

Sudbury & District Board of Health - January 21, 2016 Meeting

1. CALL TO ORDER

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2. ROLL CALL

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3. REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST

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5. DELEGATION / PRESENTATION

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Marc Lefebvre, Manager, Population Health Assessment and Surveillance, Resources, Research, Evaluation and Development (RRED) Division

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None

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health / Chief Executive Officer

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10. RISE AND REPORT	

MOTION: Rise and Report

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12. ADJOURNMENT

MOTION: Adjournment

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The Chair will call the meeting to order and welcome members.

From: Renee Chaperon [mailto:renee.chaperon@stcharlesontario.ca]
Sent: Tuesday, January 05, 2016 1:09 PM
To: Rachel Quesnel <quesnelr@sdhu.com>
Cc: 'Paul Schoppmann' <mayor@stcharlesontario.ca>; Penny Sutcliffe <sutcliffep@sdhu.com>; Denis Turcot <dturcot@markstay-warren.ca>; renee.chaperon@stcharlesontario.ca
Subject: RE: SEMA rep on the Sudbury & District Board of Health

Hi Rachel,

Sorry about the delay.

The new rep for St.-Charles will be Richard Lemieux. He can be contacted via email at rlemieux@stcharlesontario.ca and his phone number is 705-626-3664.

Let me know if you need anything else.

Renee Chaperon

Chief Administrative Officer - Clerk
Municipality of St.-Charles
T: (705) 867-2032
F: (705) 867-5789
www.stcharlesontario.ca

Board of Health attendance is taken and recorded.

The Chair will ask Board members whether there are any conflicts of interest.

This is an opportunity for Board members to announce a conflict which would then eliminate the individual(s) from any discussion on that topic.

**AGENDA – FIRST MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT
THURSDAY, JANUARY 21, 2016 – 1:30 P.M.**

1. CALL TO ORDER

- Sudbury East Municipal Association (SEMA) Appointment of Richard Lemieux to the Sudbury & District Board of Health

2. ROLL CALL

3. REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

4. ELECTION OF OFFICERS

APPOINTMENT OF CHAIR OF THE BOARD

(2015 Chair: René Lapierre – 1 term)

MOTION: THAT the Sudbury & District Board of Health appoints _____ as Chair for the year 2016.

APPOINTMENT OF VICE-CHAIR OF THE BOARD

(2015 Vice-Chair: Claude Belcourt – 1 term)

MOTION: THAT the Sudbury & District Board of Health appoints _____ as Vice-Chair for the year 2016.

APPOINTMENT TO EXECUTIVE COMMITTEE

*(2015 Board Executive: Janet Bradley – 3 terms; Jeffery Huska – 1 term;
Stewart Meikleham – 1 term; René Lapierre – 1 term;
Claude Belcourt – 2 terms)*

MOTION: THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2016:

1. _____, Board Member at Large
2. _____, Board Member at Large
3. _____, Board Member at Large
4. _____, Chair
5. _____, Vice-chair
6. Medical Officer of Health/Chief Executive Officer
7. Director, Corporate Services
8. Secretary Board of Health (ex-officio)

5. DELEGATION / PRESENTATION

i) Population Health Profile, Sudbury & District Health Unit

- Marc Lefebvre, Manager, Population Health Assessment and Surveillance, Resources, Research, Evaluation and Development (RRED) Division
- SDHU Population Health Profile Summary Report dated January 2016

6. CONSENT AGENDA

i) Minutes of Previous Meeting

- a. Seventh Meeting – November 19, 2015

ii) Business Arising From Minutes

None

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health / Chief Executive Officer

- a. MOH/CEO Report, January 2016

v) Correspondence

a. Public Health Funding

- Letter from the Haliburton, Kawartha, Pine Ridge District Health Unit to the Minister of Health and Long-Term Care dated November 19, 2015
- Letter from the Algoma Public Health to the Minister of Health and Long-Term Care dated December 4, 2015
- Letter from the Elgin St. Thomas Public Health to the Minister of Health and Long-Term Care dated January 5, 2016

Sudbury & District Board of Health Motion #49-15

- Letter from the Township of Nairn and Hyman to the Minister of Health and Long-Term Care dated December 16, 2015

b. Healthy Babies Healthy Children Program Funding

Sudbury & District Board of Health Motion #28-15

- Letter from the Thunder Bay District Health Unit to the Minister of Children and Youth Services dated November 20, 2015

c. Basic Income Guarantee

- Letter from the Leeds, Grenville & Lanark District Health Unit to the Federal and Provincial Ministers dated December 21, 2015

d. Food Security and the Transformation of Social Assistance in Ontario

- Letter from the Huron County to the Minister of Community and Social Services dated January 7, 2016

e. Smoke-Free Multi-Unit Housing

Sudbury & District Board of Health Motion #55-15

- Letter from the Township of Nairn and Hyman to the Smoke Free Housing Ontario dated December 16, 2015

f. Cannabis

Sudbury & District Board of Health Motion #54-15

- Letter from the Township of Nairn and Hyman to the Prime Minister dated December 16, 2015
- Email response from the Prime Minister's Office dated January 8, 2016

vi) Items of Information

- | | | |
|----|--|--|
| a. | alPHa Information Break | November 20, 2015
December 8, 2015
December 22, 2015 |
| b. | Thank you notes from Staff | |
| c. | Sudbury Start Article, <i>Public health looking upstream</i> | December 27, 2015 |

APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approves the consent agenda as distributed.

7. NEW BUSINESS

i) Board Attendance

- Summary – 2015

ii) Board Survey Results from Monthly Board Meeting Evaluations

- 2015 Evaluation Summary Results

iii) Associate Medical Officer of Health Appointment

- Briefing Note from the Sudbury & District Health Unit's Medical Officer of Health and Chief Executive Officer dated January 14, 2016

APPOINTMENT OF AN ASSOCIATE MEDICAL OFFICER OF HEALTH

MOTION: WHEREAS the Health Protection and Promotion Act, R.S.O. 1990, c.H.7, s.62 states that every board of health may appoint one or more associate medical officers of health; and

WHEREAS s.64 of the Health Protection and Promotion Act states that no person is eligible for appointment as an associate medical officer of health unless he or she is a physician; and

WHEREAS R.R.O. 1990, REGULATION 566 QUALIFICATIONS OF BOARDS OF HEALTH STAFF which establishes the requirements for employment as an associate medical officer of health in addition to those set out in section 64 of the Act includes that the person be the

holder of a fellowship in community medicine from The Royal College of Physicians and Surgeons of Canada; and

WHEREAS the Health Protection and Promotion Act, R.S.O. 1990, c.H.7, s.64 states that no person is eligible for appointment as an associate medical officer of health unless the Minister approves the proposed appointment; and

WHEREAS the Sudbury & District Board of Health concurs with the recommendation of the Medical Officer of Health to appoint Dr. Ariella Zbar as an Associate Medical Officer of Health for the Sudbury & District Health Unit

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health appoint Dr. Ariella Zbar as an Associate Medical Officer of Health for the Sudbury & District Health Unit, effective August 8, 2016, subject to the following conditional requirements:

- 1) Submission of evidence of Dr. Zbar's specialty certificate and master degree certificates in public health and masters of business administration indicating successful completion of all program requirements for a Master of Public Health (MPH) and Masters of Business Administration (MBA) degree and specialty certification in Public Health and Preventive Medicine from the Royal College of Physicians and Surgeons of Canada.**
- (2) A copy of Dr. Zbar's current Certificate of Registration for Independent Practice and a current Certificate of Professional Conduct from the College of Physicians and Surgeons of Ontario.**
- (3) Evidence of adequate and acceptable professional liability insurance.**
- (4) Submission of a satisfactory police record check.**
- (5) Submission of a signed Sudbury & District Health Unit Confidentiality Agreement.**
- (6) Approval of the proposed appointment by the Ontario Minister of Health and Long Term Care.**

FURTHER THAT the Sudbury & District Board of Health share this motion with the Minister of Health and Long-Term Care for approval of the appointment.

- iv) Ministry of Health and Long-Term Care *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario, a discussion paper***
- Briefing Note from the Sudbury & District Health Unit's Medical Officer of Health and Chief Executive Officer dated January 14, 2016
 - MOHLTC *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* Discussion Paper dated December 17, 2015
 - Letter from the Minister of Health dated December 17, 2015
 - alPha News Release dated December 17, 2015

PATIENTS FIRST: A PROPOSAL TO STRENGTHEN PATIENT-CENTRED HEALTH CARE IN ONTARIO DISCUSSION PAPER

MOTION: That the Sudbury & District Board of Health receive the briefing note concerning, Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario; and

That the Board of Health direct the Medical Officer of Health to engage with the Association of Local Public Health Agencies (aLPHa) in the development of key positions, consistent with the key considerations of this briefing note, for communication with the Ministry of Health and Long-Term Care; and

That the Board of Health seek engagement with constituent municipalities and with the Federation of Northern Ontario Municipalities (FNOM) to determine any municipal concerns about the proposed changes in governance and funding; and

Further that the Board of Health seek engagement with the North East LHIN to discuss matters arising from the discussion paper.

8. ADDENDUM

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

9. IN CAMERA

IN CAMERA

MOTION: That this Board of Health goes in camera. Time: _____ p.m.

- Labour Relations or Employee Negotiations

10. RISE AND REPORT

RISE AND REPORT

MOTION: That this Board of Health rises and reports. Time: _____ p.m.

11. ANNOUNCEMENTS / ENQUIRIES

Please remember to complete the Board Evaluation following the Board meeting:
<https://fluidsurveys.com/s/sdhuBOHmeeting/>

12. ADJOURNMENT

ADJOURNMENT

MOTION: THAT we do now adjourn. Time: _____ p.m.

APPOINTMENT OF CHAIR OF THE BOARD

(2015 Chair: René Lapierre – 1 term)

**MOTION: THAT the Sudbury & District Board of Health appoints
_____ as Chair for the year 2016.**

APPOINTMENT OF VICE-CHAIR OF THE BOARD

(2015 Vice-Chair: Claude Belcourt – 1 term)

MOTION: THAT the Sudbury & District Board of Health appoints
_____ **as Vice-Chair for the year**
2016.

APPOINTMENT TO EXECUTIVE COMMITTEE

*(2015 Board Executive: Janet Bradley- 3 terms; Jeffery Huska – 1 term;
Stewart Meikleham – 1 term; René Lapierre – 1 term;
Claude Belcourt – 2 terms)*

MOTION: THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2016:

1. _____, Board Member at Large
2. _____, Board Member at Large
3. _____, Board Member at Large
4. _____, Chair
5. _____, Vice-chair
6. **Medical Officer of Health/Chief Executive Officer**
7. **Director, Corporate Services**
8. **Secretary Board of Health (ex-officio)**

SDHU Population Health Profile

Summary Report

Sudbury & District Health Unit
January 2016



Sudbury & District

Health Unit

Service de
santé publique

Authors

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Marc Lefebvre, Manager of Population Health Assessment and Surveillance

Acknowledgements

The authors would like to thank Dr. Daniela Kempkens for her valuable feedback on this report.

Thank you also to Dr. Penny Sutcliffe and Renée St Onge for their careful review of this report, and to Laurie Gagnon and Jessica Bastelak for its web and print formatting.

Contact for More Information

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This report is available online at www.sdhu.com. Ce rapport est disponible en français.

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Sudbury, ON: Author.

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While data are currently available on the above-noted topics, additional data on communicable diseases, injuries, and other topics relevant to public health in our communities will be added to the *SDHU Population Health Profile* in the future.

The SDHU works hard to understand health and what keeps us healthy. We know that our health is influenced by many factors—genetics, individual lifestyles and behaviours, and the physical, social, and economic environments in which we live. In the 2013 report, *Opportunity for All* (available at www.sdhu.com), we looked at select health outcomes (such as how long we live, our risk of injury, etc.) and their relationship with socioeconomic factors in our most populated community, the City of Greater Sudbury. We asked: Do we all have the same opportunity for health? The answer was no. While this current report presents what we know about the health status of the population in the SDHU area, it does not explore the relationship between various socio-economic factors and health. Work is currently underway on a separate report which will help to further understand these interactions and further inform our actions to foster health equity.

Introduction

As part of its requirements under the Ontario Public Health Standards (OPHS), the Sudbury & District Health Unit (SDHU) provides the public and partner stakeholders information on health status, health behaviours, preventive health practices, health care utilization, and demographic indicators¹. Additionally, the SDHU is committed to providing public health programs and services that are evidence-informed and responsive to the needs and emerging issues of our communities.

The *SDHU Population Health Profile* provides valuable information about the local context, and is one of the many sources of evidence that inform effective public health practice. The *SDHU Population Health Profile* is useful to help address issues that are important and relevant to foster healthy communities, and to provide equal opportunities for all.

The *SDHU Population Health Profile: Summary Report* highlights the key findings on population level indicators of health from the *SDHU Population Health Profile*, available online at www.sdhu.com. The *SDHU Population Health Profile* provides data on the following:

- Self-rated health and self-rated mental health
- Mortality – reported as avoidable mortality and potential years of life lost
- Health care utilization – reported through rates of, emergency room visits and hospitalizations
- Cardiovascular disease
- Cancer
- Health behaviours and risks – including information on smoking, alcohol use, obesity, physical activity, nutrition, and food insecurity

The *SDHU Population Health Profile* presents health status data for residents living in the geographic area served by the SDHU, which includes Greater Sudbury, and the districts of Sudbury and Manitoulin. The SDHU serves an area of approximately 46,550 square kilometres in northeastern Ontario. It is the fourth largest health unit catchment area in Ontario. For more details see: www.sdhu.com.

Where possible, local rates presented in the *SDHU Population Health Profile* are compared with those reported for northeastern Ontario and Ontario as a whole. While this summary report highlights key findings, the comprehensive online report provides further context and detail on age, sex, and geography for all of the indicators. Unless otherwise indicated, rates are standardized using the 2006 Canadian population.

¹ OPHS, MOHLTC, 2008

Self-rated Health and Self-rated Mental Health

One simple measure of health is self-rated health. This is measured by asking individuals to describe their health using one of the following categories: excellent, very good, good, fair or poor.

- In 2013–2014, survey results indicated that 60% of individuals aged 12 and older in the SDHU area rated their health as either “excellent” or “very good”, while 28% rated their health as “good”, and 12% rated their health as either “fair” or “poor”.
- The proportion of the population that rated their health as “excellent” or “very good” in the SDHU area has been consistently similar to that reported in northeastern Ontario and Ontario overall.
- Between 2005 and 2013–2014, the proportion of the population that rated their health as “excellent” or “very good” in the SDHU area has not varied significantly.

In addition to self-rated health, self-rated mental health is also an important measure. Individuals were asked to describe their mental health using the same categories as the self-rated health.

- In 2013–2014, survey results indicated that 37% of individuals aged 12 and older in the SDHU area rated their health as either “excellent” or “very good”, while 42% rated their health as “good”, and 21% rated their health as either “fair” or “poor”.
- In 2013–2014, the proportion of the population that rated their mental health as “excellent” or “very good” in the SDHU area has been consistently similar to that reported in northeastern Ontario and Ontario overall.
- Between 2005 and 2013–2014, the proportion of the population that rated their mental health as “excellent” or “very good” in the SDHU area has not varied significantly.

Mortality

Avoidable Mortality

Avoidable mortality refers to deaths among persons less than 75 years of age from either a treatable or preventable cause.

Preventable causes are causes of death that can be avoided by prevention efforts, such as lifestyle changes like reducing smoking or excessive alcohol consumption, or by public health interventions, such as vaccinations and injury prevention programs. The social determinants of health – the social and economic factors that shape the conditions in which people are born, grow up, live and work – also impact health outcomes, including mortality. For more details please see the *Opportunity for All* report at www.sdhc.com.

Treatable causes are those causes of deaths that progress from illnesses or conditions that could have been avoided or delayed by screening, early detection, and appropriate treatment.

- In the SDHU area, there were 773 avoidable deaths in 2011.
- The avoidable mortality rate in the SDHU area was 327 deaths per 100,000 population in 2011.
- The SDHU area rate has consistently been similar to the northeastern Ontario rate and higher than the rate for Ontario.
- The SDHU area avoidable mortality rate decreased from 2002 to 2011.

Potential Years of Life Lost from Avoidable Causes

Potential years of life lost (PYLLs) is a measure of premature death (younger than 75 years of age). PYLLs are calculated by adding up, for each death, how many years the deceased would have needed to live to reach the age of 75. Example: a person dying at the age of 70 would add 5 PYLLs to the total.

Thus, the number of PYLLs can increase both by increasing the overall number of deaths before age 75, but also by having the same number of deaths but at earlier ages.

- In 2011, SDHU area residents lost 12,303 years of potential life due to death from avoidable causes before the age of 75.
- The rate of potential years of life lost (PYLLs) in the SDHU area was 5,968 PYLLs per 100,000 population in 2011.
- The rate in the SDHU area has generally been similar to the rate in northeastern Ontario, and both the SDHU area and northeastern Ontario have had a consistently higher rate than the Ontario rate.
- In general, in the SDHU area, the rate has decreased from 2002 to 2011, with fluctuations from year to year.

Leading Causes of Death

This section looks at the most common causes of death in the SDHU area. They are mostly related to chronic diseases, which is consistent with causes of death in all developed nations. It also looks at which diseases result in more deaths before the age of 75, or causing the most “years of life lost”.

The data are presented in two different ways: 1) with different types of cancers shown separately, and 2) with all cancers grouped as a single category.

Leading Causes of Death

- The two most common causes of death in the SDHU area between 2002 and 2011 have been ischemic heart disease (heart attack) and lung cancer, with ischemic heart disease causing 16% of deaths and lung cancer causing 13% of deaths.
- Between 2002 and 2011, on average, 329 people died of ischemic heart disease and 157 people died of lung cancer each year in the SDHU area.
- The percentage of deaths from both ischemic heart disease and lung cancer in the SDHU area is higher than the percentage of deaths by these diseases in Ontario.

Leading Causes of Potential Years of Life Lost (PYLL)

- Between 2002 and 2011, ischemic heart disease (heart attack), lung cancer, and suicide resulted in the largest number of potential years of life lost (PYLLs) in the SDHU area.
- Ischemic heart disease caused 12% of PYLLs, lung cancer caused 9% of PYLLs, and suicide accounted for 6% of PYLLs.
- On average, between 2002 and 2011, early death from ischemic heart disease resulted in 1,453 PYLLs, lung cancer resulted in 1,073 PYLLs, and suicide accounted for 754 PYLLs each year.
- The percentage of PYLLs caused by ischemic heart disease, lung cancer, and suicide in the SDHU area is higher than in Ontario overall.

Leading Causes of Death (All Cancers Combined)

- When all cancers are grouped together, it is by far the most common cause of death in the SDHU area. Between 2002 and 2011, 39% of local deaths were due to cancer. Ischemic heart disease (heart attack) caused 16% of deaths.
- Between 2002 and 2011, on average, 527 people died of cancer and 329 people died of ischemic heart disease each year.
- The percentage of deaths from cancer is higher in Ontario than it is in the SDHU area, while the percentage of deaths from ischemic heart disease is higher in the SDHU area than it is in Ontario.

Leading Causes of Potential Years of Life Lost (All Cancers Combined)

- The most common causes of potential years of life lost (PYLLs) in the SDHU area between 2002 and 2011 was cancer, which accounted for 31% of PYLLs. Ischemic heart disease (heart attack) caused 12% of PYLLs during that period.
- On average, between 2002 and 2011, cancer resulted in 3,743 PYLLS each year.
- The percentage of PYLLs from cancer in the SDHU area is lower than in Ontario overall.

Health Care Utilization

Health care utilization is a measure of the use of health services including emergency department visits and hospital admissions. Rates of emergency room visits and hospitalizations are an indicator of how common a disease or injuries are within an area. People who do not seek medical attention for their disease or injury are not captured by this indicator.

Emergency Department Visits

Typically, the need to visit the emergency department occurs when there is an illness (physical or mental) or injury. Note that geographic areas with fewer walk-in clinics could have higher rates of emergency department visits, as patients go to the emergency department for non-emergency care.

- In the SDHU area, there were 103,436 emergency department visits in 2013.
- In 2013, the emergency department visit rate for the SDHU area was 511 visits per 1,000 population.
- The rate of emergency department visits in the SDHU area is much lower than the rate for northeastern Ontario and has been only slightly higher than the overall Ontario rate.
- The emergency department visit rate in the SDHU area has remained stable between 2004 and 2013.

Hospitalizations

Hospitalizations include persons admitted to hospital for illness (physical or mental), injury, or diagnostic procedure. The numbers and rates of hospitalization exclude healthy newborn infants born at the hospital.

- In the SDHU area, there were 21,174 hospitalizations in 2013.
- In 2013, the hospitalization rate in the SDHU area was 99 per 1,000 population.
- The rate of hospitalization in the SDHU area has been consistently lower than that of northeastern Ontario, yet both the SDHU area and northeastern Ontario rates are higher than the rate for Ontario.
- Between 2004 and 2013, the hospitalization rate in the SDHU area decreased.

Cardiovascular Disease

Cardiovascular disease refers to many different diseases of the circulatory system including the heart and blood vessels². Diseases of the blood vessels may impact other organs (brain, kidneys) or areas of the body (extremities). Individuals can reduce their risks of cardiovascular disease by being active, eating well, reducing alcohol consumption, and living smoke-free. High blood pressure increases the risk of all other cardiovascular diseases and is often modifiable with lifestyle changes.

Hypertension

Hypertension is a chronic condition of consistently high blood pressure over a long period of time. Blood pressure is the force of blood inside the walls of blood vessels. High blood pressure is usually defined as a systolic blood pressure (top number) at 140 mmHg or higher and/or a diastolic blood pressure (bottom number) at 90 mmHg or higher.

- In 2013–2014, survey results indicated that prevalence rate of hypertension was 20% in the SDHU area.
- The prevalence rate of hypertension in the SDHU area has consistently been similar to that reported in northeastern Ontario, and in Ontario overall.
- Between 2005 and 2013–2014, the rate of hypertension in the SDHU area has not varied significantly.

Ischemic Heart Disease

Ischemia is defined as a shortage of oxygen rich blood flow to organs and tissues in the body. This type of heart disease includes angina (chest pain) and myocardial infarction or ‘heart attack’ (complete blockage of blood vessels of the heart).

- In the SDHU area, there were 1,135 hospitalizations due to ischemic heart disease in 2013.
- In 2013, the rate of hospitalization due to ischemic heart disease in the SDHU area was 468 hospitalizations per 100,000 population.
- The rate of hospitalization due to ischemic heart disease in the SDHU area has consistently been lower than the rate in northeastern Ontario, while the rate in both the SDHU area and northeastern Ontario have consistently been higher than that of Ontario.
- Between 2004 and 2013, the rate of hospitalization due to ischemic heart disease in the SDHU area has decreased.

² Public Health Agency of Canada, 2015. www.phac-aspc.gc.ca/cd-mc/cvd-mcv

Stroke (Cerebrovascular Disease)

A stroke refers to a problem of circulation (blockage) in the blood vessels of the brain. Sometimes the stroke involves a partial blockage causing temporary effects, or a complete blockage with long-term effects. Vessels in the brain may also burst causing long-term effects.

- In the SDHU area, there were 333 hospitalizations due to stroke in 2013.
- In 2013, the rate of hospitalization due to stroke in the SDHU area was 139 hospitalizations per 100,000 population.
- The rate of hospitalization due to stroke in the SDHU area has been generally similar to that in northeastern Ontario, while the rates in both areas have consistently been higher than the rate in Ontario.
- Between 2004 and 2013, the rate of hospitalization due to stroke in the SDHU area has generally decreased.

Other Heart Diseases

There are many diseases of the heart, in addition to ischemic heart diseases. Examples of such conditions include:

- Congenital heart diseases – where a person is born with a heart defect
 - Cardiomyopathy – where the heart muscle is abnormal
 - Arrhythmias – where the heart chambers do not beat in a proper, coordinated rhythm
 - Heart failure – where the heart is weakened and cannot pump blood efficiently
 - Cardiac arrest – where the heart stops beating completely
- In the SDHU area, there were 1,012 hospitalizations due to other heart diseases in 2013.
- In 2013, the rate of hospitalization due to other heart diseases in the SDHU area was 418 hospitalizations per 100,000 population.
- The rate of hospitalization due to other heart diseases in the SDHU area has been generally slightly lower to that in northeastern Ontario, while rates in both areas have been consistently higher than the rate in Ontario.
- Between 2004 and 2013, the rate of hospitalization due to other heart diseases in the SDHU area has generally decreased.

Other Circulatory Diseases

Other diseases affect the circulation of blood throughout the body. These can include:

- Atherosclerosis – the “hardening” of the arteries due to a buildup of plaque from cholesterol, fatty tissue, and other materials.
 - Embolism and/or Thrombosis – where blood flow to one part of the body is slowed, or stopped completely, due to a blood clot, fatty tissue, or another cause.
 - Aneurysm – a balloon-like bulge in a weakened blood vessel wall, which may burst causing bleeding and death.
 - Varicose veins – where veins, often in the leg, become enlarged and twisted. This is particularly common in older women, and can result from pregnancy.
- In the SDHU area, there were 289 hospitalizations due to other circulatory diseases in 2013.
 - In 2013, the rate of hospitalization due to other circulatory diseases in the SDHU area was 121 hospitalizations per 100,000 population.
 - The rate of hospitalization due to other circulatory diseases in the SDHU area has been generally similar to that in northeastern Ontario, while the rates in both areas have consistently been higher than the rate in Ontario.
 - Between 2004 and 2013, the rate of hospitalization due to other circulatory diseases in the SDHU area has fluctuated, but has decreased overall.

Cancer³

All cancers involve cells that grow abnormally and may spread throughout the body. There are many different types of cancers, and the causes of each type can be different. Certain risk factors, such as smoking, can increase risks for many different types of cancer. In general, the risk of developing cancer increases with age⁴. About one in three people in Canada are expected to develop cancer in their lifetime.

All Cancers⁵

- In the SDHU area, there was a total of 1,180 new cases of cancer in 2009.
- In 2009, the cancer rate in the SDHU area was 430 new cases per 100,000 population.
- The rate of cancer in the SDHU area has been similar to that of northeastern Ontario, while rates in both areas have been consistently higher than the rate of cancer in Ontario overall.
- Between 2000 and 2009, the rate of cancer in the SDHU area has generally remained stable.

Breast Cancer

Breast cancer is defined as abnormal cell growth, most often in the ducts or lobules of breast tissue. Most commonly found in women, it can develop in the breast tissue of men. One in nine women in Canada are expected to develop breast cancer in their lifetime⁴.

- In the SDHU area, there were 154 cases of breast cancer in females in 2009.
- In 2009, the rate of female breast cancer in the SDHU area was 108 cases per 100,000 females.
- The annual breast cancer rate in SDHU area and northeastern Ontario females have been similar and are generally lower than the breast cancer rate in Ontario females.
- There was no clear trend in breast cancer rates in SDHU area females between the years of 2000 and 2009.

Cervical Cancer

Cervical cancer is an abnormal, malignant cell growth in the cervix (the passageway between the vagina and the uterus). The main risk factor for cervical cancer is the sexually transmitted human papilloma virus (HPV) that infects the cervix⁴. HPV vaccines are available to protect against the most common HPV types that are linked to cervical cancer. Screening for cervical cancer is available in Ontario.

Rates of cervical cancer are too low to provide reliable estimates by age or by geographic area below the health unit level. Also, cervical cancer mortality rates are too low to be reliably reported.

- In the SDHU area, there were 6 new cases of cervical cancer in 2009.

³ Rates are age-standardized using the 1991 Canadian Population

⁴ Public Health Agency of Canada, 2015. www.phac-aspc.gc.ca/cd-mc/cancer

⁵ Except non-melanoma skin cancers, which are not tracked by cancer registries in Canada.

- In 2009, the rate of cervical cancer in the SDHU area was 6 new cases per 100,000 females.
- The annual rate of new cervical cancer cases in the SDHU area has generally been slightly higher than that of northeastern Ontario, and the rates in both the SDHU area and northeastern Ontario have consistently been higher than the Ontario rate.
- Between 2000 and 2009, the cervical cancer rate in the SDHU area has remained fairly stable.

Colorectal Cancer

Colorectal cancer is the growth of abnormal cells inside the colon or rectum. This type of cancer is more common in men than women, and more common as people age. Screening for colorectal cancer saves lives.

- In the SDHU area, there were 136 new cases of colorectal cancer in 2009.
- In 2009, the rate of colorectal cancer in the SDHU area was 49 new cases per 100,000 population.
- The annual colorectal cancer rate in the SDHU area has been similar to northeastern Ontario, yet in general, both the rates in the SDHU area and northeastern Ontario have been consistently higher than that in Ontario.
- Between 2000 and 2009, colorectal cancer rates in the SDHU area have generally decreased.

Lung Cancer

Lung cancer is the growth of abnormal cells in the lungs as tumours. There are many risk factors, but the most common cause for lung cancer is smoking.

- In the SDHU area, there were 202 new cases of lung cancer in 2009.
- In 2009, the lung cancer rate in the SDHU area was 72 new cases per 100,000 population.
- The lung cancer rate in the SDHU area is generally similar to that in northeastern Ontario, and the rates in both the SDHU area and northeastern Ontario are consistently higher than that of Ontario.
- Between 2000 and 2009, the rate of lung cancer in the SDHU area was fairly stable.

Melanoma

Melanoma is an abnormal growth of the cells of the skin that produce melanin (colour). It is the least common but most serious of all of the skin cancers. There are many risk factors for melanoma, however the most common risk is exposure to ultraviolet rays from the sun or tanning beds.

Rates of melanoma are too low to provide reliable estimates by age or by geographic area below the health unit level. Also, melanoma mortality rates are too low to be reliably reported.

- In the SDHU area, there were 31 new cases of melanoma in 2009.
- In 2009, the rate of melanoma⁶ in the SDHU area was 12 new cases per 100,000 population.

⁶ Due to small numbers, the rates reported for the SDHU area should be interpreted with caution.

- Melanoma rates were similar in the SDHU area, northeastern Ontario, and Ontario.
- Between 2000 and 2009, melanoma rates remained stable.

