

Appendix A: ODPH response to Public Health [Modernization Discussion Paper](#) questions.

Further feedback and additional perspectives related to the key challenges raised in the discussion paper are provided below. We note that improving our collective nutrition, food, and eating behaviours should be a priority for the overall health (and resulting reduction of health care costs) of the people of Ontario. It is our position that the modernization of public health should include the necessary resources to support achievement of this priority.

Registered Dietitians noted as RD within this response.

Insufficient Capacity	
1. What is currently working well in the public health sector?	<ul style="list-style-type: none"> Highly skilled and multidisciplinary workforce that is able to collaborate with partners and stakeholders at both the local and provincial level (e.g., municipalities, school boards, primary health care, social services, community organizations, businesses, colleges and universities) to develop and support evidence informed programs, services and resources. These connections, relationships and partnerships with our local communities give public health the ability to tailor our work to address their needs and ensure access to and effectiveness of public health programs and services that support healthy communities and citizens. The addition of dedicated nutrition and RD expertise at Public Health Ontario (PHO) is invaluable, unique and relevant, especially when collaborating with regional and local public health units on provincial projects, epidemiological data analysis, needs assessments, and evaluation strategies and is well placed to inform the development of provincial health promotion strategies. Upstream approaches are employed to address structural determinants of health (e.g., supporting municipalities to offer healthy food and beverage options in rec centres, child care centres) and address population level risk factors; this is a skill-set unique to public health professionals and not always addressed in other health promotion efforts.

	<ul style="list-style-type: none"> ● Well-established provincial networks and organizations such as Ontario Dietitians in Public Health, OPHA-alPHa Health Equity workgroup, Ontario Chronic Disease Prevention Managers in Public Health (OCDPMPH), Ontario Public Health Evaluation Network (OPHEN), Association of Public Health Epidemiologists in Ontario (APHEO), Public Health Ontario (PHO) that allow limited numbers of professional staff to work together to develop evidence informed programs, services and resources for shared implementation across the province. ● ODPH provides infrastructure that facilitates communication, networking, joint advocacy efforts, planning and delivery of programs, resources and tools and reduces duplication of effort. It also provides timely and relevant professional development. Without this organization most Ontario public health units would be challenged to meet the OPHS requirements or to do their work effectively and efficiently.
2. What are some changes that could be considered to address the variability in capacity in the current public health sector?	<ul style="list-style-type: none"> ● Ensure adequacy and equity of funding model for all health units to appropriately address all OPHS requirements led by a diverse, multidisciplinary workforce. ● Ensure that provincial and local leadership has clear guidance and understanding of the multidisciplinary nature of the Public Health Standards (e.g. Mental Health, Health Equity, Healthy Growth and Development, Healthy Environments) and consider how to increase capacity to focus on healthy eating and nutrition within the many relevant standards to reflect the evidence that diet quality is a key risk factor for prevention and burden of illness. ● Ensure mechanisms are in place to demonstrate that the role of Registered Dietitians (RDs) in public health is leveraged to deliver quality programs and services as well as contribute to management tables. Collaborative efforts across disciplines and programs fosters a systems approach and collaboration in the health and social service areas. Appropriate staffing ensures priority areas are not underserved, including

	<p>(but not limited to) the inclusion of RDs with public health expertise.</p> <ul style="list-style-type: none"> • There is opportunity for local PHUs and the MOH to better utilize RDs and ODPH to enhance capacity for PH nutrition locally and across the province.
<p>3. What changes to the structure and organization of public health should be considered to address these challenges?</p>	<ul style="list-style-type: none"> • Stronger provincial leadership, coordination and guidance at the MOH level and through PHO, with continued support for local PHUs to tailor programs and be flexible to local need. • Provincial workgroups/networks (e.g. ODPH) could be strengthened so they can continue to support collaboration, reduce duplication and improve consistency across health units where warranted. • The Ministry should consider implementing more regular, ongoing communication and dialogue with organizations such as ODPH, who have content expertise and implementation experience. • For ODPH, it would be helpful if all RDs working in local public health units/agencies were supported to be members in this association to further enhance collaboration and effective/efficient use of resources. This would improve accountability to ensure the actions, programs, resources, and tools align with mandated programs and services.
<p>Misalignment of Health, Social and other Services</p>	
<p>4. What has been successful in the current system to foster collaboration among public health, the health sector and social services?</p>	<ul style="list-style-type: none"> • Public health has a long history of community collaboration and recognizes that collaboration with social service and other health care stakeholders promotes more interdisciplinary practice, effective communication and delivery of services that are responsive to local needs and issues, plus serves to ensure comprehensive and consistent health promotion messaging. • Public Health RDs work in local communities to facilitate understanding of local needs including identification of priority populations, and barriers to healthy eating. We identify and support implementation of interventions that will work in our local context and monitor their impact and adjust for continuous improvement. Beyond providing education and

