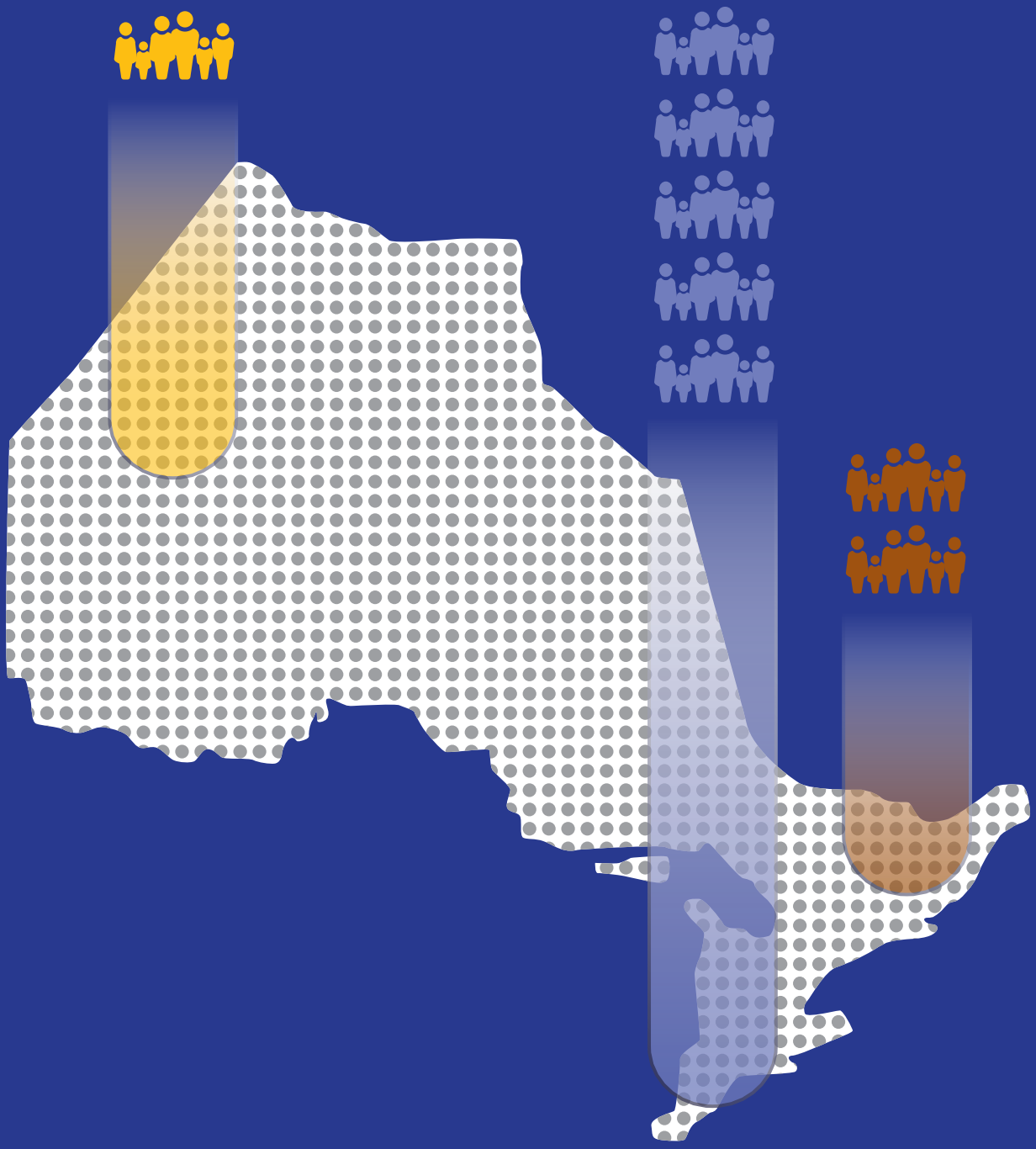
Ontario



MAPPING WELLNESS: ONTARIO'S ROUTE TO HEALTHIER COMMUNITIES

2015 ANNUAL REPORT

Of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario

Ministry of Health and Long-Term Care

Chief Medical Officer of Health
21st Floor, 393 University Avenue
Toronto ON M7A 2S1
Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

Médecin hygiéniste en chef
393 avenue University, 21e étage
Toronto ON M7A 2S1
Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

Ontario

A Message from Ontario's Chief Medical Officer of Health

If I were to ask Ontarians what they could do to improve their health, most would talk about making personal changes. They could stop smoking, eat healthier foods, exercise more, drink less alcohol and sleep more. These personal lifestyle choices are important but they are often influenced by factors that are not necessarily in our control, such as income, education, our relationships with family and friends, where we live and work, our physical environment and access to health services.

For example, if you spend three hours commuting to and from work each day, you may not have the time to exercise. If you don't have a car and there are no supermarkets within walking distance of your home, you may find it harder to eat healthy meals. If you don't know your neighbours and have few friends or family nearby, you may become isolated and stressed.

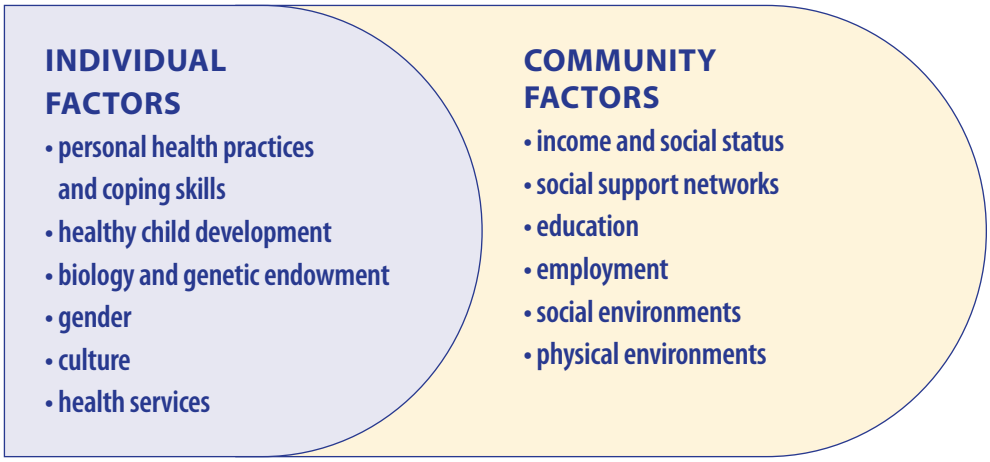
On the other hand, Ontarians who live in communities with safe, clean water, clean air, affordable housing, healthy affordable food, education, good jobs, good incomes, supportive friends and neighbours, parks and green space, opportunities to be active and socialize, safe roads and good transportation, low crime rates and good health services will be healthier. In general, they will live longer and be less likely to become patients or need costly health services.