Prostate Cancer

Prostate cancer is abnormal cell growth causing a tumour in the prostate (a gland below the bladder in men). It is the most common cancer in Canadian men. There are many different risk factors that may increase the chances of developing this type of cancer. In the SDHU area, there were 135 new cases of prostate cancer in 2009.

- In 2009, the rate of prostate cancer was 103 cases per 100,000 men.
- The rate of prostate cancer in the SDHU area has generally been lower than that of northeastern Ontario, and the rates in both the SDHU area and northeastern Ontario have generally been lower than that of Ontario.
- In general, the rate of prostate cancer in the SDHU area has decreased between 2000 and 2009.

Health Behaviours and Risks

Smoking

For the purpose of monitoring trends in smoking, a person can be classified based on their “smoking status”. “Current smokers” are people who currently smoke cigarettes, even just occasionally. “Former smokers” are people who are currently non-smokers but did smoke cigarettes at one time. “Never smokers” are people who have completely abstained from smoking cigarettes in their lifetime. Here we present summary rates of adult “current smokers” and youth “never smokers.”

Adult Current Smokers

- In 2013–2014, survey results indicated that the prevalence rate of current smokers was 25% in the SDHU area adults.
- The prevalence rate of current smokers in SDHU area adults has consistently been similar to that reported in northeastern Ontario, but higher than Ontario overall.
- Between 2005 and 2013–2014, the rate of current smokers in the SDHU area has not varied significantly.

Youth Never Smokers⁷

A youth never smokers is defined here as a person aged 12 to 19 years who has never smoked a whole cigarette in their lifetime.

- In 2013–2014, survey results indicated that 79% of youth in the SDHU area had never smoked a whole cigarette.
- The prevalence rate of youth who have never smoked a whole cigarette in the SDHU area has consistently been similar to that reported in northeastern Ontario, but in general, lower than Ontario overall.
- Between 2005 and 2013–2014, the rate of youth who have never smoked a whole cigarette in the SDHU area has not varied significantly.

Exposure to Environmental Tobacco Smoke at Home

Exposure to environmental tobacco smoke, also known as second-hand smoke, can be harmful to health. Here we present rates of non-smokers aged 12 years and over who were regularly (every day or almost every day) exposed to tobacco smoke in their home.

- In 2013–2014, survey results indicated that the prevalence rate of exposure to environmental tobacco smoke at home was 4% in the SDHU area.
- The prevalence rate of exposure to environmental tobacco smoke at home in the SDHU area has consistently been similar to that reported in northeastern Ontario, and Ontario overall since 2009–2010.

⁷ Rates are not age-standardized

- Between 2005 and 2013–2014, the rate of exposure to environmental tobacco smoke at home in the SDHU area has declined over the years.

Exposure to Environmental Tobacco Smoke in Public Places

Exposure to environmental tobacco smoke, also known as second-hand smoke, can be harmful to health. Here we present rates of non-smokers aged 12 years and over who were regularly (every day or almost every day) exposed to tobacco smoke in public places such as bars, restaurants, shopping malls, arenas, bingo halls, bowling alleys, etc.

- In 2013–2014, survey results indicated that the prevalence rate of exposure to environmental tobacco smoke in public places was 14% in the SDHU area.
- The prevalence rate of exposure to environmental tobacco smoke in public places in the SDHU area has consistently been similar to that reported in northeastern Ontario, and Ontario overall.
- Between 2005 and 2013–2014, the rate of exposure to environmental tobacco smoke in public places in the SDHU area has not changed significantly over the years.

Exposure to Environmental Tobacco Smoke in a Vehicle

Exposure to environmental tobacco smoke, also known as second-hand smoke, can be harmful to health. Here we present rates of non-smokers aged 12 years and over who were regularly (every day or almost every day) exposed to tobacco smoke in a car or other private vehicle.

- In 2013–2014, survey results indicated that the prevalence rate of exposure to environmental tobacco smoke in a vehicle was 9% in the SDHU area.
- The prevalence rate of exposure to environmental tobacco smoke in a vehicle in the SDHU area has consistently been similar to that reported in northeastern Ontario, but higher than Ontario overall.
- Between 2005 and 2013–2014, the rate of exposure to environmental tobacco smoke in a vehicle in the SDHU area has not changed significantly over the years.

Alcohol

This report draws information from the Canadian Community Health Survey (CCHS) where alcohol consumption or use means having had a ‘drink’ or “serving” defined as:

- one bottle or can of beer or a glass of draft, or
- one glass of wine or a wine cooler, or
- one drink or cocktail with 1 and a 1/2 ounces of liquor.

Heavy Drinking

Heavy drinking is defined as consuming at least 5 or 4 servings of alcohol (for males and females, respectively) on at least one occasion per month in the previous 12 months. This level of alcohol consumption can have serious health and social consequences.

This definition has changed over the years. Prior to 2013, the threshold was 5 or more servings for both males and females.

Rates of heavy drinking presented in this section are calculated for the population aged 12 and over.

- In 2013–2014, survey results indicated that the prevalence rate of heavy drinking was 27% in the SDHU area.
- The prevalence rate of heavy drinking in the SDHU area has consistently been similar to that reported in northeastern Ontario, but higher than Ontario overall.
- Between 2005 and 2013–2014, the rate of heavy drinking in the SDHU area has not varied significantly.

Exceeding the Low-Risk Alcohol Drinking Guidelines

Canada’s low-risk alcohol drinking guidelines were developed to help Canadians moderate their alcohol consumption and to prevent both immediate and long-term alcohol-related harms. Here, we present rates of individuals aged 19 years and older who reported drinking in excess of these guidelines. This includes:

- males that drank more than 15 drinks per week, or females that drank more than 10 drinks per week, OR
 - males that drank more than 3 drinks per day, or females that drank more than 2 drinks per day, OR
 - males and females with less than 2 non-drinking days a week, OR
 - males or females that drank 5 or more drinks on any one occasion in the previous year.
- In 2013–2014, survey results indicated that the prevalence rate of drinking above the low risk alcohol drinking guidelines was 36% in the SDHU area.
 - The prevalence rate of drinking above the low-risk alcohol drinking guidelines in the SDHU area has consistently been similar to that reported in northeastern Ontario, but higher than Ontario overall.

- Between 2005 and 2013–2014, the rate of heavy drinking in the SDHU area has not varied significantly.

Youth Alcohol Consumption⁸

In this section, we present rates of reported alcohol use (as defined above) in the previous 12 months among youth aged 12 to 18 years.

- In 2013–2014, survey results indicated that the prevalence rate of alcohol use in youth aged 12 to 18 years was 54% in the SDHU area.
- The prevalence rate of alcohol use in SDHU area youth has consistently been similar to that reported in northeastern Ontario, but higher than Ontario overall.
- Between 2005 and 2013–2014, the rate of alcohol use in SDHU area youth has not varied significantly.

Body Mass Index (Adjusted), Overweight and Obese

A person's body mass index (BMI) is calculated by dividing their weight (in kilograms) by the square of their height (in meters). For adults, aged 18 and over, this score is grouped into the following categories: underweight (BMI <18.5), normal weight (BMI 18.5-24.9), overweight (BMI 25.0-29.9) and obese (BMI ≥ 30.0).

Body mass index scores based on self-reported height and weight are known to under-represent the true rate of overweight/obesity in the community. The rate of obesity presented in this section has been adjusted to correct for this underestimation.

Obesity (Adjusted Body Mass Index)

- In 2013–2014, survey results indicated that the prevalence rate of obesity was 32% in the SDHU area.
- The prevalence rate of obesity in the SDHU area has consistently been similar to that reported in northeastern Ontario, but higher than Ontario overall.
- Between 2005 and 2013–2014, the rate of obesity in the SDHU area has increased significantly.

Physical Activity

How physically active a person is can be measured by the physical activity index (PAI). This index combines information on:

- the activities the person did,
- the amount of time they spent doing those activities,
- how demanding the activities are (measured in “kilo-calories” (kcal) of energy spent per hour), and
- how much the person weighs (in kilograms).

Based on the above, the person is categorized as active, moderately active or inactive, as follows:

⁸ Rates are not age-standardized

- Active: 3.0+kcal/kg/day of energy expenditure on average
- Moderately active: 1.5-2.9 kcal/kg/day of energy expenditure on average
- Inactive: less than 1.5 kcal/kg/day of energy expenditure on average

In this section, we present rates of individuals aged 12 and over who are classified as “active” based on activity they do during their leisure time.

Physical Activity – Active

- In 2013–2014, survey results indicated that 32% of the SDHU population was physically active.
- The prevalence rate of physically active individuals in the SDHU area has been similar to that reported in northeastern Ontario and Ontario overall.
- Between 2005 and 2013–2014, the population rate of physical activity in the SDHU area has not varied significantly.

Nutrition – Fruit and Vegetable Consumption

For each food group, Canada’s Food Guide (2011) provides recommendations on the number of servings that Canadians should eat each day. Here, we present rates of individuals aged 12 and older who reported consuming at least the minimum number of recommended servings of fruits and vegetables for their age and sex which are as follows:

- Children 12-13 years: 6 servings of fruits and vegetables daily;
- Females 14+ years: 7 servings of fruits and vegetables daily;
- Males 14-50 years: 8 servings of fruits and vegetables daily;
- Males 51+ years: 7 servings of fruits and vegetables daily.
- In 2013–2014, survey results indicated that 13% of the SDHU population aged 12 and older were meeting the Canada Food Guide recommended intake of fruits and vegetables.
- The prevalence rate of the population meeting the recommended intake of fruits and vegetables in the SDHU area has consistently been similar to that reported in northeastern Ontario and Ontario overall.
- Between 2005 and 2013–2014, the rate of the population meeting the recommended intake of fruits and vegetables in the SDHU area has not varied significantly.

Food Insecurity

Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life⁹. Based on a set of 18 questions, a household's food security status is categorized here as follows:

- Food secure: Little indication of difficulty with income-related food access.
- Moderately food insecure: Indication of compromise in quality and/or quantity of food consumed.
- Severely food insecure: Indication of reduced food intake and disrupted eating patterns.

Below we present rates of individuals aged 12 years and over living in households classified as moderately or severely food insecure within the past 12 months.

- In 2013–2014, survey results indicated that 7% in the SDHU population aged 12 and older lived within a food insecure household.
- The prevalence rate of food insecurity has been similar to that reported in northeastern Ontario and Ontario overall.
- Between 2005 and 2013–2014, the rate of food insecurity in the SDHU area has not varied significantly.

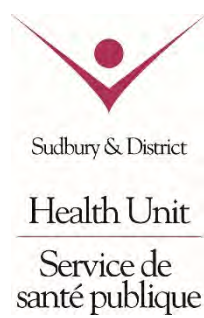
⁹ Agriculture and Agri-food Canada, 2009. *Canada's Action Plan for Food Security*.
www.agr.gc.ca/index_e.php?s1=misb&s2=fsec-seca&page=action

Conclusion

This report summarizes approximately ten years of recently available data from a variety of sources used to produce the first installment in a number of chapters of the *Sudbury & District Health Unit Population Health Profile* (www.sdh.u.com). As previously mentioned, additional data on communicable diseases, injuries, the relationship between various socio-economic factors and health, and other topics relevant to public health in our communities, will be added to the *SDHU Population Health Profile* in the future. Our findings so far tell us that:

- Over the years, similar proportions of SDHU residents rated their overall health and mental health as very good or excellent when compared to Ontario residents. Utilization rates of health care (ER visits and hospitalizations) have been lower in the SDHU area compared to the northeast, but higher than in the province overall.
- Rates of avoidable mortality and Potential Years of Life Lost (PYLL) in the SDHU area were similar to those in the northeast, but again, higher than in Ontario overall. Also, hospitalization rates for most cardiovascular diseases in the SDHU area were similar to the northeast, but higher than in Ontario.
- While incidence rates (newly diagnosed cases) of lung, colorectal, and cervical cancers were higher in the SDHU area compared to Ontario, melanoma incidence rates were similar compared to the province. Incidence rates of prostate and breast cancer in the SDHU area were lower than in Ontario overall.
- Finally, though rates of fruit and vegetable consumption, physical activity, and food insecurity were similar when compared to the province, the SDHU area had higher rates of smoking and alcohol consumption.

This information will contribute to the evidence for effective public health practice to which the SDHU is committed, and assist our community partners as we work together to ensure healthy communities and equitable opportunities for all.



Profil de santé de la population sur le territoire du du SSPSD

Rapport récapitulatif

Service de santé publique de Sudbury et du district
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Sudbury & District

Health Unit

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Introduction

Dans le cadre de ses obligations en vertu des Normes de santé publique de l'Ontario (NSPO), le Service de santé publique de Sudbury et du district (SSPSD) fournit au public et à ses partenaires des renseignements sur l'état de santé, les comportements liés à la santé, les pratiques sanitaires préventives, le recours aux soins de santé et les indicateurs démographiques.¹ De plus, le SSPSD s'engage à fournir des programmes et des services de santé publique fondés sur des données probantes et adaptés aux besoins et aux enjeux qui se présentent dans nos collectivités.

Le profil de santé de la population sur le territoire du SSPSD procure des renseignements précieux sur le contexte local, et il représente l'une des nombreuses sources de données probantes qui orientent la pratique efficace en santé publique. Il permet de s'attacher à des questions qui sont importantes et pertinentes afin de promouvoir la santé des collectivités et de permettre à tout le monde d'avoir les mêmes possibilités.

Le profil de santé de la population sur le territoire du SSPSD : rapport récapitulatif souligne les principales découvertes sur les indicateurs de santé à l'échelle de la population qui découlent du profil, offert en ligne au sdhu.com. Ce dernier fournit des données sur les éléments suivants :

- la santé et la santé mentale autoévaluées,
- la mortalité, présentée comme étant évitable, et les années potentielles de vie perdues
- le recours aux soins de santé – présenté sous forme de taux de visites au service des urgences et d'hospitalisation
- les maladies cardiovasculaires
- le cancer
- les comportements et les risques liés à la santé, y compris les renseignements sur le tabagisme, la consommation d'alcool, l'obésité, l'activité physique, la nutrition et l'insécurité alimentaire

Le présent profil de santé de la population expose des données sur l'état de santé des résidents vivant dans le secteur géographique du SSPSD, qui englobe le Grand Sudbury et les districts de Sudbury et de Manitoulin. Le SSPSD sert un territoire d'environ 46 550 kilomètres carrés dans le nord-est de l'Ontario. Il s'agit du quatrième secteur de bureau de santé en importance en Ontario. Afin d'obtenir plus de détails, reportez-vous au : www.sdhu.com.

Autant que possible, les taux locaux qui sont présentés dans le profil sont comparés à ceux qui sont présentés pour le nord-est et l'ensemble de l'Ontario. Bien que le présent rapport récapitulatif mette en évidence les principales découvertes, le rapport complet en ligne fournit plus de contexte et de

¹ NSPO, MSSLD, 2008

détails sur l'âge, le sexe et la géographie pour tous les indicateurs. À moins d'indication contraire, les taux sont normalisés d'après la population canadienne en 2006.

Même s'il existe des données sur les sujets mentionnés précédemment, d'autres données sur les maladies transmissibles, les blessures et d'autres sujets touchant la santé publique dans nos collectivités seront ajoutées plus tard au profil.

Au SSPSD, nous nous efforçons de comprendre la santé et ce qui permet de la conserver. Nous savons que notre santé est influencée par bien des facteurs (la génétique, le mode de vie et les comportements de chaque personne, et les environnements physique, économique et social dans lesquels nous vivons). Dans le rapport 2013 « *Possibilités pour tous* » (www.sdhc.com), nous avons examiné certains résultats pour la santé (comme notre longévité, notre risque de blessure) et leur rapport avec des facteurs socioéconomiques dans notre collectivité la plus peuplée, la ville du Grand Sudbury. Nous avons posé la question suivante : avons-nous TOUS les mêmes possibilités d'être en santé? La réponse a été non. Bien que le présent profil expose ce que nous savons sur l'état de santé de la population sur le territoire du SSPSD, il ne traite pas du lien qui existe entre divers facteurs socioéconomiques et la santé. Un rapport distinct est actuellement en chantier et il permettra de mieux comprendre ces interactions et d'orienter davantage notre action afin de promouvoir l'équité en matière de santé.

Santé et santé mentale autoévaluées

L'une des mesures simples concernant la santé est la santé autoévaluée. Elle s'obtient en demandant aux personnes de classer leur état de santé dans l'une des catégories suivantes : excellent, très bon, bon, passable ou mauvais.

- En 2013–2014, les résultats d'un sondage ont révélé que sur le territoire du SSPSD, 60 % des personnes de 12 ans ou plus estimaient que leur santé était soit « excellente », soit « très bonne », alors que 28 % la jugeaient « bonne » et que 12 % l'évaluaient comme étant « passable » ou « mauvaise ».
- La proportion de la population qui a évalué sa santé comme étant « excellente » ou « très bonne » sur le territoire du SSPSD a toujours été semblable à celle présentée pour le nord-est et l'ensemble de l'Ontario.
- De 2005 à 2013-2014, la proportion de la population qui a évalué sa santé comme étant « excellente » ou « très bonne » sur le territoire du SSPSD n'a pas changé considérablement.

La santé mentale autoévaluée est une autre mesure importante. Les personnes doivent décrire la leur en la classant parmi les mêmes catégories que pour la santé autoévaluée.

- En 2013–2014, les résultats d'un sondage ont révélé que sur le territoire du SSPSD, 37 % des personnes de 12 ans ou plus estimaient que leur santé était soit « excellente », soit « très bonne », alors que 42 % la jugeaient « bonne » et que 21 % l'évaluaient comme étant « passable » ou « mauvaise ».
- En 2013-2014, la proportion de la population qui a évalué sa santé mentale comme étant « excellente » ou « très bonne » sur le territoire du SSPSD a toujours été semblable à celle présentée pour le nord-est et l'ensemble de l'Ontario.
- De 2005 à 2013-2014, la proportion de la population qui a évalué sa santé mentale comme étant « excellente » ou « très bonne » sur le territoire du SSPSD n'a pas changé considérablement.

Mortalité

Mortalité évitable

La mortalité évitable correspond aux décès chez les personnes de moins de 75 ans dont la cause est soit traitable, soit évitable.

Les causes évitables sont les causes de décès qui peuvent être évitées par des efforts de prévention, soit des changements de mode de vie comme moins fumer ou réduire la consommation excessive d'alcool, ou par des interventions en santé publique, comme la vaccination et les programmes de prévention des blessures. Les déterminants sociaux de la santé, soit les facteurs économiques et sociaux qui façonnent les conditions dans lesquelles les gens naissent, grandissent, vivent et travaillent, influencent aussi les résultats pour la santé, dont la mortalité. Afin d'obtenir plus de détails, veuillez vous reporter au rapport Possibilités pour tous au : www.sdhu.com.

Les causes traitables sont les causes de décès qui évoluent à partir d'un mal ou d'un état qui aurait pu être évité ou retardé par un dépistage précoce et un traitement approprié.

- Sur le territoire du SSPSD, il y a eu 773 décès évitables en 2011.
- Sur ce même territoire, le taux de mortalité évitable était de 327 décès pour 100 000 habitants en 2011.
- Le taux pour le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario et plus élevé qu'à l'échelle provinciale.
- De 2002 à 2011, sur le territoire du SSPSD, le taux de mortalité évitable a diminué.

Années potentielles de vie perdues en raison de causes évitables

Les années potentielles de vie perdues (APVP) représentent une mesure du décès prématuré (avant l'âge de 75 ans). Elles se calculent en additionnant, pour chaque décès, le nombre d'années que la personne décédée aurait dû vivre pour atteindre 75 ans. Exemple : dans le cas d'une personne qui meurt à 70 ans, le nombre d'APVP s'élève à cinq.

Ainsi, le nombre d'APVP peut augmenter par la hausse du nombre global de décès avant l'âge de 75 ans, mais aussi par un même nombre de décès à des âges plus jeunes.

- En 2011, les résidents du territoire du SSPSD ont perdu 12 303 années potentielles de vie en raison de décès dus à des causes évitables avant l'âge de 75 ans.
- En 2011, le taux d'APVP sur le territoire du SSPSD était de 5 968 pour 100 000 habitants.
- Le taux sur le territoire du SSPSD n'a pas changé dans l'ensemble dans le nord-est de l'Ontario, et le taux dans les deux secteurs a toujours été plus élevé qu'à l'échelle provinciale.
- En général, sur le territoire du SSPSD, le taux a diminué de 2002 à 2011, et a fluctué d'année en année.

Principales causes de décès

La présente section porte sur les causes les plus courantes de décès sur le territoire du SSPSD. Celles-ci sont surtout liées aux maladies chroniques, ce qui est conforme aux causes de décès présentées dans tous les pays développés. Elle porte également sur les maladies qui entraînent davantage de décès avant l'âge de 75 ans ou qui font perdre le plus d'années potentielles de vie.

Les données sont présentées de deux manières différentes : 1) séparément selon les types de cancers et 2) dans une seule catégorie, tous cancers confondus.

Principales causes de décès

- De 2002 à 2011, sur le territoire du SSPSD, les deux causes les plus courantes ont été les cardiopathies (maladies du cœur) ischémiques (crises cardiaques), avec 16 % des décès, et le cancer du poumon, avec 13 % des décès.
- De 2002 à 2011, 329 personnes sont mortes d'une cardiopathie ischémique et 157 sont mortes d'un cancer du poumon, en moyenne, chaque année, sur le territoire du SSPSD.
- Sur le territoire du SSPSD, la proportion de décès dus à une cardiopathie ischémique et à un cancer du poumon est plus élevée qu'à l'échelle provinciale.

Principales causes d'années potentielles de vie perdues (APVP)

- De 2002 à 2011, ce sont les cardiopathies ischémiques, le cancer du poumon et le suicide qui ont fait perdre le plus d'années potentielles de vie sur le territoire du SSPSD.
- Les cardiopathies ischémiques ont causé 12 % des APVP; le cancer du poumon a causé 9 % des APVP; et le suicide a causé 6 % des APVP.
- De 2002 à 2011, en moyenne, les décès prématurés dus à une cardiopathie ischémique ont fait perdre 1453 années potentielles de vie par année; le cancer du poumon en a fait perdre 1073; et le suicide, 754.
- La proportion d'années potentielles de vie qu'ont fait perdre une cardiopathie ischémique, le cancer du poumon et le suicide sur le territoire du SSPSD est plus élevée que pour l'ensemble de la province.

Principales causes de décès (tous cancers confondus)

- Le cancer, tous types confondus, est de loin la cause la plus courante de décès sur le territoire du SSPSD. De 2002 à 2011, 39 % des décès ont été dus au cancer. Les cardiopathies ischémiques ont causé 16 % d'entre eux.
- De 2002 à 2011, 527 personnes sont mortes du cancer et 329 sont mortes d'une cardiopathie ischémique, en moyenne, chaque année.
- La proportion des décès dus au cancer est plus forte en Ontario que sur le territoire du SSPSD, et pour la cardiopathie ischémique, c'est l'inverse.

Principales causes d'APVP (tous cancers confondus)

- De 2002 à 2011, sur le territoire du SSPSD, la cause la plus courante d'APVP a été le cancer, avec 31 %. Les cardiopathies ischémiques ont fait perdre 12 % des années potentielles de vie durant cette période.
- De 2002 à 2011, le cancer a fait perdre 3743 années potentielles de vie, en moyenne, chaque année.
- La proportion d'APVP dues au cancer est plus faible sur le territoire du SSPSD qu'à l'échelle provinciale.

Recours aux soins de santé

Le recours aux soins de santé est une mesure de l'utilisation des services de santé, y compris les visites au service des urgences et les admissions à l'hôpital. Les taux de visites au service des urgences et d'hospitalisation représentent un indice de la mesure dans laquelle une maladie ou des blessures sont courantes sur un territoire. Les personnes qui ne consultent pas un médecin pour leur maladie ou leur blessure ne sont pas prises en compte.

Visites au service des urgences

En général, les gens doivent se rendre au service des urgences en raison d'une maladie (physique ou mentale) ou d'une blessure. Notez que dans les secteurs géographiques où les cliniques sans rendez-vous sont moins nombreuses, les taux de visites au service des urgences risquent d'être plus élevés, car les patients y vont pour des soins non urgents.

- Sur le territoire du SSPSD, il y a eu 103 436 visites au service des urgences en 2013.
- En 2013, le taux de visites au service des urgences sur le territoire du SSPSD était de 511 pour 1000 habitants.
- Le taux de visites au service des urgences sur le territoire du SSPSD est bien plus faible que pour le nord-est de l'Ontario et a dépassé de peu le taux pour toute la province.
- De 2004 à 2013, le taux de visites au service des urgences est demeuré stable sur le territoire du SSPSD.

Hospitalisations

Les hospitalisations englobent les personnes admises à l'hôpital pour une maladie (physique ou mentale), une blessure ou un examen diagnostic. Les nombres d'admissions et les taux d'hospitalisation excluent les bébés en santé qui sont nés à l'hôpital.

- Sur le territoire du SSPSD, 21 174 personnes ont été hospitalisées en 2013.
- En 2013, le taux d'hospitalisation sur le territoire du SSPSD était de 99 pour 1000 habitants.
- Le taux d'hospitalisation sur le territoire du SSPSD a toujours été plus faible que pour le nord-est de l'Ontario, mais il est plus élevé dans les deux secteurs qu'à l'échelle provinciale.
- De 2004 à 2013, le taux d'hospitalisation sur le territoire du SSPSD a diminué.

Maladie cardiovasculaire

L'expression « maladie cardiovasculaire » englobe plusieurs maladies de l'appareil circulatoire, constitué du cœur et des vaisseaux sanguins². Les maladies des vaisseaux sanguins peuvent avoir des effets sur d'autres organes (cerveau, reins) ou parties du corps (extrémités). Réduisez le risque de maladie cardiovasculaire en faisant de l'activité physique, en mangeant bien, en réduisant votre consommation d'alcool et en vivant sans fumée. Une pression sanguine élevée augmente le risque pour toutes les autres maladies cardiovasculaires et peut souvent être réduite par des changements de mode de vie.

Hypertension

L'hypertension est un état chronique où la pression sanguine est toujours élevée sur une longue période. La pression sanguine est la force qu'exerce le sang sur les parois des vaisseaux sanguins.² L'hypertension se définit normalement comme étant une pression systolique (valeur maximale) de 140 mm d'Hg ou plus ou une pression diastolique (valeur minimale) de 90 mm d'Hg ou plus.

- En 2013-2014, les résultats d'un sondage ont révélé que le taux de prévalence de l'hypertension était de 20 % sur le territoire du SSPSD.
- Le taux de prévalence de l'hypertension sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario et l'ensemble de la province.
- De 2005 à 2013-2014, le taux d'hypertension sur le territoire du SSPSD n'a pas changé considérablement.

Cardiopathie ischémique

L'ischémie se définit comme une insuffisance de l'apport sanguin aux organes et aux tissus du corps. Ce genre de maladie du cœur inclut l'angine (douleur à la poitrine) et l'infarctus du myocarde ou crise cardiaque (blocage complet des vaisseaux sanguins du cœur).

- Sur le territoire du SSPSD, 1135 personnes ont été hospitalisées en raison d'une cardiopathie ischémique en 2013.
- En 2013, le taux d'hospitalisation due à une cardiopathie ischémique sur le territoire du SSPSD était de 468 pour 100 000 habitants.
- Le taux d'hospitalisation due à une cardiopathie ischémique sur le territoire du SSPSD a toujours été moins supérieur à celui présenté pour le nord-est de l'Ontario, alors que les taux pour les deux secteurs ont toujours été plus élevés qu'à l'échelle provinciale.
- De 2004 à 2013, le taux d'hospitalisation due à une cardiopathie ischémique sur le territoire du SSPSD a diminué.

² Agence de la santé publique du Canada, 2015. www.phac-aspc.gc.ca/cd-mc/cvd-mcv

Accident vasculaire cérébral

Un accident vasculaire cérébral (AVC) renvoie à un problème de circulation (blocage) dans les vaisseaux sanguins du cerveau. Parfois, il s'agit d'un blocage partiel dont les effets sont temporaires, ou d'un blocage complet dont les effets durent longtemps. Les vaisseaux du cerveau peuvent aussi éclater, ce qui a des effets à long terme.

- Sur le territoire du SSPSD, 333 hospitalisations étaient dues à un AVC en 2013.
- En 2013, le taux d'hospitalisation due à un AVC sur le territoire du SSPSD était de 139 pour 100 000 habitants.
- Le taux d'hospitalisation due à un AVC sur le territoire du SSPSD a généralement été semblable à celui présenté pour le nord-est de l'Ontario, alors que les taux pour les deux secteurs ont toujours été plus élevés qu'à l'échelle provinciale.
- De 2004 à 2013, le taux d'hospitalisation due à un AVC sur le territoire du SSPSD a généralement diminué.

Autres maladies du cœur

Il existe bien d'autres maladies du cœur que les cardiopathies ischémiques. En voici quelques exemples :

- Maladies du cœur congénitales (où la personne est née avec une malformation cardiaque)
 - Cardiomyopathie (où le muscle cardiaque est anormal)
 - Arythmies (où les cavités cardiaques ne battent pas au bon rythme ou de manière coordonnée)
 - Insuffisance cardiaque (où le cœur est affaibli et ne peut pomper le sang efficacement)
 - Arrêt cardiaque (où le cœur arrête complètement de battre)
- Sur le territoire du SSPSD, il y a eu 1012 hospitalisations dues à d'autres maladies du cœur en 2013.
 - En 2013, le taux d'hospitalisation due à d'autres maladies du cœur sur le territoire du SSPSD était de 418 pour 100 000 habitants.
 - Le taux d'hospitalisation due à d'autres maladies du cœur sur le territoire du SSPSD a été légèrement moins élevé en général que pour le nord-est de l'Ontario, alors que les taux dans les deux secteurs ont toujours été plus élevés qu'à l'échelle provinciale.
 - De 2004 à 2013, le taux d'hospitalisation due à d'autres maladies du cœur sur le territoire du SSPSD a généralement diminué.

