



Sudbury & District Board of Health - Regular Meeting - Third Meeting

Wednesday, April 20, 2016

1:30 p.m.

SDHU Boardroom

Sudbury & District Board of Health - Regular Meeting - April 20, 2016

1.0 CALL TO ORDER

- Page 6

2.0 ROLL CALL

- Page 7

3.0 REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST

- Page 8

April 20, 2016, Board of Health Agenda Page 9

4.0 DELEGATION / PRESENTATION

i) Community Drug Strategy

5.0 CONSENT AGENDA

i) Minutes of Previous Meeting

a. Second Meeting - February 18, 2016 Page 16

ii) Business Arising From Minutes

iii) Report of Standing Committees

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

MOH/CEO Report, April 2016 Page 22

Financial Statements to end of February 2016 Page 36

v) Correspondence

a. Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings

Board Motion 11-16

Letter from the Premier of Ontario to Dr. Sutcliffe dated March 8, 2016 Page 39

Letter from the Peterborough County-City Health Unit to the Premier of Ontario dated March 15, 2016 Page 40

Letter from the Grey Bruce Health Unit to the Premier of Ontario dated March 24, 2016 Page 44

b. Environmental Health Program Funding

Letter from the North Bay Parry Sound District Health Unit to the Minister of Health and Long-Term Care dated February 22, 2016 Page 45

Letter from the Grey Bruce Health Unit to the Minister Page 47

c. Herpes Zoster Vaccine

Letter from the Peterborough County-City Health Unit to the Minister of Health and Long-Term Care dated February 25, 2016 Page 50

Letter from the Grey Bruce Health Unit to the Minister of Health and Long-Term Care dated March 24, 2016 Page 52

d. Smoke-Free Multi-Unit Housing

Board Motion 55-15

Letter from the Federation of Northern Ontario Municipalities to Dr. Sutcliffe dated March 8, 2016 Page 55

Letter from the Porcupine Health Unit to the Minister of Municipal Affairs and Housing dated March 21, 2016 Page 56

e. Bill 139: Smoke-Free Schools Act

Letter from the North Bay Parry Sound District Health Unit to the Minister of Health and Long-Term Care dated February 22, 2016 Page 57

Letter from the Grey Bruce Health Unit to the Minister of Health and Long-Term Care dated March 24, 2016 Page 59

f. Cannabis

Letter from the Durham Region Regional Clerk to the Prime Minister of Canada dated February 8, 2016 Page 60

Letter from the Middlesex-London Health Unit to the Prime Minister of Canada dated February 12, 2016 Page 62

g. Basic Income Guarantee

Letter from the North Bay Parry Sound District Health Unit to the Minister Responsible for the Poverty Reduction Strategy dated February 22, 2016 Page 66

Letter from the Wellington-Dufferin-Guelph Public Health to the Minister of Families, Children and Social Development dated March 2, 2016 Page 75

h. Northern Ontario Evacuations of First Nation Communities

Letter from the Porcupine Health Unit to the Premier of Ontario dated March 21, 2016 Page 88

i. Advocacy for Amendments to the Ontario Fluoridation Legislation

Letter from the Windsor-Essex County Board of Health to the Minister of Health and Long-Term Care dated March 18, 2016 Page 89

vi) Items of Information

a. aPHa Information Break

February 23, 2016 Page 95

March 10, 2016	Page 98
March 30, 2016	Page 101
b. Resignation Letter from the SDHU Director, Clinical and Family Services dated March 16, 2016	Page 103
c. Globe and Mail Article: Why did Calgary cave to chemophones over fluoride?	Page 104
d. SDHU Workplace Health Newsletter	
English	Page 106
French	Page 110
MOTION: Approval of Consent Agenda	Page 114
6.0 NEW BUSINESS	
i) Appointment to Board of Health Finance Standing Committee	
C-II-11 Board of Health Finance Standing Committee Terms of Reference	Page 115
MOTION: Appointment to Board Finance Standing Committee	Page 117
ii) MOH Position Description Revised	
-	Page 118
MOTION: MOH/CEO Position Description	Page 124
iii) Board Executive Committee	
MOTION: MOH/CEO Renewal Employment Contract	Page 125
iv) alPHa Annual General Meeting and Conference	
Notice of 2016 Annual General Meeting	Page 126
Call for Board of Health Nominations for 2016-2017 & 2017-2018 alPHa Board of Directors	Page 127
Summary of Health Unit Voting Delegates for alPHa's AGM Resolutions Session	Page 132
MOTION: alPHa Annual General Meeting and Conference	Page 133
v) Performance Monitoring Plan	
Strategic Priorities: Narratives Report, April 2016	Page 134
vi) Ontario Minister of Health and Long-Term Care's Discussion Paper: Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario	
Briefing Note from the Sudbury & District Health Unit's Medical Officer of Health to the Sudbury & District Board of Health Chair dated April 13, 2016	Page 142
alPHa's Response to the Minister of Health and Long-Term Care on the Discussion Paper dated February 29, 2016	Page 144
Letter from the Ottawa Public Health to the Minister of Health and Long-Term Care dated February 18, 2016	Page 148

<i>Letter from the Haliburton, Kawartha, Pine Ridge District Health Unit to the Minister of Health and Long-Term Care dated February 18, 2016</i>	Page 151
<i>Letter from the Grey Bruce Health Unit to the Association of Local Public Health Agencies dated March 7, 2016</i>	Page 154
<i>Letter from the Peterborough County-City Health Unit to the Premier of Ontario and the Minister of Health and Long-Term Care dated March 31, 2016</i>	Page 160
<i>MOTION: Patients First: Public Health and the NE LHIN</i>	Page 162
vii) Strengthening Ontario's Smoking and Vaping Laws	
<i>Public Consultation Paper dated March 10, 2016</i>	Page 163
<i>MOTION: Strengthening Ontario's Smoking and Vaping Laws</i>	Page 176
viii) Community Water Fluoridation	
Presentation by Charlene Plexman, Manager, Clinical and Family Services Division	
<i>MOTION: Community Water Fluoridation</i>	Page 177
7.0 ADDENDUM	
<i>MOTION: Addendum</i>	Page 178
8.0 IN CAMERA	
<i>MOTION: In Camera</i>	Page 179
9.0 RISE AND REPORT	
Labour Relations or Employee Negotiations	
<i>MOTION: Rise and Report</i>	Page 180
10.0 ANNOUNCEMENTS / ENQUIRIES	
<i>For completion: meeting evaluation</i>	Page 181
11.0 ADJOURNMENT	
<i>MOTION: Adjournment</i>	Page 182

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

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 – THIRD MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT
WEDNESDAY, APRIL 20, 2016 – 1:30 P.M.**

- 1. CALL TO ORDER**
- 2. ROLL CALL**
- 3. REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST**
- 4. DELEGATION / PRESENTATION**
 - i) Community Drug Strategy**
 - Sandra Laclé, Director, Health Promotion Division
- 5. CONSENT AGENDA**
 - i) Minutes of Previous Meeting**
 - a. Second Meeting – February 18, 2016
 - 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, April 2016
 - v) Correspondence**
 - a. Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings**