Building our communities for health will keep Ontarians healthier and make them less likely to become patients or need costly health care services.

By focusing on community wellness, we can improve the health of all Ontarians.

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

Individual and community health factors that contribute to health:



How healthy are Ontario's communities now? What can we do to make them healthier?

This report – the first in a series I am issuing on practical strategies to improve community wellness – talks about the importance of being able to monitor Ontario's health over time: community by community. It focuses on the information we need to collect to help us make informed evidence-based decisions about how to invest in wellness. To improve health, we need to **understand** the health of our communities, **share** that information with our communities, **invest** in community wellness and **strengthen** our communities by ensuring that everyone has the same opportunities for health and wellness.

Please join me in a province-wide effort to create healthier communities and healthier Ontarians.

TABLE OF CONTENTS

I. THE CASE FOR MAPPING WELLNESS

Mapping Personal Health

When you go for a check-up, your primary care provider will check your blood pressure and weight, and order any tests you may need.

You will be asked about your family history and about your diet, exercise, smoking and alcohol use. Your provider may ask questions about your social situation.

All this information is recorded in your chart and used to create a map of your personal health. Your primary care provider uses this information to treat any problems you have by prescribing medications, referring you to other services or suggesting steps you can take to stay healthy or improve your health – and then checking again with you over time to see whether the treatment and advice has helped.

Mapping Community Health

Public health professionals take a similar approach to mapping community health. They gather information to create a map of the wellness of their communities and of the neighbourhoods and populations within their communities.

Public health units track information on factors that influence both personal and community wellness, such as the birth weight of babies, family incomes and how ready five-year-olds are to start school. They monitor air quality and smoking rates. They track immunization rates in school children as well as the most common causes of preventable deaths, such as heart disease and motor vehicle collisions.

With this information, public health units can identify key threats to wellness in a community. They can identify neighbourhoods where people are thriving and the factors that contribute to their health as well as neighbourhoods or groups in the community whose health is at risk.

Public health units then use this information to decide how best to use their resources to improve wellness – for the whole community and for certain groups and individuals in the community.

For example:

High smoking rates?

- Launch new smoking cessation campaigns.

High rates of diabetes and heart disease?

- Awareness programs.
- Policy on menu labelling to promote healthy diets.

Childhood obesity?

- More playgrounds and park space.

Higher number of motor vehicle collisions or pedestrian deaths?

- Reduce speed limits.
- Redesign high-risk intersections.

Large proportion of babies with low birth weight?

- More pre-natal programs.
- More early child development programs.

Who is Responsible for Mapping Community Wellness?

Ontario has 36 public health units that are responsible for mapping community wellness and working with community partners – service providers, community organizations, other municipal government departments, policy makers, program planners and researchers – to collect data, identify issues and priorities, and develop programs and services that improve health.

- A public health unit is an official health agency established by a group of municipalities in a geographic area.
- Health units administer health promotion and disease prevention programs, and communicable disease control programs.
- Each health unit is governed by a Board of Health, which is an autonomous corporation under the Health Protection and Promotion Act, and is administered by a Medical Officer of Health.
- Each Board is largely made up of elected representatives from the local municipal councils.
- The Ministry of Health and Long-Term Care cost-shares the expenses of each public health unit, including programs, with the municipalities.

This map depicts the geographic boundaries of Ontario's 36 public health units.

II. THE CASE FOR STRONG LOCAL DATA

Using Local Data to Map Community Wellness

To map community wellness, public health units need good local data.

Local data is important because health issues vary from community to community. Each Ontario community has a different mix of ages, ethnicities, work and education opportunities, and its own history, culture, strengths and needs. Within each community, neighbourhoods can also differ dramatically in terms of ethnic mix, income, access to schools, stores and other services, mix of commercial and industrial businesses, amount of parkland and open space, safety and health needs. Some neighbourhoods may have a high proportion of families and children living in poverty, while others might have high rates of teens with mental health problems. Some might be home to large numbers of newcomers while others have a growing number of seniors living on their own. One cannot assume, for example, that if one community has high rates of motor vehicle collisions or childhood obesity, a neighbouring community will have the same problems.

A community's overall wellness is affected by the health of each neighbourhood.

Health issues in a community or neighbourhood can also change over time. For example, if a major plant closes in a community and people lose jobs, incomes in some neighbourhoods may drop and residents may have more stress-related health problems. A neighbourhood that was once home to small industries and warehouses may gradually be converted to housing. To stay healthy, it may need more grocery stores and green space than in the past. As newcomer populations integrate into a community, they may gradually move out of one neighbourhood into another and a new ethnic group may move in. In a neighbourhood that was once home to young families, the children grow up and leave home, and there is gradually less need for children's services and more need for seniors' programs.

In many cases, health units lack the high-quality local data they need to map community wellness. Without that data, public health units are flying blind.

Using Local Data to Target Health Problems

WITH GOOD LOCAL DATA GATHERED CONSISTENTLY OVER TIME, HEALTH UNITS CAN:

1 Target programs and services to neighbourhoods and populations with the greatest needs

Some health risks are more concentrated in specific neighbourhoods or populations. When health units know where the problems are, they can work with local partners to develop targeted programs and help achieve the goal of Ontario's Patients First: Action Plan for Health Care[1] : *the right services for the right people in the right place at the right time*. For example, a community with high rates of smoking in certain neighbourhoods may introduce intense programs aimed at smokers in those areas.

Targeted and tailored programs are more cost effective because they direct resources to where they are needed most. They also have more impact on the health of the individuals involved, which leads to a healthier community.