Autres maladies de l'appareil circulatoire

D'autres maladies touchent la circulation sanguine. Il peut s'agir de ce qui suit :

- Athérosclérose (le « durcissement » des artères dû à une accumulation de plaque provenant du cholestérol, de tissu adipeux et d'autres matières)
 - Embolie ou thrombose (où le flux sanguin vers une partie du corps est ralenti ou arrêté complètement en raison d'un caillot, de tissu adipeux ou d'une autre cause)
 - Embolie ou thrombose (où le flux sanguin vers une partie du corps est ralenti ou arrêté complètement en raison d'un caillot, de tissu adipeux ou d'une autre cause)
 - Varices (où des veines, souvent dans la jambe, s'élargissent et se tordent; situation particulièrement courante chez les femmes plus âgées et pouvant découler d'une grossesse)
- Sur le territoire du SSPSD, il y a eu 1012 hospitalisations dues à d'autres maladies du cœur en 2013.
- En 2013, le taux d'hospitalisation due à d'autres maladies du cœur sur le territoire du SSPSD était de 418 pour 100 000 habitants.
- Le taux d'hospitalisation due à d'autres maladies du cœur sur le territoire du SSPSD a été légèrement moins élevé en général que pour le nord-est de l'Ontario, alors que les taux dans les deux secteurs ont toujours été plus élevés qu'à l'échelle provinciale.
- De 2004 à 2013, le taux d'hospitalisation due à d'autres maladies de l'appareil circulatoire sur le territoire du SSPSD a fluctué, mais il a diminué dans l'ensemble.

Cancer³

Tous les cancers se définissent par la croissance anormale de cellules et peuvent se répandre dans tout le corps. Il existe divers types de cancers, et les causes de chacun peuvent varier. Certains facteurs de risque, comme le tabagisme, peuvent augmenter le risque pour bien des types de cancers. En général, le risque de cancer augmente avec l'âge⁴. Environ une personne sur trois au Canada devrait développer un cancer au cours de sa vie.

Tous les cancers⁵

- Sur le territoire du SSPSD, il y a eu 1180 nouveaux cas de cancer en 2009.
- En 2009, le taux de cancer sur le territoire du SSPSD était de 430 nouveaux cas pour 100 000 habitants.
- Le taux de cancer sur le territoire du SSPSD a été semblable à celui présenté pour le nord-est de l'Ontario, alors que les taux dans les deux secteurs ont toujours été plus élevés qu'à l'échelle provinciale.
- De 2000 à 2009, le taux de cancer sur le territoire du SSPSD est généralement demeuré stable.

Cancer du sein

Le cancer du sein se définit par la croissance de cellules anormales, le plus souvent dans les canaux ou les lobules du tissu mammaire. Ce cancer, qui touche surtout les femmes, peut toucher le tissu mammaire des hommes. Une femme sur neuf au Canada devrait développer un cancer du sein au cours de sa vie⁴.

- Sur le territoire du SSPSD, il y a eu 154 cas de cancer du sein chez des femmes en 2009.
- En 2009, le taux de cancer du sein chez les femmes sur le territoire du SSPSD était de 108 cas pour 100 000.
- Le taux annuel de cancer du sein chez les femmes sur le territoire du SSPSD et dans le nord-est de l'Ontario a été semblable et il est généralement moins élevé qu'à l'échelle provinciale.
- De 2000 à 2009, il n'y a eu aucune tendance claire dans les taux de cancer du sein chez les femmes sur le territoire du SSPSD.

Cancer du col de l'utérus

Le cancer du col de l'utérus se définit par la croissance de cellules anormales malignes dans le col de l'utérus (le passage entre le vagin et l'utérus). Le principal facteur de risque dans le cas de ce cancer est le virus du papillome humain (VPH), qui se transmet sexuellement et qui touche le col de

³ Les taux sont normalisés selon l'âge d'après la population canadienne en 1991.

⁴ Agence de la santé publique du Canada, 2015. www.phac-aspc.gc.ca/cd-mc/cancer.

⁵ Sauf les cancers de la peau avec mélanome bénin, qui ne figurent pas dans les registres du cancer au Canada.

l'utérus⁴. Des vaccins contre le VPH sont offerts pour offrir une protection contre les VPH les plus courants qui sont liés à ce cancer. Il est possible de dépister ce dernier en Ontario.

Les taux de cancer du col de l'utérus sont trop faibles pour permettre d'effectuer une estimation fiable selon l'âge ou le secteur géographique en dessous du niveau pour le Service de santé publique. De plus, les taux de mortalité due au cancer du col de l'utérus sont trop faibles pour être présentés de manière fiable.

- Sur le territoire du SSPSD, il y a eu six nouveaux cas en 2009.
- En 2009, le taux de cancer du col de l'utérus sur le territoire du SSPSD était de 6 nouveaux cas pour 100 000 femmes.
- Le taux annuel de nouveaux cas de cancer de l'utérus sur le territoire du SSPSD a été légèrement plus élevé dans l'ensemble que pour le nord-est de l'Ontario, et les taux dans les deux secteurs ont toujours été plus élevés qu'à l'échelle provinciale.
- De 2000 à 2009, le taux de cancer du col de l'utérus sur le territoire du SSPSD est demeuré assez stable.

Cancer colorectal

Le cancer colorectal se définit par la croissance de cellules anormales à l'intérieur du colon ou du rectum. Ce type de cancer est plus courant chez les hommes que chez les femmes, et sa fréquence augmente avec l'âge. Le dépistage du cancer colorectal sauve des vies.

- Sur le territoire du SSPSD, il y a eu 136 nouveaux cas en 2009.
- En 2009, le taux de cancer colorectal sur le territoire du SSPSD était de 49 nouveaux cas pour 100 000 habitants.
- Le taux annuel de cancer colorectal sur le territoire du SSPSD a été semblable à celui présenté pour le nord-est de l'Ontario, mais en général, les taux dans les deux secteurs ont toujours été plus élevés qu'à l'échelle provinciale.
- De 2000 à 2009, les taux de cancer colorectal sur le territoire du SSPSD ont généralement diminué.

Cancer du poumon

Le cancer du poumon se définit par la croissance de cellules anormales sous forme de tumeurs dans les poumons. Il existe bien des facteurs de risque, mais la cause la plus courante de cancer du poumon est le tabagisme.

- Sur le territoire du SSPSD, il y a eu 202 nouveaux cas de cancer du poumon en 2009.
- En 2009, le taux de cancer du poumon sur le territoire du SSPSD était de 72 nouveaux cas pour 100 000 habitants.
- Le taux de cancer du poumon sur le territoire du SSPSD est généralement semblable à celui présenté pour le nord-est de l'Ontario, et les taux dans les deux secteurs sont toujours plus élevés qu'à l'échelle provinciale.
- De 2000 à 2009, le taux de cancer du poumon sur le territoire du SSPSD a été assez stable.

Mélanoma

Le mélanome se définit par une croissance anormale de cellules de la peau qui produisent de la mélanine (un pigment). Il s'agit du cancer de la peau le moins courant, mais c'est le plus grave. Il existe de nombreux facteurs de risque liés au mélanome, mais le plus courant est l'exposition aux rayons ultraviolets qu'émettent le soleil et les lits de bronzage.

Les taux de mélanome sont trop faibles pour procurer une estimation fiable selon l'âge ou le secteur géographique en dessous du niveau pour le Service de santé publique. De plus, les taux de mortalité due au mélanome sont trop faibles pour être présentés de manière fiable.

- Sur le territoire du SSPSD, il y a eu 31 nouveaux cas en 2009.
- En 2009, le taux de mélanome⁶ sur le territoire du SSPSD était de 12 nouveaux cas pour 100 000 habitants.
- Les taux de mélanome ont été semblables sur le territoire du SSPSD, dans le nord-est de l'Ontario et à l'échelle provinciale.
- De 2000 à 2009, les taux de mélanome sont demeurés stables.

Cancer de la prostate

Le cancer de la prostate se définit par une croissance de cellules anormales qui entraîne la formation d'une tumeur dans la prostate (une glande située en dessous de la vessie chez l'homme). Il s'agit du cancer le plus courant chez les Canadiens. Il existe bien des facteurs qui peuvent en augmenter le risque. Sur le territoire du SSPSD, il y a eu 135 nouveaux cas en 2009.

- En 2009, le taux de cancer de la prostate était de 103 cas pour 100 000 hommes.
- Le taux de cancer de la prostate sur le territoire du SSPSD a été généralement plus faible que dans le nord-est de l'Ontario, et les taux dans les deux secteurs ont été généralement moins élevés qu'à l'échelle provinciale.
- En général, le taux de cancer de la prostate sur le territoire du SSPSD a diminué de 2000 à 2009.

⁶ En raison des faibles nombres, il y a lieu d'interpréter les taux présentés pour le territoire du SSPSD avec prudence.

Comportements et risques liés à la santé

Tabagisme

Aux fins de la surveillance des tendances en matière de tabagisme, une personne peut être classée selon son « statut tabagique ». Les « fumeurs actuels » sont les personnes qui fument actuellement la cigarette, même occasionnellement. Les « anciens fumeurs » sont ceux qui ne fument pas, mais qui ont déjà fumé la cigarette. Les « personnes qui n'ont jamais fumé » sont celles qui se sont complètement abstenues de fumer la cigarette au cours de leur vie. Ici, nous présentons les taux sommaires de « fumeurs actuels » chez les adultes et de « personnes qui n'ont jamais fumé » chez les jeunes.

Fumeurs actuels chez les adultes

- En 2013-2014, les résultats d'un sondage ont révélé que le taux de fumeurs actuels était de 25 % chez les adultes sur le territoire du SSPSD.
- Le taux de prévalence des fumeurs actuels chez les adultes sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario, mais plus élevé qu'à l'échelle provinciale.
- De 2005 à 2013-2014, le taux de fumeurs actuels sur le territoire du SSPSD n'a pas changé considérablement.

Personnes qui n'ont jamais fumé chez les jeunes⁷

Les personnes qui n'ont jamais fumé chez les jeunes se définissent comme des personnes de 12 à 19 ans qui n'ont jamais fumé une cigarette entière au cours de leur vie.

- En 2013-2014, les résultats d'un sondage ont révélé que 79 % des jeunes sur le territoire du SSPSD n'avaient jamais fumé une cigarette entière.
- Le taux de prévalence des jeunes qui n'ont jamais fumé une cigarette entière sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario, mais il est généralement moins élevé qu'à l'échelle provinciale.
- De 2005 à 2013-2014, le taux de jeunes qui n'ont jamais fumé une cigarette entière sur le territoire du SSPSD n'a pas changé considérablement.

Exposition à la fumée de tabac ambiante à domicile

L'exposition à la fumée de tabac ambiante, également connue sous le nom de fumée secondaire, peut être mauvaise pour la santé. Ici, nous présentons les taux de non-fumeurs âgés de 12 ans ou plus qui ont été régulièrement (chaque jour ou presque) exposés à la fumée de tabac à leur domicile.

- En 2013-2014, les résultats d'un sondage ont révélé que le taux de prévalence de l'exposition à la fumée de tabac ambiante à domicile a été de 4 % sur le territoire du SSPSD.

⁷ Les taux ne sont pas normalisés selon l'âge.

- Le taux de prévalence de l'exposition à la fumée de tabac ambiante à domicile sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario, et à celui présenté pour toute la province depuis 2009-2010.
- De 2005 à 2013-2014, le taux d'exposition à la fumée de tabac ambiante à domicile sur le territoire du SSPSD a diminué.

Exposition à la fumée de tabac ambiante dans des lieux publics

L'exposition à la fumée de tabac ambiante, également connue sous le nom de fumée secondaire, peut être mauvaise pour la santé. Ici, nous présentons les taux de non-fumeurs âgés de 12 ans ou plus qui ont été régulièrement (chaque jour ou presque) exposés à la fumée de tabac dans des lieux publics comme des bars, des restaurants, des centres commerciaux, des arénas, des salles de bingo, des salles de quilles, etc

- En 2013-2014, les résultats d'un sondage ont révélé que le taux de prévalence de l'exposition à la fumée de tabac ambiante dans des lieux publics a été de 14 % sur le territoire du SSPSD.
- Le taux de prévalence de l'exposition à la fumée de tabac ambiante dans des lieux publics sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario, et à celui présenté pour toute la province.
- De 2005 à 2013-2014, le taux d'exposition à la fumée de tabac ambiante dans des lieux publics sur le territoire du SSPSD n'a pas changé considérablement.

Exposition à la fumée de tabac ambiante dans un véhicule par secteur géographique

L'exposition à la fumée de tabac ambiante, également connue sous le nom de fumée secondaire, peut être mauvaise pour la santé. Ici, nous présentons les taux de non-fumeurs âgés de 12 ans ou plus qui ont été régulièrement (chaque jour ou presque) exposés à la fumée de tabac dans une voiture ou un autre véhicule privé.

- En 2013-2014, les résultats d'un sondage ont révélé que le taux de prévalence de l'exposition à la fumée de tabac ambiante dans un véhicule a été de 9 % sur le territoire du SSPSD.
- Le taux de prévalence de l'exposition à la fumée de tabac ambiante dans un véhicule sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario, mais plus élevé qu'à l'échelle provinciale.
- De 2005 à 2013-2014, le taux d'exposition à la fumée de tabac ambiante dans un véhicule sur le territoire du SSPSD n'a pas changé considérablement.

Alcool

L'information exposée dans le présent rapport est tirée de l'Enquête sur la santé dans les collectivités canadiennes (ESCC), où l'expression « consommation d'alcool » signifie avoir pris un « verre » défini comme suit :

- une bouteille ou une canette de bière, ou bien un verre de bière en fût, ou
- un verre de vin ou de vin panaché (*wine cooler*), ou
- un verre ou un cocktail contenant une once et demie de spiritueux.

Forte consommation d'alcool

La forte consommation d'alcool se définit comme la consommation d'au moins quatre ou cinq verres d'alcool (pour les femmes et les hommes, respectivement) à au moins une occasion par mois au cours des 12 mois précédents. Ce niveau de consommation d'alcool peut causer de graves problèmes sociaux et de santé.

Cette définition a changé au fil des ans. Avant 2013, le seuil était de cinq verres ou plus pour les hommes et les femmes.

Les taux de forte consommation d'alcool qui sont exposés dans la présente section sont calculés pour les personnes de 12 ans ou plus.

- En 2013-2014, les résultats d'un sondage ont révélé que le taux de prévalence de la forte consommation d'alcool était de 24 % sur le territoire du SSPSD.
- Le taux de prévalence de la forte consommation d'alcool sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario, mais plus élevé qu'à l'échelle provinciale.
- De 2005 à 2013-2014, le taux de forte consommation d'alcool sur le territoire du SSPSD n'a pas changé considérablement.

Dépassement des directives de consommation d'alcool à faible risque

Les directives de consommation d'alcool à faible risque du Canada ont été mises au point pour aider les Canadiens à modérer leur consommation d'alcool et à prévenir les effets néfastes immédiats et à long terme. Ici, nous présentons les taux chez les personnes de 19 ans ou plus qui ont déclaré avoir dépassé les directives. Cela inclut :

- les hommes qui ont bu plus de 15 verres par semaine et les femmes qui en ont bu plus de 10, OU
- les hommes qui ont bu plus de trois verres par jour et les femmes qui en ont bu plus de deux, OU
- les hommes et les femmes qui ont passé moins de deux jours par semaine sans boire, OU
- les hommes ou les femmes qui ont bu au moins cinq verres à une occasion donnée au cours de l'année précédente.

- En 2013-2014, les résultats d'un sondage ont révélé que le taux de prévalence de la consommation d'alcool supérieure aux directives de consommation d'alcool à faible risque était de 36 % sur le territoire du SSPSD.
- Le taux de prévalence de la consommation d'alcool supérieure aux directives de consommation d'alcool à faible risque sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario, mais plus élevé qu'à l'échelle provinciale.
- De 2005 à 2013-2014, le taux de forte consommation d'alcool sur le territoire du SSPSD n'a pas changé considérablement.

Consommation d'alcool chez les jeunes⁸

Dans la présente section, nous exposons les taux de consommation d'alcool déclarée (telle que définie précédemment) au cours des 12 mois précédents chez les jeunes de 12 à 18 ans.

- En 2013-2014, les résultats d'un sondage ont révélé que le taux de prévalence de la consommation d'alcool chez les jeunes de 12 à 18 ans était de 54 % sur le territoire du SSPSD.
- Le taux de prévalence de la consommation d'alcool chez les jeunes sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario, mais plus élevé qu'à l'échelle provinciale.
- De 2005 à 2013-2014, le taux de consommation d'alcool chez les jeunes sur le territoire du SSPSD n'a pas changé considérablement.

Indice de masse corporelle (ajusté), surpoids et obésité

L'indice de masse corporelle (IMC) d'une personne se calcule en divisant son poids (en kilogrammes) par le carré de sa taille (en mètres). Chez les adultes, de 18 ans ou plus, les cotes sont regroupées dans les catégories suivantes : poids insuffisant (IMC <18,5), poids normal (IMC de 18,5 à 24,9), surpoids (IMC de 25,0 à 29,9) et obésité (IMC \geq 30,0).

Il est connu que les cotes d'indice de masse corporelle fondées sur la taille et le poids autodéclarés sous-représentent le véritable taux de surpoids ou d'obésité dans la collectivité. Le taux d'obésité qui est exposé dans la présente section a été ajusté en conséquence.

Obésité (indice de masse corporelle ajusté)

- En 2013-2014, les résultats d'un sondage ont révélé que le taux de prévalence de l'obésité était de 32 % sur le territoire du SSPSD.
- Le taux de prévalence de l'obésité sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario, mais plus élevé qu'à l'échelle provinciale.
- De 2005 à 2013-2014, le taux d'obésité sur le territoire du SSPSD a augmenté considérablement.

⁸ Les taux ne sont pas normalisés selon l'âge.

Activité physique

Le niveau d'activité physique d'une personne peut se mesurer par l'indice d'activité physique (IAP). Cet indice combine des renseignements sur :

- les activités de la personne,
- le temps consacré à ces activités,
- la mesure dans laquelle les activités étaient exigeantes (en « kilocalories » [kcal] d'énergie dépensée à l'heure),
- le poids de la personne (en kilogrammes).

D'après ce qui précède, la personne est classée comme étant active, modérément active ou inactive de la manière suivante :

- Active : 3,0 kcal/kg/jour ou plus de dépense d'énergie en moyenne
- Modérément active : de 1,5 à 2,9 kcal/kg/jour de dépense d'énergie en moyenne
- Inactive : moins de 1,5 kcal/kg/jour de dépense d'énergie en moyenne

Dans la présente section, nous exposons les taux chez les personnes de 12 ans ou plus qui sont classées comme étant « actives » d'après leur niveau d'activité pendant les moments de loisir.

Activité physique – personnes actives

- En 2013-2014, les résultats d'un sondage ont révélé que 32 % de la population sur le territoire du SSPSD était physiquement active.
- Le taux de prévalence des personnes physiquement actives sur le territoire du SSPSD était semblable à celui présenté pour le nord-est de l'Ontario et pour toute la province.
- De 2005 à 2013-2014, le taux d'activité physique sur le territoire du SSPSD n'a pas changé considérablement.

Nutrition – consommation de fruits et légumes

Pour chaque groupe alimentaire, le Guide alimentaire canadien fournit des recommandations sur le nombre de portions que les Canadiens devraient consommer chaque jour. Ici, nous exposons les taux de personnes de 12 ans ou plus qui ont déclaré avoir consommé au moins le nombre minimum de portions de fruits et légumes qui est recommandé pour leur âge et leur sexe, soit :

- enfants de 12 à 13 ans : six portions de fruits et légumes par jour;
 - personnes de sexe féminin de 14 ans ou plus : sept portions de fruits et légumes par jour;
 - personnes de sexe masculin de 14 à 50 ans : huit portions de fruits et légumes par jour;
 - hommes de 51 ans ou plus : sept portions de fruits et légumes par jour.
- En 2013-2014, les résultats d'un sondage ont révélé que 13 % des personnes de 12 ans ou plus sur le territoire du SSPSD consommaient les portions de fruits et légumes recommandées dans le Guide alimentaire canadien.

- Le taux de prévalence des personnes qui consommaient les portions recommandées de fruits et légumes sur le territoire du SSPSD a toujours été semblable à celui présenté pour le nord-est de l'Ontario et pour toute la province.
- De 2005 à 2013-2014, le taux de personnes qui consomment les portions recommandées de fruits et légumes sur le territoire du SSPSD n'a pas changé considérablement.

Insécurité alimentaire

La sécurité alimentaire est assurée lorsque tout le monde, en tout temps, a physiquement et économiquement accès à une quantité suffisante d'aliments salubres et nutritifs pour répondre à ses besoins alimentaires et obtenir les aliments privilégiés pour mener une vie active et saine⁹. Fondé sur un ensemble de 18 questions, l'état de sécurité alimentaire d'un ménage est classé ici comme suit :

- Situation de sécurité alimentaire : peu d'indications d'une difficulté d'accès à la nourriture en raison du revenu
- Situation d'insécurité alimentaire modérée : indications de compromis sur la qualité de la nourriture ou la quantité consommée
- Situation de grave insécurité alimentaire : indications d'apport réduit en aliments et d'habitudes alimentaires perturbées

Ci-dessous, nous exposons les taux de personnes de 12 ans ou plus ayant vécu au sein d'un ménage classé comme étant en situation d'insécurité alimentaire modérée ou grave au cours des 12 mois précédents.

- En 2013-2014, les résultats d'un sondage ont révélé que 7 % des personnes de 12 ans ou plus sur le territoire du SSPSD vivaient dans un ménage en situation d'insécurité alimentaire.
- Le taux de prévalence de l'insécurité alimentaire a été semblable à celui présenté pour le nord-est de l'Ontario et pour toute la province.
- De 2005 à 2013-2014, le taux d'insécurité alimentaire sur le territoire du SSPSD n'a pas changé considérablement.

⁹ Agriculture et agroalimentaire Canada, 2009. *Plan d'action du Canada pour la sécurité alimentaire*. www.agr.gc.ca/index_e.php?s1=misb&s2=fsec-seca&page=action

Conclusion

Le présent rapport résume environ dix années de données récentes provenant de diverses sources qui ont servi à produire la première tranche d'une série de chapitres du *Profil de santé de la population sur le territoire du SSPSD* (www.sdh.u.com). Comme mentionné précédemment, d'autres données sur les maladies transmissibles, les blessures, le rapport entre divers facteurs socioéconomiques et la santé et d'autres sujets touchant la santé publique dans nos collectivités seront ajoutées au profil.

Nos conclusions nous indiquent jusqu'à présent ce qui suit :

- Au fil des ans, des proportions semblables de personnes vivant sur le territoire du SSPSD ont coté leur santé et leur santé mentale comme étant très bonnes ou excellentes dans l'ensemble comparativement aux résidents de l'Ontario. Les taux de recours aux soins de santé (visites au service des urgences et hospitalisations) sur le territoire du SSPSD ont été inférieurs à ceux présentés pour le nord-est, mais plus élevés qu'à l'échelle provinciale.
- Les taux de mortalité évitable et d'années potentielles de vie perdues (APVP) sur le territoire du SSPSD ont été semblables à ceux présentés pour le nord-est, mais, encore une fois, plus élevés qu'à l'échelle provinciale. De plus, les taux d'hospitalisation pour la plupart des maladies cardiovasculaires sur le territoire du SSPSD ont été semblables à ceux présentés pour le nord-est, mais plus élevés qu'à l'échelle provinciale.
- Bien que les taux d'incidence (nouveaux cas) de cancer du poumon, du cancer colorectal et du cancer du col de l'utérus étaient plus élevés sur le territoire du SSPSD qu'en Ontario, les taux d'incidence de mélanome étaient semblables à ceux présentés pour toute la province. Les taux d'incidence de cancer de la prostate et du sein sur le territoire du SSPSD étaient moins élevés qu'à l'échelle provinciale.
- Enfin, même si les taux de consommation de fruits et légumes, d'activité physique et d'insécurité alimentaire étaient semblables à ceux présentés pour toute la province, les taux de tabagisme et de consommation d'alcool étaient supérieurs sur le territoire du SSPSD.

L'information exposée dans les présentes s'ajoutera aux données probantes pour la pratique efficace en santé publique, laquelle le SSPSD a promis d'adopter. Elle aidera aussi nos partenaires communautaires à mesure que nous collaborerons afin d'assurer la santé des collectivités et de permettre à tous d'avoir des possibilités pour tous.



Sudbury & District

Health Unit

Service de
santé publique

**MINUTES – SEVENTH MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM
THURSDAY, NOVEMBER 19, 2015, AT 1:30 P.M.**

BOARD MEMBERS PRESENT

Claude Belcourt
René Lapierre
Ken Noland
Paul Schoppmann

Janet Bradley
Stewart Meikleham
Rita Pilon
Mark Signoretti

Jeffery Huska (excused 2:50 to 3:05 pm)
Paul Myre
Ursula Sauvé
Carolyn Thain

BOARD MEMBERS REGRETS

Robert Kirwan

STAFF MEMBERS PRESENT

Nicole Frappier
Marc Piquette
Dr. P. Sutcliffe

Sandra Laclé
Rachel Quesnel
Shelley Westhaver

Stacey Laforest
Renée St Onge

GUESTS

Daniela Kempkens, NOSM Resident
Media

R. LAPIERRE PRESIDING

1.0 CALL TO ORDER

The meeting was called to order at 1:30 p.m.

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

There were no declarations of conflict of interest.

4.0 DELEGATION / PRESENTATION

i) Achieving Healthy Weights in the Sudbury and Manitoulin Districts

- Tracey Weatherbe, Manager, Health Promotion Division
- Sandra Laclé, Director, Health Promotion Division

The Board Chair invited guests to speak to Achieving Healthy Weights in the Sudbury and Manitoulin Districts. S. Lacle and T. Weatherbe provided current Canadian healthy weights statistics, described the “Balanced Approach” for achieving healthy weights, and shared Sudbury & District Health Unit (SDHU) initiatives that promote achievement of childhood healthy weights.

In 2003, the Sudbury & District Board of Health passed motion #72-03 Obesity Prevention and the Promotion of Healthy Weight in Sudbury and District which set the stage for the SDHU’s Balanced Approach Philosophy and has guided our Healthy Weights programming over the past 13 years. This philosophy considers the spectrum of eating and weight-related problems and recognizes that health is influenced by a variety of factors including our

physical, mental, emotional and spiritual well-being. The vision is that our communities will have healthy supportive and built environments that enhance positive mental and physical wellbeing, where all individuals can flourish and thrive, and achieve their healthy weight.

In 2013, following the provincial release of the Healthy Kids Strategy, the SDHU released a *No Time to Wait Report Card* which will re-evaluate our progress in 2016 and reflect back on our original "B" grade.

Board members were also provided with an update on the local Healthy Kids Community Challenge initiatives.

In conclusion, obesity is a complex issue and there are no easy, straightforward solutions. At the SDHU, we aim at collaborating in order to best coordinate our work as it relates to the components of healthy eating, physical activity, sleep and mental health promotion. We promote a variety of approaches, at multiple levels that involve many sectors such as health, education, government, non-profit, primary care and private.

Questions and comments were entertained and speakers thanked for their presentation.

5.0 CONSENT AGENDA

As agreed by the Board, a consent agenda is being implemented starting with this Board meeting. An email was sent to the Board on November 16 with a reminder to contact the Board secretary with any questions for clarification regarding items listed on today's agenda under the Consent Agenda. The Chair clarified that consent agenda items requiring further discussion can be moved to New Business.

Dr. Sutcliffe noted that a number of Board members did contact us via email with questions regarding items from the November Board Consent Agenda and clarification was provided by email prior to today's Board meeting.

There were no consent agenda items identified for discussion.

i) Minutes of Previous Meeting

- a. Sixth Meeting – October 15, 2015

ii) Business Arising From Minutes

iii) Report of Standing Committees

- a. Board of Health Finance Standing Committee Meeting Notes, November 2, 2015

iv) Report of the Medical Officer of Health / Chief Executive Officer

- a. MOH/CEO Report, November 2015

v) Correspondence

- a. **Enforcement of the Immunization of School Pupils Act (ISPA)**

Sudbury & District Board of Health Motion #25-15

- Letter from the Middlesex-London Health Unit to the Minister of Health and Long-Term Care dated October 15, 2015

- b. **Healthy Babies Healthy Children (HBHC) Program**
Sudbury & District Board of Health Motion #28-15
 - Letter from the Middlesex-London Health Unit to the Minister of Children and Youth Services and the Minister of Health and Long-Term Care dated October 15, 2015
 - Letter from the Wellington-Dufferin-Guelph Board of Health to the Minister of Children and Youth Services dated November 4, 2015
- c. **Northern Ontario Evacuations of First Nations Communities**
Sudbury & District Board of Health Motion #32-15
 - Letter from the Perth District Health Unit to the Premier of Ontario dated October 26, 2015
 - Letter from the Algoma Public Health to the Premier of Ontario dated October 28, 2015
- d. **Ministry of Health and Long-Term Care (MOHLTC) One-Time Funding for 2015-16 re Panorama**
 - Letter from the Minister of Health and Long-Term Care dated October 30, 2015
- e. **Reinstatement of the Long-Form Census**
 - The Globe and Mail Article, November 5, 2015
 - The Star Article, November 5, 2015
 - Letter of Congratulations from the Sudbury & District Health Unit to the Prime Minister of Canada dated November 9, 2015
- f. **Amendments to the Ontario Public Health Standards Protocols**
 - Memo from the MOHLTC to Board of Health Chairs dated October 26, 2015
 - Letter from the MOHLTC to the Board of Health Chairs dated October 14, 2015 Re: Reporting of Infection Prevention and Control (IPAC) lapses
- g. **Price Report**
 - Letter from the Association of Local Public Health Agencies (alPHA) Board President to the Minister of Health and Long-Term Care dated October 20, 2015
- h. **Nutritious Food Basket**
 - Letter from Wellington-Dufferin-Guelph Board of Health to the Minister Responsible for the Poverty Reduction Strategy/Deputy Premier dated November 4, 2015
- i. **Syrian Refugee Crisis**
 - Letter from the Minister of Health and Long-Term dated November 12, 2015
- vi) **Items of Information**
 - a. alPHA Information Break October 15, 2015
November 3, 2015
 - b. Times Colonist: Trevor Hancock: How we keep
Canada healthy is a great story October 28, 2015
 - c. Sudbury Star article: City (of Greater Sudbury) gets
bad grade for health October 25, 2015
 - d. SDHU's 2015 Flu Shot Clinics
 - e. Remarks from the Minister of Health and Long-Term
Care to the 2015 HealthAchieve Conference November 4, 2015

48-15 APPROVAL OF CONSENT AGENDA

Moved by Pilon – Schoppmann: THAT the Board of Health approves the consent agenda as distributed.