Sudbury & District Board of Health Motion #11-16

 - Letter from the Premier of Ontario to Dr. Sutcliffe dated March 8, 2016
 - Letter from the Peterborough County-City Health Unit to the Premier of Ontario dated March 15, 2016
 - Letter from the Grey Bruce Health Unit to the Premier of Ontario dated March 24, 2016
 - b. Environmental Health Program Funding**
 - Letter from the North Bay Parry Sound District Health Unit to the Minister of Health and Long-Term Care dated February 22, 2016
 - Letter from the Grey Bruce Health Unit to the Minister of Health and Long-Term Care dated March 24, 2016

c. Herpes Zoster Vaccine

- Letter from the Peterborough County-City Health Unit to the Minister of Health and Long-Term Care dated February 25, 2016
- Letter from the Grey Bruce Health Unit to the Minister of Health and Long-Term Care dated March 24, 2016

d. Smoke-Free Multi-Unit Housing

Sudbury & District Board of Health Motion #55-15

- Letter from the Federation of Northern Ontario Municipalities to Dr. Sutcliffe dated March 8, 2016
- Letter from the Porcupine Health Unit to the Minister of Municipal Affairs and Housing dated March 21, 2016

e. Bill 139: Smoke-Free Schools Act

- Letter from the North Bay Parry Sound District Health Unit to the Minister of Health and Long-Term Care dated February 22, 2016
- Letter from the Grey Bruce Health Unit to the Minister of Health and Long-Term Care dated March 24, 2016

f. Cannabis

- Letter from the Durham Region Regional Clerk to the Prime Minister of Canada dated February 8, 2016
- Letter from the Middlesex-London Board of health to the Prime Minister of Canada dated February 12, 2016

g. Basic Income Guarantee

- Letter from the North Bay Parry Sound District Health Unit to the Minister Responsible for the Poverty Reduction Strategy dated February 22, 2016
- Letter from the Wellington-Dufferin-Guelph Board of Health to the Minister of Families, Children and Social Development dated March 2, 2016

h. Northern Ontario Evacuations of First Nation Communities

- Letter from the Porcupine Health Unit to the Premier of Ontario dated March 21, 2016

i. Advocacy for Amendments to the Ontario Fluoridation Legislation

- Letter from the Windsor-Essex County Board of Health to the Minister of Health and Long-Term Care dated March 18, 2016

vi) Items of Information

- | | |
|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| a. alPHa Information Break | February 23, 2016
March 10, 2016
March 30, 2016 |
| b. Letter of Resignation from the SDHU Director, Clinical and Family Services | March 16, 2016 |
| c. The Globe and Mail Article: <i>Why did Calgary cave to chemophobes over fluoridation?</i> | February 19, 2016 |
| d. SDHU Workplace Health Newsletter | Spring/Summer 2016 |

APPROVAL OF CONSENT AGENDA

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

6. NEW BUSINESS

i) Appointment to Board of Health Finance Standing Committee

- C-II-11 Board of Health Finance Standing Committee Terms of Reference

APPOINTMENT TO BOARD FINANCE STANDING COMMITTEE

(2015 Board Membership: Carolyn Thain; Claude Belcourt; René Lapierre)

MOTION: THAT the Board of Health appoint the following individuals to the Board Finance Standing Committee for the year 2016:

1. _____, Board member at large
2. _____, Board member at large
3. _____, Board member at large
4. Medical Officer of Health/Chief Executive Officer
5. Director, Corporate Services
6. Manager, Accounting Services
7. Board Secretary

ii) MOH Position Description *Revised*

- Revised Position Description

MOH/CEO POSITION DESCRIPTION

MOTION: BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the revised position description for the Medical Officer of Health/Chief Executive Officer, dated March 2016.

iii) Board Executive Committee

MOH/CEO RENEWAL EMPLOYMENT CONTRACT

MOTION: WHEREAS the term of the current employment contract agreement for the Medical Officer of Health/CEO for the Sudbury & District Health Unit is until December 31, 2016; and

Whereas the Board of Health is required to provide notice in order to commence negotiations for a renewal agreement no later than two months prior to the expiry of the agreement; and

WHEREAS the Board of Health Executive Committee has historically reviewed the MOH/CEO contract agreement; and

WHEREAS the Board of Health Executive Committee Terms of Reference stipulate that the Executive Committee of the Board of Health may, from time to time, be assigned responsibilities by the Board of Health in areas such as: policy, personnel, and property; and

WHEREAS responsibilities assigned to the Board of Health Executive Committee must be delegated by majority vote of the full Board;

THEREFORE BE IT RESOLVED THAT the Board of Health assign to the Board of Health Executive Committee the responsibility to engage in discussions with the MOH/CEO regarding a renewal agreement, execute an updated employment contract with the MOH/CEO and report back to the Board of Health following execution of the updated agreement.

iv) alPha Annual General Meeting and Conference

- Notice of 2016 Annual General Meeting
- Call for Board of Health Nominations for 2016-2017 & 2017-2018 alPha Board of Directors
- Summary of Health Unit Voting Delegates for alPha's AGM Resolutions Session

2016 ALPHA ANNUAL GENERAL MEETING AND CONFERENCE

MOTION: WHEREAS the SDHU has a modest travel budget to cover remuneration, registration, travel, meals, and accommodation as per the Board Manual Policy and Procedure I-I-10, permitting Board members to attend official Board of Health functions; and

WHEREAS the SDHU is allocated four votes at the Annual General Meeting; and

THEREFORE, BE IT RESOLVED THAT in addition to the Medical Officer of Health, the following Board member(s) attend(s) the 2016 alPha Annual General Meeting as voting delegates for the Sudbury & District Board of Health:

v) Performance Monitoring Plan

- Strategic Priorities: Narratives Report, April 2016

vi) Ontario Minister of Health and Long-Term Care's Discussion Paper: Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario

- Briefing Note from the Sudbury & District Health Unit's Medical Officer of Health to the Sudbury & District Board of Health Chair dated April 13, 2016
- alPha's Response to the Minister of Health and Long-Term Care on the Discussion Paper dated February 29, 2016
- Letter from the Ottawa Public Health to the Minister of Health and Long-Term Care dated February 18, 2016

- Letter from the Haliburton, Kawartha, Pine Ridge District Health Unit to the Minister of Health and Long-Term Care dated February 18, 2016
- Letter from the Grey Bruce Health Unit to the Association of Local Public Health Agencies dated March 7, 2016
- Letter from the Peterborough County-City Health Unit to the Premier of Ontario and the Minister of Health and Long-Term Care dated March 31, 2016

PATIENTS FIRST: PUBLIC HEALTH AND THE NE LHIN

MOTION: THAT the Sudbury & District Board of Health seek to collaborate with the boards of health for Porcupine, Timiskaming, Algoma and North Bay Parry Sound to engage further with the North East LHIN for the purposes of relationship building and exploring the potential implications for the northeast of the proposals in Patients First; and

THAT to this end, an initial meeting be sought between the respective Board of Health Chairs and Medical Officers of Health/Chief Executive Officers and the Board and Chief Executive Officer for the North East LHIN.

vii) Strengthening Ontario's Smoking and Vaping Laws

- Public Consultation Paper dated March 10, 2016

STRENGTHENING ONTARIO'S SMOKING AND VAPING LAWS

MOTION: WHEREAS as strong regulatory environment is essential for effective tobacco control as supported by the World Health Organization Framework Convention on Tobacco Control; and

WHEREAS Sudbury & District Board of Health motion 54-15 calls for a public health framework for the anticipated legalization of cannabis; and

WHEREAS the Sudbury & District Board of Health motion #57-14 calls for enhanced public health measures in the manufacturing, quality, promotion and sale of e-cigarettes; and

WHEREAS the proposed changes to regulations made under the Smoke Free Ontario Act and Electronic Cigarettes Act, 2015 as described in the MOHLTC Public Consultation Paper, March 10, 2016 further strengthen the tobacco regulatory framework, and are consistent with Board of Health motions regarding cannabis and e-cigarettes, and include following:

1. Expand no smoking rules to apply to medical marijuana;
2. Prohibit the use of e-cigarettes – including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes – in all enclosed public places, enclosed workplaces, and other specified outdoor areas;

3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes;
4. Expand the definition of “e-cigarette” to include “e-substance”;
5. Expand the list of places where e-cigarettes are prohibited from sale;
6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