	<p>training, RDs are recognized as credible, regulated health professionals working in the public interest and aware of local community resources. RDs coordinate and support collaborative evidence informed intervention efforts/programs across the lifespan. We also work at the policy level and have valuable input into local, regional, provincial and federal policies (including school curriculum, provincial and national food guidelines, Food Policy Councils etc.)</p> <ul style="list-style-type: none"> ● Registered Dietitians are an integral and necessary part of the interdisciplinary public health team required to address the most pressing health needs of the Ontario public.
5. How could a modernized public health system become more connected to the healthcare system or social services?	<ul style="list-style-type: none"> ● Health units serve as knowledge brokers, connecting their communities to resources and facilitating connections between local healthcare organizations and social services. ● Opportunities and systems need to be bolstered to support the process of determining common health priorities within local health and social services that have similar goals or priorities to address and promote the health of Ontarians. ● A modernized public health system should ensure that public health staff have the necessary opportunities to work with local health and social services on initiatives that improve health and reduce inequities (e.g., increased access to healthy foods where people live, work and play; support local agencies and services in the delivery of effective food literacy programs). Many Public Health Dietitians are already doing this effectively.
6. What are some examples of effective collaborations among public health, health services and social services?	<ul style="list-style-type: none"> ● Public health is already connected to the healthcare system and other social and community sectors. What is working well: <ul style="list-style-type: none"> - Maintaining public health's unique role, including mandate, and upstream approach which addresses structural and individual determinants of health through a variety of approaches and partnerships. - Involving stakeholders, including municipalities, schools, hospitals and other health care

	<p>facilities, social services, community organizations, businesses, law enforcement and academic organizations.</p> <ul style="list-style-type: none"> - Sharing similar boundaries and catchment areas (e.g., school boards, municipalities). - Collaborating on health and social issues (e.g., local opioid strategies, tobacco and vaping by-law development; age-friendly built environments, community drug and alcohol strategies, healthy eating environments in child care centres, workplaces and recreation centres). <ul style="list-style-type: none"> ● Public health agencies and staff including RDs, are a crucial component of many community partnerships such as: <ul style="list-style-type: none"> - Collaboration on hospital or health centre committees - Schools and school boards - Recreation facilities - Municipalities and First Nation communities - Workplaces - Child care centres - Canada Prenatal Nutrition Program partnerships - Food systems organizations (e.g., local food strategies, Food Policy Councils) - Poverty reduction roundtables - Community hubs (i.e., collaboratives to mobilize resources to help individuals and families reduce acutely elevated risk, often involving a wide variety of sectors such as social services, justice, health)
Duplication of Effort	
7. What functions of public health units should be local and why?	<ul style="list-style-type: none"> ● Basic public health programs and services. For example: <ul style="list-style-type: none"> - Public Health inspection - Communicable disease control - Healthy Babies Healthy Children - Health promotion initiatives planned and implemented with local partners - Food Policy Councils - Monitoring Food Affordability

	<ul style="list-style-type: none"> - Improving the food choices at municipal facilities such as recreation centres, child care facilities, schools etc. ● Successful implementation at the local level requires local capacity. For example: <ul style="list-style-type: none"> - Broad uptake and implementation of childcare menu policies and guidelines relied on connections of public health RDs with their local childcare providers - PPM 150 was not as successful as expected due to the lack of implementation support and local capacity ● Community engagement is an essential part of public health. Without two-way knowledge translation, relationship building, trust building, and shared planning at the local level, health unit staff experience resistance in adopting evidence informed population health approaches. Effective action in local policy and program implementation and coordination, requires that staff have the ability to act on local windows of opportunity when they arise. ● Effective health promotion is much more than health education, information or campaigns. It involves policy, partnerships, capacity building, and understanding of target population needs and values. Health promotion for all priority topics including nutrition and healthy eating, would benefit from additional leadership; however, capacity must be retained locally. The unique knowledge, skills, and expertise of public health professionals in the local context ensures that programs and resources are efficient, coordinated, complementary, and effective in the local community. This work cannot be effectively done at the provincial level. Local capacity in health promotion, including public health nutrition, is essential for local public health units.
8. What population health assessments, data and analytics are helpful to drive local improvements?	<ul style="list-style-type: none"> ● There is limited availability of nutrition-related data compared to many other areas. We need appropriate and useful nutrition indicators and assessment tools as well as the data to support nutrition policies, practice and evaluation.