CARRIED

6.0 NEW BUSINESS

i) Assessor's Report: Algoma Public Health

- Sudbury & District Health Unit's Review of the Assessors Report on Algoma Public Health Unit
- Graham Scott's Assessors Report on Algoma Public Health Unit, April 24, 2015
- MOHLTC's Action on Assessor's Report, June 2015

The Assessor's Report and the MOHLTC's Action on Assessor's Report were previously shared with the Board in June and discussion took place regarding the recommendations and potential implications.

Since June, the SDHU senior managers conducted an internal review of the recommendations to consider these in light of the SDHU context and identify any recommendations or actions for the SDHU. Dr. Sutcliffe identified that our review indicated that we would benefit from further orientation and training in support of the governance roles of the Board of Health members. There were no questions regarding the SDHU report findings and recommended actions.

ii) Public Health Funding

- Letter and Resolution from the aPHa Board to the Minister of Health and Long-Term Care dated November 3, 2015
- Letter from the Leeds, Grenville & Lanark District Health Unit to the Minister of Health and Long-Term Care dated October 22, 2015
- Letter from the Elgin St. Thomas Public Health to the Minister of Health and Long-Term Care dated November 2, 2015

Since the MOHLTC's recent announcement of the new public health funding model, local Boards are advocating for change to the funding formula and further investment in public health. As anticipated, the Association of Local Public Health agencies (aPHa) Board of Directors passed a Public Health Funding Formula resolution for which it is proposed that the Sudbury & District Board of Health endorse.

49-15 PROVINCIAL PUBLIC HEALTH FUNDING

Moved by Noland – Meikleham: THAT the Sudbury & District Board of Health endorse the correspondence and resolution concerning the public health funding formula, passed October 30, 2015 from the aPHa Board of Directors;

AND FURTHER THAT the Sudbury & District Board of Health call on the Ministry of Health and Long Term Care to increase investments in public health, ensuring Ontarians benefit from a world-class public health system within Ontario's transformed health system;

AND FURTHER THAT this motion be forwarded to constituent municipalities, the Association of Municipalities of Ontario, the Federation of Northern Ontario Municipalities, Ontario Boards of Health, the Association of Local Public Health Agencies, and other local partners.

CARRIED

iii) 2016 Cost-Shared Budget

- Briefing Note and Appendices from the Sudbury & District Health Unit's Medical Officer of Health and Chief Executive Officer dated November 12, 2015

C. Thain, Board Finance Standing Committee Chair, reported that the Finance Standing Committee met twice regarding the 2016 cost-shared budget. The Committee also discussed the long-term local impacts of the new provincial public health funding formula, cost reduction initiatives were identified and budget principles were applied to initiative. Much work has gone into the development of a balanced budget due to the implementation of the provincial funding formula. The Finance Standing Committee supports the recommended budget tabled today and recommends approval by the Board.

Dr. Sutcliffe reviewed key highlights of the budget briefing note. The Finance Standing Committee was thanked for their work resulting in today's recommendation that the Board approve the 2016 operating budget of \$22,873,326. The proposed 2016 budget represents a 0.55% overall decrease compared to the 2015 Board approved budget resulting of a 2.0% reduction in the cost-shared provincial grant and a 2.5% increase in the municipal levy.

The proposed budget includes cost reduction initiatives that were necessary to achieve a balanced budget for this year and in anticipation of long-term funding pressures attributable to the province-wide implementation of the new public health funding formula.

Board members were reminded that funding for public health is specified in the Health Protection and Promotion Act which stipulates that obligated municipalities shall pay the expenses incurred in the performance of the required functions and duties in accordance with the Act, regulations and guidelines. The HPPA notes that the Minister may make grants on such conditions considered appropriate.

For 2015, the Ministry advised health units that the 2.0% growth funding available for mandatory programs would be distributed proportionately to eight health units who had not reached their model-based share. Health units have been told to plan for 0% provincial funding on the go forward. Other potential implications include the review of the OPHS and OPHOS expected to be completed by end of 2016.

Comprehensive internal communication has taken place to ensure SDHU staff are aware of the new funding formula and its implications for 2015 and beyond. Information sessions have been held for the unions, management and all staff.

A five-year projected deficit from 2016 to 2020 illustrates the order of magnitude of the anticipated fiscal pressures on a cumulative long-term deficit with no increase in funding should the SDHU not take decision action now.

The budget proposals were assessed for fit with the principles approved by the Finance Standing Committee as was the final recommended budget in its entirety.

It was noted that the recommended budget does not include the VBD Contingency Control Measure totalling \$500,000 which was included in prior budgets. The elimination of the contingency measure revenues and expenses results from a MOHLTC change to considering and funding extraordinary costs related to control measures based on in-year requests to the MOHLTC.

It was clarified that the recommended budget is presented with a flat-line or 0% growth over the 2015 ministry approved Unorganized Territories funding as we anticipate no increases related to the delivery of services to the Unorganized Territories for the next several years.

There is an increase to the revenue related to incorporating a consultation fee to the existing travel vaccine user fees and from the recovery of administrative expenses from the recently increased Smoke-Free-Ontario funding.

The 0.55% overall decrease in expenditures for 2016 compared to 2015 cost-shared budget includes benefits reductions of .29%, salary cost increases of .96% and operating cost reductions of 1.22%.

The salary and benefit costs includes a 1.41% increase and 1.55% decrease respectively.

There is no vacancy rate built in the 2016 recommended budget.

The cost reduction initiatives incorporated in the proposed budget were reviewed. It was pointed out that staff were invited to submit cost reduction initiatives and over 100 staff ideas were received for which some are reflected in the proposed initiatives tabled today or will be noted for consideration for the future. Senior Management continues to receive, assess, prioritize and act on the ideas submitted.

Non-salary changes reflecting a 9.87% decrease were reviewed. One of the changes include a significant reduction in the staff development budget from 1.3% to 0.5%.

Questions were entertained. The Board members were pleased to see that staff are contributing to find solutions to this challenging situation.

IN CAMERA

50-15 IN CAMERA

Moved by Meikleham – Noland: That this Board of Health goes in camera.

Time: 2:11 p.m.

CARRIED

- Personal matters involving one or more identifiable individuals, including employees or prospective employees
- Labour relations or employee negotiations

RISE AND REPORT

51-15 RISE AND REPORT

Moved by Pilon – Noland: That this Board of Health rises and reports.

Time: 2:51 p.m.

CARRIED

C. Belcourt reported that the Board discussed personal and labour relations matters and one motion emanated from the in-camera discussion:

52-15 APPROVAL OF BOARD IN CAMERA MEETING NOTES

Moved by Mekleham – Noland: THAT this Board of Health approve the meeting notes of the May 21, 2015, Board in-camera meeting and that these remain confidential and

restricted from public disclosure in accordance with exemptions provided in the Municipal Freedom of Information and Protection of Privacy Act.

CARRIED

The briefing note appendices which included the budget principles and financial budget sheets for the proposed 2016 cost shared budget were reviewed.

Questions or comments invited. One point will be clarified relating to a decrease in expenditure for Espanola. It was clarified that a communication plan for internal and external communication would be actioned following today's meeting, and would include timely communication with the SDHU constituent municipalities regarding the municipal levies.

53-15 2016 COST-SHARED BUDGET

Moved by Myre – Sauvé: THAT the Sudbury & District Board of Health approve the 2016 operating budget for cost-shared programs and services in the amount of \$22,873,326.

CARRIED

iv) Cannabis

- Centre for Addiction and Mental Health Cannabis Policy Framework, October 2014, Executive Summary
- Liberal Platform on Marijuana

The federal Liberal platform includes the legalization of cannabis. In anticipation of this and the known risks and local statistics on cannabis usage, the SDHU is proactively advocating for a public health approach that would include strict health-focused regulations.

Questions were entertained. The Board recognized that there would be challenges such as addressing driving under the influence. Also, there are lessons learned from other countries that can be applied and there are transferrable principles on how we dealt with tobacco that can be applied to how we can deal with cannabis.

The Board was pleased that a proactive approach is proposed.

54-15 CANNABIS REGULATION AND CONTROL: Public Health Approach to Cannabis Legalization

Moved by Bradley – Thain: WHEREAS the election platform of Canada's recently elected federal government includes the intention to legalize, regulate, and restrict access to marijuana; and

WHEREAS within the current criminalization context, cannabis is widely used in the SDHU catchment area: 23.5% of youth used in the previous 12 months, 52.3% of people aged ≥19 have tried cannabis and 13% currently use cannabis; and

WHEREAS the health risks of cannabis use are significantly lower than tobacco or alcohol but are increased in those who use it frequently, begin at an early age and/or who have higher risk of cannabis-related problems (i.e. certain psychiatric conditions, cardiovascular disease, pregnancy); and

WHEREAS a public health approach focused on high-risk users and practices – similar to the approach favoured with alcohol and tobacco that includes strategies such as controlled availability, age limits, low risk use guidelines, pricing, advertising restrictions, and general and targeted prevention initiatives – allows for more control over the risk factors associated with cannabis-related health and societal harms; and

WHEREAS the Ontario Public Health Standards require boards of health to reduce the frequency, severity, and impact of preventable injury and of substance misuse;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support a public health approach to the forthcoming cannabis legalization framework, including strict health-focused regulations to reduce the health and societal harms associated with cannabis use; and

FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

CARRIED

i) Smoke-Free Multi-Unit Housing

- Northwestern Health Unit Motion 88-2015 dated October 23, 2015
- Smoke-Free Housing Ontario Coalition Advocacy Letter dated October 10, 2014

Today's motion focuses on protecting residents who reside in multi-unit housing against health-harming effects of tobacco smoke. The Smoke-Free Housing Ontario Coalition has urged the private and public sectors to advocate to reduce the impacts of second-hand smoke exposure in multi-unit housing throughout Ontario.

It was pointed out that the Manitoulin Sudbury District Services Board supported smoke-free social housing effective January 2015.

Discussion ensued regarding the definitions of multi-unit dwellings and tobacco as well as the challenges that may take place with implementation and enforcement. It was concluded that this advocacy motion supports and joins the efforts of others in an attempt to change societal norms.

55-15 ENDORSEMENT OF ACTION FOR SMOKE-FREE MULTI-UNIT HOUSING

Moved by Thain – Bradley: WHEREAS smoking in multi-unit housing results in significant exposure to the health-harming effects of tobacco smoke; and

WHEREAS area municipalities and service boards that are landlords of multi-unit housing can adopt no-smoking policies that set an example and protect health, such as that adopted by the Manitoulin Sudbury District Services Board to support smoke-free social housing effective January 1, 2015;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Northwestern Health Unit motion (88-2015) on smoke-free multi-unit housing, the efforts of the Smoke-Free Housing Ontario Coalition and others, in the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

- (1) Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties;***
- (2) Advocate that all future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;***
- (3) Encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties;***
- (4) Advocate that all future public/social housing developments in Ontario should be smoke-free from the onset;***
- (5) Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.***

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Smoke-Free Housing Ontario Coalition, the Ontario Minister of Municipal Affairs and Housing, local members of Provincial Parliament (MPP), the Chief Medical Officer of Health, the Association of Local Public Health Agencies (aLPHa), all Ontario Boards of Health, the Association of Municipalities of Ontario, the Federation of Northern Ontario Municipalities and SDHU municipalities for their information and support.

CARRIED

ii) Staff Appreciation Day

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated November 12, 2015

Dr. Sutcliffe reported that such as motion has been presented to the Sudbury & District Board of Health for its consideration on an annual basis since the mid-70s. The Board has historically granted an additional day off for the staff during the holiday season and more recently the holiday timelines has been broadened to accommodate varying religion. The Board discussed bringing forward a motion on an annual basis and it was concluded that the motion provides an opportunity for the Board to acknowledge and thank the staff for their work and contributions.

56-15 STAFF APPRECIATION DAY

Moved by Myre – Sauvé: THAT this Board of Health approve a Staff Appreciation Day for the staff of the Sudbury & District Health Unit during the upcoming holiday season. The Staff Appreciation Day may be taken between the dates of December 1, 2015, to February 29, 2016. Essential services will be available and provided at all times during the holiday period except for statutory holidays when on-call staff will be available.

CARRIED

iii) Annual Board Self-Evaluation

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated November 12, 2015

Board members were thanked for completing the annual self-evaluation survey. The results were shared at today's meeting for information and discussion.

Dr. Sutcliffe observed that some comments in the Board evaluation results are consistent with management's review of the Algoma Public Health Assessor's Report; therefore, further discussion and orientation regarding governance and the role of Board members would likely be beneficial. Future annual evaluations will consider our newly implemented consent agenda.

11.0 ADDENDUM

DECLARATION OF CONFLICT OF INTEREST

There were no declarations of conflict of interest.

57-15 ADDENDUM

Moved by Schoppmann – Huska: THAT this Board of Health deals with the items on the Addendum.

CARRIED

i) Review and Modernization of the Ontario Public Health Standards

- Letter from the Minister of Health and Long-Term Care to Board of Health Chairs and Medical Officers of Health dated November 16, 2015

The MOHLTC has announced the review and modernization of the Ontario Public Health Standards to be concluded by December 2016. The letter does not reference a review of the Ontario Public Health Organizational Standards; however, we understand that the review will include these. Consultation and engagement with local health units is expected.

8.0 ANNOUNCEMENTS / ENQUIRIES

The SDHU's United Way Workplace Campaign has set a target to raise \$16,000 for this year's United Way Campaign. Board members are invited to participate in the fundraising campaign. Donation forms were distributed.

Board members were encouraged to complete the Board evaluation regarding today's Board meeting.

9.0 ADJOURNMENT

58-15 ADJOURNMENT

Moved by Meikleham – Noland: THAT we do now adjourn. Time: 3:37 p.m.

CARRIED

(Chair)

(Secretary)

Medical Officer of Health/Chief Executive Officer Board of Health Report, January 2016

Words for thought...



Proposals related to Public Health:

*Integrate local population and public health planning with other health services.
 Formalize linkages between LHINs and public health units.*

To better integrate population health within our health system, we propose that LHINs and public health units build on the collaborations already underway, and work more closely together to align their work and ensure that population and public health priorities inform health planning, funding and delivery.

To support this new formal relationship:

- The ministry would **create a formal relationship between the Medical Officers of Health and each LHIN**, empowering the Medical Officers of Health to work with LHIN leadership **to plan population health services**.
- The ministry would **transfer the dedicated provincial funding for public health units to the LHINs** for allocation to public health units. The LHINs would ensure that all transferred funds would be used for public health purposes.
- The **LHINs** would **assume responsibility for the accountability agreements** with public health units.
- Local **boards of health** would continue to **set budgets**.
- The respective **boards of health**, as well as land ambulance services, would continue to be **managed at the municipal level**. As part of a separate initiative to support more consistent public health services across the province, the ministry is modernizing the Ontario Public Health Standards and Organizational Standards to identify gaps and duplication in service delivery; determine capacity and resource needs; and develop options for greater effectiveness.
- The ministry would also appoint an **Expert Panel to advise on opportunities to deepen the partnership between LHINs and public health units**, and **how to further improve public health capacity and delivery**.

Source : [MOHLTC Discussion Paper](#)

Date: December 17, 2015

Chair and Members of the Board,

Welcome to 2016!

Along with many other provincial initiatives such as the review of the Ontario Public Health Standards and the release of the much anticipated discussion paper from Ontario's Minister of Health and Long-Term Care outlining proposals to transform Ontario's health system, 2016 promises to bring new developments and transformation to Ontario's public health system.

There have been varying reactions to the release of the discussion paper throughout the health care sectors. The Association of Local Public Health Agencies (alPHA) released a news release, which is included in today's Board agenda package. alPHA's Board of Directors has begun to develop a response process for the Minister of Health's discussion paper, *Patients First – A Proposal to Strengthen Patient-Centred Health Care in Ontario*. As a first step, a short survey was sent to all

health units to collect initial reactions to the discussion paper. alPHA will be looking for themes in the responses to support a response from the Association.

The discussion paper makes note that an Expert Panel will be struck to advise on opportunities to deepen the partnership between LHINs and public health units, and how to further improve public health capacity and delivery. We are anxious to hear further details of this Panel and how we might engage.

Although the *Patients First* paper notes the development of smaller areas within LHINs (sub-LHINs), there are no details yet available. In anticipation of this development, the Sudbury East Community Health Centre has invited the SDHU to meet to discuss possible collaboration for an application they plan to prepare regarding sub-LHINs.

I am very pleased to share with you new developments and highlights from SDHU activities since the November 2015 Board of Health meeting.

GENERAL REPORT

1. Sudbury & District Board of Health

Welcome to Richard Lemieux as the Sudbury East Municipal Association (SEMA) representative replacing Paul Schoppmann. A Board orientation session will be held for Mr. Lemieux in late January or early February.

2. Electronic Board Meetings

January 2016 marks one-year post-implementation of transitioning to paperless meetings for the Board and the Senior Management Executive Committee. All Board members were issued an iPad to access the Board agenda packages and key resources electronically via a BoardEffect app for the duration of their term on the Sudbury & District Board of Health.

Since the implementation, BoardEffect has upgraded their web-based platform. BoardEffect will also be upgrading the iPad app through which Board members access their packages. The upgrade will provide for new features such as synchronization of meeting book annotations, surveys and discussion forums. The update to the BoardEffect App will occur in two stages: Downloading/installing the App update and secondly, the new view will be activated. Board members will be advised once a release date is announced and clear instructions and training will be provided.

3. Human Resources

As previously communicated via email to the Board, the long-term recruitment efforts for an Associate Medical Officer of Health have been successful and Dr. Ariella Zbar has signed the letter of offer for the full-time permanent position of Associate Medical Officer of Health effective August 8, 2016 pending completion of her Fellowship exam and the Minister's approval of her appointment. Dr. Zbar will be reporting directly to me as the Medical Officer of Health and has the same authority under Ontario's public health legislation.

I have been supporting the Board for Algoma Public Health to transition to a new model for MOH coverage. The Board is working diligently to recruit and I expect that they will have a new model in place within the first quarter of this year. I have been providing Acting MOH coverage to the Algoma Public Health since January 2015.

4. Quarterly Compliance Report

The SDHU is compliant with the terms and conditions of our Public Health Accountability Agreement. The SDHU has procedures in place to uphold the Ontario Public Health Organization Standards, to provide for the effective management of our funding and to enable the timely identification and management of risks.

The SDHU has paid all payable remittances for employee income tax deductions and Canada Pension Plan and Employment Insurance premiums, as required by law to December 31, 2015, on December 31, 2015. The Employer Health Tax has been paid as required by law, to December 31, 2015, with a cheque dated January 15, 2016. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to December 31, 2015, with a cheque dated January 31, 2016. There are no outstanding issues regarding compliance with the Occupational Health & Safety Act, Ontario Human rights Code, or Employment Standards Act.

5. Local and Provincial Meetings

I participated in a Health Quality Ontario's Health Equity Summit on December 3 and the SDHU was invited to review the draft HQO Health Equity Report.

I attended the face-to-face alPHa Board of Directors meeting on December 4 and the Council of Medical Officers of Health teleconference on December 8. A meeting was also held between alPHa, COMO and the Deputy Minister, Dr. B. Bell on December 14.

I presented the 2016 Board approved budget to the CGS Finance Committee on December 8.

Meetings have been held with NOSM regarding the Public Health Preventive Medicine residency program to discuss preceptor goals and expectations.

As part of the review of the Ontario Public Health Standards, I will participate as a member of the Practice & Evidence Program Standards Advisory Committee (PEPSAC), which will be chaired by the Chief Medical Officer of Health. The Committee's inaugural meeting is January 18, 2016, in Toronto.

I will also be participating on the Centre for Addiction and Mental Health Mental Health Promotion Guiding Principles Working Group for which the first meeting is anticipated to take place in February.

I am very pleased to share with you new developments and highlights from each of the SDHU divisions over the last two months since the November 2015 Board of Health meeting.

CLINICAL & FAMILY SERVICES DIVISION

1. Control of Infectious Diseases

Influenza: There has been one community case of influenza A identified during the month of December.

The 2015-16 Universal Influenza Immunization Program (UIIP) has immunized 3 933 individuals with this year's trivalent or quadravalent influenza vaccine at the SDHU or community based clinics.

Influenza vaccine continues to be available to those wishing to receive it. We continue to distribute Influenza vaccine to providers and pharmacies in the community. Forty-nine (49) pharmacies have taken part in this year's UIIP compared to 40 pharmacies that took part in the program last year.

For the 2015-16 UIIP, the SDHU has distributed 61 648 doses of influenza vaccine to all area health care practitioners and pharmacies beginning October 2015. This is an increase of 9 388 doses compared to this time last year.

Respiratory Outbreaks: There has been two identified respiratory outbreaks in long-term care homes during the month of December. The causative agent for one of the outbreaks was influenza B, while the other outbreak causative agent was Parainfluenza 4.

The Control of Infectious Diseases team continues to monitor all reports of respiratory illness.

2. Family Health Team

Prenatal Education: In November and December, 44 pregnant women and their support persons attended 'in-person' prenatal classes at SDHU's main site and 12 clients registered for online prenatal.

Family Health team staff members collaborated with the Shkagamik Kwe Health Centre to facilitate three prenatal sessions for 10 clients in December.

Breastfeeding: On November 20, 2015, Family Health team staff members presented on Family Health team programming topics (e.g. breastfeeding, Baby Friendly Initiative [BFI], parenting, etc.) to 60 Laurentian University students in the second year nursing program in both French and English. Staff facilitated a breastfeeding education session with eight clients from the Atikameksheng Anishnawbek First Nation in November.

Eight mothers attended the Breastfeeding support group at the Minnow Lake site in December and one new client started receiving telephone peer support in November.

On November 26, the SDHU received the BFI pre-assessment site visit report from the lead Assessor with the Breastfeeding Committee of Canada (BCC), Marg Lasalle. The internal BFI working group is pulling together a work plan to address the requirements from the report, which will be submitted for review and approval by the BFI Assessor. Once the work plan is approved, a date for the external site visit for BFI designation can be booked for some time in 2016.

Positive Parenting Program (Triple P): In November and December, Family Health team staff facilitated eight one-to-one sessions for parents of teens, seven parents participated in Level 4 Group (0-12 years) and two parents took part in the Level 5 Transitions program for divorced/separated parents. In Sudbury East, three parents participated in Group Teen.

SDHU continues its partnership with the Aboriginal Peoples Alliance of Northern Ontario (APANO) where staff facilitated a parenting discussion group with 5 clients on the topics of "disobedience and bedtime problems".

A new partnership was established with Cambrian College to offer parenting sessions to students taking part in Cambrian's student upgrading program. Ten students participated in the first session held on November 26.

Child Health Community Events: Family Health team staff members facilitated several sessions at Our Children, Our Future's Minnow Lake and Capreol sites in the past two months. A total of 29 clients attended sessions on healthy eating for pregnant women, safe sleep, and introduction to solids.

On November 5, staff members from Family Health and School teams co-facilitated a resiliency and strength-based approach session with 15 members of the Greater Sudbury Police Services' Community Mobilization Team.

On December 5, the Rayside Neighbourhood Team hosted a breakfast with Santa for nearly 400 people of this community. Public health resources and information were shared with the participating families.

3. Sexual Health / Sexually Transmitted Infections (STI) / Blood Bourne Infections (BBI) including Human Immunodeficiency Virus (HIV) Program

Information Sharing: In November and December, the Sexual Health team delivered six presentations to a variety of community groups including Trans Gendered InnerSelves, Laurentian University residence (2), Children's Aid Society Transitional Youth Group Program, Les jeunes de la rue, Better Beginnings Better Futures Youth Group and the Mental Health and Addictions Program at HSN. Participation for the presentations yielded 137 attendees.

Condom Required Campaign: In November a media campaign to promote condom use was carried out. Three downtown bars in Greater Sudbury—Peddlers Pub, SRO and Ten Lounge—participated in this campaign by distributing advertising coasters, displaying posters and making condoms available in their washrooms. A total of 2 800 condoms and 1 800 coasters were distributed. A paid ad to promote condom use was also posted on Facebook, reaching 49 602 people with 1 462 clicking the link in the ad to visit related content on the SDHU website.

World Aids Day Awareness: A radio ad to promote HIV testing was aired three times a day from November 23 to December 6 on Hot 93.5 FM.

On November 30, the Sexual Health Program nurses were joined by HAVEN, Ontario Aboriginal HIV/Aids Strategy Transgender InnerSelves, and The Point in a meet-and-greet event in the foyer of the Rainbow Centre. They interacted with 52 people. The focus of the event was HIV awareness and promotion of anonymous testing.

At the request of the Director of Care of Mnaamodzawin Health Services, a member of the Sexual Health team and the Ontario Aboriginal HIV AIDS Strategy provided support to staff and clients during the launch of Manaamodzawin's first HIV Rapid testing event at Sheshegwaning First Nation on December 2.

MyTest: During the month of November and December, 16 individuals accessed the online testing process for chlamydia. To date 92 individuals have tested via MyTest for chlamydia and gonorrhea since March 31, 2015.

4. Dental Team

Effective January 1, 2016, all of the provincially funded oral health programs for children will be amalgamated into one streamlined program, Healthy Smiles Ontario. The SDHU Dental team is working closely with families and providers to ensure continued care for children accessing financial assistance programs. The new program will increase the number of children who are eligible for the financial assistance program, which could help reduce the incidence and impact of oral health diseases in children. The 2016 year will be a transition period for the oral health programs as we await the new Healthy Smiles Ontario protocol, which will be incorporated into the Ontario Public Health Standards.

ENVIRONMENTAL HEALTH DIVISION

1. Control of Infectious Diseases

A media release was issued on November 6, 2015, informing the public of a local laboratory confirmed case of tularemia. The media release also provided the public with general information on tularemia and precautions to take when handling wild game.

During the months of November and December, Seventeen (17) sporadic enteric cases were investigated and eight enteric outbreaks were declared in institutions. The causative organism of one enteric outbreak, which occurred in a long-term care facility, was confirmed to be Norovirus.

A media release was issued on December 18, 2015, informing the public that the SDHU had received reports of increased gastrointestinal illness likely due to Norovirus in long-term care facilities, daycares and in the community. The media release also provided the public with general information on Norovirus and precautions that can be taken to prevent becoming infected with, or spreading the virus.

2. Food Safety

The recall of Back to the Garden Inc. brand Organic Sprouted Chia Seed Powder, due to possible contamination with Salmonella, prompted public health inspectors to conduct checks of 47 local premises. All affected establishments had been notified, and subsequently had removed the recalled product from sale.

During the month of November, public health inspectors issued one closure order to a food premises due to lack of hot water. The closure order has since been rescinded and the premises allowed to reopen.

Public health inspectors issued one charge to one food premises for an infraction identified under the *Food Premises Regulation*.

During the months of November and December, staff issued 42 Special Event Food Service Permits to various organizations for events serving approximately 5 295 attendees.

Through Food Handler Training and Certification Program sessions offered in November and December, 152 individuals were certified as food handlers.

3. Health Hazard

In November and December, 27 health hazard complaints were received and investigated.

On November 10, 2015, SDHU members attended a Hoarding Workshop, hosted by Aboriginal Peoples Alliance Northern Ontario working in partnership with New Opportunities and Hope Supportive Partnerships Advocating Community Empowerment and Better Beginnings Better Futures. The purpose of the workshop was to discuss strategies for addressing hoarding and to foster connections between participating agencies in order to better support clients in need of services.

4. Ontario Building Code

During the months of November and December, 45 sewage system permits, 7 renovation applications, and 5 consent applications were received.

5. Rabies Prevention and Control

Thirty-nine (39) rabies-related investigations were carried out in the months of November and December. One individual received rabies post-exposure prophylaxis due to exposure to a wild animal.

A media release was issued on December 17, 2015, informing the public that raccoons recently captured in the Hamilton and Haldimand-Norfolk areas had tested positive for rabies. These were Ontario's first cases of raccoon rabies since 2005. The media release reminded the public of precautionary measures to take to prevent rabies and focused on the importance of vaccinating pets against rabies. The release also served to remind the public that all animal bites, scratches or contacts that may result in transmission of rabies should be reported to the Sudbury & District Health Unit as soon as possible.

6. Safe Water

Public health inspectors investigated two blue-green algae complaints in the month of November, both of which were subsequently identified as blue-green algae capable of producing toxin.

During November and December, 87 residents were contacted regarding adverse private drinking water samples and public health inspectors investigated 11 regulated adverse water sample results.

Additionally, during the months of November and December, one boil water order and one drinking water advisory were issued. The drinking water advisory was issued in response to a truck falling off a barge and into the Killarney Channel, causing fuel and oil to leak into the waterway. The drinking water advisory was lifted following site remediation and water being tested to ensure its safety. Furthermore, one boil water order and one drinking water order were rescinded.

7. Tobacco Enforcement

During the months of November and December, tobacco enforcement officers charged six individuals for smoking on school property. One retail employee was charged for selling tobacco to a person who is less than 19 years of age.

On January 1, 2016, the Electronic Cigarettes Act and amendments to the Smoke-Free Ontario Act came into effect. Under the new Electronic Cigarettes Act, sale and supply of electronic cigarettes to a person who is less than 19 years of age is prohibited. The amendments to the Smoke-Free Ontario Act prohibit smoking on outdoor grounds of hospitals, except in designated smoking areas where available.

HEALTH PROMOTION DIVISION

1. Healthy Eating

Throughout 2015, the Nutrition Physical Activity Action Team (NPAAT) supported Sustain Ontario and local partners, including Eat Local Sudbury Co-operative, in planning the 2015 Bring Food Home Conference. Bring Food Home is a biennial conference that is led by Sustain Ontario and supported by local community partners. *Bring Food Home 2015* was held in Sudbury from November 20 to 22, 2015, and over 270 conference delegates participated in tours, workshops, discussions and local food feasts. The conference provided the opportunity for participants from across the food system to learn

from each other in the effort to support the development of a healthy, resilient, safe, and sustainable food system.