TARGETING NEIGHBOURHOODS WITH HIGH RATES OF DIABETES

Peel Region has one of the highest rates of diabetes in Ontario. If nothing changes, by 2022 one in every 10 adults will develop diabetes. Peel Public Health worked with researchers at the St. Michael's Hospital Centre for Research on Inner City Health to map the problem and publish a diabetes atlas for the region. The findings? Some census tracts, particularly those in Brampton, had rates of diabetes 1.4 times higher than the regional average. When they looked at other factors that could be adding to the risk, such as obesity, income and ethnicity, they found that diabetes rates were highest in neighbourhoods with:

- wide streets and high-traffic intersections, which discourage walking
- large populations of people from ethnicities that are more likely to develop diabetes, such as people from the Caribbean and South Asians. (South Asians are genetically susceptible to developing diabetes at a younger age and lower weight than Caucasians.)

Peel Public Health is now collaborating with the region's planning department to develop policies, such as modifying the layout of roads, which will create more walkable neighbourhoods.

[1] *Ministry of Health and Long-Term Care. Patients First: Action Plan for Health Care. Government of Ontario. Toronto: 2015.*

2 Target health resources to the most important health problems in the community

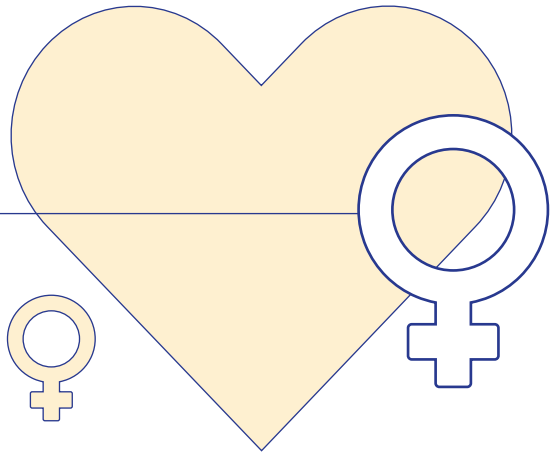
Using local data to map community wellness, health units can identify the most important health problems – both in terms of the number of people affected and their impact. Health problems that threaten a large number of people, cause significant harm or lead to preventable deaths become community priorities. Health problems that often move to the top of the list include high rates of teen suicide, domestic violence, high rates of smoking, increases in overdose deaths, issues related to road safety and any threats to water or air quality. In communities and neighbourhoods with a high proportion of young families, child health is a priority, while in those with an aging population, services for seniors might be the priority.

ENHANCING HEALTH BY REDUCING INTIMATE PARTNER VIOLENCE

Intimate partner violence includes physical aggression, sexual coercion, psychological abuse and/or controlling behaviours that occur within an intimate relationship. It can occur between partners of all sexual orientations and gender identities. Intimate partner violence is a serious and preventable public health issue that can cause significant harm to those who experience the violence, their families and society. It also creates a large economic burden for Canadian society, costing about $7.4 billion each year in medical care, mental health services, justice system services and lost productivity.

The problem is more common than we think. In Canada, one in three women has experienced physical or sexual intimate partner violence during their lifetime and on any given day, over 6,000 women and children are living in shelters to escape abuse. In 2013, 4,695 incidents of physical or sexual intimate partner violence were reported to the Toronto Police Service. There is currently a lack of local population survey data in Ontario that can examine the prevalence of intimate partner violence or the socio-demographic subgroups at increased risk. National research shows that although men can experience intimate partner violence, women are more likely to experience severe and chronic forms of abuse. In a Toronto population survey conducted between 2009 and 2011, 10 per cent of women and 6 per cent of men reported physical abuse by an intimate partner in the past 10 years.

To tackle this health problem, Toronto Public Health looked at research on both the factors associated with intimate partner violence and those that can reduce the likelihood of abuse, including positive parenting, school connectedness, social support, income security, gender equality and intolerance of violence. In November 2015, Toronto Public Health launched *Action on Intimate Partner Violence Against Women 2016–2019*, a comprehensive plan that includes program and policy interventions to educate children and adolescents about healthy relationships, address social and cultural norms that perpetuate violence, encourage the public to identify and help women affected by violence, provide more services to support and empower women, and address the unique and intersecting issues that affect Indigenous, LGBTQ2S and other vulnerable communities. It also recommends improving local surveillance and research on intimate partner violence to better inform practice and policy to address this important public health issue.



3 Respond quickly to health threats

The health of a community can change quickly. It can be affected by many factors, including the loss of a major employer, environmental threats and outbreaks of diseases.

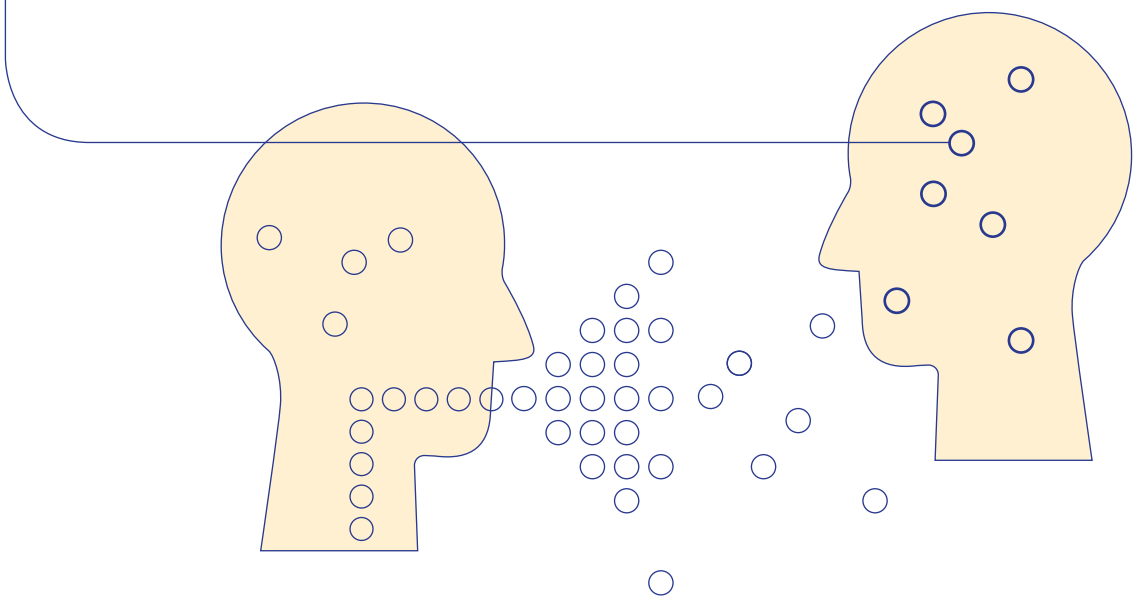
When health units have good local data, they can identify new health threats early and take steps to protect everyone. For example, if one doctor sees a patient with an E. coli infection, it may be an isolated problem. However, when doctors across a region are reporting people with similar symptoms, the public health system can act quickly to find the source of the infection and stop it.