THEREFORE be it resolved that the Sudbury & District Board of Health fully endorse the proposals as described in the March 10, 2016 MOHLTC Public Consultation Paper.

viii) Community Water Fluoridation

- Presentation by Charlene Plexman, Manager, Clinical and Family Services Division

COMMUNITY WATER FLUORIDATION

MOTION: WHEREAS tooth decay remains the most common chronic disease in Canadian Children; and

WHEREAS water fluoridation is the most cost-effective, safe and internationally recognized method to prevent dental decay and to ensure that citizens receive the benefits of reduced dental decay; and

WHEREAS children living in fluoridated communities in Ontario have less tooth decay than children living in non-fluoridated communities and the effect tends to be maximized among children from lower socioeconomic groups; and

WHEREAS dental treatment costs are substantially higher than the costs of preventing dental disease; and

WHEREAS a recently introduced bill by a Member of Provincial Parliament supports community water fluoridation, and calls for changes to the Fluoride Act and other relevant legislation to support mandatory fluoridation of municipal drinking water; and

WHEREAS the decision on April 11, 2016 of the Council of the Township of Nairn and Hyman to discontinue the practice of fluoridating its community water supply is expected to result in a negative impact on the oral health among residents; and

WHEREAS the Sudbury & District Board of Health has consistently supported the principle and administration of community water fluoridation in Sudbury and districts;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health reaffirm its support for community water fluoridation and

advocate for the implementation of provincial regulation mandating community water fluoridation; and

FURTHER THAT this motion be shared with relevant area municipalities, dental associations, community stakeholders, boards of health, the Minister of Health and Long-Term Care and the Chief Medical Officer of Health.

7. ADDENDUM

ADDENDUM

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

8. IN CAMERA

IN CAMERA

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

- Labour Relations or Employee Negotiations

9. RISE AND REPORT

RISE AND REPORT

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

10. ANNOUNCEMENTS / ENQUIRIES

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

11. ADJOURNMENT

ADJOURNMENT

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

**MINUTES – SECOND MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM
THURSDAY, FEBRUARY 18, 2016, AT 1:30 P.M.**

BOARD MEMBERS PRESENT

Janet Bradley
Richard Lemieux
Rita Pilon

Jeffery Huska
Stewart Meikleham
Mark Signoretti

Robert Kirwan
Ken Noland
Carolyn Thain

BOARD MEMBERS REGRETS

Claude Belcourt
Ursula Sauvé

René Lapierre

Paul Myre

STAFF MEMBERS PRESENT

Nicole Frappier
Rachel Quesnel
Shelley Westhaver

Sandra Laclé
Renée St Onge

Stacey Laforest
Dr. P. Sutcliffe

J. BRADLEY 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) 2015 Year-In Review

- Shelley Westhaver, Director, Clinical and Family Services Division
- Stacey Laforest, Director, Environmental Health Division
- Sandra Laclé, Director, Health Promotion Division
- Nicole Frappier, Assistant Director, Strategic Engagement Unit
- Renée St Onge, Director, Resources, Research, Evaluation and Development (RRED) Division

Dr. Sutcliffe indicated that annually, the senior managers showcase the scope, breadth, and volume of divisional work by presenting a high level year-in review summary. This presentation complements the annual statistical report for 2015 included in this month's Medical Officer of Health and Chief Executive Officer report to the Board.

The program and assistant directors were introduced and each presented an overview of their divisional highlights of program activities undertaken in 2015. Questions and comments were entertained.

The Board observed that the SDHU and other local health units cover many aspects of prevention, promotion and protection making a positive impact on the health of Ontarians and

questioned how this work may be impacted by the recently released Discussion Paper. Other boards of health have also questioned the future of public health in Ontario.

Dr. Sutcliffe reported that two Senior Directors from the NorthEast LHINs joined the SDHU Senior Management Executive Committee (EC) meeting on February 4, 2016. The exchange was informative although we need to ensure we are using common definitions of key terms, such as population health.

The deadline to provide feedback regarding the Patients First report is February 29, 2016. Dr. Sutcliffe is actively involved in helping draft a provincial response to this report with the Association of Local Public Health Agencies (aLPHa).

Further to the Sudbury & District Board of Health's motion *03-16 Patients First: A Proposal To Strengthen Patient-Centred Health Care in Ontario Discussion Paper*, Dr. Sutcliffe is engaging with NE LHINs, local municipalities and FONOM to determine whether there are any municipal concerns about the proposed changes in governance and funding.

There are many questions left unaddressed in the Discussion Paper. There is currently no proposal that the funding model change.

The directors were thanked for their presentation and the Board concluded that this was a great comprehensive overview.

5.0 CONSENT AGENDA

There were no consent agenda items identified for discussion.

i) Minutes of Previous Meeting

- a. First Meeting – January 21, 2016

ii) Business Arising From Minutes

iii) Report of Standing Committees

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

- a. MOH/CEO Report, February 2016

v) Correspondence

a. Nutritious Food Basket 2015: Limited Incomes = A Recipe for Hunger

Sudbury & District Board of Health Motion #43-15

- Letter from the Premier of Ontario to Dr. Sutcliffe dated November 19, 2015
- Letter from the Township of Nairn and Hyman to the Premier of Ontario dated December 16, 2015
- Email from the Prime Minister's Office to Dr. Sutcliffe dated January 31, 2016

b. Cannabis

Sudbury & District Board of Health Motion #54-15

- Letter from the Grey Bruce Health Unit to the Prime Minister dated January 20, 2016
- Letter from the Windsor-Essex County Health Unit to the Prime Minister dated February 1, 2016

c. Smoke-Free Multi-Unit Housing

- Letter from the North Bay Parry Sound District Health Unit to the Smoke-Free Housing Ontario Coalition dated January 20, 2016

d. Ontario Society of Nutrition Professionals in Public Health Position Statement on Responses to Food Insecurity

- Letter from the Haldimand-Norfolk Board of Health to the Ontario Society of Nutrition Professionals in Public Health dated January 25, 2016

e. Mental Health Promotion in Ontario

- Letter from the Peterborough County-City Health Unit to the Minister of Health and Long-Term Care dated February 5, 2016

f. Bill 139: Smoke-Free Schools Act

- Letter from Hastings Prince Edward Public Health to the MPP Prince Edward-Hastings dated December 10, 2015

vi) Items of Information

- | | |
|--------------------------------------------------------------------------------------------------------------------------------|-------------------|
| a. alPHa Information Break | February 5, 2016 |
| b. Zika Virus | |
| i. Board of Health Update | February 10, 2016 |
| ii. MOHLTC News Release | January 29, 2016 |
| c. The Chief Public Health Officer's Report on the State of Public Health in Canada 2015: <i>Alcohol Consumption in Canada</i> | January 2016 |

09-16 APPROVAL OF CONSENT AGENDA

Moved by Lemieux – Noland: THAT the Board of Health approves the consent agenda as distributed.

CARRIED

6.0 NEW BUSINESS

i) Board of Health Meeting Date, April 2016

Further to an email poll that was sent to the Board, a change in meeting date is being recommended for the Board's regular meeting in April. The time and meeting location would not change.

10-16 BOARD OF HEALTH MEETING DATE

Moved by Noland – Lemieux: WHEREAS the Sudbury & District Board of Health regularly meets on the third Thursday of the month; and

WHEREAS By-Law 04-88 in the Board of Health Manual stipulates that the Board may, by resolution, alter the time, day or place of any meeting;

THEREFORE BE IT RESOLVED THAT this Board of Health agrees that the regular Board of Health meeting scheduled for 1:30 pm Thursday, April 21, 2016, be moved to 1:30 pm Wednesday, April 20, 2016.