	<ul style="list-style-type: none"> Resources could be put in place to collect local data and inform provincial data. For example, all public health units should have full access to Rapid Risk Factor Surveillance System (RRFSS); PHO could be resourced to have additional capacity for data analysis and population health assessments. Monitoring Food Affordability - while it is mandatory there is no requirement to do it annually and no longer a Ministry protocol. We need provincial leadership to create an updated protocol for Ontario based on the new (2019) food guide (once Health Canada releases the revised National Nutritious Food Basket along with dietary guidance on amounts of food for age/sex groups). Monitoring food affordability is essential because it provides specific local data that can be used to inform public health initiatives that help to reduce health inequities and poverty. The National Collaborating Centre for Methods and Tools defines a model for evidence-informed decision making in public health that includes community health issues and local context, existing public health resources, community and political climate, and the best available research findings. It emphasizes the need for local public health expertise to integrate all relevant factors into any local decisions or recommendations.
9. What changes should the government consider to strengthen research capacity, knowledge exchange and shared priority setting for public health in the province?	<ul style="list-style-type: none"> Ensure that all Public health Units (PHUs) in Ontario employ Registered Dietitians to lead, inform and support their local efforts related to improving food policies, food environments and resultant healthy eating behaviours, to fulfill the requirements of the Ontario Public Health Standards ODPH can be considered an example for public health decision makers to examine during the public health modernization process, as a well-established model for how professional collaboration has strengthened research capacity, knowledge exchange and shared priority setting. When there is hesitancy to share evidence-reviews and local practice-based research, it creates a need for duplication of work. A provincial portal or registry for

	<p>PHUs and professional associations, possibly housed by PHO, could profile the work that's been done or is underway to support collaboration instead of duplication.</p> <ul style="list-style-type: none"> ● Prioritizing the development of nutrition indicators and assessment tools that can be used at the local level would support local programming. For example, the Locally Driven Collaborative Project (LDCP) Healthy Eating Team is wrapping up this spring and has created a tool for measuring food literacy. ● Academic partnerships with local and provincial public health organizations should be encouraged and supported to increase the availability of quality research evidence and practice-based research.
10. What are public health functions, programs or services that could be strengthened if coordinated or provided at the provincial level? Or by Public Health Ontario?	<ul style="list-style-type: none"> ● Public health nutrition is the application of a nutrition lens to public health functions - including population health assessment, health promotion, disease and injury prevention, health surveillance and health protection. ● Strengthen the role and capacity of PHO to provide leadership in best evidence in healthy eating and nutrition research and messaging. For example, while limited in staffing capacity, the nutrition and RD expertise at Public Health Ontario is invaluable, unique and relevant, especially when collaborating with regional and local public health units on provincial projects, epidemiological data analysis, needs assessments, and evaluation strategies and is well placed to inform the development of provincial health promotion strategies. ● More formal collaboration between the existing representatives on the Federal, Provincial, Territorial Working Group on Nutrition (FPTGN) and RDs working in public health. For example, regular meetings between ODPH and Ontario's FPTNG reps would enhance effective practice, allowing the work of Ontario public health dietitians to better align, collaborate and inform on public health nutrition initiatives across the country. ● A specific example is the need for provincial leadership on development of a revised protocol and costing tool