RESPONDING TO A MEASLES OUTBREAK

Measles is a serious illness caused by a virus that spreads when people cough or sneeze. Ontario funds measles vaccination for all children; however, not all children are vaccinated. During a measles outbreak, people who haven't been vaccinated are at high risk of becoming infected. Once infected, a person can also spread the virus to infants who are too young to be immunized.

During a 2015 measles outbreak in the Niagara Region, public health nurses used Panorama, the province's immunization information system, to quickly identify 36 of 950 children in four schools who had not been vaccinated against measles. To keep them from being exposed, the children were excluded from school and their parents were encouraged to allow them to be vaccinated.

Instead of having to close the schools to stop the outbreak, which would mean taking children away from learning and parents away from work, the public health unit was able to target its efforts to the children who were vulnerable. In the process, public health nurses connected with the families, built trust and talked about the importance of immunization – for their children and for the community. As a result, 25 of the 36 children were vaccinated. The children and the community are now better protected against measles.



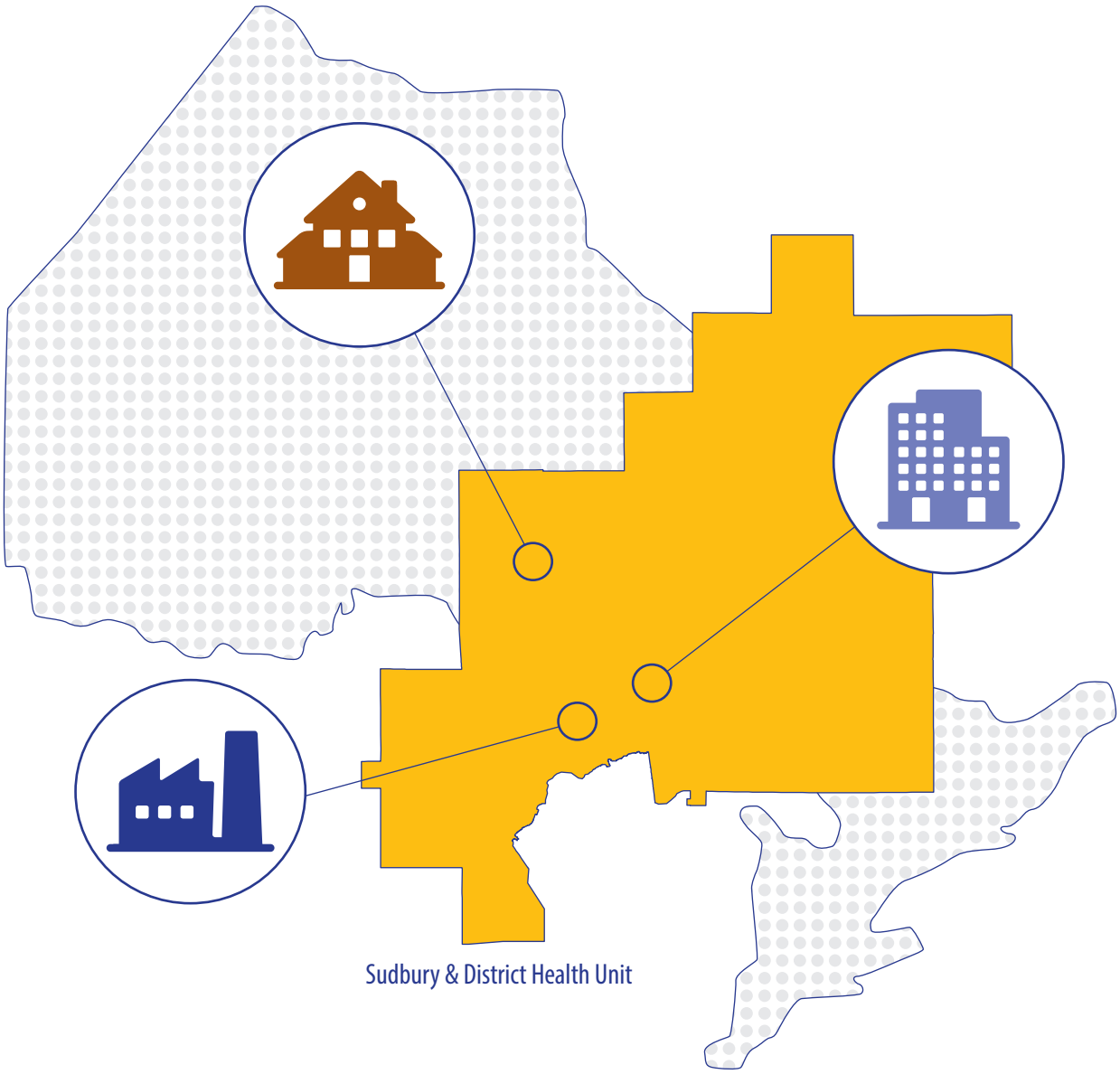
Using Local Data to Engage Communities in Wellness

Good local data can drive change. The more people who know about their community's health, the more likely they are to do something to improve their own health and to support investments that improve wellness. The more communities that invest in wellness, the healthier they will be . . . and the people who live there will be less likely to become patients and need costly health and social services.

Public health units in Ontario are working hard to gather local data and use it to empower communities to invest in wellness.