Health Promotion staff supported a community kitchen for residents in a local apartment building for seven weeks, as well as a four-week after-school cooking club with children and caregivers at the Chelmsford Public School. Staff have also been liaising with a registered dietitian colleague at the Centre de santé communautaire de Sudbury-Est to support the delivery of community kitchen programming in St.-Charles, Noëlville and Warren.

Health Promotion staff organized and hosted a community screening of the Canadian movie, *Just Eat It: A Food Waste Story*, the evening of November 28, 2015, at the Sheridan Auditorium, Sudbury Secondary School. Following the screening, the movie director joined the audience, via Skype, to answer questions and to share in a community dialogue about this very important topic. As well, in partnership with the SDHU Green Team, Health Unit staff were invited to view an abbreviated version of the *Just Eat It!* movie.

2. Healthy Weights

Health Promotion staff, focusing on healthy weights programming, have been actively supporting the Healthy Kids Community Challenge projects in the City of Greater Sudbury and on Manitoulin Island. Intervention plans and budgets for the first theme have been completed and submitted to the Ministry. Theme one focuses on physical activity and will end on June 30, 2016.

Additionally, a Health Promotion staff member participated in a discussion panel, hosted by the Laurentian Interprofessional Health Council, on the Interprofessional Management of Obesity. This event provided students, from different facilities of health, an opportunity to learn how to approach obesity prevention with an interprofessional perspective.

3. Physical Activity

In partnership with Independent Living Sudbury Manitoulin, the Sudbury Accessible Sports Council and the Children's Treatment Centre (HSN), Health Promotion staff hosted an event to promote opportunities for adaptive sport within our community. Participants had the opportunity to ask questions to a panel of local young athletes, chat with coaches, use different kinds of equipment and to be introduced to new skills. Sports represented included wheelchair basketball, Nordic skiing, sledge hockey, adaptive rowing, boccia, and track and field.

In the fall of 2015, Health Promotion staff worked with service provider, Liem Strategic Intergration Inc. (LSI Inc.), to conduct Rural Recreation Assessments (RRA) for the Township of Baldwin, The Township of Sables-Spanish Rivers and the Municipality of St.-Charles. Onsite community assessments, involving interviews with community stakeholders as well as geographic information system (GIS) mapping, were undertaken, in all three municipalities, between November 17 and 20, 2015. During the assessment, information was collected about the municipalities' community characteristics, the physical environment (including the natural and built environments), recreational programs, and policies regarding physical activity opportunities. Health Promotion staff look forward to supporting the efforts of each municipality as they contemplate, prioritize and act on various recommendations from the RRA.

Ultimately, the Rural Recreation Assessments serve to:

- Identify directions and recommendations that will bring the community together and encourage collaboration among different service providers to improve health and support active living.

- Identify practical and incremental actions that best use available resources that are available to the municipality and community partners.
- Increase community opportunities for people to participate in structured and unstructured physical activities.
- Recommend projects that are eligible for community infrastructure, and sports and recreation grant opportunities.

Health Promotion staff in Espanola continued to support and promote the Skate Exchange Program in their local communities. From mid-November to mid-December, 10 pairs of skates were distributed to community members and staff from Our Children Our Future.

4. Prevention of Substance Misuse

As a member of the Manitoulin Injury Prevention Coalition, SDHU public health nurses partnered with the OPP, MTO, Manitoulin Withdrawal Management Service, and Manitoulin Northshore Victim Services to provide educational activities during Drug Awareness week at the end of November 2015. The Coalition led multiple activities including; a Wii game using fatal vision goggles and distraction techniques, an Intoxiclock demonstration with student engagement, poster displays and mocktail creation. Resources were also provided for additional information.

The social media component of the *Alcohol – Let's Get Real* social marketing campaign was launched in November 2015. Social media messages are being posted on both Facebook and Twitter daily. The goal is to create conditions for community dialogue about social, environmental, and health implications of alcohol use in addition to sharing evidence-informed information.

5. School Health

Throughout November and December, Health Promotion staff in Sudbury East continued to promote pathways to resilient school communities programming in their local schools. Public health nurses met with school staff at St-Joseph Catholic Elementary School in Killarney and Markstay Public School in Markstay to review SDHU programming and provide resources on building resiliency. Additional activity information was provided to staff at École de la Rivière des Français in French River.

Health promotion staff in Chapleau responded to school requests and conducted four sessions of classroom chats from the end of November to mid-December. Public health nurses led classroom chats on puberty for Grade 5 and 6 students at École Sacré-Coeur while classroom chats on contraception and sexually transmitted infections were delivered to Grade 9 students at Chapleau High School.

6. Exposure to UVR and Screening for the Early Detection of Cancer

Three cancer screening awareness educational sessions were provided to the staff of the Jarret Value Centre. The Jarret Value Centre employs and provides training to individuals with developmental disabilities. At the first two sessions, 15 female staff learned about the importance of cervical and breast cancer screening and, at the third session, the female staff, as well as 10 male staff, heard about the importance of colorectal cancer screening. The presentations were very well received by all in attendance.

RESOURCES, RESEARCH, EVALUATION AND DEVELOPMENT (RRED) DIVISION

1. Health Equity

Throughout November and December 2015, the SDHU continued to promote the *You Can Create Change* campaign. A number of messages have been featured through internal communications and on social media, and all messages developed to date were posted within city buses in Greater Sudbury in December. A new banner featuring the *You Can Create Change* message has been posted on the outside the SDHU building. The *You Can Create Change* webpage (www.sdhhu.com/change) also continues to be updated with new content targeting specific groups of professionals, including health care providers. Currently, SDHU staff are working on finalizing a video for the campaign. Over the coming months, the campaign will also involve evaluation and stakeholder engagement components.

Three staff members from the SDHU attended a presentation on Homelessness in Sudbury on November 13, 2015. Members of Laurentian University's Poverty, Homelessness and Migration (PHM) project presented the results of a homelessness count carried out in the City of Greater Sudbury, which also included self-reported reasons for homelessness. Staff from the City of Greater Sudbury, the Corner Clinic, the N'Swakamok Native Friendship Centre, and the Canadian Mental Health Association also shared information on new services available for homeless persons in Sudbury. Homelessness needs and future opportunities were also discussed.

2. Population Health Assessment and Surveillance

The RRED division is very pleased today to be releasing the first installment of our SDHU Population Health Profile. The profile is a comprehensive look at key indicators of health status in our area, currently reporting 10-year trends in the following topic areas: mortality, health-care utilization, cardiovascular disease, cancer, self-rated health, and health behaviours such as smoking, drinking and physical activity. The profile will be an "evergreen" document available on our website, www.sdhhu.com, with data from more recent years being added to the report quickly after they become available. Future installments of the profile will include sections on other health topics, including communicable diseases, mental health, injuries, and reproductive outcomes, as well as a report on the relationship between socio-economic factors and health.

3. Staff Development

On December 11, 2015, the SDHU's Management Forum participated in a full-day interactive professional development session provided by Gary Petingola and Sheila Damore-Petingola from Mindfulness on the Rocks. This session focused on increasing leadership competencies related to the "Leads through Self" Leadership competency through mindfulness training. A post-workshop evaluation revealed 96% of respondents agreed the goals of the workshop were met and all survey respondents reported the workshop made a connection between the SDHU's leadership competency and mindfulness.

4. Student Placement Program

The RRED Division is pleased to be hosting a public health officer (PHO) from the Public Health Agency of Canada (PHAC) Canadian Public Health Service Program. This program aims to build Canada's public health capacity by employing and training professionals. Public health officers are graduate students who are employees of PHAC and placed within various jurisdictions across the country. We were successful in recruiting a Masters' student from the University of Alberta's School of Public Health, who will spend 16 weeks at the SDHU working on a project on the return on investment of public health.

5. Knowledge Exchange

On December 7, 2015, the 7th *Annual Diversity in Research Conference* was hosted by the Faculties of Health and Education at Laurentian University. The Manager of Research, Evaluation and Knowledge Exchange presented a poster on the study “Voices and Visions. Perspectives and Experiences of Teen Mothers in Sudbury, Ontario”, and participated in a panel discussion on the topic of “Interprofessional Research and Community Engagement”.

On November 20, 2015, the Manager, Research, Evaluation and Knowledge Exchange participated in a panel discussion on collaborative research approaches in the francophone health sector. Panel members, which also included partners from Laurentian University, Health Sciences North, and Collège Boréal, discussed factors for success in research collaboration, its challenges, and future opportunities for multidisciplinary collaborative research.

On November 17, 2015, staff from the RRED Division provided a presentation on research to PhD students in Laurentian University’s Rural and Northern Health program. The presentation focused on the Louise Picard Public Health Research Grant, including an overview of a successfully funded project—Voices and Visions. Perspectives and Experiences of Teen Mothers in Sudbury.

Respectfully submitted,

Original signed by

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer



November 19, 2015

The Honourable Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4

Dear Minister Hoskins

RE: Association of Local Public Health Agencies' (alPHA) Resolution: Public Health Funding Formula

On behalf of the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit, I am writing to endorse alPHA's correspondence and related Resolution: Public Health Funding Formula (enclosed).

We share your primary interest in supporting people to be as healthy as possible, as outlined in Ontario's health care system's strategic plan, Patients First: Action Plan for Health Care. The new Public Health Funding Model will make it challenging for Boards of Health to continue to build and maintain capacity to work within our communities to protect and promote health and prevent disease.

We appreciate your consideration of the resolution and your commitment to work with alPHA and Ontario's boards of health, so we can fulfill our mandates and serve our communities.

Yours truly

BOARD OF HEALTH FOR THE HALIBURTON,
KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

Mark Lovshin, Chair
Board of Health, HKPR District Health Unit

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LINDSAY OFFICE

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Lindsay, Ontario K9V 3L5
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Fax • (705) 324-0455

The Honourable Eric Hoskins

November 19, 2015

Page 2

Encl./ 1

Copy to: Hon. Kathleen Wynne, Premier of Ontario
Hon. Charles Sousa, Minister of Finance
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health (A)
Roselle Martino, Executive Director, Public Health Division
Jackie Wood, Assistant Deputy Minister (A), Health Promotion Division
Laura Pisko, Assistant Deputy Minister (A), Health Promotion Division
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Paulina Salamo, Director (A) Public Health Standards, Practice & Accountability
Brent Feeney, Manager, Funding and Accountability Unit (MOHLTC)
Brian Pollard, Director, Health Sector Models Branch (MOHLTC)
Victor Fedeli, Critic, Finance (PC)
Catherine Fife, Critic, Finance (NDP)
Jeff Yurek, Critic, Health (PC)
France G  linas, Critic, Health and Long-Term Care (NDP)
Gary McNamara, President, Association of Municipalities of Ontario (AMO)
Chairs, Boards of Health



December 4, 2015

The Honourable Eric Hoskins
Minister of Health
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins:

Re: Public Health Funding

At its meeting on November 25, 2015 the Board of Health for the District of Algoma Health Unit considered the correspondence forwarded by the alPHA Board of Directors and other health units in regard to the new public health funding model.

This Board supports their recommendations and passed the attached resolution for your consideration.

Sincerely,

Lee Mason
Chair, Board of Health

Attachment

Cc: Hon. Kathleen Wynne, Premier
Hon. David Orazietti, MPP for Sault Ste. Marie
Michael Mantha, MPP for Algoma – Manitoulin
Algoma District Municipal Association
Association of Local Public Health Agencies
Ontario Boards of Health
Algoma Municipalities
Federation of Northern Ontario Municipalities



DATE: November 25, 2015

MOVED: Sue

SECONDED: Candace

SUBJECT: Public Health Funding

THAT the Algoma Public Health Board of Health endorse the correspondence and Resolution concerning the public health funding formula, passed October 30, 2015 from the alPha Board of Directors and other health units.

AND FURTHER THAT the Algoma Public Health Board of Health call on the Ministry of Health and Long Term Care to increase investments in public health, ensuring Ontarians benefit from a world-class public health system within Ontario's transformed Health system;

AND FURTHER THAT, this resolution be forwarded to the Premier of Ontario, the Minister of Health and Long-Term Care, the Association of Municipalities of Ontario, the Federation of Northern Ontario Municipalities, alPha, Local MPs and MPPs, All Municipalities in Algoma and All Ontario Boards of Health.

ALA

CARRIED: Chair's Signature

Lee Mason - Chair

Ian Frazier - Vice Chair

Sue Jensen

Candace Martin

Dennis Thompson



January 5, 2016

The Honourable Eric Hoskins
Minister of Health
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins,

RE: Public Health Funding

At its meeting on December 9, 2015 the Elgin St. Thomas Board of Health endorsed the attached correspondence and resolution concerning the public health funding formula passed October 30, 2015 by the Association of Local Public Health Agencies' Board of Directors.

Sincerely,

Heather Jackson, Chair
Elgin St. Thomas Board of Health

c Association of Local Public Health Agencies
Ontario Boards of Health

alPHa's members are
the 36 public health
units in Ontario.

alPHa Sections:

Boards of Health
Section

Council of Ontario
Medical Officers of
Health (COMOH)

**Affiliate
Organizations:**

ANDSOOHA - Public
Health Nursing
Management

Association of Ontario
Public Health Business
Administrators

Association of
Public Health
Epidemiologists
in Ontario

Association of
Supervisors of Public
Health Inspectors of
Ontario

Health Promotion
Ontario

Ontario Association of
Public Health Dentistry

Ontario Society of
Nutrition Professionals
in Public Health

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Fax: (416) 595-0030
E-mail: info@alphaweb.org

November 3, 2015

Hon. Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

Re: Public Health Funding Model

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHa), I am writing today to provide our comments following the October 2nd alPHa Board of Directors dialogue with Ministry staff about the development and implementation of the Public Health Funding Formula that was announced to our members on September 4th 2015.

We were very pleased to welcome Paulina Salamo and Brent Feeney from the Public Health Division and Brian Pollard from the Health Sector Models Branch to our meeting. They provided us with details about the development of the new public health funding model, its relationship to the fiscal management of the health care sector as a whole and its implementation in the short term. This and the ensuing dialogue were very helpful to us in formulating the following comments.

We recognize the fiscal challenges that Ontario continues to face and understand the reality that governments are under intense pressure to demonstrate fiscal accountability to the public. We fully understand that there was a need to develop a defensible formula for how tax dollars are allocated to boards of health, and appreciate that efforts were made to develop an evidence-informed model that would facilitate their equitable distribution.

As you are likely aware, our members have been awaiting the release of the Funding Review Working Group's report, Public Health Funding Model for Mandatory Programs (December 2013), for nearly two years, with the expectation that an opportunity to provide fully informed feedback on the proposed recommendations would be afforded to them prior to a Government response. As it was not offered, we are taking this opportunity to present our initial response.

Page 68 of 142

Our major concern is about the cumulative impact of the new approach to funding boards of health in the coming years. Boards of health have received modest funding increases in recent years even while other parts of the health sector have been frozen, and this underscores the essential roles boards of health play in the prevention of disease and the protection and promotion of health in Ontario. We would argue that imposing a freeze on boards of health, which, as annual costs rise, is essentially a cut to health protection, prevention and promotion, will have negative impacts on the communities served by boards of health.

Many of Ontario's boards of health experience difficulties in meeting the public health needs of their communities, let alone their health promotion and protection obligations at current funding levels. If these levels remain static or decline for the foreseeable future, cuts to already stretched services will be inevitable and it is not unreasonable to assume that the impact of such cuts will be magnified in the smaller health units, where health status is poorer and the capacity to improve it is already limited. This, we fear, may inadvertently demonstrate public health's value-for-money as negative health outcomes and increasing pressures on local health care providers rise in correlation to ever-increasing limitations on the capacity of local boards of health to mitigate them.

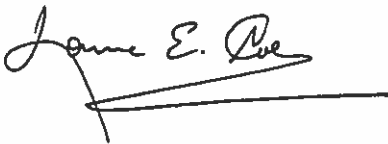
In the broader context of health system transformation, we continue to argue that curtailing investments in demonstrably cost-effective upstream health promotion and protection interventions is short-sighted. The Commission on the Reform of Ontario's Public Services (chaired by Don Drummond), recommended a heightened focus on public health's role in preventing health problems, having observed a correlation between health outcomes and the amount provinces spend on public health. The Commission also recommended avoiding applying the same degree of fiscal restraint to all parts of the health system.

In your strategic plan for Ontario's health care system, *Patients First: Action Plan for Health Care*, you recognize the importance of supporting people to be as healthy as possible. We share that primary interest with you and are concerned about the erosion of what is arguably the best local public health system in Canada. Local boards of health need to continue to build and maintain capacity to work with communities to effect healthy conditions in which people can thrive in good health.

We know that the new funding model comes with the understanding that, as a new model, it will need to be evaluated, revised and improved. We urge you to work closely with us to establish a process to review the model with a view to exploring whether relatively minor changes can result in a distribution of growth money that may better reflect the needs of boards of health and the communities they serve across Ontario.

For your consideration, we have attached the resolution passed by alPha's Board of Directors following the October 2nd meeting. We look forward to working with you to ensure that Ontario's boards of health can fulfill their mandates and continue their essential role in making Ontario the healthiest place in which to grow up and grow old.

Yours truly,

A handwritten signature in black ink, appearing to read "Lorne E. Coe", with a long horizontal line extending from the end of the signature.

Lorne Coe
President

COPY: Hon. Kathleen Wynne, Premier of Ontario
Hon. Charles Sousa, Minister of Finance
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health (A)
Roselle Martino, Executive Director, Public Health Division
Jackie Wood, Assistant Deputy Minister (A), Health Promotion Division
Laura Pisko, Assistant Deputy Minister (A), Health Promotion Division
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Paulina Salamo, Director (A) Public Health Standards, Practice and Accountability Branch
Brent Feeney, Manager, Funding and Accountability Unit (MOHLTC)
Brian Pollard, Director, Health Sector Models Branch (MOHLTC)
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Catherine Fife, Critic, Finance (NDP)
Jeff Yurek, Critic, Health (PC)
France G  linas, Critic, Health and Long-Term Care (NDP)
Gary McNamara, President, Association of Municipalities of Ontario (AMO)
Chairs, Boards of Health

ATTACHED: Resolution

alPHa Board of Directors' Resolution

Passed October 30, 2015

TITLE: Public Health Funding Formula

- WHEREAS** public health interventions result in significant improvements in the health of the population and cost savings in the health care system; and
- WHEREAS** the reviews of the Walkerton E.coli outbreak in 2001 and the SARS epidemic in 2005 resulted in widespread recognition that Ontario's public health system had significant weaknesses and that investments were required to create a robust public health system essential for the protection of the health of the citizens of Ontario; and
- WHEREAS** investments in Ontario's public health system have occurred since the SARS epidemic, however, public health programs delivered through boards of health still only receive 1.4 percent or \$700.4 million of the \$50.2 billion total Ministry of Health and Long Term Care 2015-16 budget; and
- WHEREAS** grants provided by the Ministry of Health and Long-Term Care, enabled by the *Health Protection and Promotion Act*, constitute the majority of funding for boards of health in Ontario; and
- WHEREAS** the majority of the remaining funding for boards of health comes from the obligated municipalities as assigned in the *Health Protection and Promotion Act*; and
- WHEREAS** the Ministry of Health and Long-Term Care has accepted the recommendations contained in the December 2013 report: *Public Health Funding Model for Mandatory Programs: The Final Report of the Funding Review Working Group*; and
- WHEREAS** the intent of the recommendations was to develop a funding model for grants from the Ministry of Health and Long-Term Care to boards of health that identify an appropriate funding share for each Board that reflects its needs in relation to all other; and
- WHEREAS** in 2015, the Ministry of Health and Long-Term Care began the application of the public health funding model recommended in the Report without further consultation with boards of health; and
- WHEREAS** boards of health have been advised to plan for 0% funding increases for the foreseeable future; and
- WHEREAS** funding increases at or near 0% are de facto cuts as annual costs rise; and
- WHEREAS** the primary goals of boards of health are to prevent illness and to protect and promote the health of Ontarians; and

WHEREAS the impacts on public health programming, municipal funding contributions and population health outcomes resulting from the changes to the Ministry of Health and Long-Term Care's funding model need to be examined with a view to quality improvement;

NOW THEREFORE BE IT RESOLVED THAT alPHa urge the Ministry of Health and Long Term Care to commit to maintaining a minimum cost of living annual growth rate for grants provided to all boards of health to fund public health programs;

AND FURTHER THAT alPHa urge the Ministry of Health and Long-Term Care to make an evidence-informed decision to adjust upwards the overall percentage of the Ministry's total budget that is allocated to fund public health programs delivered through boards of health;

AND FURTHER THAT alPHa urge the Ministry of Health and Long-Term Care to engage in a process to implement a comprehensive monitoring strategy in close consultation with Ontario's boards of health to evaluate the impacts of the new funding model, both in terms of health outcomes and total public health expenditures at the local level.



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Established: March 7, 1896 Office of the Clerk Treasurer, CAO E-mail: nairncentre@personainternet.com

December 16, 2015

The Honourable Eric Hoskins
Minister of Health & Long Term Care
10th Floor, 80 Grosvenor Street
Toronto ON M7A 2C4

RE: Provincial Public Health Funding

Dear Honourable Minister:

Please be advised that our Council adopted the following motion at their meeting of December 14, 2015:

INVESTMENTS IN PUBLIC HEALTH

RESOLUTION #2015-19-263

MOVED BY: Riet Wigzell

SECONDED BY: Rod MacDonald

RESOLVED: that Council supports resolution #49-15 adopted by the Sudbury and District Health Unit on November 19, 2015 requesting the Ministry of Health and Long Term Care to increase investments in public health, ensuring Ontarians benefit from a world-class public health system within Ontario's transformed health system.

CARRIED

Sincerely Yours,

Robert Deschene,
CAO

LF/lc
cc: Sudbury & District Health Unit
Michael Mantha, MPP, Algoma - Manitoulin

SUDBURY & DISTRICT HEALTH UNIT	
Medical Officer of Health and CEO	
DEC 24 2015	
Environ. Health	_____
Clinical Services	_____
Corporate Services	_____
Health Promotion	_____
RRR	_____
Board	_____
Committee	_____
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Health Unit**

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November 20, 2015

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto, ON M5S 2S3

Dear Minister MacCharles:

Re: Healthy Babies Healthy Children Program Funding

On October 21, 2015, at a regular meeting of the Board of Health for the Thunder Bay District, the Board considered the attached resolution from Sudbury and District Health Unit regarding the Healthy Babies Healthy Children Program. The following resolution was passed.

Resolution No. 129-2015

“THAT with respect to Report No. 52 – 2015 (Healthy Babies Healthy Children), we recommend that a letter be sent to the Minister of Children and Youth Services to support the resolution from the Sudbury and District Health Unit advocating to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.”

Thank you for your attention to this important public health issue.

Sincerely,

Norm Gale, Chair
Thunder Bay District Board of Health

Cc: Ontario Boards of Health

Encl.

December 21, 2015

The Honourable Jean-Yves Duclos
Minister of Families, Children and
Social Development
House of Commons
Ottawa, Ontario K1A 0A6

The Honourable MaryAnn Mihychuk
Minister of Employment, Workforce and Labour
Ministry of Labour
House of Commons
Ottawa, ON K1A 0A6

The Honourable Jane Philpott
Minister of Health
Ministry of Health
House of Commons
Ottawa, ON
K1A 0A6

The Honourable Kevin Daniel Flynn
Minister of Labour
Ministry of Labour
14th Floor
400 University Avenue
Toronto, ON M7A 1T7

The Honourable Eric Hoskins
Minister of Health and Long-Term Care
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th Floor
56 Wellesley Street West
Toronto, ON M5S 2S3

The Honourable Deborah Matthews
Minister Responsible for the
Poverty Reduction Strategy
Room 4320, 4th Floor, Whitney Block
99 Wellesley Street West
Toronto, ON M7A 1W3

Dear Minister Duclos, Minister Mihychuk, Minister Philpott, Minister Flynn, Minister Hoskins,
Minister MacCharles, and Minister Matthews:

Re: Basic Income Guarantee

I am writing today to express our support for a joint federal-provincial (Ontario) investigation into a basic income guarantee for Ontarians and all Canadians.

Several reports in recent years have described the extent of poverty and growing income inequality in Ontario and Canada.^{1,2} The relationship between income and health has also been well established; countless analyses have consistently and clearly shown that as income rises, health outcomes improve. In doing so, they also demonstrate that lower income people are at far greater risk from a range of preventable medical conditions, including cancer, diabetes, heart disease and mental illness.³ From a public health perspective, there is a strong literature base demonstrating the relationship between both low absolute income, the extent of income inequality in a society, and a range of adverse health and social outcomes. It is, therefore, reasonable to conclude that improving incomes would be an effective public health intervention.

Given that 16.5% of people in Leeds, Grenville and Lanark live in low income situations based on the after-tax low-income (2011 National Household Survey, Statistics Canada), the avoidable burden of disease from low income and income inequalities is substantial.

In response to these key social and public health challenges, a growing number of individuals and organizations in the health, economics, social, and political sectors have proposed the introduction of a basic income guarantee for all Canadians, also known as guaranteed annual income. A basic income guarantee ensures everyone has sufficient income to meet basic needs and live with dignity, regardless of work status. It can be achieved through a range of policy approaches.

Basic income is a concept that has been examined and debated for decades, including through pilot projects in the United States, Canada, and other countries more recently.^{4,5} Mincome, in particular, a pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in the 1970s, demonstrated several improved health and educational outcomes.⁴ Basic income concepts which are already present in our current system of progressive taxation, credits and benefits for families with children and income guarantee for seniors have contributed to health and social improvements in those age groups.^{6,7} While these measures are undoubtedly important and valuable to those who benefit from them, we are convinced that there would be great merit in a serious exploration of the arguments that favour a basic income guarantee as a simpler solution that would benefit more people.

There has been recent support for a basic income guarantee from several health and social sector groups, including the Canadian Medical Association, the Canadian Public Health Association, the Ontario Public Health Association, and the Canadian Association of Social Workers, among others. Beyond the health and social sectors, a non-governmental organization, Basic Income Canada Network, is now dedicated to achieving a basic income guarantee in Canada, and several citizen groups are forming across Ontario and Canada in support of this issue.

Advocating for improved income security policies is supportive of the Leeds, Grenville and Lanark District Health Unit's strategic direction on Health Equity, which states that the health unit 'strives to address the challenges that prevent all residents from having the opportunity to reach their optimal health.'

We hope that you will respond favourably to our request for joint federal-provincial consideration and investigation into a basic income guarantee as a policy option for reducing poverty and income insecurity.

Sincerely,



Anne Warren, Chair
Leeds, Grenville and Lanark District Health Unit

c. The Right Honourable Justin Trudeau, Prime Minister of Canada
The Honourable Kathleen Wynne, Premier of Ontario
Dr. David Williams, Ontario Chief Medical Officer of Health
Linda Stewart, Association of Local Public Health Agencies
Pegeen Walsh, Ontario Public Health Association
Ontario Boards of Health
Leeds, Grenville and Lanark Members of Parliament
Leeds, Grenville and Lanark Members of Provincial Parliament
Champlain and South East Local Health Integration Network
Gary McNamara, President, Association of Municipalities Ontario
Brock Carlton, Chief Executive Officer, Federation of Canadian Municipalities
Leeds, Grenville and Lanark Municipalities

References

1. Canadian Index of Wellbeing. How are Ontarians Really Doing?: A Provincial Report on Ontario Wellbeing. Waterloo, ON: Canadian Index of Wellbeing and University of Waterloo, 2014
2. Conference Board of Canada. How Canada Performs: A Report Card on Canada. 2013. Accessed April 27, 2015. <http://www.conferenceboard.ca/hcp/details/society/incomeinequality.aspx>
3. Auger, N and Alix, C. Income, Income Distribution, and Health in Canada. In: Raphael, D (Ed). Social Determinants of Health, 2nd edition. Toronto: Canadian Scholars Press Inc, 2009.
4. Forget, E. The Town with No Poverty: The Health Effects of a Canadian Guaranteed Annual Income Field Experiment. Canadian Public Policy xxxvii(3) 283-306, 2011. <http://utpjournals.metapress.com/content/xj02804571g71382/fulltext.pdf>
5. Pasma, C. Basic Income Programs and Pilots. Ottawa: Basic Income Canada Network, 2014. http://www.thebigpush.net/uploads/2/2/6/8/22682672/basic_income_programs_and_pilots_february_3_2014.pdf
6. Emery, J.C.H., Fleisch, V.C., and McIntyre, L. How a Basic income guarantee Could Put Food Banks Out of Business. University of Calgary School of Public Policy Research Papers 6 (37), 2013. <http://www.policyschool.ucalgary.ca/sites/default/files/research/emery-foodbankfinal.pdf>
7. Milligan, K., and Stabile, M. "Do Child Tax Benefits Affect the Well-Being of Children? Evidence from Canadian Child Benefit Expansions". American Economic Journal: Economic Policy 3(3): 175-205, 2011.



January 7, 2016

The Honorable Helena Jaczek
Ministry of Community and Social Services
6th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1E9
hjaczek.mpp@liberal.ola.org

Re: Food Security and the Transformation of Social Assistance in Ontario

Dear Minister Jaczek,

As the Minister of Community and Social Services, we are writing to you to request an update on the transformation of social assistance in Ontario. The results of the 2015 Nutritious Food Basket Costing for the Huron County Health Unit were accepted at the December 3, 2015 Board of Health meeting. The report demonstrates an urgent need to address the financial barriers that people living with low income experience in accessing nutritious food.

The cost of the Nutritious Food Basket in Huron County in May 2015 for a family of four (male between 31-50 years of age, female between 31-50 years of age, 14 year old boy, 8 year old girl) is \$883. This is a 17% increase in food costs since 2009. Despite the increasing costs of food, the real issue is that incomes are too low and many individuals and families just do NOT have enough money to pay for their basic needs such as shelter and food. This issue poses serious health risks for our community.

We look forward to receiving a response detailing next steps towards Social Assistance Reform as supported by Ontario's Poverty Reduction Strategy. People in Huron County living on income from Ontario Works or the Ontario Disability Support Program are unable to make ends meet. Your urgent attention is required to ensure people living with low incomes have access to healthy food.

