipalities (FCM), and the Association of Municipalities of Ontario (AMO) for their endorsement and advocacy.

Should you require further information, please do not hesitate to contact the undersigned at 905.420.4660, extension 2019.

Yours truly

Susan Cassel
City Clerk

SC:am

Copy: Robert Cerjanec, MPP Ajax
Lorne Coe, MPP Whitby
Jennifer French, MPP Oshawa
Todd McCarthy, MPP Durham
Laurie Scott, MPP Haliburton—Kawartha Lakes—Brock
Alexander Harras, Regional Clerk, Region of Durham
Federation of Canadian Municipalities (FCM)
Association of Municipalities of Ontario (AMO)

All Ontario Municipalities

Chief Administrative Officer

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