SUDBURY & DISTRICT HEALTH UNIT: Using data to tackle health inequities

In 2012, the Sudbury & District Health Unit used local data to classify neighbourhoods across the City of Greater Sudbury, based on their social and economic characteristics (e.g., household income, employment, education) as most or least deprived and then analyzed the wellness of people in those neighborhoods (e.g., self-rated health, emergency department visits, obesity).



The findings?

When they compared the "most deprived" with the "least deprived" neighbourhoods, they found dramatic health differences:

- infant mortality was **2.4** times higher
- obesity was **2** times higher
- emergency department visits for mental health episodes were **4.4** times higher

If the City of Greater Sudbury could improve wellness in the "most deprived" neighbourhoods, they could have a huge impact on health. If everyone in the city had the same opportunities for health as those living in the "least deprived" neighbourhoods, each year there would be:

- **1** fewer infant deaths
- **17** fewer teen births (a decrease of 39 per cent)
- **11,231** fewer obese people
- **264** fewer hospitalizations for mental health episodes
- **14,077** fewer emergency department visits
- **9,706** more people who rate their health as excellent or very good (seven per cent of the population)
- **131** more residents living past the age of **75**

The impact?

The Sudbury & District Health Unit developed a report, *Opportunity for All (2013)*, as well as health profiles for each ward within the city. The information, which was shared with city councillors, health organizations, schools and police, is now being used to drive new health initiatives designed to reduce disparities. For example:

- Community partners developed a community garden on a school site to improve food security
- Schools worked with community partners to develop care pathways and supports for students with mental health issues
- School boards developed a strengths-based approach to help students develop the skills they need to avoid harmful alcohol and drug use

DURHAM REGION: Using Data to Target Neighbourhood Health Issues

In 2015, the Durham Regional Health Unit's Health Neighbourhoods project compiled data and maps on the wellness of the 50 different neighbourhoods in the region. This information, along with reports, indicator summaries and dynamic neighbourhood profiles was publicly released online, to help inform members of the community.

"It really is great information … that's going to help us tremendously … [in putting] our resources toward supporting people that need our support. I think it's one of the most positive programs I've seen in a long time and I hope that we'll be able to utilize it in a lot of different ways to meet the needs of those that are most vulnerable."

— Councillor Dan Carter

The findings?

In general, Durham residents enjoy good health but there are differences between neighbourhoods.

Rural neighbourhoods • Lower birth rates • Fewer young children • More seniors • More injuries • Fewer newcomers • More vegetables/fruit consumption • Less childhood asthma • Fewer adults with diabetes

Urban neighbourhoods • Higher birth rates • More young children • Less seniors • More newcomers • Less injuries • Less fruit/vegetable consumption • More childhood asthma • More adults with diabetes

Durham Region identified seven priority neighbourhoods that make up only 15 per cent of the region's population, but account for:

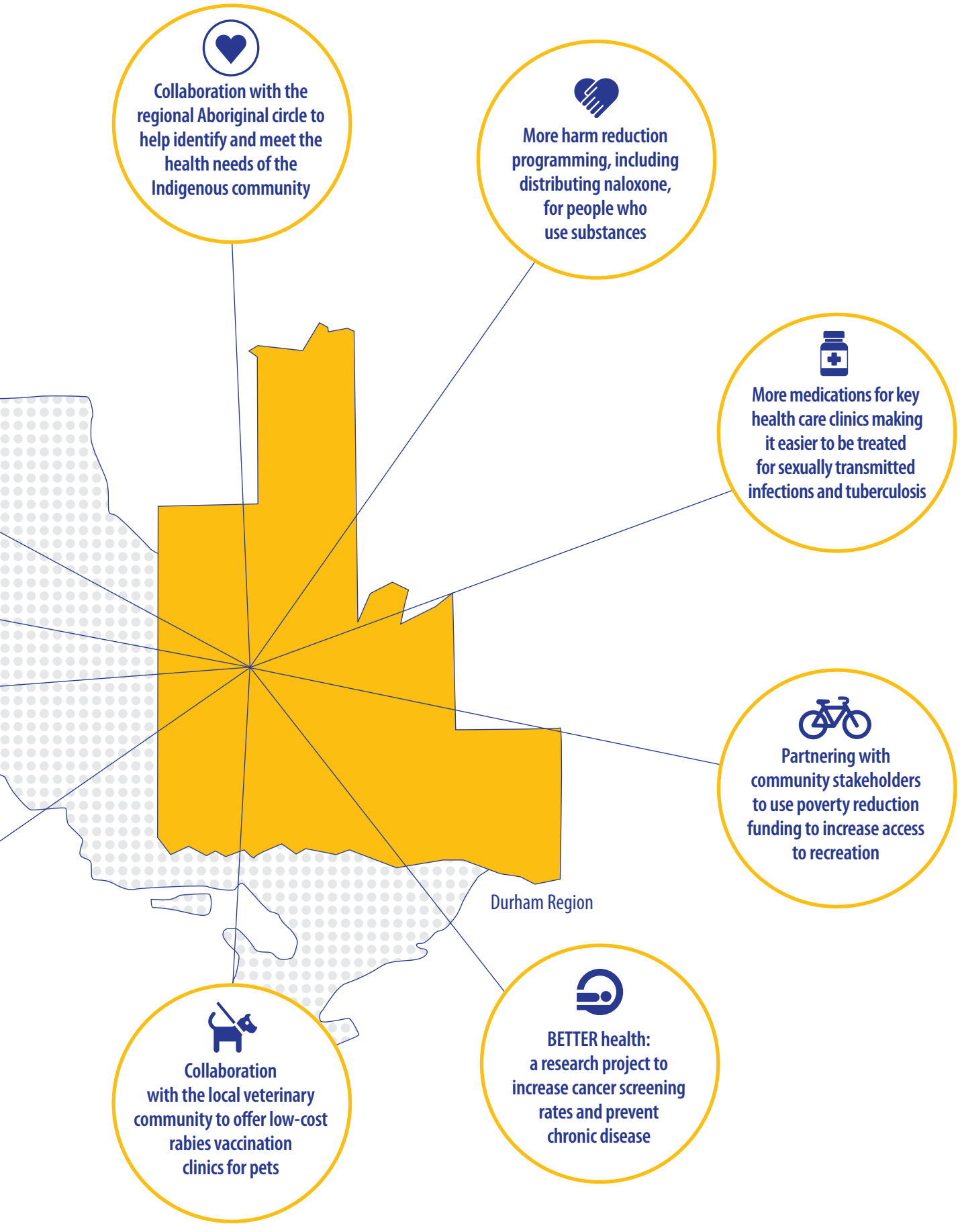
- **one-third** of all children under age six living in low-income households
- over **one-quarter** of all teen pregnancies
- **4** of every **10** people with a hepatitis C infection
- **3** of every **10** ambulance calls to residences