	<p>for monitoring food costs/affordability (the Monitoring Food Affordability Reference Document suggests that health units use their own tool for costing. It makes no sense for this to be created locally; this work needs to be done on the provincial level).</p> <ul style="list-style-type: none"> Professional development opportunities that benefit public health professionals to improve their practice are limited; access to the few opportunities currently available (e.g. The Ontario Public Health Convention (TOPHC)) is further limited due to costs to attend.
11. Beyond what currently exists, are there other technology solutions that can help to improve public health programs and services and strengthen the public health system?	<ul style="list-style-type: none"> More consistent and appropriate use of existing technology including: <ul style="list-style-type: none"> SMS/chat functions to support easier real-time communication and less email Robust and accessible document sharing platforms, phone and video conferencing that includes document and presentation sharing Training and education platforms, including webinars, videoconferencing Investments in technology to support virtual work spaces for meetings and collaboration among public health units
Inconsistent Priority Setting	
12. What processes and structures are currently in place that promote shared priority setting across public health units?	<ul style="list-style-type: none"> The Ontario Public Health Standards (OPHS) and accountability and reporting functions embedded in them, provide a common framework for priority setting that can be tailored to address local priorities and situations. However current models of governance may limit the usefulness of this framework - more could be done to support identification of provincial goals and indicators that could then be measured more systematically at the local level. ODPH supports collaborations amongst members for nutrition related public health programs, services, surveillance, evaluation, knowledge translation, research, etc. It also encourages sharing of work done in individual health units to inform others including related HU priorities.

	<ul style="list-style-type: none"> ● The establishment of the PHO Applied Public Health Science Specialist - Health Eating and Food Environments position has been very helpful to promote collaboration and shared priority setting
13. What should the role of Public Health Ontario be in informing and coordinating provincial priorities?	<ul style="list-style-type: none"> ● PHO should have a central role given expertise of staff and be resourced appropriately to coordinate and support provincial-level population work, and to lead the development of provincial policies and strategies. ● For example, <ul style="list-style-type: none"> - lead the development and implementation of tools to support the Monitoring Food Affordability, - support for surveillance, analysis and reporting on, or sharing data - support to create province wide indicators - support for CQI training and implementation - leadership in best evidence in healthy eating research and common messaging
14. What models of leadership and governance can promote consistent priority setting?	<ul style="list-style-type: none"> ● Ensure that boards of health and other decision makers and leaders have appropriate knowledge and skill sets related to public health, population health and upstream thinking ● Leadership and governance needs to be built on principles of respect, collaboration, evidence informed decision making, financial accountability; multi-year planning for long term outcomes rather than by election cycle ● Recognize that the skills and expertise of RDs are essential and need to be maintained in all health units. ● We note that our ODPH leadership model is based on mutually determined by-laws and a strategic plan that reflects current public health nutrition priorities and concerns (i.e., Evidence Informed Public Health).
Indigenous and First Nation Communities	
15. What has been successful in the current system to foster collaboration	<ul style="list-style-type: none"> ● OPHS Relationship Building with Indigenous Communities Guideline and Health Equity Standard indicates how important it is for public health to work

<p>among public health and Indigenous communities and organizations?</p>	<p>on developing relationships with Indigenous communities and organizations</p> <ul style="list-style-type: none"> • Relationships based on trust, self-determination, respect, and commitment have been successful to foster collaboration recognizing that this takes time to build given the 150 years of distrust of government by Indigenous communities and organizations. • Public health staff need to first understand the history and current context for Indigenous Peoples before engaging with Indigenous communities and organizations, therefore it is essential that more opportunities for cultural safety and cultural humility training be available for all public health staff. • Food systems work is one area where public health RDs can enhance opportunities to collaborate with and support Indigenous communities and organizations throughout Ontario. At Northwestern Health Unit (NWHU) and Thunder Bay District Health Unit (TBDHU), Public Health RDs are supporting Indigenous community members as they work towards food sovereignty and self-determined food systems. For example, Understanding Our Food Systems is a collaborative participatory, action-based project led by fourteen First Nations communities and supported by a collaborative partnership between the Thunder Bay District Health Unit and the Indigenous Food Circle. The project is supported by a passionate team of researchers, facilitators and community development professionals. The group works to build a deeper understanding of Indigenous food security and sovereignty. More information will be available on this website, soon: www.understandingourfoodsyste.ms.com.
<p>16. Are there opportunities to strengthen Indigenous representation and decision making within the public health sector?</p>	<ul style="list-style-type: none"> • Yes, reconciliation must be prioritized across the province, regardless of Indigenous representation within catchment areas. • OPHS has established a mandate to work with Indigenous communities, but those communities may not have mandates to work with public health. Public Health must show Indigenous communities that we are open to and welcome their involvement. And that it