Sincerely,

Tyler Hessel
Chair, Huron County Board of Health

cc. MPP Lisa Thompson, Huron-Bruce, lisa.thompson@pc.ola.org
Association of Local Public Health Agencies
Ontario Boards of Health

Huron County Health Unit

77722B London Road, RR 5, Clinton, ON N0M 1L0 CANADA
Tel: 519.482.3416 Confidential Fax: 519.482.9014

www.huronhealthunit.ca



TOWNSHIP OF NAIRN AND HYMAN

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Established: March 7, 1896 Office of the Clerk Treasurer, CAO E-mail: nairncentre@personainternet.com

December 16, 2015

Smoke Free Housing Ontario
Non-Smokers' Rights Association
Smoking and Health Action Foundation
720 Spadina Avenue, #221
Toronto, Ontario M5S 2T9

ATTENTION: Ms. Lorraine Fry and
Ms. Donna Kosmack
Co-Chairs, Smoke-Free Housing Ontario

RE: Endorsement of Action for Smoke-Free Multi-Unit Housing

Dear Ms. Fry and Ms. Kosmack:

Please be advised that our Council adopted the following motion at their meeting of December 14, 2015:

SECOND-HAND SMOKE IN MULTI-UNIT HOUSING

RESOLUTION #2015-19-264


MOVED BY: Rod MacDonald

SECONDED BY: Riet Wigzell

RESOLVED: that Council supports resolution #55-15 adopted by the Sudbury and District Health Unit on November 19, 2015 requesting that actions and policies be put into place to reduce the exposure of second-hand smoke in multi-unit housing.

CARRIED

Sincerely Yours,


Robert Deschene,
CAO

LF/lc

cc: Sudbury & District Health Unit
The Honourable Ted McMeekin, Minister of Municipal Affairs & Housing
Michael Mantha, MPP, Algoma - Manitoulin

SUDBURY & DISTRICT HEALTH UNIT	
Medical Officer of Health and CEO	
DEC 24 2015	
Environ. Health	_____
Clinical Services	_____
Corporate Services	_____
Health Promotion	_____
RRRD	_____
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December 16, 2015

The Honourable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa ON K1A 0A6

Dear Honourable Prime Minister:

RE: Cannabis Regulation & Control

Please be advised that our Council adopted the following motion at their meeting of
December 14, 2015:

PUBLIC HEALTH APPROACH – CANNABIS LEGISLATION
RESOLUTION #2015-19-265

MOVED BY: Riet Wigzell

SECONDED BY: Rod MacDonald

RESOLVED: that Council supports resolution #54-15 adopted by the Sudbury and District Health Unit on November 19, 2015 supporting a public health approach to the forthcoming cannabis legislation framework, including strict health-focused regulations to reduce the health and societal harms associated with cannabis use.

CARRIED

Sincerely Yours,

Robert Deschene,
CAO

LF/lc

cc: Sudbury & District Health Unit
Carol Hughes, MP, Algoma – Manitoulin - Kapuskasing
Michael Mantha, MPP, Algoma - Manitoulin

SUDBURY & DISTRICT HEALTH UNIT	
Medical Officer of Health and CEO	
DEC 24 2015	
Environ. Health	_____
Clinical Services	_____
Corporate Services	_____
Health Promotion	_____
FILED	_____
Board	_____
Committee	_____
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-----Original Message-----

From: Prime Minister/Premier Ministre [<mailto:PM@pm.gc.ca>]

Sent: Friday, January 08, 2016 11:43 AM

To: Rachel Quesnel <quesnelr@sdhu.com>

Cc: Jody Wilson-Raybould <mcu@justice.gc.ca>; Jane Philpott <Minister_ministre@hc-sc.gc.ca>

Subject: Office of the Prime Minister / Cabinet du Premier ministre

Dear Dr. Sutcliffe:

Thank you for writing to the Prime Minister.

Please be assured that your comments, offered on behalf of the Sudbury & District Board of Health, have been noted and that they will receive due consideration from the Ministers, who have already received copies of your correspondence.

Once again, thank you for taking the time to write.

S. Russell

Executive Correspondence Officer

Agent de correspondance

de la haute direction



Information Break

November 20, 2015

This semi-monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

Save the Date: February 25, 2016

Mark your calendars...alPHa will be holding its Winter Session meeting for MOH and board of health members on **Thursday, February 25, 2016** in Toronto. At this day-long session in the same location, COMO members will meet as a group at the same time as Board of Health members convene as a section. Check this space for updates in the weeks ahead when we will have more details on the venue, program and registration.

Government Items of Interest

The new federal government recently released a number of mandate letters to its ministers. Of note to public health, The Honourable Dr. Jane Philpott was appointed Canada's Minister of Health on November 4th.

[Read the federal Minister of Health Mandate Letter here](#)

Also on November 4th, Ontario health minister Dr. Eric Hoskins spoke at the 2015 HealthAchieve Conference where he outlined a vision for health system transformation, citing health equity as the main driver of this change. The goal of transformation, he said, is "end-to-end, population-based integration across the health care system. That includes public health; it includes primary care; and it includes home and community care."

[Read Minister Hoskins' speech at 2015 HealthAchieve here](#)

alPHA Risk Management Workshop - November 5, 2015

Many thanks to speakers and attendees who participated recently in alPHA's risk management workshop, *Managing Uncertainty: Risk Management for Boards of Health*. Over 70 attendees from across the province heard presentations from Algoma assessor Graham Scott, Corinne Berinstein, a risk management expert from the Ontario Treasury Board, as well as Tony Hanlon and Justin Pino from Algoma Public Health and Hazel Gilchrist from KFL&A Public Health. Participants learned about the good governance practice of adopting a risk management approach and culture for their organization. To view the proceedings and presentations, click on the link below. (NOTE: Users must be registered to the alPHA website, and enter a login ID and password.) [View the proceedings and presentations from the workshop](#) (login required)

Recent alPHA Correspondence

On behalf of members, alPHA recently wrote to government ministers regarding the reinstatement of the mandatory long-form census and the expansion of the HPV program to include male students. alPHA also wrote Minister of Health Eric Hoskins in support of the creation of an Ontario Overdose Coordinator and Action Plan. [Read alPHA's correspondences on the above here](#)

Upcoming Events

February 25, 2016 - alPHA Winter Session & COMOH Meeting; details to come.

April 4-6, 2016 - [TOPHC 2016](#), Collaborate.Innovate.Transform., Allstream Centre, Toronto, Ontario.

June 5, 6 & 7, 2016 - alPHA Annual General Meeting and Conference - 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.

alPHA is the provincial association for Ontario's public health units. You are receiving this update because you are a member of a board of health or an employee of a health unit.

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Information Break

December 8, 2015

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Integrated Public Health & Health Promotion Divisions

On November 30, Sharon Lee Smith, the Associate Deputy Minister of Health and Long-Term Care announced the merger of the ministry's Public Health and Health Promotion Divisions into a single entity. The new Population and Public Health Division (PPHD) is headed by Roselle Martino, who was appointed Assistant Deputy Minister, effective immediately. She was previously the Executive Director of the Public Health Division. The integration is a move by the province to align the ministry with its strategic and health transformation agenda.

Health Transformation Update

A recent Globe and Mail article reported that the Minister of Health is expected to release a policy paper in the coming weeks that will give more detail on the province's plan to transform the health system. The November 23 article quotes Minister Hoskins that staff is "putting together a document which we hope will serve as a starting point for discussions and consultations about how we can better integrate various parts of the system and improve patient experience." Given this statement by the Minister and other sources, the alPHA Board of Directors will be closely monitoring developments on the issue in the weeks ahead.

[Read the Globe and Mail article here](#)

Government Items of Interest

On December 7 a provincial advisory panel released its report, Planning for Health, Prosperity and Growth in the Greater Golden Horseshoe: 2015-2041. The report makes recommendations on the various land use plans for the Greater Golden Horseshoe (GGH), Niagara Escarpment, Oak Ridges Moraine, and Greenbelt. Although focused on the GGH area of the province, the report may be useful and help inform local planning in other jurisdictions.

[Read the Planning for Health, Prosperity and Growth report here](#)

[Learn more about the review process here](#)

As part of its commitment to fighting climate change, Ontario recently passed legislation to permanently ban coal-fired electricity generation. *The Ending Coal for Cleaner Air Act* prevents new and existing facilities from burning coal for the sole purpose of generating electricity. It also sets maximum fines for violations of the law.

[Read the news release here](#)

[Read the Ontario Climate Change Strategy here](#)

The Province of Ontario is now accepting 2016-2017 applications to its Sport and Recreation Communities Fund, a program that promotes community sport, recreation and physical activity. The deadline for agencies and organizations to apply is January 21, 2016, 5:00 PM EST.

[Read the news release here for more information](#)

Recent alPHa Correspondence

alPHa recently wrote to federal minister of health Jane Philpott regarding her mandate letter from the Prime Minister. Also of particular note, alPHa received a reply from Deb Matthews, Deputy Premier and President of the Treasury Board, concerning an alPHa Board resolution advocating for a basic income guarantee.

[Read alPHa's correspondences and replies on the above here](#)

Upcoming Events

February 25, 2016 - alPHa Winter Session & COMOH Meeting, Toronto; details to come.

April 4-6, 2016 - [TOPHC 2016](#), Collaborate.Innovate.Transform, Allstream Centre, Toronto, Ontario.

June 5, 6 & 7, 2016 - alPHa Annual General Meeting and Conference - 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.

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Information Break

December 22, 2015

This semi-monthly update is a tool to keep alPHA's members apprised of the latest news in public health including provincial announcements, legislation, alPHA correspondence and events.

All the best for a happy, healthy and safe Holiday Season from alPHA!

Minister Hoskins Releases "Patients First" Discussion Paper

On December 17, Hon. Eric Hoskins, Minister of Health and Long-Term Care, released his much anticipated discussion paper entitled *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. The paper includes proposals to integrate local population and public health planning with other health services and and formalize linkages between Local Health Integration Networks (LHINs) and local public health units.

[Read the Patients First discussion paper here](#)
[Read alPHA's news release here](#)

alPHA's Board of Directors is developing a response process to the Patients First discussion paper. As a first step, we have designed an online survey to collect members' initial reactions to the paper. So let us know your thoughts, concerns and suggestions for moving forward by completing the survey before Friday, January 8.

[Click here to go to alPHA's survey](#)

alPHa Board Motion on Cannabis Legislation

At the alPHa Board's meeting of December 4, the following motion was passed: "*THAT the alPHa Board of Directors support a public health approach to the forthcoming cannabis legalization framework, including strict health-focused regulations to reduce the health and societal harms associated with cannabis use.*"

Preceding the motion was a presentation to the Board by the Centre for Addiction and Mental Health on its cannabis policy position as well as the evidence on which its position rests.

Support Public Health Nutritionists' Position on Food Insecurity Responses

The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) has issued its *Position Statement on Responses to Food Insecurity*, which identifies a basic income guarantee as an effective way to address the urgent issue of household food insecurity. OSNPPH is asking Boards of Health in Ontario to endorse this position by passing a motion at their next meeting (if they haven't already). On December 4, the alPHa Board of Directors endorsed the statement.

[Read the OSNPPH position statement on food insecurity here](#)

alPHa Website Feature: Current Job Openings

alPHa keeps a list of current job postings among public health units on its website in its Current Openings page under the Careers tab. The list, which is updated regularly, contains postings submitted voluntarily by health units and their HR departments. If you are interested in submitting a job posting, please contact Karen Reece at

karen@alphaweb.org

[Visit the latest health unit job postings here](#)

Upcoming Events

February 25, 2016 - alPHa Winter Session & COMOH Meeting, Toronto; details to come.

April 4-6, 2016 - [TOPHC 2016](#), Collaborate.Innovate.Transform, Allstream Centre, Toronto, Ontario.

June 5, 6 & 7, 2016 - alPHa Annual General Meeting and Conference - 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.

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Please note that if you unsubscribe, you will no longer receive notices, important announcements, and correspondence from alPHa.

Additional thank you notes from staff:

Please extend my thanks and gratitude to the Board of Health, as well as the Executive Committee for their very generous gift of an Appreciation Day for staff. It is much appreciated.

Stephanie

The school team would like to thank the BOH for the beautiful gift! Spending time with family is truly a gift that keeps giving. Please let them know on our behalf.

Julie

On behalf of myself, and the Environmental Health Division, I would like to express my sincere gratitude to the Board of Health for approving a Staff Appreciation Day this holiday season, and to wish Board of Health Members and their loved ones a very happy Holiday Season and all the best in the New Year.

Sincerely,

Stacey Laforest

Director, Environmental Health

On behalf of myself and the entire RRED Division, please extend my thanks to members of the Board of Health for granting us with a Staff Appreciation Day. It is very nice to have received this gift of an additional day off as a gesture of acknowledgement. I will take advantage of an extra day to spend some quality time with my family during the holiday season. I know from speaking with many members of the Division that they plan to do the same.

Gros merci,

Renée

Director/Directrice

Resources, Research, Evaluation and Development (RRED) Division

Thank you for the staff appreciation day. In these difficult times, this is much appreciated. Happy Holidays!

Nicole Proulx

Hel Hoed.

Susan MacArthur

Paula Ross

Arella Rauhman
Michelle Lim

Jenny Wickham

Sylvie Plimstead

T. Cuper

Bridget King

Lisa

Melanie Martin

Carol Craig

Sudbury + District Board of Health
Thank you very much
for approving the Staff
Appreciation Day - it is
greatly appreciated.

Sincerely,
Nutrition, Physical
Activity Action Team

Thank you so much for
the generous gift
Sharon Rose

Thank you so much
very much appreciated!!
for the
gift

Thank you for
your generosity -
S. Pina

you thoughtfulness
I greatly appreciate
M. Linn

Thank you for your
thoughtfulness, it is
greatly appreciated
Amberland

Thank you for your
generosity
Sharon

Thank you for
your generosity!
Joan Dubs

Thank you!
Bernie

To the Board of Health
Thank you for the appreciation day

With warmest thanks,
grateful hearts,
and deep appreciation
for your
thoughtfulness.

Thank you for the
generous gift!
Julie Krasse

Dear Members of the Board of Health,
Dr. Sutcliffe, Sandra, Marc, Shelley,
Renee, Stacey, Nicole & all of the SOTU
management team.

On behalf of the ONA members
I would like to thank you
for the appreciation day. Having
opportunities to spend time with family,
friends & loved ones as treasured by
ONAMembers. I would also like
to thank you for all your work
in making the SOTU a great place
to work for our ONAMembers.
I look forward to working with
you in the New Year.

Kind regards

Ronda C. Baez
ONA - Banguing Unit
President

Public health looking 'upstream'

Sunday, December 27, 2015 10:00:27 EST PM



Dr. Penny Sutcliffe is the Sudbury and District Health Unit Medical Officer of Health. (John Lappa, The Sudbury Star)

Penny Sutcliffe is the medical officer of health for the Sudbury and District Health Unit. She recently took time to spell out the role of the SDHU and public health challenges the unit faces going forward.

How long have you been MOH for the SDHU?

I was hired by the Sudbury and District Board of Health as the medical officer of health and CEO in August 2000 – just over 15 years ago! Before that I worked as a MOH in Yellowknife, NWT. My first MOH position was in Thompson, northern Manitoba after completing the University of Toronto's medical specialty program in Public Health and Preventive Medicine in 1997.

How many employees does the SDHU have and how many branch offices?

The SDHU has 250 permanent full-time and part-time employees. We also have 60 temporary or casual employees. Our employees include a broad range of public health professionals (epidemiologists, nurses, public health inspectors, health promoters, nutritionists, and more) who work from the 1300 Paris Street main office in Sudbury, the Rainbow Centre in Sudbury and four district offices in Espanola, Chapleau, St. Charles and Mindemoya.

What size population does the SDHU serve?

At latest count, there are 194,620 people in the SDHU catchment area. This includes 19 municipalities and a landmass of 46,500 km².

What exactly is the difference between health care and public health?

Simply put, health care is about treating us when we are ill and public health is about preventing us from becoming ill. There are many more nuances (for example, health care professionals also work with patients to screen for and prevent disease and public health professionals ensure people are treated so they don't infect others), but in general, health care works with patients and public health works with partners to support healthy people, communities and populations. Together, we are all part of the publicly funded health system charged with protecting and promoting health, and preventing and treating disease.

The social determinants of health are often cited when the discussion turns to public health and socioeconomic factors that influence health and well-being. What are the social determinants of health?

It is a fact that not everyone has the same opportunity for health. These different opportunities are beyond differences in individual biology or genetics. Opportunities for health are supported (or hampered) by our education, income, social network, employment, food availability, housing, early childhood experiences and more. These are examples of the social determinants of health. They impact on a person's opportunities for health and on the lifestyle choices available to them. Evidence from around the world and locally has shown that as a person's income and social status moves up, their health status improves.

SDHU personnel often refer to the work they do as being "upstream." What is meant by that?

"Upstream" is a simple way to describe the work done by the public health system to protect and promote health. This is distinguished from "downstream" – the work done by the health-care system to treat disease. The concept comes from the parable of people falling off a cliff into a river. Drowning, they flail until EMS picks them up downstream and transports them to clinics and hospitals to be treated and saved. Public health looks upstream to find out why people are falling into the river in the first place. Reasons are many and include lack of knowledge (education), no clear walking paths (supportive environment), no municipal or provincial regulations about cliff-side fences (healthy public policy), inadequate swimming skills (personal skills and behaviours), etc.

How can public health reduce social inequities in health?

Social inequities in health are avoidable differences in health between groups of people. They are caused by social circumstances (e.g. income, education, social status) and are not inevitable and therefore considered fixable and ultimately, unjust.

Public health clearly does not have all the levers on its own to change these social circumstances. However, because we see these circumstances through a health lens, we are a key bridge between the health system and other sectors – working together so that decision makers in education, private sector, municipalities, environment, social services, etc., improve opportunities for health for everyone. Examples include identifying priority schools and at risk populations; ensuring that the uneven availability of healthy foods is included in decision making about planning and pricing; advocating for income and support levels that take the local cost of housing and nutritious eating into account; and working on coalitions to address housing issues for vulnerable or marginalized populations.

The SDHU often takes political positions on issues such as increasing the money people on social assistance receive, restoring the special diet allowance for those on social assistance, and fair wages and working conditions. For instance, you made a presentation earlier this year to the Changing Workplaces Review. Is it part of public's health's mandate to advocate for citizens on issues such as these?

The number one priority of public health is healthy people. All of our actions are intended to improve opportunities for health for all – regardless of social and economic circumstances. But the reality is that not everyone has the same opportunities for health. The SDHU actions on social assistance levels, fair wages, working conditions, nutritious food basket, poverty reduction, etc., are all about levelling up these opportunities so that individuals are not disadvantaged in their efforts and desires to be healthy. There is nothing partisan about working to achieve health for all. The provincial government mandate for public health makes this clear, requiring all boards of health to acknowledge and aim to reduce existing health inequities.

The SDHU launched a new campaign in October of this year called You Can Create Change. What is that meant to do and how do citizens get involved?

The You Can Create Change campaign is all about informing and inspiring people to take action on what seem like big-hairy-intractable issues. The campaign's goal is to raise awareness of the social and economic factors that determine health. But more importantly, the campaign shares the message that individual actions are important. Inspired by anthropologist Margaret Mead, we believe that committed citizens can actually change the world – it is the only thing that ever has!

Our sdhu.com/change website contains an ever-growing list of how people can make a difference. Examples include acts such as voting, volunteering, donating, learning about the social determinants of health, connecting with local agencies and organizations, speaking up, creating neighbourhood groups, etc.

What is the biggest public health challenge facing the area served by the SDHU?

Meaningful employment opportunities are critical to health. They not only provide the means to buy healthy food, afford safe housing and engage in an active life, they also create a sense of purpose and belonging. As Ontario faces growing economic pressures, and northern and rural communities experience out-migration, as well as the vagaries of a largely resource-based economy, there is a risk of growing poverty and a growing gap between the have and have-nots. Our ability to sustain our services and infrastructures, and to remain cohesive and inclusive as communities may be put to the test. Health is about so much more than health care. The health of the public is very much determined by an economic environment that leaves no one behind, and that supports vibrant and inclusive communities. These are not insignificant challenges but I firmly believe that northern Ontario is up to the test.

APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approves the consent agenda as distributed.

ATTENDANCE REGISTER 2015 BOARD MEETINGS

Date of Meeting	01/15/15 (cancelled)	02/19/15	04/16/15	05/21/15	06/18/15	09/17/15	10/15/15	11/19/15	Total	%
Type of Meeting	Board	Board	Board	Board	Board	Board	Board	Board		
Belcourt, Claude		√	√	√	√	√	√	√	7/7	100 %
Bradley, Janet		√	√	√	√	regrets	√	√	6/7	86 %
Huska, Jeffery		√	√	√	regrets	regrets	√	√	5/7	71 %
Kirwan, Robert		√	√	regrets	√	√	regrets	regrets	4/7	57 %
Lapierre, René		√	√	√	√	√	√	√	7/7	100 %
Meikleham, Stewart		√	regrets	absent	√	absent	√	√	4/7	57 %
Myre, Paul		√	√	regrets	√	√	√	√	6/7	86 %
Noland, Ken		√	√	√	√	√	√	√	7/7	100 %
Pilon, Rita		√	√	√	√	√	√	√	7/7	100 %
Sauvé, Ursula		regrets	regrets	√	√	√	regrets	√	4/7	57 %
Schoppmann, Paul		√	√	√	regrets	regrets	√	√	5/7	71 %
Signoretti, Mark		√	√	regrets	√	√	√	√	6/7	86 %
Thain, Carolyn		√	√	√	√	√	√	√	7/7	100 %

Board of Health Manual Policy G-I-30 - By-law 04-88

Board members who are elected or appointed representatives of their municipalities shall be bound by the rules of attendance that apply to the councils of their respective municipalities. Failure to attend without prior notice at three consecutive Board meetings, or failure to attend a minimum of 50% of Board meetings in any one calendar year will result in notification of the appointing municipal council by the Board chair and may result in a request by the Board for the member to resign and/or a replacement be named.

Board members appointed by the Lieutenant Governor-in Council are answerable to the Board of Health for their attendance. Failure to provide sufficient notice of non-attendance at three consecutive meetings or failure to attend a minimum of 50% of Board meetings without just cause may result in a request by the Board for the member to resign.

Board of Health Post-Meeting Evaluation 2015

At each regularly scheduled Board of Health meeting, members are asked to complete a confidential and anonymous evaluation. Ongoing feedback from Board of Health members is important to ensure meetings are effective, informative, and enjoyable. Results from the evaluation surveys for all seven Board of Health meetings have been analyzed and a summary of these results is being shared with the Board of Health.

Overall, most of the members (91%-100%) who attended Board of Health meetings completed post meeting evaluations in 2015 with the exception of the May meeting where the response rate was less than half (44%). See Table 1 below.

Table 1: Board of Health Response Rate by Month, 2015

Month	Completed Evaluations	Attendance	Response Rate%
February	11	12	92%
April	10	10	100%
May	4	9	44%
June	10	11	91%
September	9	9	100%
October	11	11	100%
November	10	10	100%

Board members who completed a post-meeting evaluation were asked to reflect on various aspects of the meeting and state their level of agreement or disagreement with the following statements:

1. The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.
2. The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.
3. The MOH/CEO report was informative, timely and relevant to my governance role.
4. Overall, Board members participated in a responsible way and made decisions that further the SDHU vision and mission.
5. There is alignment with items that were included in the Board agenda package and the SDHU's 2013-2017 Strategic Plan.
6. Board members' conduct was professional, cordial and respectful.

Figures 1-6 provide a monthly breakdown of responses to each statement.

Figure 1: Statement #1: The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role

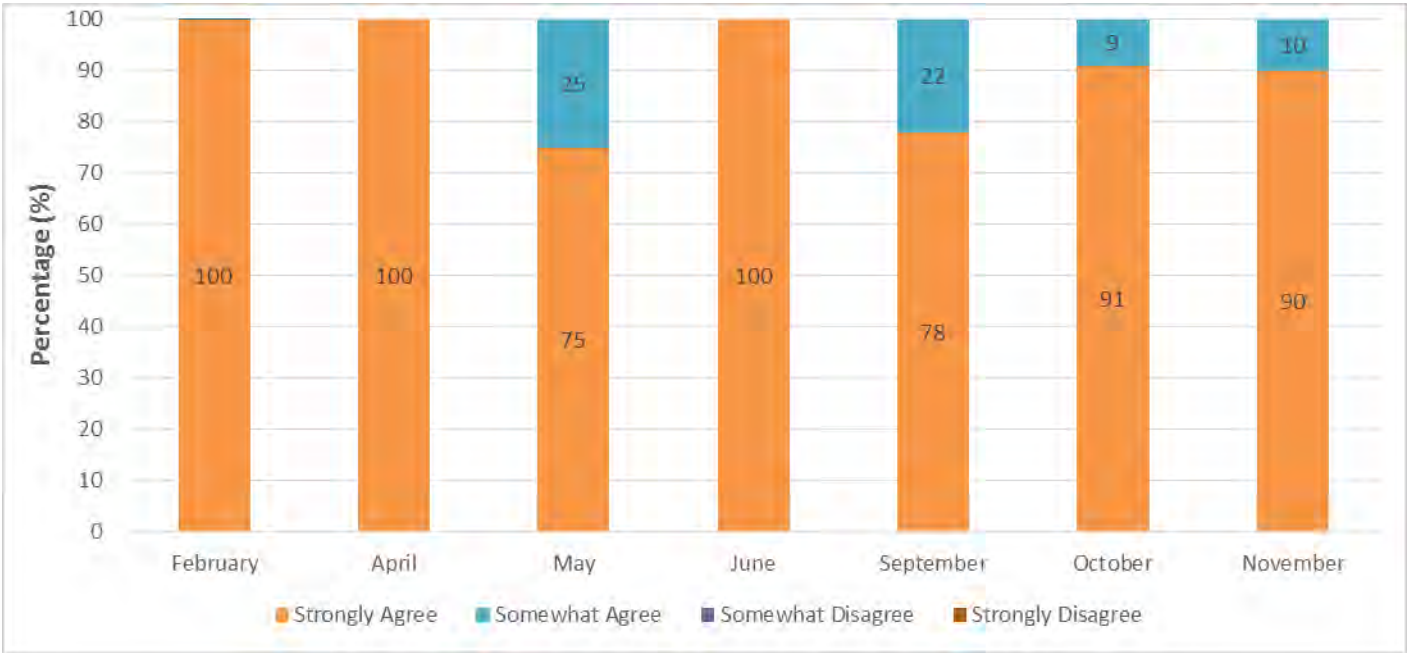


Figure 2: Statement #2: The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject

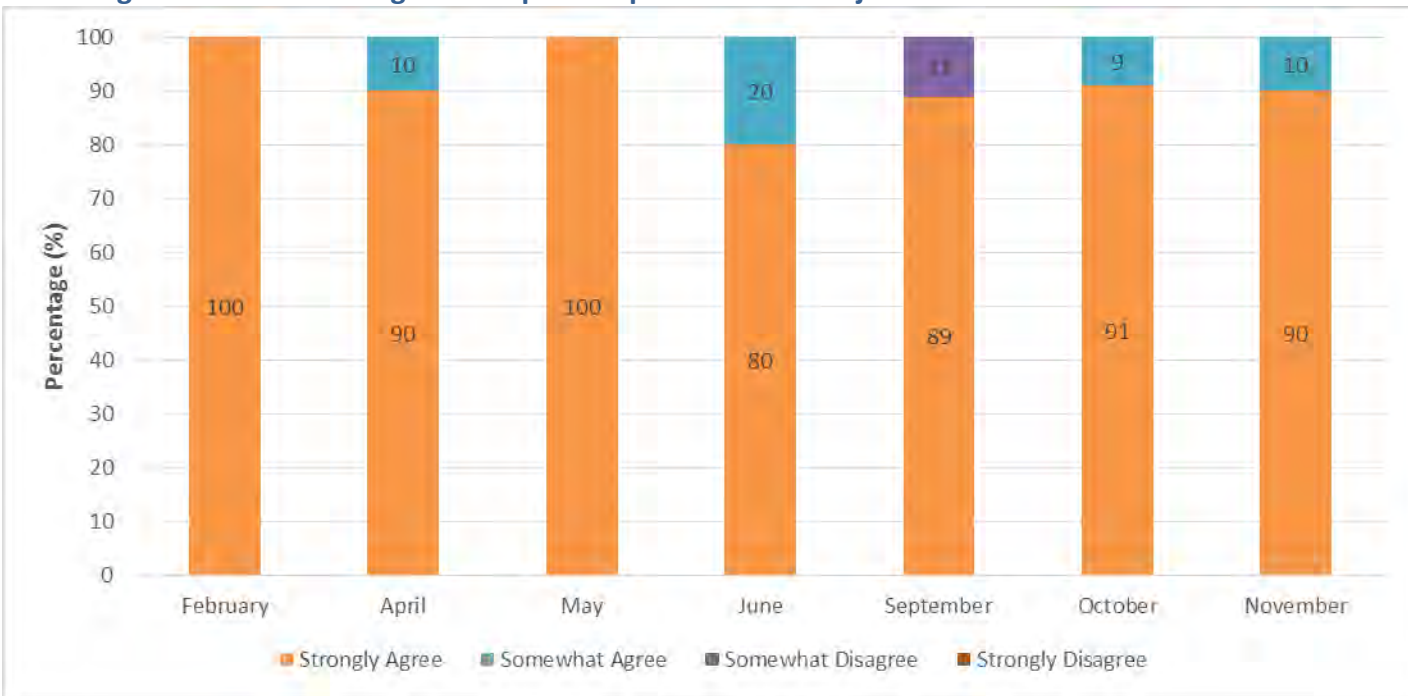


Figure 3: Statement #3: The MOH/CEO report was informative, timely and relevant to my governance role