Each of these priority neighbourhoods is unique and has strengths as well as challenges, so portraying them as similar would be misleading. For example, breastfeeding rates are low in some priority neighbourhoods but high in others. Kindergarten children in one of the priority neighbourhoods are more likely to walk or bike to school than those in many other Durham neighbourhoods. Because each neighbourhood is different, each needs its own mix of targeted programs.

The impact?

Community response to Health Neighbourhoods has been overwhelmingly positive. Local media have published articles that have helped engage the public and many community organizations are using the information to build partnerships and take action.

Durham Region, in collaboration with community partners, has used the data to target resources to priority neighbourhoods, including:


Collaboration with the regional Aboriginal circle to help identify and meet the health needs of the Indigenous community
More harm reduction programming, including distributing naloxone, for people who use substances
More medications for key health care clinics making it easier to be treated for sexually transmitted infections and tuberculosis
Partnering with community stakeholders to use poverty reduction funding to increase access to recreation
BETTER health: a research project to increase cancer screening rates and prevent chronic disease
Collaboration with the local veterinary community to offer low-cost rabies vaccination clinics for pets
Durham Region

III. CHALLENGES IN GETTING GOOD LOCAL DATA

Public health units work hard to gather the local data they need to map community wellness, but the process is not easy or consistent across the province. They rely mainly on a mix of national and provincial data sources (see examples in Table 1) – all of which have limitations. Health units also pull data from other local sources, such as police statistics and housing/shelter statistics. Both Sudbury & District Health Unit and Durham Regional Health Unit pulled data from more than 20 different sources to create their neighbourhood profiles. Some health units conduct local surveys to augment the data that is available.

It's also important to note that Sudbury and Durham are larger health units with more resources to invest in collecting data. Regardless of size, public health units face challenges getting good local data, including:

1. **Relevance** Many health units rely on information from national sources such as the Census and Vital Statistics and the Canadian Community Health Survey (CCHS), which do not cover all health indicators of interest to Ontario and do not reach enough households in some areas to be relevant for some communities.
2. **Timeliness** National data are helpful but they are not timely. Public health units have only just received vital statistics data and cancer incidence and mortality data for 2012. It is difficult to respond to communities' changing health needs when the information is more than five years old.
3. **Consistency** To understand community wellness, it's important to gather consistent information over a long period of time. The most effective way to do that is to ask the same or similar questions every few years, and then compare the results. Ideally, all communities would be asking the same questions so it would be possible to compare health between health unit areas as well as between communities in a health unit and neighbourhoods within a community.
4. **Inclusivity** Most data sources available to public health units are either specific to certain life stages/health indicators or have other limitations. For instance, Ontario has data on children at birth and when they enter school but not at other times in their lives.

The Association of Public Health Epidemiologists (APHEO) in collaboration with Public Health Ontario, recently published a detailed report on the gaps in current data sources, including the lack of consistent and inclusive information on:

- the eating habits and physical activities of children under age 12
- the health of pregnant women and their access to pre-natal and other health services
- alcohol use and factors that influence alcohol use (e.g., number of bars in a neighbourhood)
- the factors that threaten healthy families, such as violence, poverty, employment and housing, and their impact on health
- the impact of structural, social and socioeconomic factors on community and individual health

Many of these are data gaps that some health units cannot fill on their own. Ontario needs a more consistent approach to be able to collect more inclusive data.

The Canadian Health Survey on Children and Youth (ages 1 to 17) being developed by Statistics Canada will help fill some data gaps.

GOOD DATA FOR THE PURPOSES OF MAPPING COMMUNITY WELLNESS IS:

- **Relevant to the community** – reflects the population's current health status and is detailed and granular enough to inform programs and services targeted to specific neighbourhoods or populations
- **Timely** – accessible to those who use it as quickly as possible
- **Consistent** – defined and interpreted in the same way, and collected at regular intervals to be able to measure changes over time
- **Inclusive** – represents all aspects of health and the entire population of a community or neighbourhood including vulnerable groups often missed in data collection (e.g., people who are homeless, people who use substances, refugees)
- **Affordable** – can be gathered at a reasonable cost

5 Affordability To get more consistent, comprehensive local data, a number of Ontario's health units, including Sudbury and Durham, are currently part of the Rapid Risk Factor Surveillance System (RRFSS) (see Table 1 for description). This survey is more flexible than the Canadian Community Health Survey because it allows health units to select and add questions and to request that some areas or populations be over-sampled to provide enough detailed, granular information to map their wellness. However, the cost of participating puts the survey out of reach of some health units.

STRATEGIES TO CLOSE DATA GAPS

Efforts are underway to close data gaps and integrate existing sources of data. Several health units are involved in Public Health Ontario's **Locally Driven Collaborative Projects** grants to identify promising ways to collect, integrate, analyze and report health data on school-age children. For example, the Sudbury & District Health Unit and Durham Regional Health Unit are co-leading a project with other health units that involves working with primary care providers to develop an EMR (electronic medical record) based surveillance system to measure childhood weights. Providers will measure and record children's height and weight in the EMR. They will also ask parents questions from the toddler and preschooler NutriSTEP® screening tool to identify any nutritional risk and protective factors. Health units will then have local-level data on overweight and obesity in young children (aged 18 months to six years) and the factors that are increasing risk.