CARRIED

ii) Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings under the Health Protection and Promotion Act

- Letter, resolution, and backgrounder from the Haliburton, Kawartha, Pine Ridge District Health Unit to the Premier of Ontario dated January 21, 2016

The proposed motion supports the Haliburton, Kawartha, Pine Ridge District Health Unit motion to enact provincial legislation governing invasive Personal Services Settings as there are currently no legislation or guidelines.

11-16 ENDORSEMENT OF RESOLUTION FOR ENACTMENT OF LEGISLATION TO ENFORCE INFECTION PREVENTION AND CONTROL PRACTICES WITHIN INVASIVE PERSONAL SERVICE SETTINGS UNDER THE HEALTH PROTECTION AND PROMOTION ACT

Moved by Pilon – Kirwan: WHEREAS adherence to Infection Prevention and Control (IPAC) best practices is essential in reducing the risk of infectious disease transmission through invasive procedures performed in personal services settings such as tattoo and body piercing establishment; and

WHEREAS the Ontario Public Health Standards requires that boards of health perform routine inspections of all personal services settings at least once per year to ensure adherence to best practices for IPAC; and

WHEREAS the Ontario Public Health Standards requires that boards of health investigate complaints regarding potential health hazards including IPAC lapses in personal services settings; and

WHEREAS provincial legislation does not currently exist outlining legal requirements for IPAC practices and operator responsibility and;

WHEREAS creation of provincial legislation governing invasive Personal Services Settings would support a consistent progressive enforcement model amongst Ontario's 36 public health units;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Haliburton, Kawartha, Pine Ridge District Health Unit motion recommending that the Government of Ontario enact legislation implementing IPAC requirements for invasive personal services settings under the Health Protection and Promotion Act with short-form wording under the Provincial Offences Act.

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Premiere of Ontario, the Minister of Health and Long-term Care, local members of Provincial Parliament, the Chief Medical Officer of Health, the Association of Local Public Health Agencies (alPHA), and all Ontario Boards of Health.

CARRIED

iii) **SDHU 2013 – 2017 Performance Monitoring Plan and Annual Performance Monitoring Report**

- Presentation by Krista Galic, Specialist, Quality & Monitoring
- 2015 Performance Monitoring Report, February 2016

Member of the Joint Board/Staff Performance Monitoring Working Group, C. Thain, indicated that the group met on January 26, 2016, to review the 2015 Performance Monitoring Report. J. Bradley and R. Pilon are also Board members on the working group. The working group reviews the performance monitoring report which is presented to the Board annually.

Board members were reminded that the main purpose of our Performance Monitoring Plan is to ensure the Board of Health is kept informed of the Sudbury & District Health Unit's performance on key accountability measures, which are grounded within the 2013–2017 Strategy Map. It is part of our commitment to transparency and accountability, ensures the SDHU is meeting its obligations and further demonstrates our commitment to excellence.

K. Galic was introduced and invited to present highlights of the 2015 report. Questions and comments were entertained and K. Galic was thanked for her presentation.

12-16 SDHU 2015 PERFORMANCE MONITORING REPORT

Moved by Kirwan – Huska: WHEREAS the Sudbury & District Board of Health is working toward achieving its vision of Healthier Communities for All; and

WHEREAS the Sudbury & District Board of Health is committed to transparency, accountability and continuous quality improvement through regular monitoring of performance at multiple levels; and

WHEREAS the Sudbury & District Health Unit has multiple reporting requirements that include SDHU-Specific Performance Monitoring Indicators, the Ontario Public Health Organizational Standards, and the Public Health Accountability Agreement Indicators; and

WHEREAS the Sudbury & District Board of Health approved, in June 2013, the SDHU 2013-2017 Performance Monitoring Plan as a means to provide the Board of Health with accountability measures on key focus areas grounded within the 2013–2017 Strategy Map;

WHEREAS key former accreditation standards have been incorporated in the SDHU 2013-2017 Performance Monitoring Plan due to the cessation of the Ontario Council on Community Health Accreditation (OCCHA);

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health approve the 2015 Performance Monitoring Report.

CARRIED

Dr. Sutcliffe thanked the Board for its endorsement. She noted that SDHU staff will be presenting the SDHU's Performance Monitoring Plan at the 2016 Ontario Public Health Convention (TOPHC) in Toronto this April. Board members who are on the Working Group have been asked to do a short video and other Board members are invited to submit statements to incorporate within this presentation to highlight the governance perspective of this Plan.

7.0 ADDENDUM

There was no addendum.

8.0 ANNOUNCEMENTS / ENQUIRIES

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

9.0 ADJOURNMENT

13-16 ADJOURNMENT

Moved by Huska – Kirwin: THAT we do now adjourn. Time: 2:41 p.m.

CARRIED

(Chair)

(Secretary)

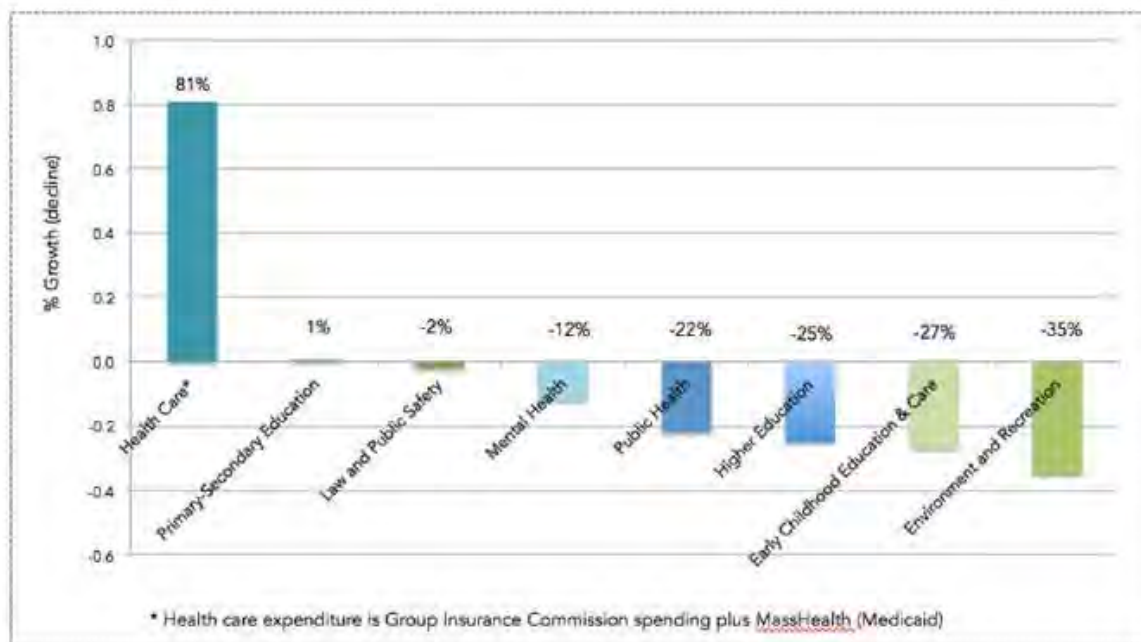
Medical Officer of Health/Chief Executive Officer Board Report, April 2016

Words for thought...

Public health is responsible for extraordinary achievements over the past century, such as remarkable gains in life expectancy and substantial decreases in infectious disease mortality, and could make similar critical contributions to health in this century. Public health should be ascendant, but ample evidence suggests that it is on the defensive today, underappreciated, and underfunded. Government actions to improve the health of populations are widely suspect, as illustrated by the controversies involving efforts to curb soda container sizes in New York City, state and federal efforts to limit reproductive health rights, and global efforts to address climate change.