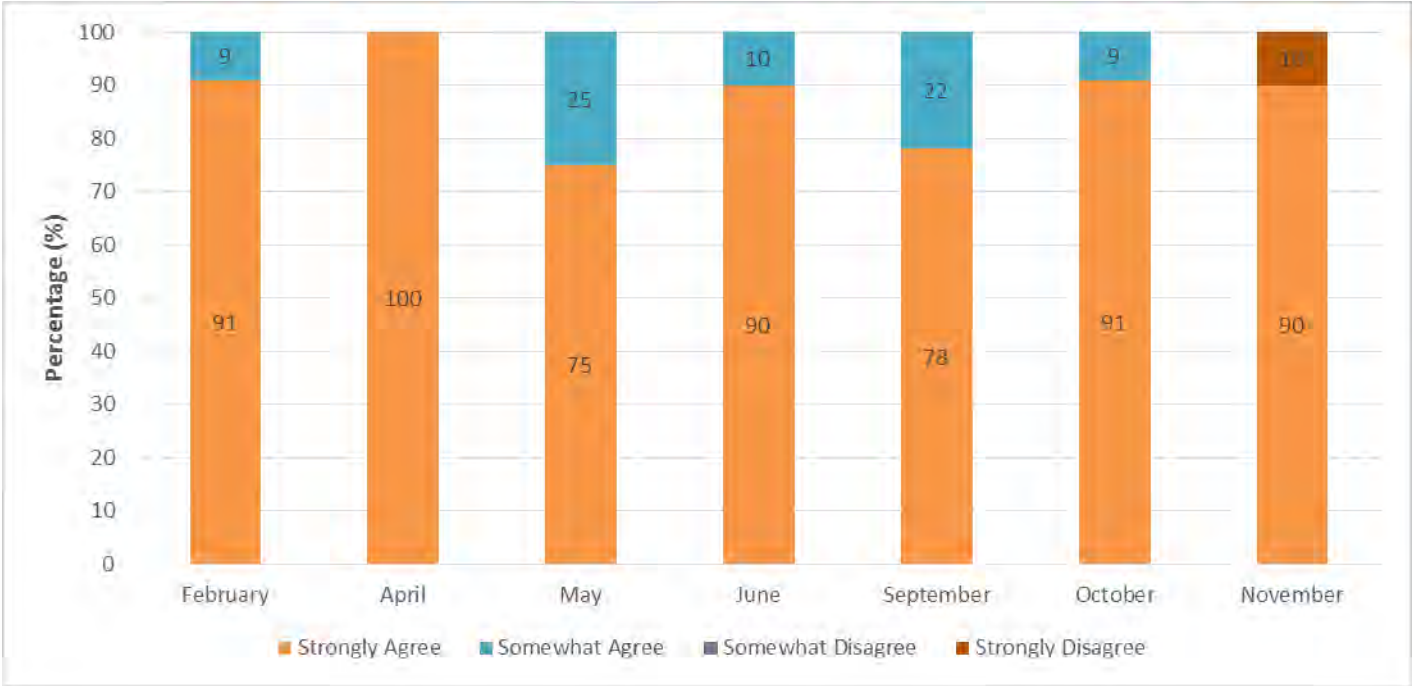


Figure 4: Statement #4: Overall, Board members participated in a responsible way and made decisions that further the SDHU vision and mission

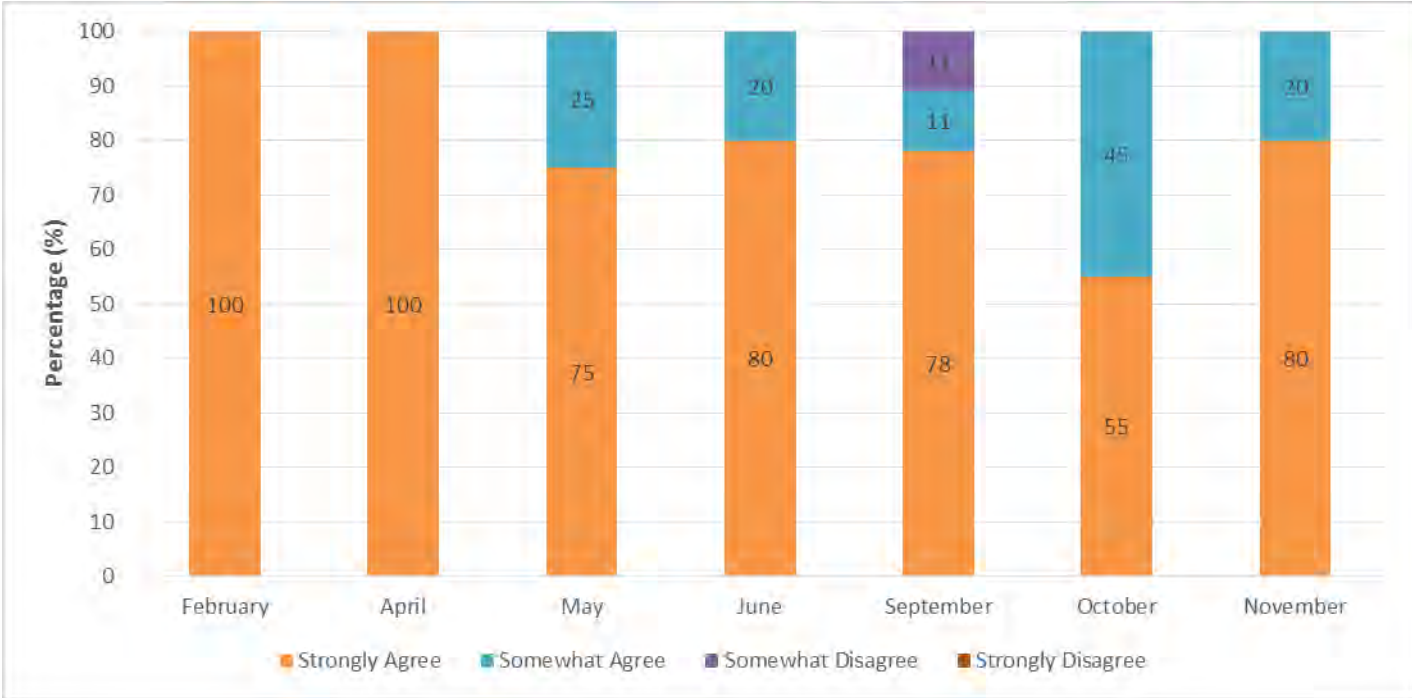


Figure 5: Statement #5: There is alignment with items that were included in the Board agenda package and the SDHU's 2013-2017 Strategic Plan

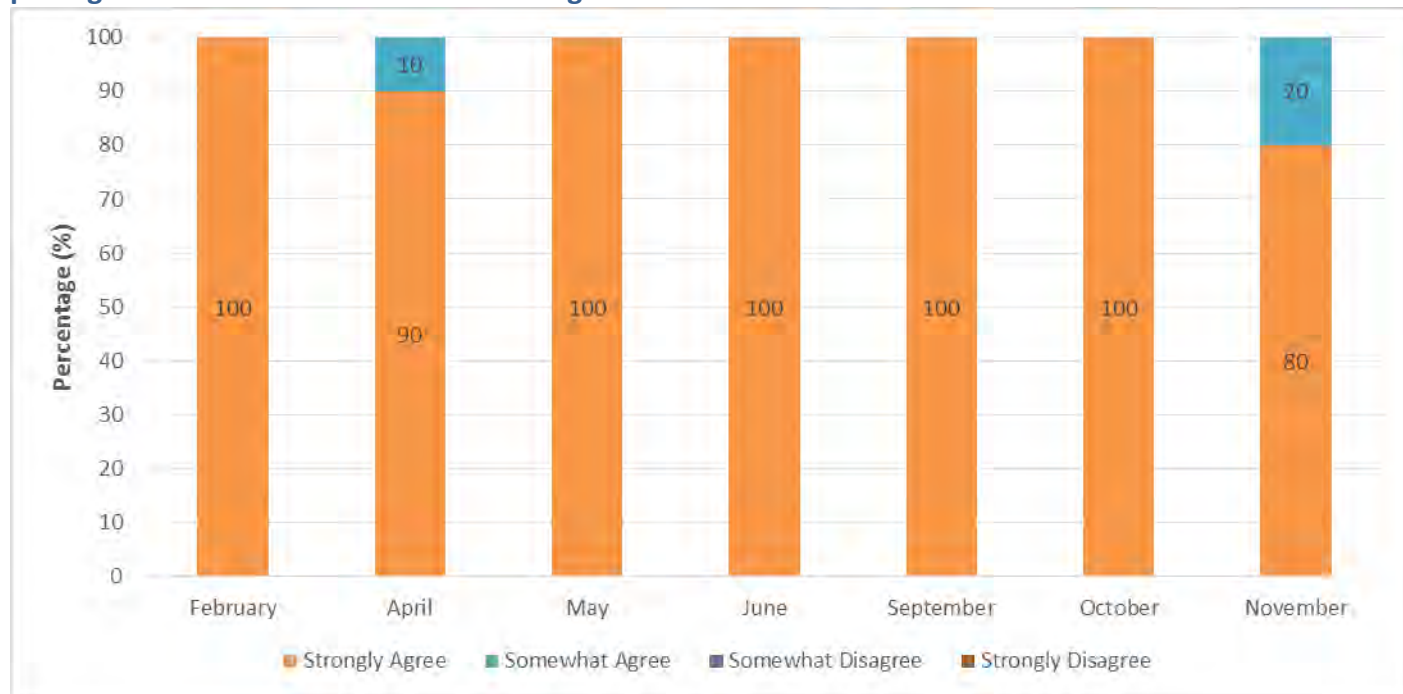
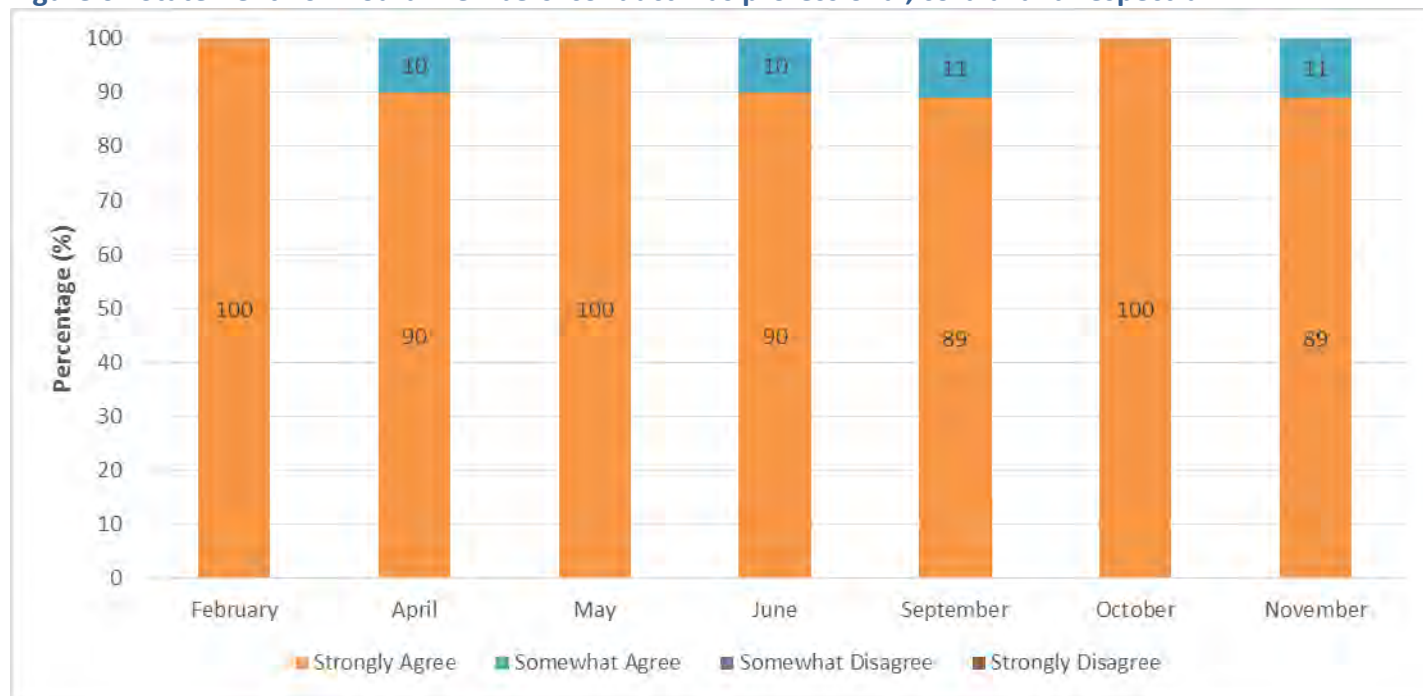


Figure 6: Statement #6: Board members' conduct was professional, cordial and respectful



Overall compiled responses for all seven monthly Board of Health meetings are found in Table 2.

Table 2: Overall Compiled Response to Statements

Statement	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	Total Responses
1. The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.	58 (92.1%)	5 (7.9%)	0	0	63
2. The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.	59 (90.8%)	5 (7.7%)	1 (1.5%)	0	65
3. The MOH/CEO report was informative, timely and relevant to my governance role.	58 (89.2%)	6 (9.2%)	0	1 (1.5%)	65
4. Overall, Board members participated in a responsible way and made decisions that further the SDHU vision and mission.	53 (81.5%)	11 (16.9%)	1 (1.5%)	0	65
5. There is alignment with items that were included in the Board agenda package and the SDHU's 2013-2017 Strategic Plan.	62 (95.4%)	3 (4.6%)	0	0	65
6. Board members' conduct was professional, cordial and respectful.	60 (93.8%)	4 (6.2%)	0	0	64

Comments:

The evaluation surveys also provide an opportunity for additional comments from Board of Health members. All of the comments were grouped into four categories; a summary of comments within each category is presented below.

Praise and Appreciation

Comments within this category include positive comments about the preparation of agendas and staff presentations, and reference to a committed Board with strong staff support. A number of comments reflected appreciation for all the work put towards meetings.

Great Discussions

Comments in this category reflected appreciation of increasing Board member participation over time as well as open and respectful engagement by all members and the Chair. Other comments included positive reflection on inclusion of the consent agenda, and on responses to Board member questions by staff present.

Documentation and Presentations

Many respondents commented positively on the documents provided through agenda packages and on the opportunity to learn through the delegations presentations.

Room for Improvement

A number of comments were also put forth relating to areas for improvement. These included a recommendation for a more thorough presentation of the annual financial statements with participation from the external auditor (note: a Board Finance Committee has since been struck), a recommendation for shorter addendums, and a recommendation for provision of additional notice for conference opportunities.

Conclusion:

Overall, the results from the post-meeting evaluation surveys demonstrate that Board of Health meetings are positive experiences for members. Board members further noted recognition of preparatory work and engagement at meetings and identified some areas for process improvement.

Briefing Note

To: René Lapierre, Chair, Sudbury & District Board of Health
From: Dr. Penny Sutcliffe, Medical Officer of Health/Chief Executive Officer
Date: January 14, 2016
Re: Associate Medical Officer of Health Recruitment

☐ For Information

☐ For Discussion

☒ For a Decision

Issue:

The Health Protection and Promotion Act (HPPA) requires boards of health to appoint a full time medical officer of health (MOH) and states that every board may appoint one or more associate medical officers of health (AMOH). A qualified physician has been successfully recruited to the SDHU Associate Medical Officer of Health position. The Board's formal endorsement of this appointment is being sought.

Recommended Action:

That the Board of Health appoint Dr. Ariella Zbar as an Associate Medical Officer of Health for the Sudbury & District Health Unit, effective August 8, 2016, subject to the conditions as detailed in the letter of offer.

Background:

The Sudbury & District Health Unit has had three Associate Medical Officers of Health (AMOH) as follows:

- Dr. Lamptey September 2010 to August 2013
- Dr. Etches September 2005 to January 2009
- Dr. Northan January 1989 to August 1993

Dr. Sarah Strasser also served as a public health physician, supporting the MOH during 2005.

Recruitment of public health specialist physicians to northern Ontario is challenging and in addition to the SDHU AMOH position, two of the five northeastern health units have longstanding vacancies.

The 2006 Final Report of the Public Health Capacity Review Committee which was struck in the aftermath of SARS, recommended that every health unit should have one or more AMOHs.

2013–2017 Strategic Priorities:

1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
3. Strengthen evidence-informed public health practice.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

O: October 19, 2001
R: October 2013

SDHU AMOHs have supported the MOH, the Board and the organization in achieving our public health mandate. The AMOH provides leadership and surge capacity, having the following duties under the HPPA:

The associate medical officer of health of a board of health, under the direction of the medical officer of health of the board, shall assist in the performance of the duties of the medical officer of health and, for the purpose, has all the powers of the medical officer of health. R.S.O. 1990, c. H.7, s. 68 (1).

and

Where the office of medical officer of health of a board of health is vacant or the medical officer of health is absent or unable to act, the associate medical officer of health of the board shall act as and has all the powers of the medical officer of health. R.S.O. 1990, c. H.7, s. 68 (2).

Dr. Ariella Zbar is currently in her final year of Public Health and Preventive Medicine specialty training with the Queen's University residency program. She holds a Master of Public Health and a Master of Business Administration from Johns Hopkins University and a Doctor of Medicine from the University of British Columbia. Dr. Zbar was interviewed by a panel including the MOH and two directors and met with the Chair of the Board of Health and all of the senior management team.

Dr. Zbar will sit her Royal College Fellowship exams in the spring of 2016. Her offer of employment contains conditions including successful completion of these exams and approval by the Minister of Health and Long-Term Care of the Board's appointment.

Financial Implications:

The base salary for this position is within the 2016 cost-shared budget.

The AMOH position may be eligible for additional compensation as per the current Ontario Physician Services Agreement and an application will be made on Dr. Zbar's behalf to the Ministry of Health and Long Term Care. If eligible for the additional compensation these amounts are covered fully by the ministry.

Ontario Public Health Standard:

Contributes to all.

Strategic Priority:

Contributes to all.

2013–2017 Strategic Priorities:

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APPOINTMENT OF AN ASSOCIATE MEDICAL OFFICER OF HEALTH

MOTION: WHEREAS the Health Protection and Promotion Act, R.S.O. 1990, c.H.7, s.62 states that every board of health may appoint one or more associate medical officers of health; and

WHEREAS s.64 of the Health Protection and Promotion Act states that no person is eligible for appointment as an associate medical officer of health unless he or she is a physician; and

WHEREAS R.R.O. 1990, REGULATION 566 QUALIFICATIONS OF BOARDS OF HEALTH STAFF which establishes the requirements for employment as an associate medical officer of health in addition to those set out in section 64 of the Act includes that the person be the holder of a fellowship in community medicine from The Royal College of Physicians and Surgeons of Canada; and

WHEREAS the Health Protection and Promotion Act, R.S.O. 1990, c.H.7, s.64 states that no person is eligible for appointment as an associate medical officer of health unless the Minister approves the proposed appointment; and

WHEREAS the Sudbury & District Board of Health concurs with the recommendation of the Medical Officer of Health to appoint Dr. Ariella Zbar as an Associate Medical Officer of Health for the Sudbury & District Health Unit

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health appoint Dr. Ariella Zbar as an Associate Medical Officer of Health for the Sudbury & District Health Unit, effective August 8, 2016, subject to the following conditional requirements:

- 1) Submission of evidence of Dr. Zbar's specialty certificate and master degree certificates in public health and masters of business administration indicating successful completion of all program requirements for a Master of Public Health (MPH) and Masters of Business Administration (MBA) degree and specialty certification in Public Health and Preventive Medicine from the Royal College of Physicians and Surgeons of Canada.
- (2) A copy of Dr. Zbar's current Certificate of Registration for Independent Practice and a current Certificate of Professional Conduct from the College of Physicians and Surgeons of Ontario.
- (3) Evidence of adequate and acceptable professional liability insurance.
- (4) Submission of a satisfactory police record check.
- (5) Submission of a signed Sudbury & District Health Unit Confidentiality Agreement.
- (6) Approval of the proposed appointment by the Ontario Minister of Health and Long Term Care.

FURTHER THAT the Sudbury & District Board of Health share this motion with the Minister of Health and Long-Term Care for approval of the appointment.

Briefing Note

To: René Lapierre, Chair, Sudbury & District Board of Health

From: Dr. Penny Sutcliffe, Medical Officer of Health/Chief Executive Officer

Date: January 14, 2016

Re: Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario
MOHLTC Discussion Paper, December 17, 2015

☐ For Information

☐ For Discussion

☒ For a Decision

Issue:

The Ministry of Health and Long-Term Care (MOHLTC) December 17, 2015 discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, (attached) has significant implications for the role and accountabilities of all local boards of health, including the Sudbury & District Board of Health, and pulls public health more into the acute care system.

The MOHLTC is seeking feedback on questions posed in the discussion paper. The paper notes an intention to continue the conversation about the proposal in a variety of forums – as yet to be determined. It is understood that feedback should be shared by the end of February. The discussion paper anticipates draft legislation to be before the Legislative Assembly in the spring of 2016.

The Association of Local Public Health Agencies (alPHA) is engaging in a consultative process to gather feedback from local public health and develop key positions to communicate with the MOHLTC.

Recommended Action:

MOTION: That the Sudbury & District Board of Health receive the briefing note concerning, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*; and

That the Board of Health direct the Medical Officer of Health to engage with the Association of Local Public Health Agencies (alPHA) in the development of key positions, consistent with the key considerations of this briefing note, for communication with the Ministry of Health and Long-Term Care; and

That the Board of Health seek engagement with constituent municipalities and with the Federation of Northern Ontario Municipalities (FNOM) to determine any municipal concerns about the proposed changes in governance and funding; and

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Further that the Board of Health seek engagement with the North East LHIN to discuss matters arising from the discussion paper.

Key Considerations:

1. Geography and coordination: The proposal greatly expands the role of each of the 14 LHINs and creates geographical sub-LHINs to manage all primary care and other health service resources. The SDHU is one of five health units within the NE LHIN boundary. Careful consideration needs to be given to jurisdiction and boundary issues and the organizational capacity of public health to engage at multiple tables.
2. Funding: While local boards of health would continue to set budgets, provincial funding (currently up to 75% of the cost-shared budget) would be allocated by the LHINs to public health units. This may imply that each LHIN will receive a global amount of funding for public health and then decide how that total funding is to be allocated amongst the health units within its boundaries. Potential impacts of any transformation on municipal funding allocations to local public health should be explicitly considered and addressed and funding levels for public health programs should be protected and enhanced.
3. Governance and accountability: The MOHLTC would create a formal relationship between the Medical Officer of Health and the LHIN, empowering the Medical Officer of Health to work with the LHIN to plan population health services. There are no further details and the envisioned relationship between the respective boards is not described. Governance roles and respective responsibilities of different governing entities should be clarified.

The LHIN would be responsible for public health performance management and administering accountability agreements. It is unknown what will happen with the current processes and whether common expectations will be maintained across the province.

4. Programming: Key differences between local public health units and the current LHIN-funded health care sector agencies include that public health is:
 - responsible for programs and services that mainly focus on populations not individuals
 - responsible for programs and services that mainly focus on primary prevention of disease and injury, broad concepts of health promotion, conventional health protection, and epidemiological disease surveillance
 - accountable for advancing healthy public policy agendas
 - accountable for monitoring and supporting the health status of groups within a geographically defined jurisdiction
 - closely linked to municipal, educational, social service and community partner agencies
 - funded from multiple levels and departments of government and government agencies

Local public health should be supported to ensure that the primary focus of their work remains on prevention and on mechanisms to address non health system determinants of health. As the LHIN will be responsible for integration of health services and division of those services amongst

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providers, the implications for the role of public health regarding our more clinical services remains uncertain. Any proposed changes should explicitly address the risk of weakening or diverting capacity within local public health from existing roles and responsibilities as set out in statute, standards and accountability agreements for boards of health, medical officers of health and public health inspectors.

Financial Implications:

Unknown at this time. However, there are concerns about an expectation of an increased role for public health within the LHIN system with no additional financial resources.

The financial implications are unknown regarding the current review of the Ontario Public Health Program and Services, including the Organizational Standards.

Acknowledgement: Adapted with permission from the work of public health colleagues in Ottawa Public Health, Durham Region and Niagara Region.

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PATIENTS FIRST

A PROPOSAL TO STRENGTHEN
PATIENT-CENTRED HEALTH CARE
IN ONTARIO

DISCUSSION PAPER
December 17, 2015

PATIENTS FIRST

Message from the Minister of Health and Long-Term Care

Over the past decade, Ontario's health care system has improved significantly. Together, we have reduced wait times for surgery, increased the number of Ontarians who have a primary health care provider and expanded services for Ontarians at home and in their communities. There are, however, a number of areas where we need to do more.

Too often, health care services can be fragmented, uncoordinated and unevenly distributed across the province. For patients, that means they may have difficulty navigating the system or that not all Ontarians have equitable access to services. Too often our system is not delivering the right kind of care to patients who need it most.

The next phase of our plan to put patients first is to address structural issues that create inequities. We propose to truly integrate the health care system so that it provides the care patients need no matter where they live. Our proposal is focused on population health and integration at the local level. It would improve access to primary care, standardize and strengthen home and community care, and strengthen population and public health. It would also ensure that services are distributed equitably across the province and are appropriate for patients.

With this paper, we are seeking your input on our proposal, and your advice about how to integrate other improvements including, for example, community mental health and addictions services. Through this engagement process, we want to hear from providers, patients and caregivers around the province, in cities and rural communities, in our diverse cultural communities and in our French-language communities. We want to engage with First Nations, Métis and Inuit partners about how this process can complement our ongoing work to strengthen health outcomes in Indigenous communities.

As Ontario's Minister of Health and Long-Term Care, I am excited that we have the opportunity to work together to continue developing one of the best health care systems in the world—a system that truly puts patients first. I hope you will join us, and contribute your expertise. We can't succeed without it.



A handwritten signature in black ink, which appears to read "Eric Hoskins". The signature is fluid and cursive.

Dr. Eric Hoskins
Minister of Health and Long-Term Care

EXECUTIVE SUMMARY

PUTTING PATIENTS FIRST

Ontario is committed to developing a health care system that puts patients first. Over the past 10 years, the province has improved access to primary care, provided more care for people at home, reduced hospital wait times, invested in health promotion programs, and taken steps to make the system more transparent and more accountable. But there are still gaps in care.

GAPS IN CARE

Ontarians, including patients, care providers and system experts have identified challenges in our health care system.

- Some Ontarians – particularly Indigenous peoples, Franco-Ontarians, members of cultural groups (especially newcomers), and people with mental health and addiction challenges – are not always well-served by the health care system.
- Although most Ontarians now have a primary care provider, many report having difficulty seeing their provider when they need to, especially in evenings, nights or weekends — so they go to emergency departments and walk-in clinics instead.
- Some families find home and community care services inconsistent and hard to navigate, and many family caregivers are experiencing high levels of stress.
- Public health services are disconnected from the rest of the health care system, and population health is not a consistent part of health system planning.
- Health services are fragmented in the way they are planned and delivered. This fragmentation can affect the patient experience. It can also result in inefficient use of patient and provider time and resources, and can result in poor health outcomes.

Many of these challenges arise from the disparate way different health services are planned and managed. While local hospital, long-term care, community services, and mental health and addiction services are all planned by the province's 14 Local Health Integration Networks (LHINs), primary care, home and community care services and public health services are planned by separate entities in different ways. Because of these different structures, the LHINs are not able to align and integrate all health services in their communities.

A PROPOSAL TO STRENGTHEN PATIENT-CENTRED CARE

To reduce gaps and strengthen patient-centred care, the Ministry of Health and Long-Term Care is proposing to expand the role of the Local Health Integration Networks. In *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, the ministry provides more detail about the four components:

1. More effective integration of services and greater equity.

To make care more integrated and responsive to local needs, make LHINs responsible and accountable for all health service planning and performance.

Identify smaller sub-regions as part of each LHIN to be the focal point for local planning and service management and delivery.

In their expanded role, LHINs would be responsible for working with providers across the care continuum to improve access to high-quality and consistent care, and to make the system easier to navigate – for all Ontarians. The LHIN sub-regions would take the lead in integrating primary care with home and community care.

2. Timely access to primary care, and seamless links between primary care and other services.

Bring the planning and monitoring of primary care closer to the communities where services are delivered. LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management.

The LHINs would work closely with primary care providers to plan services, undertake health human resources planning, improve access to inter-professional teams for those who need it most and link patients with primary care services. The ministry would continue to negotiate physician compensation and primary care contracts.

3. More consistent and accessible home and community care.

Strengthen accountability and integration of home and community care.
Transfer direct responsibility for service management and delivery from the Community Care Access Centres (CCACs) to the LHINs.

With this change, LHINs would govern and manage the delivery of home and community care, and the CCAC boards would cease to exist. CCAC employees providing support to clients would be employed by the LHINs, and home care services would be provided by current service providers. This shift would create an opportunity to integrate home and community care into other services. For example, home care coordinators may be deployed into community settings, such as community health centres, Family Health Teams and hospitals.

4. Stronger links between population and public health and other health services.

Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units.

The Medical Officer of Health for each public health unit would work closely with the LHINs to plan population health services. LHINs would be responsible for accountability agreements with public health units, and ministry funding for public health units would be transferred to the LHINs for allocation to public health units. Local boards of health would continue to set budgets, and public health services would be managed at the municipal level.

With the above four changes the ministry would continue to play a strong role in setting standards and performance targets, which would help ensure consistency across the province. The LHINs would be responsible for performance management, and for preparing reports on quality and performance that would be shared with the public and providers.

A PATH FORWARD

With *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, the ministry will engage the public and providers to discuss the proposal. The ministry has many questions concerning how to plan for and implement the proposed approach successfully. The full paper includes a series of discussion questions. The ministry is committed to listening. You are invited to review the full paper at www.health.gov.on.ca/en/news/bulletin and submit feedback or pose questions to health.feedback@ontario.ca.

The ministry looks forward to continuing the conversation...and to taking the next steps towards building a high-performing, better connected, more integrated, patient-centred health system.

OUR PROMISE

Put Patients First

In the *Patients First: Action Plan for Health Care* (February 2015), the Ontario Ministry of Health and Long-Term Care set clear and ambitious goals for Ontario's health care system:

Access

Improve access - providing faster access to the right care.

Connect

Connect services - delivering better coordinated and integrated care in the community closer to home.

Inform

Support people and patients - providing the education, information and transparency Ontarians need to make the right decisions about their health.

Protect

Protect our universal public health care system - making decisions based on value and quality, to sustain the system for generations to come.

To achieve these goals, the ministry must put patients, clients and caregivers first. We must create a responsive health system where:

- care providers work together to provide integrated care,
- patients and their caregivers are heard and play a key role in decision making and in their care plans,
- people can move easily from one part of the system to another,
- someone is accountable for ensuring that care is coordinated at the local level.