Table 1: Examples of Current Data Sources and Their Limitations

NAME	DESCRIPTION	LIMITATIONS
Canada Census	A national household survey conducted every five years that collects demographic and statistical information (e.g., age, ethnicity, education, income, employment, housing, disabilities)	• Long-form not used in 2011 so some data not available
Vital Statistics Canada	A national database on births, marriages and deaths, including cause of death	• Data not always complete • Time lag of ± five years to obtain data
Canadian Community Health Survey	An annual telephone survey of about 108,000 households across Canada that gathers data on a number of health indicators and is able to link them with demographic and socio-economic data	• Relies on self-reported data • Doesn't reach enough households in some health unit areas to provide relevant, granular data at the neighbourhood level • Doesn't provide data on children • Doesn't include many indicators of interest to Ontario communities
Ontario Health Survey	Conducted in 1990 and 1996/97 to provide consistent information about community health across the province	• Information now more than 20 years old • Survey no longer done
Rapid Risk Factor Surveillance System (RRFSS)	An annual telephone survey of about 18,000 Ontario households conducted through York University that collects information on risk behaviours, chronic health conditions and use of health services	• Covers a limited number of topics • Self-reported data and reaches only some Ontarians (particularly those who have land lines – although it is starting to use cell phone numbers as well) • Health units have to pay to participate
Better Outcomes Registry and Network (BORN)	Ontario database on births from hospitals, labs, midwifery practices and clinical programs	• Reporting varies by public health unit and may lag by six to 15 months • Does not capture the small number of births each year in hospitals with no obstetrical services • Indigenous births are under-represented
Early Development Instrument (EDI)	An Ontario assessment of school readiness completed by teachers on all five-year-olds in kindergarten	• Does not provide data on developmental progress of children under age five
Panorama	Ontario's immunization registry/information system	• Currently contains only immunizations for school-aged children

IV. RECOMMENDATIONS: ONTARIO'S ROUTE TO HEALTHIER COMMUNITIES

Ontario's public health units have the knowledge, skills and community partners to develop strong wellness programs and close health gaps. To deliver the right programs to the right people in their communities, they need better data. To identify new and changing needs and assess the impact of their programs and services, they need a better way to gather that information consistently over time.

To give public health units access to better data so they can invest in wellness based on evidence, we recommend a four-part strategy:

1

UNDERSTAND OUR COMMUNITIES:

Implement a provincial population health survey that collects data at the local community and neighbourhood levels

The goal is to be able to map and understand community wellness. The survey will provide comprehensive inclusive data on the health status of all neighbourhoods and populations, including vulnerable groups that are often missed in current surveys and databases. It will also be flexible enough that health units can select or add questions relevant to their communities' unique needs. The proposed province-wide Ontario population health survey would:

- fill current gaps
- create a level playing field, giving all health units and their community partners the data they need to improve wellness
- help the Local Health Integration Networks (LHINs) and the new sub-LHIN areas develop health services that achieve the goals of the Patients First: Action Plan for Health Care

Ontario should find the most cost-effective way to administer the survey – perhaps by leveraging the Statistics Canada infrastructure.

2

SHARE WITH OUR COMMUNITIES

Give the public and community partners access to more integrated and meaningful information

Once we have good local data on a community's wellness, it is important to share that information with the people who live there. In the past, community health data were accessible mainly to researchers and policy makers, and even these professionals faced barriers getting the information they needed. With new technologies, it's now possible – while still ensuring confidentiality and privacy – to:

- pull together data from a number of different sources
- look at data by important characteristics of interest
- map data so people within a community can understand both needs and strengths
- put that data online where people can see and use it.

As is the case in Durham, we want all residents in a community to have easy access to information on wellness and use it to set health priorities based on real-life needs. People working in health organizations and other community services will be able to act – individually and together – to improve community and individual wellness.

Consistent with the government's current efforts, we support integrating data from different sources to map community wellness and then sharing that data.

It's important to make better use of existing data as well as fill the data gaps.

3

INVEST IN OUR COMMUNITIES

Use the data to improve wellness and delay or avoid unnecessary health care spending

With good local data, public health units and their partners can develop programs that meet the specific needs of a population, a neighbourhood or the whole community. They can also develop programs to address specific health issues – such as smoking, obesity or motor vehicle collisions – that affect a number of neighbourhoods. Equipped with the right data, communities can invest in programs and services that improve wellness and reduce health costs. As the Sudbury data showed, if all neighbourhoods had the same opportunities for health, there would be fewer accidental deaths, people would live longer and there would be fewer hospital visits.

4

STRENGTHEN OUR COMMUNITIES

Use the data to reduce health disparities and reinforce health equity

Efforts to understand community health – like those in Sudbury and Durham – will identify health disparities. Some neighbourhoods and groups will be healthier or more advantaged than others. The proposed provincial population health survey, which will collect socio-economic as well as health data, will help health units identify these disparities. By targeting resources to those in greatest need, we will strengthen our communities and improve health and wellness for all.

It should be as easy for people to find accurate information about the health of their neighbourhood as it is for people who are buying a home to find out about house prices and the location of schools and parks.

V. CONCLUSION

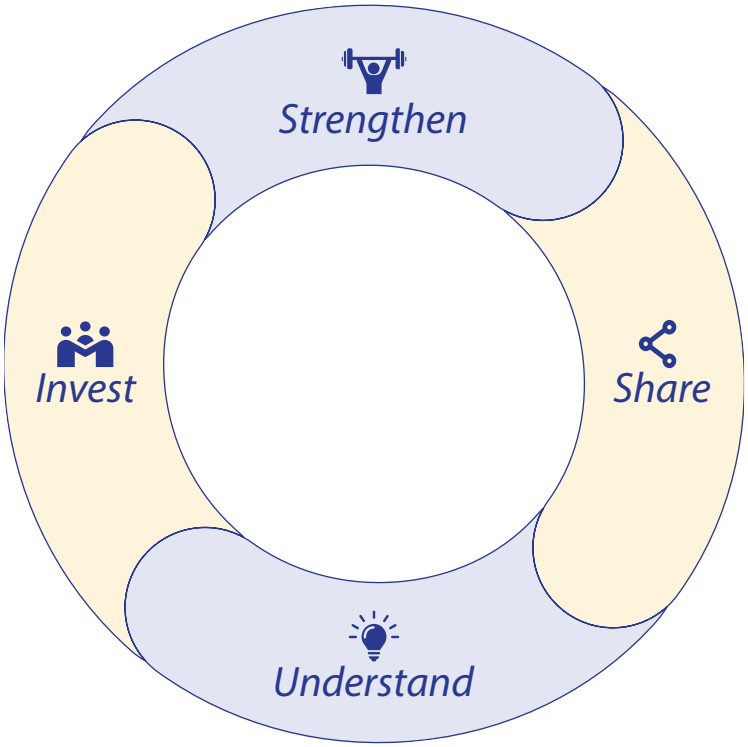
When we focus on community wellness, we improve the health of everyone who lives there.