By contrast, traditional medicine continues to be privileged. The burgeoning precision medicine agenda and the continuing emphasis on the treatment for cancer have captured the imagination of funding agencies and politics at the highest levels. The result is diversion of resources in the direction of individualized efforts at disease prediction through genomic approaches, and away from the structural changes with broader population-based effects that have long characterized public health action. Public health is not alone, sharing funding and infrastructure deficiencies with transportation, education, and even public safety.

eFigure. Health care spending crowds out investments in key determinants of health: Change in
 Massachusetts State Government spending, FY01-FY14, adjusted for inflation (CPI)



Reproduced from "Healthy People/Healthy Economy: An Initiative to Make Massachusetts the National Leader in
 Health and Wellness." 2015.^V Data from Massachusetts Budget and Policy Center Budget Browser.

The potential of public health to continue to improve the health of populations is being challenged and undermined by multiple factors, including an overemphasis on curative medicine. A lack of clarity about its population-centered purpose has made public health less effective than it could be.

Source: Galea S and Annas G. Aspirations and Strategies for Public Health. *JAMA*. January 23, 2016.

Chair and Members of the Board,

The recent article from the Journal of the American Medical Association succinctly articulates concerns from the Ontario public health field about the proposals contained within the *Patients First* Ministry of Health and Long-Term Care (MOHLTC) discussion paper. The MOHLTC discussion paper promotes health system integration, including closer ties between public health and the treatment care system through the Local Health Integration Networks. Authors Galea and Annas propose aspirations and strategies for the American public health context:

Aspirations for Public Health

1. Take a leadership role in confronting and influencing the social, political, and economic factors that determine population health to sustainably protect the health of the public against old and new threats.
2. Take a leadership role in reducing inequities by working to narrow health gaps across groups in ways that promote social justice and human rights.

Public Health Strategies

1. Relentlessly prioritize actions to do what matters most to the health of populations.
2. Engage the mechanisms that explain how core foundational structures produce population health.
3. Move from government-dominated public health to multisectorial public health.
4. Formally adopt the Universal Declaration of Human Rights as the Code of Public Health Ethics.

We may be wise to pursue these paths ourselves to ensure that the implementation of *Patients First* results in continued potential for public health to improve the health of populations.

Please see below highlights from Sudbury & District Health Unit (SDHU) initiatives and actions since the February Board of Health meeting.

GENERAL REPORT

1. Algoma Public Health

Effective March 1, 2016, Dr. Alex Hukowich is the Associate Medical Officer of Health at Algoma Public Health (APH). I continue to be the APH Acting Medical Officer of Health and Dr. Hukowich reports to me while APH continues their recruitment efforts.

2. MOH/CEO Performance Map and Position Description

The SDHU maintains a policy of ongoing evaluation of the job performance of its employees as a means of ongoing monitoring and quality improvement. As per the SDHU's performance management policy, the Medical Officer of Health performance review was due to take place. Feedback was sought from the members of the Senior Management Team as well as from the members of the Board Executive Committee and helped inform discussion with the Board Chair. The MOH/CEO performance map was conducted by the Board Chair on March 4, 2016 with the Board Chair.

In consultation with the Board Chair, the Medical Officer of Health position description was also reviewed as per the Health Unit policy and proposed revisions are included with today's Board agenda for the Board's approval.

3. Human Resources

As previously shared by email, Shelley Westhaver, Director of Clinical and Family Services announced her retirement effective May 31, 2016. Shelley has worked with the SDHU for over 26 years and we will all sorely miss her. I am sure you join me in wishing her well in her retirement.

I was pleased to announce on April 13 that Sandra Laclé, current Director of Health Promotion is the new Director of Clinical and Family Services. Sandra transitions to this new role from her Director, Health Promotion position effective June 1, 2016. She has extensive experience with many public health portfolios since her early days with the SDHU in 1991. This experience includes almost a decade of leading SDHU clinical services, including HBHC and child health. Sandra has also served as acting CEO for Algoma Public Health and for the SDHU on several occasions. Recruitment for the Director of Health Promotion position is currently underway.

4. BoardEffect

Board members will have noticed that BoardEffect app upgrade. There is a training video on the Home page that can also be found in *Browse Files* under *Resource Library* in a *BoardEffect Training Video* folder.

5. The Ontario Public Health Conference (TOPHC)

On April 5, 2016, R. St Onge, Director, RRED Division, and A. Berthiaume, Foundational Standard Specialist, presented on the SDHU Performance Monitoring Plan at The Ontario Public Health Conference (TOPHC). The presentation touched on the development of the plan, the reporting mechanisms included in the plan, and Board of Health members' roles with performance monitoring at the SDHU. The presenters also shared samples of our various reports. The presentation was well-received by audience members and thanks go to Board of Health members who provided helpful input.

6. Board Training Sessions

Governance: On Thursday, May 5, 2016, a governance training session will be held from 9 a.m. until 3 p.m. in the Ramsey Room at the SDHU. The session will be facilitated by consultant, John Fleming. Lunch will be provided.

Risk Management: On Friday, May 27, 2016, a risk management training session will be held from 10 a.m. until 3:30 p.m. in the Ramsey Room at the SDHU. The session will be facilitated by Corinne Berinstein, Senior Audit Manager, Health Audit Services Team (HAST), Ontario Internal Audit Division, Treasury Board Secretariat. Lunch will be provided.

7. 2015 Performance Monitoring Report

The Public Health Accountability Agreement Indicators section of the 2015 Performance Monitoring Report, presented to the Board of Health in February 2016, initially reported a variance on the Oral Health Assessment and Surveillance: % of JK, SK and Grade 2 students screened. Although the SDHU was 100% compliant with this indicator, the Ministry reported it as a variance due to a data entry error that the Health Unit was not permitted to correct. However, since the 2015 report was produced, the Ministry corrected the data entry error and has indicated that SDHU has met the target for this indicator. The final 2015 Performance Monitoring Plan report was edited to reflect this.

8. Sudbury & District Health Unit's Public Health Champion Award

For 2016, the theme of the Public Health Champion award will be based on the *You Can Create Change* campaign. Given that the award has a health equity theme, the award ceremony will take place in October to align with the International Day for the Eradication of Poverty. The call for nominations will be launched via a media release in June, with a submission deadline in early September. Selection of the award recipient will occur in September with the involvement of the Joint Board of Health/Staff Public Health Champions Selection Committee.

9. Local and Provincial Meetings

I, along with Board Chair, R. Lapierre, and Director of Corporate Services, M. Piquette, participated in the alPha risk management workshop in Toronto on February 24. This workshop was a follow-up to the successful *Managing Uncertainty: Risk Management for Boards of Health* workshop held on November 5, 2015. Speakers included Graham Scott and Corinne Berinstein.

The Council of Ontario Medical Officers of Health (COMOH) had a face-to-face meeting on February 25 and discussed relevant public health programs and services issues as well as received a delegation from Deputy Minister, Dr. Bell.

A face-to-face alPha Board meeting was held on February 26. The Board discussed timely public health topics affecting all health units in Ontario such as the Patients First Discussion Paper, public health funding and Ministry standards.

I attended the Roundtable on the Patients First Discussion Paper hosted by the MOHLTC in Sudbury on February 29.

On March 11, I participated in the alPha Executive Committee teleconference meeting as well as a COMOH Executive teleconference on April 12.

I am a member of the Practice & Evidence Program Standards Advisory Committee and attended a meeting in Toronto on March 21.

Health Sciences North invited the SDHU to a discussion forum regarding population health. R. St Onge and I participated on March 23

10. Financial Report

The approved 2016 cost-shared budget was \$22,873,326 reflecting a decrease of .55% compared to 2015.

The 2016 Budget request was submitted to the MOHLTC on February 29, 2016. The Ministry funding announcement is not expected prior to June. The Ministry continues to emphasize the government's direction regarding fiscal constraint and the need to protect service delivery.