	<p>really is a partnership, mutually beneficial, based on trust and respect</p> <ul style="list-style-type: none"> • This should be considered at all levels of PH not just local levels of PH (not just the HU level)
Francophone Communities	
17. What has been successful in the current system in considering the needs of Francophone populations in planning, delivery and evaluation of public health programs and services?	<ul style="list-style-type: none"> • ODPH is fortunate in that Francophone RDs who work with Francophone populations within their respective HU are members of ODPH and have an active voice in representing the needs of their community on various work groups. For example, Francophone RDs are able to review resources (website content and print) which have been translated from an external source to ensure alignment with the language used in public health and within their respective Francophone communities. • Some PHUs also provide in-kind services to translate materials or verify translated materials. This has allowed ODPH to provide many of its resources (not all) in French (Cent\$less, BrightBites, Child Care, Pediatric Nutrition Guidelines) which supports French language programming in non-Francophone health units.
18. What improvements could be made to public health service delivery in French to Francophone communities?	<ul style="list-style-type: none"> • Funding and capacity are barriers for ODPH to be able to provide both Francophone communities and people access to resources and training in French. • Increased access to translation and interpretation services including American Sign Language (ASL) and Langue de signes Quebecois (LSQ) across the province would improve equitable access to French language programming and resources. Similarly, increased access to these kinds of language services to support other diverse populations would be welcome. • Increased access to bilingual professional education and training to increase the numbers of bilingual public health professionals including RDs, would help improve access to public health services for Francophone communities and people across the province.

Learning from Past Reports	
19. What improvements to the structure and organization of public health should be considered to address these challenges?	<ul style="list-style-type: none"> • Organizations, like ODPH, increase efficiencies and decrease duplication. Adequate support for these organizations at the PHU and provincial level allows successful engagement with local priorities, successes and challenges, and informed input on centralized approaches. • RDs are underutilized - the role of RDs as a regulated health profession and the potential our organization (ODPH) has to provide leadership related to public health and nutrition is not used to its full potential by local PHUs nor the Ministry of Health. We encourage provincial and local leaders to recognize, appreciate and utilize the full skill set RDs can contribute to addressing the barriers to healthy eating, and creating supportive environments and policy, so that population health outcomes are achieved across the lifespan and across the province. • MOH should ensure mechanisms are in place to ensure RD capacity at the local PH level as a critical component of public health programs.
20. What about the current public health system should be retained as the sector is modernized?	<ul style="list-style-type: none"> • Ability to act on local priorities in a timely manner. • Public Health Units are the leaders in upstream, population health approaches to health promotion. Currently, there are others in the health system doing health promotion work; however, they mainly focus on health education and secondary/tertiary prevention (i.e. for people with identified risk for or diagnosed with chronic or acute diseases). Public health is better positioned to provide comprehensive primary health promotion for all which includes addressing root causes embedded in the Determinants of Health (DOH). We need to ensure that public health units maintain their role in facilitating health promotion work led by multidisciplinary teams. • Public health services need to continue to be rooted in local needs. Boards of Health must have strong involvement of those who understand and are connected to communities and should also have a strong understanding of the role of public health.

	<ul style="list-style-type: none"> ● It is important to have staff working front-line in communities, who are also very much involved with informing and developing programs and services at the provincial level. ● The need for ongoing surveillance to inform programs and services both provincially and locally is critical.
21. What else should be considered as the public health sector is modernized?	<ul style="list-style-type: none"> ● Efforts to ensure cross-Ministry and cross-sector collaboration (e.g., amongst Ministries and amongst public health professionals and organizations working in School Health and Ministry of Education). ● Health in All Policy lens be applied across government ministries ● Inclusion of regulated health professionals are crucial to keep a highly skilled, credible, professional and nimble workforce. Registered Dietitians are the only regulated health professionals with integrated nutrition and public health competencies. Multi-disciplinary collaboration is essential. ● It is also critical that public health staff have the capacity to support and preceptor students including dietetic practicum and Masters students who will be entering the College of Dietitians of Ontario. Preceptorship is an important opportunity to ensure a skilled public health workforce for the future. ODPH is connected to the Dietetic Education Leadership Forum of Ontario to support opportunities in public health competencies. ● Recognition of Public Health Standards as the guiding framework for health promotion and disease prevention, and the development of an evidence informed strategy that includes shared priorities and goals for healthy eating and nutrition would provide focus and increase efficiencies. ● Look to professional associations like ODPH when Ministries consult on public health issues, to ensure front line professional issues and evidence-informed practice are front and centre.