The first step in improving wellness is to understand it. How healthy are our communities now? What are the most pressing health issues? Who is most affected? Communities across Ontario need relevant, timely, consistent, inclusive and affordable local data to be able to respond quickly to health threats and target health resources to their most important health problems and to the neighbourhoods and populations with the greatest needs.

To make the best use of its resources, Ontario needs to consistently map and analyze wellness, community by community. Good local data will help us **understand** community wellness, **share** that information with Ontarians, **invest** in wellness in our communities and **strengthen** our communities by ensuring that everyone has the same opportunity for wellness. It will also help us understand how investments in different community services – such as health or social programs, school-based initiatives, recreation programs, park space, changes in road safety or transportation systems – affect our health directly or indirectly.

Gathering the right data is only the first step. Then we must use it to reduce health disparities and benefit all Ontarians.

STRENGTHEN OUR COMMUNITIES:



VI. ACKNOWLEDGEMENTS

Advisory Committee:
Michael Hillmer, Lawrence Loh, Heather Manson, Doug Manuel, Michael Sherar, Emma Tucker

Advising Staff:
Fiona Kouyoumdjian, David McKeown

Staff:
Catherine Fraser, Gillian MacDonald, Laura Seeds, Mikayla Wicks

Writer:
Jean Bacon

Publishing:
Leora Conway, Lucia De Stefano

Contributing Public Health Units:
Peel Regional Health Unit, Niagara Regional Area Health Unit, City of Toronto Health Unit, Halton Regional Health Unit, Durham Regional Health Unit, Sudbury & District Health Unit

Other:
Sarah Cox, Meghan Walker

VII. APPENDIX

Ontario Health Units' Vacant Medical Officer of Health (MOH) Positions*

Filed by acting MOHs as of February 3, 2017

District of Algoma Health Unit**
Haldimand-Norfolk Health Unit
Hastings & Prince Edward Counties Health Unit
Huron County Health Unit
Oxford County Health Unit
Porcupine Health Unit
Renfrew County & District Health Unit
Timiskaming Health Unit
City of Toronto Health Unit
Total = 9 Health Units with MOH Vacancies

**Under 62.(1)(a) of the Health Protection and Promotion Act, every board of health shall appoint a full-time medical officer of health.*
***Vacancies may include positions filled by qualified physicians awaiting appointment by boards of health and ministerial approval.*

Ontario Public Health Units' Vacant Associate Medical Officer of Health (AMOH) Positions*

As of February 3, 2017

District of Algoma Health Unit
Durham Regional Health Unit
Grey Bruce Health Unit
Halton Regional Health Unit**
Thunder Bay District Health Unit
City of Toronto Health Unit
Total = 6 Health Units with AMOH Vacancies

**Under 62.(1)(b) of the Health Protection and Promotion Act, every board of health shall appoint one or more associate medical officers of health.*

***Vacancies may include less than or more than one FTE position per health unit and include positions filled by qualified physicians awaiting appointments by boards of health and ministerial approval.*

VIII. BIBLIOGRAPHY

Association of Public Health Epidemiologists in Ontario (APHEO) Core Indicators Working Group in Collaboration with Public Health Ontario (PHO). (2016). Gaps in Public Health Indicators and Data in Ontario. Revised ed. Toronto, ON: Association of Public Health Epidemiologists in Ontario.

City of Toronto Health Unit. (2017). Personal communication.

Durham Regional Health Unit. (2016). Overview Report: Health Neighbourhoods in Durham Region. Revised ed.

Durham Regional Health Unit. (2017). Personal communication.

City of Toronto Health Unit. (2015). Staff Report for Action on Intimate Partner Violence Against Women. Toronto, ON: Author.

Halton Regional Health Unit. (2017). Personal communication.

Kirst M, Lazgare LP, Zhang YJ, O'Campo, P. (2015). The effects of social capital and neighborhood characteristics on intimate partner violence: A consideration of social resources and risks. American Journal of Community Psychology, 55(3-4):314- 325.

Koehler G. What's behind Peel's high diabetes rate? Urban planning and ethnic backgrounds. U of T News. 2014.

McKeown D. (2015). Action on intimate partner violence against women. Presentation. Toronto, ON.

Niagara Regional Area Health Unit. (2017). Personal communication.

Office of the Chief Medical Officer of Health. (2011). 2011 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario, Maintaining the Gains, Moving the Yardstick: Ontario Health Status Report. Toronto, ON.

Office of the Chief Medical Officer of Health. (2011). 2011 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario, Maintaining the Gains, Moving the Yardstick: Technical Appendix. Toronto, ON.

Office of the Chief Medical Officer of Health. (2016). Overview: Data Sources and Limitations of the 12 Life Trajectory Indicators. Toronto, ON.

Ontario Ministry of Health and Long-Term Care. (2015). Patients First: Action Plan for Health Care. Queen's Printer for Ontario. Toronto, ON.

Peel Regional Health Unit. (2017). Personal communication.

Sudbury & District Health Unit. (2013). Opportunity for All: The Path to Health Equity. Sudbury, ON: Author.

Sudbury & District Health Unit. (2017). Personal communication.

Statistics Canada. (2015). Analysis conducted by Statistics Canada for Toronto Public Health. Source: Statistics Canada, Canadian Centre for Justice Statistics, Homicide Survey. Data available on request from Toronto Public Health.

Tucker E, King M, Phillips J, Russell L. (2014). Filling in the Gaps: RRFSS as a Data Source for Core Indicators. Presentation at Association of Public Health Epidemiologists of Ontario (APHEO) Workshop.

Catalogue no. 025756 ISSN 1912-3590 (Print) 550 March 2017