The February statements are the first set of statements presented for 2016 and they reflect the Board of Health approved budget. Adjustments due to calendarization will be reflected in the March statements. Implementation of the cost reduction initiatives reflected in the Board of Health approved budget are proceeding. Most of the strategies have been finalized and implemented. The remaining strategies are currently tracking on target. The positive variance in the cost-shared program is \$358,373 for the period ending February 29, 2016. Gapped salaries and benefits account for \$118,775 or 33% with operating expenses and other revenue accounting for \$239,588 or 67% of the

variance. The operating and revenue variance is attributable to timing and calendarization of revenues and expenses.

The 2015 audit is being conducted by Price Waterhouse Coopers (PWC). This is PWC's 5th year conducting the SDHU audit. PWC was onsite for the period from March 7 to 24, 2016 conducting their sampling and review of records. The audit report will be presented to the Board Finance Standing Committee on May 2 and will be included in the May 19, 2016 Board of Health agenda.

11. Quarterly Compliance Report

The SDHU is compliant with the terms and conditions of our Public Health Funding and 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 March 25, 2016 on March 25, 2016. The Employer Health Tax has been paid as required by law, to March 31, 2016, with a cheque dated April 15, 2016. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to March 31, 2016, with a cheque dated April 30, 2016. There are no outstanding issues regarding compliance with the Occupational Health & Safety Act, Ontario Human Rights Code, or Employment Standards Act.

Following are the divisional program highlights for March 2016.

CLINICAL AND FAMILY SERVICES DIVISION

1. Control of Infectious Diseases

Influenza: Although the season started later than usual, we have had a busy influenza season. There have been 138 cases of influenza A and 47 cases of influenza B identified to date for the 2015-2016 influenza season.

Respiratory Outbreaks: There have been eight identified respiratory outbreaks in long-term care and retirement homes to date since December 2015. The causative agent for four of the outbreaks was identified as Influenza A. The causative agent for two of the outbreaks was identified as coronavirus, and one each of rhinovirus and RSV B respectively.

Immunization of School Pupils' Act: The CID team is in the process of reviewing all student immunization records for all school-aged children up to 18 years of age to ensure compliance with the ISPA and have begun the suspension of those children who are not up-to-date with vaccination. As of April we have sent 2774 first reminder letters, 1250 second reminder letters and temporarily suspended 243 children.

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

2. Dental Health Program

In recognition of Oral Health month, the dental health team is promoting Baby's First Dental Visit. This campaign promotes the importance of early intervention and development of skills for dental professionals. Community education strategies include messaging promoted through social media and display terminals in key locations such as walk in clinics. Tooth decay in young children continues

to be a prevalent health concern. Early intervention is key to preventing disease and treating cavities in the early stages.

3. Needle Exchange Program

As of April 1, 2016, the Health Unit became the main administrative body for distributing safe injection and inhalation supplies. This includes the ordering of supplies from the Ontario Harm Reduction Distribution Program, distribution of these supplies to community partners, and reporting/monitoring. Previously, this program was funded by the Health Unit and administered by the Sudbury Action Centre for Youth (SACY) out of their downtown location.

These changes are part of a multi-phase plan to facilitate the Health Unit's ability to expand and respond to harm reduction programming needs throughout our vast service area in the context of significant budgetary constraints.

A collaborative agreement was signed with the SACY to fund 1 FTE Outreach Worker responsible for their fixed-site harm reduction services, and the provision of supplies for both fixed-site and street outreach services. The Health Unit has also signed memorandums of understandings with Réseau ACCESS Network and the Sudbury office for the Ontario Aboriginal HIV/AIDS Strategy to provide them with harm reduction supplies for their street outreach programs.

The Health Unit has also expanded its services to offer a drop-in fixed needle exchange site location at the Rainbow Centre where clients can drop off needles and pick up safe injection or inhalation supplies (e.g. stems and mouthpiece for inhaling drugs). As such, these same clients may also access complimentary public health services such as testing (i.e. Chlamydia, Gonorrhea, pregnancy), counseling (i.e. birth control), and referrals. These services are already offered at the sexual health clinic targeting priority populations such as those who are street involved and/or homeless, had sexual contact with person (s) infected with a known sexually transmitted infection, are street workers, have had a sexually transmitted infection, are or have been injection drug users, are not using contraception.

4. Prenatal Education:

In the first quarter of 2016, 64 pregnant women and their support persons attended 'in-person' prenatal classes at SDHU's main site and 33 clients registered for on-line prenatal.

On March 4, staff co-facilitated a prenatal class at Our Children, Our Future in Capreol with 6 participants.

Staff from the Chapleau office, hosted a full day prenatal class on Saturday February 27 with 11 participants.

In Espanola, the PHN provided two prenatal education sessions, "Labour & Delivery" and "Prenatal Nutrition, Drugs and Alcohol" at Sagamok First Nation Health Centre.

Breastfeeding: Six new Breastfeeding Feeding Companion volunteers have been trained to provide peer-to-peer telephone support for breastfeeding mothers. .

19 mothers attended the Breastfeeding support group at the Minnow Lake site between January and March.

On January 28 and March 10, staff presented breastfeeding information and resources to sixty 2nd year Nursing Program students.

Staff continue working through the BFI requirements and recommendations received last fall by the BCC assessor. A date for the final site visit has not yet been booked.

Positive Parenting Program (Triple P): On January 25 a new project was launched with St-Albert's Adult Learning Centre. Students are taking part in online Positive Parenting Program (Triple P) which will result in a school credit. The lead PHN meets with the students every two weeks to review their learning and respond to any questions.

Over the past three months, staff have provided parenting programming to approximately 101* parents. Services offered included one-to-one sessions with parents of teens, parent discussion groups at St-David's school and on the Shawenekezhik Health Centre in Naughton, and a Transitions Group for parents who were separated or divorced.

Staff took part in school fair for parent council members from the Sudbury Catholic District School Board. Staff spoke with 10 participants regarding Triple P.

On April 5, a Family Health PHN will present the results of the Triple P School-Based Pilot project at the Ontario Public Health Conference. Staff is highlighting successful strategies in reaching hard-to-reach families in one local school. .

On March 10, a PHN delivered Triple P Teen Seminar "Raising Responsible Teens" to 9 parents at Manitoulin Secondary School SS during Parent Night (parent teacher interviews).

*reflects repeat clients

Child Health Community Events: Presented on the topic of Resiliency to 18 parents from the Children's Treatment Centre at HSN on March 29.

On March 7, Dr. Wayne Hammond, expert in the area of resiliency helped train staff from SDHU, Teddy Bear Day Care, and Child and Community Resources as a launch to a joint project that will involve building resiliency among adult influencers of children 0-4 years of age.

Staff attended a Baby-Well Fair at Shawenekezhik Health Centre in Naughton on March 10 and provided breastfeeding and child health information to approximately 12 participants.

ENVIRONMENTAL HEALTH DIVISION

1. Control of Infectious Diseases

During the months of February and March, ten sporadic enteric cases and three infection control complaints were investigated. Eleven enteric outbreaks were declared in institutions and childcare facilities. The causative organism of two of these outbreaks was confirmed to be Norovirus.

2. Food Safety

During the months of February and March, two food product recalls prompted public health inspectors to conduct checks of 90 local premises. All affected establishments had been notified, and subsequently had removed the recalled products from sale. The recalled food products included Organic Traditions Sprouted Flaxseed and Chia Powder, and Wonderful Brand Pistachios due to possible contamination with Salmonella.

In February and March, staff issued 30 Special Event Food Service Permits to various organizations for events serving approximately 7240 attendees.

Through Food Handler Training and Certification Program sessions offered in February and March, 68 individuals were certified as food handlers.