OUR PROGRESS

Over the past 10 years, Ontario's health care system has made great progress in improving the patient experience:

- **More access to primary care.** Family physicians, nurse practitioners and other health care providers — often working in team-based practices — have improved access to primary care. Nearly four million Ontarians receive care through these new teams.
- **More care closer to home.** Home and community care providers are providing care for more clients — many with complex conditions — at home, for longer periods of time.
- **Shorter hospital wait times.** Hospitals have reduced wait times for most surgical procedures and improved emergency department wait times, despite the fact that the number of people needing these services continues to increase. Hospitals are actively using evidence, data and information on the patient experience to improve quality.
- **More support for people to stay healthy.** There is a greater focus on disease prevention and health promotion.
- **More protection for our health system.** The *Excellent Care for All Act, 2010* has put in place tools and processes that have increased transparency, enhanced the system's focus on quality, and engaged Ontarians in improving health system performance.

These accomplishments are the result of a great deal of planning and hard work by all parts of the health system: hospitals, primary care and specialized offices and clinics, home and community care, long-term care homes, LHINs, CCACs and other health service organizations that provide care to Ontarians.

TODAY, 94%
of Ontarians report having a
regular primary health care provider.

Compared to 2003,
OVER 24,000
more nurses and
6,600
more physicians are
providing patient care.

Physicians representing more than
10 MILLION
ONTARIANS
now have electronic medical records.

OVER 80%
of primary care physicians use
electronic medical records in
their practice.

Flu shots are available in
2,500
pharmacies.

Vaccines and newborn screening
programs have been expanded.

1,076
health care organizations
submit annual Quality
Improvement Programs.

A PROPOSAL

to Strengthen Patient-Centred Care

Despite the progress, there is still more to do. Listening to patients, clients, caregivers and providers, we know that some people can struggle to get the primary care and home and community care services they need, and they still find the system fragmented and hard to navigate. We also know services are not as consistent as they should be across the province.

What we have heard from Ontarians has been confirmed in a series of expert reports, including those developed by Health Quality Ontario, the Auditor General of Ontario, the Primary Health Care Expert Advisory Committee, the Expert Group on Home and Community Care, the Commission on the Reform of Ontario's Public Service (the Drummond Report), and the Registered Nurses' Association of Ontario.

To ensure Ontarians receive seamless, consistent, high quality care — regardless of where they live, how much they earn or their ethnicity — we must address the challenges that affect the system's ability to provide integrated patient-centred care.

Many of these challenges arise from the disparate way these different health services are planned and managed. Some — such as hospitals, long-term care, community services and mental health and addiction services — are planned and managed by the province's Local Health Integration Networks (LHINs). Others — such as primary care, home and community care services, and population and public health services — are currently planned and managed in different ways.

We propose expanding the LHINs' mandate to include primary care planning and performance management; home and community care management and service delivery; and developing formal linkages with public health to improve population and public health planning. Under this proposal, LHINs would assume responsibility for planning, managing and improving the performance of all health services within a region, while still maintaining clinician and patient choice.

In this paper, we describe in more detail the challenges facing the health care system as well as the structural changes being proposed. We also pose a series of questions for discussion.

IMPROVING HEALTH EQUITY AND REDUCING HEALTH DISPARITIES

Our proposed plan focuses specifically on ways to improve access to consistent, accountable and integrated primary care, home and community care, population health and public health services. Informing this proposal are the needs of diverse Ontarians who rely on our health care system, including seniors and people with disabilities, as well as health equity and the importance of the social determinants of health, such as income level and geography.

The ministry also recognizes that some Ontarians struggle to access health and social services.

- The health outcomes of **Indigenous Peoples in Ontario** — particularly those living in remote and isolated communities — are significantly poorer than those of the general population. Improving health care and health outcomes for First Nations, Métis and Inuit peoples is a ministry priority. This means the health care system must provide better supports and services for patients, families and caregivers, and these services must respect traditional methods and be culturally appropriate. To develop these services, we will build and maintain productive and respectful working relationships at both the provincial and local levels. We will meaningfully engage Indigenous partners through parallel bilateral processes. Through collaboration, we will identify the changes needed to ensure health care services address the unique needs of First Nations, Métis and Inuit peoples no matter where they live across the province.
- **Franco-Ontarians** face challenges obtaining health services in French. To meet their needs, and improve their patient experience and health outcomes, we must ensure that the health care system is culturally sensitive and readily accessible in French.
- Members of **other cultural groups, particularly newcomers**, may struggle to get the health care they need. As part of our commitment to health equity, the system must be able to recognize the challenges that newcomers face and provide culturally appropriate care and timely access.

- **People who experience mental health and addiction challenges**

also face barriers to getting the care they need when they need it.

The ministry is committed to strengthening mental health and addictions services. We will look to the work of the Mental Health and Addictions Leadership Advisory Council to ensure that changes in mental health and addiction services enhance access and improve overall system performance.

Over the next few years, as we continue to transform and restructure the health care system — making it more integrated, accessible, transparent and accountable — we will work to improve health equity and reduce health disparities. In their expanded role, LHINs would be responsible for understanding the unique needs of Indigenous peoples, Franco-Ontarians, newcomers, and people with mental health and addiction issues in their regions, and providing accessible, culturally appropriate services. At the same time, the ministry would pursue discussions with these partners to determine how best to adapt system structures to provide effective person-centred care.

THE PROPOSAL

1. More Effective Integration of Services and Greater Equity

THE ISSUE

The Ontario health care system offers excellent services, but they are fragmented in the way they are planned and delivered. This fragmentation can affect the patient experience. It can also result in inefficient use of patient and provider time and resources, and have a negative impact on health outcomes.

THE SITUATION NOW

Under the *Local Health System Integration Act, 2006*, the 14 LHINs are responsible for managing their local health systems. LHINs plan and manage performance in the acute care, long-term care, community services, and mental health and addictions sectors. Other services are managed differently. For example, CCACs are responsible for planning and contracting home care services and administering the placement process for long-term care. Although CCACs are accountable to the LHINs for their performance and receive funding from the LHINs, they have their own boards and operate rather independently. Other than the ministry, there is no organization accountable for planning primary care or specialist care services, and very little focus on managing or improving primary care performance. The province's public health services also have their own system for planning and delivering services.

Since their creation a decade ago, the LHINs have improved regional planning for and integration of some services. Across the LHINs, we've seen the impact of some successful efforts to integrate providers and services.

However, as the Auditor General recently noted, the LHINs lack the mandate and tools to align and integrate all health services. Under their current mandate, they cannot hold some parts of their local systems accountable or manage improvement in many service areas.

Through Health Quality Ontario, we also learned that there is variation across LHINs in terms of health outcomes. We have also heard that some LHIN boundaries may no longer fit patient care patterns in their communities.

EXAMPLES OF SUCCESSFUL INTEGRATION

- Collaborative care models, such as Family Health Teams, Community Health Centres, Aboriginal Health Access Centres and Nurse Practitioner-Led Clinics, allow health care providers to work together as an integrated team to deliver comprehensive care and coordinate services with a range of partners, including home and community care.
- Integrated service models, such as Health Links, bring together health care and other providers in a community to better and more quickly coordinate care for patients with complex needs.

To reduce gaps and ensure that services meet local needs, it is time to enhance the LHINs' authority. In a health care system focused on performance management and continuous quality improvement, it is also important for the ministry to hold the LHINs accountable for their performance. As part of any transformation, we must ensure their activities result in better access as well as greater consistency of services across the province.

PROPOSAL #1

To provide care that is more integrated and responsive to local needs, make LHINs responsible and accountable for all health service planning and performance.

Identify smaller regions as part of each LHIN to be the focal point for local planning and service management and delivery.

In their expanded role, LHINs would:

- Assess local priorities and current performance, and identify areas for improvement.
- Work with providers across the care continuum to improve patients' access to services, and make it easier for both patients and providers to navigate the system.
- Integrate and improve primary care, home and community care, acute care, mental health and addiction services and public health across the entire health care system.
- Drive the adoption of technology to enhance care delivery through, for example, integrated systems or virtual access to care providers through telemedicine.
- Prepare public reports about the patient experience with different health services and other reported outcomes to help drive improvements.

Although the LHINs have demonstrated that they are the right structure to enhance service integration, accountability and quality, they themselves would need some adjustments and additional tools to take on an expanded role. For example, their governance structures would need to be revisited (see Appendix) and their boundaries would need to be reviewed and possibly refined. In addition, LHINs would be asked to identify smaller geographic areas within their regions — or LHIN sub-regions — that reflect community geography, such as the current Health Links regions. Such LHIN sub-regions would be the focus for strengthening, coordinating and integrating primary health care, as well as more fully integrating primary care with home and community care, and ultimately fulfilling the clinical coordination responsibilities currently provided by the CCACs.

ACROSS ONTARIO'S 14 LHINs

- Life expectancy ranges between 78.6 and 83.6 years old.
- Smoking, obesity, and physical activity rates vary.
- The percentage of people who report that their health status is excellent or very good ranges from 6.8 per cent to 11.7 per cent.

In the transformed system, the ministry would retain its role in health workforce planning, in collaboration with LHINs and other partners.

QUESTIONS FOR DISCUSSION:

- How do we support care providers in a more integrated care environment?
- What do LHINs need to succeed in their expanded role?
- How do we strengthen consistency and standardization of services while being responsive to local differences?
- What other local organizations can be engaged to ensure patients are receiving the care they need when they need it? What role should they play?
- What other opportunities for bundling or integrating funding between hospitals, community care, primary care and possibly other sectors should be explored?
- What areas of performance should be highlighted through public reporting to drive improvement in the system?
- Should LHINs be renamed? If so, what should they be called? Should their boundaries be redrawn?

2. Timely Access to Primary Care, and Seamless Links Between Primary Care and Other Services

THE ISSUE

Despite a significant increase in the number of primary care providers, in some cases, Ontarians still find it difficult to get care when they need it. As a result, many patients use costly emergency departments for primary care problems. At the same time, primary care providers report that, because of the way the system is organized, they find it difficult to connect their patients to the other health services they need.

ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ Care delivered based on community needs
- ✓ Appropriate care options enhanced within communities
- ✓ Easier access to a range of care services
- ✓ Better connections between care providers in offices, clinics, home and hospital

THE SITUATION NOW

All high-performing health care systems are based on strong primary care services delivered through a variety of models, including family doctors and primary care nurse practitioners working as part of inter-professional teams. Effective primary care is essential to improving health outcomes.

To understand how well Ontario's primary care services perform, Health Quality Ontario compared Ontario data with international data from the Commonwealth Fund. Compared to other developed countries, it found that Ontario performs poorly on access measures, such as same- or next-day appointments when people are sick or weekend after-hours appointments. It also found that, in Ontario, access to primary care is influenced by where people live and factors such as immigration status or the language spoken most often at home

The 2015 report *Patient Care Groups: A new model of population based primary health care for Ontario*, prepared by the Primary Health Care Expert Advisory Committee led by Dr. David Price and Elizabeth Baker, highlighted the challenges that primary care providers face when trying to connect their patients with other health services and suggested ways to address many of these challenges.

PROPOSAL #2

Bring the planning and monitoring of primary care closer to the communities where services are delivered. LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management.

Set out clearly the principles for successful clinical change, including engagement of local clinical leaders.

Every Ontarian who wants a primary care provider should have one. Primary care should act as a patient's "Medical Home", offering comprehensive, coordinated, and continuous services and working with other providers across the system to ensure that patient needs are met. Making the LHIN and LHIN sub-regions the focal points for primary care planning and performance measurement would be a crucial step towards achieving these goals.

With the proposed approach:

- LHINs would work closely with primary care leaders, patients and providers to plan and monitor performance within each LHIN sub-region.

57%

of Ontarians cannot see their primary care provider the same day or next day when they are sick.

52%

find it difficult to access care in the evenings or on weekends.

Low-acuity patients account for

34%

of emergency department visits.

- Planning would include improving access to inter-professional teams for those who need it most, facilitating care plans and supporting an integrated, coordinated patient-centred experience.
- LHINs, in partnership with local clinician leaders, would be responsible for recruitment planning, linking new patients with doctors and nurse practitioners, and improving access and performance in primary care.
- To make it easier for patients to connect with primary care, each LHIN sub-region would have a process to match unattached patients to primary care providers.
- Existing relationships between patients and their care providers would continue. Patients will always have the right to choose their primary care provider, and the sub-regions would help patients change physicians or nurse practitioners to get care closer to home. Similarly, clinicians would retain choice for what patients they care for within their sub-regions.
- While LHINs would play a greater role in primary care health human resources planning, physician compensation and primary care contracts would continue to be negotiated by the government and administered centrally. Ontario Medical Association (OMA) representation rights would continue to be respected.
- To help drive continuous quality improvement in primary care, the ministry would more methodically measure patient outcomes in primary care to help understand the patient experience accessing primary care, including same-day and after-hours care, and satisfaction with service.
- LHINs would collect, assess and publish performance indicators at a sub-region level and share that information with health care providers and managers to support performance improvement, as well as to help inform the organization of primary care in each LHIN sub-region.

With the proposed emphasis on local care coordination and performance improvement, the primary care sector would be better positioned to meet the needs of communities across the province. These changes will enable the approach to Patient-Centered Medical Homes as recommended by the Ontario College of Family Physicians and others.

QUESTIONS FOR DISCUSSION

- How can we effectively identify, engage and support primary care clinician leaders?
- What is most important for Ontarians when it comes to primary care?
- How can we support primary care providers in navigating and linking with other parts of the system?
- How should data collected from patients about their primary care experience be used? What data and information should be collected and publicly reported?

There are more than
12,000
primary care physicians in
Ontario, and about
450
enter practice each year.

ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ All patients who want a primary care provider have one
- ✓ More same-day, next-day, after-hours and weekend care
- ✓ Lower rates of hospital readmissions
- ✓ Lower emergency department use
- ✓ Higher patient satisfaction

3. More Consistent and Accessible Home and Community Care

THE ISSUE

Home and community care services are inconsistent across the province and can be difficult to navigate. Many family caregivers who look after people at home are experiencing high levels of stress – due in part to the lack of clear information about the home care services available and how to access them. Primary care providers report problems connecting with home care services, and home care providers say the same thing about their links to primary care.

THE SITUATION NOW

The last major reform of home and community care was in 1996 with the creation of 43 CCACs responsible for planning, coordinating, delivering and contracting services designed to help people leave hospital earlier and stay independent in their homes for as long as possible. In 2007, the 43 CCACs were amalgamated to align geographically with the LHINs.

Bringing Care Home, the 2015 report of the Expert Group on Home and Community Care led by Dr. Gail Donner, highlighted the ongoing service challenges in the home and community care sector. According to that report, the current model is cumbersome. It lacks standardization across the province and is not consistently delivering the services that people need, including our growing population of seniors. However, the Expert Group encouraged the government to focus first on functional change before addressing any structural changes.

The ministry responded with the *Roadmap to Strengthen Home and Community Care*, which outlined a plan to improve care delivery. This work is well underway and includes bundled care initiatives, self-directed care and more nursing services at home for those who need them, among other initiatives.

The Auditor General recommended that the ministry revisit the model of home care delivery in Ontario — echoing recommendations in the 2012 report from the Commission on the Reform of Ontario's Public Service (the Drummond Report). In its 2012 report, *Enhancing Community Care for Ontarians*, the Registered Nurses' Association of Ontario also encouraged the ministry to review the duplication within the current home and community care system, and to improve linkages with primary care.

.....
Timing of first nursing and
personal support visits varies by
Community Care Access Centre.
.....

.....
One-third of informal caregivers
are distressed, twice as many
as four years ago.
.....

PROPOSAL #3

Strengthen accountability and integration of home and community care. Transfer direct responsibility for service management and delivery from the CCACs to the LHINs.

The ministry proposes to move all CCAC functions into the LHINs to help integrate home and community care with other parts of the health care system, and to improve quality and accountability. The proposed shift will create opportunities to embed home and community coordinators in other parts of the system.

Under this proposal:

- The LHIN board would govern the delivery of home and community care, and the CCAC boards would be dissolved.
- CCAC employees providing support to clients would be transitioned to and employed by the LHINs.
- Home care coordinators would be focused on LHIN sub-regions, and may be deployed into community settings (such as family health teams, community health centres or hospitals).
- Home care services would continue to be provided by current service providers. Over time, contracts with these service providers would be better coordinated and more consistent within the geographic model of the LHIN sub-regions.
- LHINs would be responsible for the long-term care placement process currently administered by CCACs.
- The ministry's ten-point plan for improving home and community care would continue under LHIN leadership.

While care planning and delivery would be done at the local level, the function of establishing clinical standards and outcomes-based performance targets for home and community care would be centralized. Having common standards and targets for the whole province will ensure more consistent and higher-quality care.

QUESTIONS FOR DISCUSSION

- How can home care delivery be more effective and consistent?
- How can home care be better integrated with primary care and acute care while not creating an additional layer of bureaucracy?
- How can we bring the focus on quality into clients' homes?

ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ Easier transitions from acute, primary and home and community care and long-term care
- ✓ Clear standards for home and community care
- ✓ Greater consistency and transparency around the province
- ✓ Better patient and caregiver experience

4. Stronger Links Between Public Health and Other Health Services

THE ISSUE

Public health has historically been relatively disconnected from the rest of the health care system. Public health services vary considerably in different parts of the province and best practices are not always shared effectively. While local initiatives and partnerships have been successful, public health experts are not consistently part of LHIN planning efforts to improve population health. Many aspects of the health care system are not able to properly benefit from public health expertise, including issues related to health equity, population health and the social determinants of health.

THE SITUATION NOW

Public health services in Ontario are managed by 36 local public health units, whose mandate is to assess population health (e.g. the health status of their community) and implement programs to improve health. Because the public health system is municipally based, public health unit areas do not align with LHIN boundaries.

Improving population health is an important goal for both local public health units and the health care system as a whole. However, many of the complex social, economic and environmental factors that affect health — such as income, education, adequate housing and access to healthy foods — lie outside the health system. In their efforts to improve health, public health units look at how these complex determinants collectively affect the health of individuals and communities.

According to the 2015 Health Quality Ontario report, population health outcomes vary across our communities. To close these gaps, the health system needs more consistent and meaningful collaboration and coordination between public health, the rest of the health care system and LHINs.

While many important public health functions — such as restaurant inspections — do not overlap with health care planning or delivery, others — such as surveillance of reportable infectious diseases, documentation of immunizations, smoking cessation programs and other health promotion initiatives — do. Where the system's and public health's interests overlap, public health would benefit from more in-depth knowledge of the population's health status available through LHINs as well as the LHINs' ability to distribute health resources to address health inequities. LHINs would also benefit from greater access to public health expertise when planning health services.

PROPOSAL #4

Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units.

To better integrate population health within our health system, we propose that LHINs and public health units build on the collaborations already underway, and work more closely together to align their work and ensure that population and public health priorities inform health planning, funding and delivery.

To support this new formal relationship:

- The ministry would create a formal relationship between the Medical Officers of Health and each LHIN, empowering the Medical Officers of Health to work with LHIN leadership to plan population health services.
- The ministry would transfer the dedicated provincial funding for public health units to the LHINs for allocation to public health units. The LHINs would ensure that all transferred funds would be used for public health purposes.
- The LHINs would assume responsibility for the accountability agreements with public health units.
- Local boards of health would continue to set budgets.
- The respective boards of health, as well as land ambulance services, would continue to be managed at the municipal level.

As part of a separate initiative to support more consistent public health services across the province, the ministry is modernizing the Ontario Public Health Standards and Organizational Standards to identify gaps and duplication in service delivery; determine capacity and resource needs; and develop options for greater effectiveness.

The ministry would also appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and public health units, and how to further improve public health capacity and delivery.

QUESTIONS FOR DISCUSSION

- How can public health be better integrated with the rest of the health system?
- What connections does public health in your community already have?
- What additional connections would be valuable?
- What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ Health service delivery better reflects population needs
- ✓ Public health and health service delivery better integrated to address the health needs of populations and individuals
- ✓ Social determinants of health and health equity incorporated into health care planning
- ✓ Stronger linkages between disease prevention, health promotion and care

WHAT WOULD THE PROPOSED CHANGES MEAN FOR ONTARIANS?

Patients, clients and family caregivers would have one point of contact in each LHIN sub-region responsible for connecting them with a primary care provider, as well as other health services and resources. All Ontarians should have better access to inter-professional providers including specialists when they need them, including better access to same-day, next-day, and after-hours and weekend care.

Ontarians — including patients recovering from a stay in hospital and people who are frail or who have chronic conditions — would find it easier to understand, access and navigate the home and community care services available to them.

Patient choice will be respected. People who have pre-existing relationships with primary care providers outside their LHIN sub-region will not have to change providers. One of the guiding principles of home care during and after the transition will be ensuring continuity of care providers.

Physicians, nurses and other care providers would work in a system and structure that supports integration, helps them do their jobs, maintains their clinical autonomy, makes the most of their time and expertise, and sets clear accountabilities. Clinicians would benefit from improved access to personal health information that makes it easier to coordinate care and track the care patients receive in different parts of the system. Health care providers would also retain choice for deciding what patients they would care for.

Specialist physicians would benefit from local planning that enhances access to their services and promotes the use of technology (e.g. e-consult and e-referral) and shared care using telemedicine to provide services for complex patients who live far from specialty care.

Hospitals would benefit because changes in the primary care and home and community care sectors would enable them to provide more continuous care, and help address intractable problems such as high rates of hospital readmissions, alternate level of care and inappropriate use of emergency services.

PATIENT CHOICE WILL BE PROTECTED

- No one will have to change primary care providers.
- Care decisions will take into account where people live, work and go to school.
- There will be no new restrictions on long-term care home choices.
- There will be no new layer of bureaucracy between Ontarians and the health services they need.

CCAC employees perform essential work that will continue under this proposal. CCAC employees who support clients would be integrated into the LHINs and their collective agreements will be respected. Some CCAC coordinators may end up working in hospitals or primary care settings, but they will still be employed by the LHINs. The CCAC management structure would be reviewed in conjunction with the management structure of expanded LHINs in order to support service planning and delivery in a way that maximizes care for patients and clients while improving efficiency.

Public health staff would see no change in the critical work they do every day in their communities. However, they would have stronger links with other parts of the health system.

Long-term care leaders and employees would have better support in managing transitions for clients between acute home and community care, and long-term care. They should benefit from better service planning and delivery in the home and community sector.

The health system itself would be more efficient. There would be less duplication of services, better sharing of information and more effective use of technology to ensure quick access to health information, including lab results and diagnostic imaging. Connections across the full continuum of care would mean, for example, that family physicians receive hospital discharge summaries and providers in the acute sector receive community care assessments. Patients would also have access to publicly available information about health system performance that is specific and relevant to them.

A PATH FORWARD

The proposed structural changes to Ontario's health care system are designed to strengthen patient-centred care and deliver high-quality, consistent and integrated health services to all Ontarians. Implementing these changes while ensuring the continuity and improvement of high-quality services will require a well-thought-out and carefully implemented plan.

The ministry has questions about how to successfully plan for and implement this proposed approach. With the release of this discussion paper, the ministry will begin an engagement process to discuss the proposal and its refinement. The ministry is committed to listening to staff and clinicians, patients, clients and caregivers, other health care partners, Indigenous peoples, and municipal and other community and government partners.

We hope to receive feedback on the questions in this proposal, including:

- How can clinicians and health care providers be supported in leadership roles in continued system evolution?
- How do we ensure changes are supportive of and responsive to future service changes that are still being worked on, such as home and community care?
- How do we create a platform for further service integration, such as enhanced community mental health and addictions services?
- What accountability measures need to be put in place to ensure progress is being made in integrating health care services and making them more responsive to the needs of the local population?
- How do we support improved integration through enhanced information systems, data collection and data sharing?
- What can be done to ensure a smooth transition from the current system to the one proposed in this proposal?
- How would we know whether the plan is working?

If there are other questions, please submit them for consideration. Feedback and questions can be sent to health.feedback@ontario.ca or submitted at www.health.gov.on.ca/en/news/bulletin.

The ministry looks forward to continuing the conversation about this proposal in a variety of forums. We hope this discussion will result in a plan that can successfully build a high-performing, better connected, more integrated, patient-centred health system — one that responds to local needs and is committed to continuous quality improvement.

The proposed model would require changes to legislation including but not limited to the *Local Health System Integration Act, 2006*, the *Community Care Access Corporations Act, 2001*, the *Home Care and Community Services Act, 1994*, the *Health Protection and Promotion Act*, among others. The ministry is reviewing relevant acts and intends to propose draft legislation for consideration by the Legislative Assembly in the spring of 2016.

APPENDIX

System Governance

The success of the proposal outlined in this paper is based on the ministry, LHINs and health care providers having the tools they need for effective governance and management. Clear and meaningful accountability relationships will be developed, and transparent performance measurement must be strengthened.

To fulfill their new responsibilities, the LHINs would require expanded boards and leadership with the necessary skills, expertise and local knowledge.

At the same time, LHINs need to be aligned with the ministry's objectives to ensure accountability to Ontarians and consistently equitable services. LHIN activities would need to be carefully defined and performance plans supported and enforced by the ministry. A variety of measures would be put in place to enhance LHIN accountability to the ministry and to Ontarians, including transparency, the identification of standards, funding and enhanced ministry authority.

As the 2008 report *High Performing Healthcare Systems: Delivering Quality by Design* demonstrated, it is possible to develop a culture of quality when objectives and structures are aligned.

QUESTIONS FOR DISCUSSION

- What other tools are needed for effective governance?
- What would be the most effective structure for LHIN boards and their executive?
- How can LHINs promote leadership at the local level?

**Ministry of Health
and Long-Term Care**

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DEC 17 2015

HLTC2980IT-2015-1706

Mr. René Lapierre

Chair

Board of Health for the Sudbury and District Health Unit

1300 Paris Street

Sudbury ON P3E 3A3

Dear Mr. Lapierre:

Over the past several years, Ontario's care providers and health system partners have worked hard to create meaningful change across the system. There has been significant progress in access to primary care, a greater focus on health promotion, and more supports at home and in the community.

Although there have been many meaningful accomplishments, the Ontario health care system remains characterized by excellent services that are separate in their delivery and funding. This affects access, quality, and consistency of care. We believe that our system needs structural change to improve delivery and sustainability of the services that Ontarians rely on.

The ministry has released *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, a discussion paper that outlines proposed changes for the health system. The proposed structural changes would see Local Health Integration Networks assume responsibility for home and community care and system integration, and have greater involvement with primary care, and improved linkages with population health planning. The discussion paper can be found here: <http://www.health.gov.on.ca/en/news/bulletin/>.

The ministry looks forward to continuing the dialogue about this proposal in a variety of forums. We are committed to a meaningful engagement process that includes all health system partners, as well as patients. We hope this input will result in a plan that can successfully build a high-performing health system that is more responsive to local needs, is better connected and integrated, drives quality and performance, and enhances transparency for providers and patients, clients and their families.

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Mr. René Lapierre

Yours sincerely,

A handwritten signature in black ink, appearing to read "Eric Hoskins", with a long, sweeping horizontal stroke at the end.

Dr. Eric Hoskins
Minister

NEWS RELEASE

December 17, 2015

For Immediate Release

Patients First - New Government Proposal for Ontario Health System

TORONTO – On behalf of member medical officers of health and boards of health, the Association of Local Public Health Agencies (alPHA) would like to congratulate the Minister of Health on the release of his proposed vision for the health system in Ontario. We are pleased to see the population health expertise of local public health recognized in the discussion paper.

"I am very pleased to see a strong role for local public health included in Patients First," says Dr. Miriam Klassen, Chair of the Council of Ontario Medical Officers of Health. "We look forward to reviewing the proposal put forward by government and providing input to ensure that investments in keeping people healthy remain a cornerstone of the pledge to change and improve Ontario's health system."

While improving the system that cares for the sick and injured is important, an essential part of the transformation is a stronger focus on keeping people healthy.

"That's where local public health comes into play," says alPHA Vice-President, Dr. Valerie Jaeger, Medical Officer of Health for Niagara Region. "We create hubs for innovation and cross-sector collaboration in communities across Ontario; providing essential leadership in the development of policies, programs and services that support population health and health equity. We look forward to being part of a transformation committed to improving health outcomes for all Ontarians."

It is now understood that good health comes from a variety of factors and influences, the majority of which are not related to the health care delivery system. In addition to working with primary care in communities across Ontario, local public health will continue to focus on its mandate to advance the factors that contribute to the health and well-being of the population through multi-sectoral partnerships at the municipal level, and advocacy for all of government approaches to healthy public policy.

About alPHA

The Association of Local Public Health Agencies (alPHA) is a non-profit organization that provides leadership to Ontario's boards of health and public health units. The Association works with governments and other health organizations, to advocate for a strong and effective local public health system in the province, as well as public health policies, programs and services that benefit all Ontarians.

About COMOH

The Council of Ontario Medical Officers of Health (COMOH) is a section of alPHA that provides a forum for local medical officers of health and associate medical officers of health to take leadership on issues that are important to the overall health of the communities they serve.

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For more information regarding this news release, please contact:

Linda Stewart
Executive Director
(416) 595-0006 ext. 22
linda@alphaweb.org

PATIENTS FIRST: A PROPOSAL TO STRENGTHEN PATIENT-CENTRED HEALTH CARE IN ONTARIO DISCUSSION PAPER

MOTION: That the Sudbury & District Board of Health receive the briefing note concerning, Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario; and

That the Board of Health direct the Medical Officer of Health to engage with the Association of Local Public Health Agencies (ALPHA) in the development of key positions, consistent with the key considerations of this briefing note, for communication with the Ministry of Health and Long-Term Care; and

That the Board of Health seek engagement with constituent municipalities and with the Federation of Northern Ontario Municipalities (FNOM) to determine any municipal concerns about the proposed changes in governance and funding; and

Further that the Board of Health seek engagement with the North East LHIN to discuss matters arising from the discussion paper.

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

IN CAMERA

MOTION: **THAT this Board of Health goes in camera. Time:_____p.m.**

RISE AND REPORT

MOTION: **THAT this Board of Health rises and reports. Time: _____p.m.**

The Board Chair will inquire whether there are any announcements and or enquiries.

Please remember to complete the Board Evaluation following the Board meeting:
<https://fluidsurveys.com/s/sdhuBOHmeeting/>

ADJOURNMENT

MOTION: THAT we do now adjourn. Time: _____ p.m.