3. Health Hazard

In February and March, 73 health hazard complaints were received and investigated. Five of these complaints involved marginalized populations.

4. Ontario Building Code

During the months of February and March, five sewage system permits, 14 renovation applications, and six consent applications were received. Public health inspectors issued one charge to a property owner for an infraction identified under Part VIII of the Ontario Building Code.

5. Rabies Prevention and Control

Thirty-five rabies-related investigations were carried out in the months of February and March. One specimen was submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis, and was subsequently reported as negative.

Two individuals received rabies post-exposure prophylaxis due to exposure to wild and stray animals.

6. Safe Water

During February and March, 17 residents were contacted regarding adverse private drinking water samples. Public health inspectors investigated seven regulated adverse water sample results.

7. Blue Green Algae Forum

Mayors, Councillors and municipal staff from across our service area were invited to attend the SDHU's blue-green algae forum on March 22, 2016. Public Health Ontario, and the Ministry of the Environment and Climate Change, presented the latest science and blue-green algae surveillance information. SDHU staff reviewed local statistics, as well as prevention and mitigation efforts to-date, and engaged attendees in discussion exploring additional measures that might be undertaken in order to further support municipalities, agencies and residents to effectively respond to blue-green algae in local waterways.

8. Tobacco Enforcement

In February and March, tobacco enforcement officers charged three individuals for smoking on school property and one retail employee for selling tobacco to a person who is less than 19 years of age.

HEALTH PROMOTION DIVISION

1. Healthy Eating

On March 9, a health promotion staff member attended a community roundtable discussion, hosted by Trinity United Church, to recognize existing partnerships, to identify emerging community needs and to explore the potential for new relationships, programs and services for the residents of Capreol.

The event was very well-attended by representatives from local organizations and networks, businesses, volunteers, residents and the municipality. Attendees identified the need to obtain a more fulsome picture of all services available in Capreol, and to build awareness of these services and to make connections between service providers. As well, a focus on young families and older adults was highlighted, with particular interest in falls prevention programming. Ongoing dialogue is anticipated.

In January 2016, an Espanola public health nurse completed a summary of results from the Espanola Eat Local Farmers' Market Questionnaire for the 2015 Farmers' Market season. Results will be used to help the market coordinators enhance the 2016 season.

2. Healthy Weights

Health promotion staff are active partners in the three, local Healthy Kids Community Challenge (HKCC) projects and are participating on various committees hosted by the selected communities in the SDHU catchment area including the City of Greater Sudbury, Shkagamik-Kwe Health Centre in Greater Sudbury, and Noojmowin Teg Health Centre on Manitoulin Island.

At the January 27 media event, the City of Greater Sudbury (CGS) launched three of the HKCC Theme #1 activities that focus on physical activity (Run, Jump, Play, Every Day) including Snow Day, Activate your Neighbourhood and Sudbury Skates. In her role as the Community Champion for the CGS HKCC initiative, Dr. Sutcliffe spoke to the critical need to change our social and physical environments as it relates to physical activity and healthy eating, and she announced the Super Healthy Kids Champions challenge. In the coming months, a total of nine initiatives will provide children and families with free or low cost opportunities to learn and participate in new activities.

On February 5, health promotion staff attended the official Shkagamik-Kwe Event Launch for the Healthy Kids Community Challenge at the Shkagamik-Kwe Community Centre.

In February 2016, health promotion staff supported a Healthy Kids Community Challenge public skating event to promote physical activity on Manitoulin Island. In addition to free skating, free healthy snacks were distributed along with a survey to gather public interest in implementing healthier eating options in the arena canteen. Free helmets were offered to children that did not have a proper injury prevention equipment, and instruction on proper fit was provided.

Three professional development sessions were delivered to HKCC partners, by health promotion staff, in Little Current and the City of Greater Sudbury in relation to weight bias and the importance of protecting and promoting mental health as we address healthy weights.

In celebration of Eating Disorders Awareness week, the Sudbury and Sudbury East offices co-hosted a community presentation by Dr. Adele Lafrance-Robinson on March 1. The session focused on providing parents and caregivers with information regarding the implications of emotion avoidance, the differences between normal and disordered eating, potential unintended consequences associated with the campaign to end obesity and what can be done to help prevent eating disorders in children and youth.

Health promotion staff are proud to be a member of the first professional chapter of the Canadian Obesity Network in northern Ontario. The Canadian Obesity Network - Sudbury Chapter held its inaugural meeting in January 2016. The group's mission is to serve as a vehicle through which health care professionals, scientists and community members can network and work collaboratively to improve the lives of Canadians affected by obesity. Their goal is to improve the health of northern and rural Ontarians and contribute to the advancement of obesity-related care and research in Canada.

3. Injury Prevention

Between November 2015 and January 2016, public health nurses at the district office in Espanola provided one-hour education sessions on child restraint safety to officers of the Espanola Police Department. A total of eight officers learned about best practice guidelines, safety recommendations, community car seat clinics and where to go for more information.

On Manitoulin Island, local public health nurses met with the team leads who are responsible for refugee sponsorships. Information was provided on how to select and correctly use child restraints. A training session was also scheduled for all volunteers who will be transporting these families.

A Public Health Nurse from the main office continues to provide car seat technician training to partners across the districts. In January, training was provided to eight technicians from the Sudbury and Manitoulin Island areas.

In March, a Public Health Nurse attended the Well Baby Day at Atikameksheng Anishinabek First Nation and provided car seat safety information to parents.

In February, SDHU staff worked with local partners and older adults from the *Stay on Your Feet Sudbury Manitoulin* falls prevention coalition. Ideas for local and regional falls prevention programming were discussed and a draft workplan was developed. In April, the SDHU will work with the other four northeast health units and the North East Local Health Integration Network to develop a regional workplan for year two of a three year strategy.

4. Physical Activity

January 2016 marked the launch of a joint skate exchange program between the SDHU and schools located in the Municipality of French River. Staff from the Sudbury East district office helped coordinate the planning of the new initiative and provided the local schools with bins for the exchange, as well as promotional items. Students and families from each of the schools will now be able to drop-off or pick-up a pair of gently used skates.

5. Prevention of Substance Misuse

Staff from the SDHU main office co-facilitated with the Greater Sudbury Police Service an event for community members and service providers working with youth and in the field of treatment, harm reduction, and substance use prevention. Dr. Wayne Hammond presented on the topic of resiliency in youth as it related to risky behaviours (e.g., substance use and misuse). The event was well attended, with over 150 in attendance. The preliminary evaluation results were very positive.

In January 2016, staff from the SDHU Workplace Health and Substance Misuse Prevention team and Strategic Engagement Unit co-presented the Ontario Public Health Standard planning cycle as it related to the development of the SDHU alcohol strategy to practicing physicians, medical officers of health, and associate medical officers of health through a webinar. The webinar was hosted by the National Collaborating Centre for Methods and Tools and opened to practicing physicians throughout Canada. A total of 24 were in attendance.

The academic detailing pilot program was launched in January 2016. The pilot topic is the Screening Brief Intervention and Referral tool and highlighting the Low Risk Alcohol Drinking Guidelines. Thirty-five registration forms were received, 3 were detailed in January, 15 were completed in February, and by the end of March another 11 will be detailed.

In February 2016, the SDHU participated (with other Ontario health units) in a telephone consultation session to inform the development of an Ontario alcohol policy. The SDHU also provided a written submission with additional detail following the consultation. The results will help inform the development of the policy. It is anticipated that the policy will be completed this spring.

From mid-January to mid-March 2016, public health nurses met with councilors throughout the Sudbury East area to discuss the development of a Sudbury East Drug Strategy. Municipal councils in Markstay-Warren, St-Charles, and Killarney passed motions to endorse the planning of the Sudbury East Drug Strategy and council members in French River will be voting on the resolution at their next meeting.

6. School Health

In February 2016, public health nurses in the Chapleau district met with a local principal from the Conseil scolaire catholique du Nouvel-Ontario to discuss *Pathways to Resilient Schools* programming and offer activity suggestions for students, staff and parents.

7. Tobacco Control

In March 2016, a survey was launched to local health care providers (e.g., pharmacists, dental health professionals, and optometrists). The survey questioned the health care providers' knowledge, attitudes and behaviours regarding the implementation process of minimal contact intervention within their practice. The survey will help assess the needs of our community as they relate to tobacco use cessation and allow for efficient and effective future planning. Results will be shared post-completion of the survey.

8. Workplace Health

Staff from the SDHU presented the SDHU internal wellness program at the Workplace Safety and Prevention Service networking meeting. There were 20 in attendance, and most were representatives from the occupational health and safety committees.

9. Return on Investment

Ontario's public health system is tasked with supporting population health, however, much of this work is "behind the scenes" and not always visible to the public. As a result, public health is often confused with other primary or acute care systems in the community. Yet, without public health's upstream efforts, we will continue to see increases in chronic disease and illness, further burdening our already stretched health care system and budget. Building off the adage *an ounce of prevention is better than a pound of cure*, the Health Promotion Division, in partnership with the RRED Division, aims to increase awareness of the vital role Ontario's public health unit's play in the health of Ontarians. As a first step, SDHU staff developed a 1-minute video highlighting the various actions of the SDHU in our community, available in both [French](#) and [English](#). Targeting the general public, this video introduces the concept of public health as an essential investment in oneself, in our community, and in our health care system.

RESOURCES, RESEARCH, EVALUATION AND DEVELOPMENT (RRED) DIVISION

1. Health Equity

Throughout January-March 2016, SDHU continued to move forward with the *You Can Create Change* campaign. New messages were promoted via internal communications, on social media, and on the

SDHU website. Since the campaign launch in late September 2015, there have been a total of 2,078 page visits and 1,373 different visitors to the *You Can Create Change* webpages. The evaluation of the campaign commenced in February 2016 and included a staff survey and engagement sessions. Feedback obtained to date will contribute to the improvement of future phases of the campaign. Engagement with community partners is planned for the coming months.

The Health Equity Knowledge Exchange Resource Team (HEKERT) continues to receive requests for permission to adapt the SDHU's *Let's Start a Conversation* video. In 2016, there have already been five new adaptation requests, including three from Ontario, one from Nova Scotia, and one from Manitoba.

2. Population Health Assessment and Surveillance

In January, staff from the RRED Division assisted the Environmental Health Division in an enteric outbreak investigation that consisted of 51 persons from Perth, Waterloo, and SDHU areas.

The Quarterly Reportable Disease Report for October to December 2015 was compiled in collaboration with the Clinical and Family Services Division and circulated to relevant SDHU staff. These reports provide information on cases of reportable diseases that were diagnosed in the SDHU service area. Four bi-weekly Acute Care Enhanced Surveillance (ACES) reports were generated in February and March. The reports summarize cases of influenza-like-illness, enteric, and other diseases of concern in the SDHU service area, and are shared with the Clinical and Family Services and Environmental Health divisions. The SDHU also continues its Daily Student Absenteeism Surveillance with data from over 100 schools analysed by an epidemiologist each morning. Schools showing significant increases in illness-related absenteeism are flagged for possible follow-up by the Clinical and Family Services and Environmental Health divisions.

RRED staff provided the City of Greater Sudbury with a summary of data on local emergency department visits due to transport-related pedestrian injuries that occurred from January 2011 to September 2015.

3. Research and Evaluation

The Manager of Research, Evaluation, and Knowledge Exchange shared the SDHU's research priorities at the second annual Evaluating Children's Health Outcomes Research Centre (ECHO) matching event on March 1. This event provides an opportunity to connect with Laurentian University students who are interested in collaborating on children's health research. This year, four students were recruited to support youth resilience work.

On March 3, the SDHU celebrated the 10th anniversary of the Louise Picard Public Health Research Grant. The Louise Picard Public Health Research Grant aims to encourage collaboration between the Health Unit staff and University faculty members to explore research areas of mutual interest. The event was co-hosted by Laurentian University and the SDHU and featured past, present and future projects funded by the grant. This year's grant recipients include:

- Dr. Annie Roy-Charland, Laurentian University and Tina Skjonsby-McKinnon, SDHU
Anti-texting and driving strategies: youth perceptions, attitudes, and behaviours
- Dr. Diana Urajnik, Laurentian University and Joelle Martel, SDHU
The role of adult influencers in building resilient children and youth
- Heather Jessup-Falcioni, Laurentian University and David Groulx, SDHU
Understanding academic best practices for entry-to-practice competencies in public health nursing

The RRED Division, in collaboration with staff from the Health Promotion Division, led the development of an evaluation plan for the evaluation of the City of Greater Sudbury's Community Drug Strategy (CDS), which included the provision of baseline data. In addition, the team conducted an evaluation of the fentanyl Patch 4 Patch program, in which local physicians and pharmacists were surveyed regarding their and their patients' experiences with the program. The results of the survey demonstrated the successful implementation of the program. Both the evaluation of the Patch 4 Patch program and the broader CDS evaluation plan were submitted for consideration to the CDS's Executive Committee on April 7.

Staff from the Health Unit continue to support the local City of Greater Sudbury's Healthy Kids Community Challenge (HKCC), and the SDHU has been identified as the lead for the local evaluation. A draft evaluation framework has been developed and will be presented to the local HKCC Planning and Advisory Committee for review and approval at their April meeting.

On March 10, I. Vettoretti, Foundational Standard Specialist, participated in a Public Health Ontario Ethics Review Board (ERB) meeting. The committee discussed topics such as consent and assent guideline documents, project review processes, and the ERB's role regarding methodology.

4. Student Placement Program

Discussion with staff and program management teams have been initiated to explore facilitators and barriers to hosting student placements in District Office locations, in order to better inform student placement program processes. Increasing opportunities for student placement in the District Offices will facilitate future recruitment efforts as well as offer valuable learning opportunities for the students regarding northern and rural public health practice.

5. Knowledge Exchange

Between January and March, a number of in-class presentations were made to approximately 60 3rd year Laurentian University School of Nursing students by staff from the SDHU. Topics included:

- Concepts related to health inequities, poverty, homelessness and food insecurity.
- The complexity of obesity and the role of public health in addressing this issue.
- Education on how the environment plays a vital role in the health of populations, and the role of public health in supporting environments that promote and protect the health of community members.
- Public health professionals' role in the prevention and control in the spread of infectious disease.

In February, D. Malaviarachchi and J. Beyers presented on "*Beyond BMI: Investigating the Feasibility of Using NutriStep® in Electronic Medical Records (EMR) to Improve Childhood Healthy Weights*" at the Northern Ontario School of Medicine's Division of Human Sciences Seminar Series.

The SDHU was well represented at *The Ontario Public Health Conference* (TOPHC) in April. TOPHC is hosted jointly by Public Health Ontario, the Ontario Public Health Association (OPHA), and the Association of Local Public Health Agencies (aLPHA). The theme for TOPHC 2016 was "Collaborate. Innovate. Transform". SDHU staff led or participated in two workshops, three poster presentations, and six oral presentations. Presentation topics ranged from evidence-informed practice to health equity communications campaign, the SDHU performance monitoring plan, population health assessment, and the implementation of a Lean project at the SDHU. In addition to this, the SDHU's two epidemiologists were invited by conference organizers to participate in the TOPHC Mentorship Program. Each was matched with a student studying epidemiology as part of a Masters of Public Health (MPH) program, with whom they met at the conference to speak about their work and provide guidance on having a successful career in local public health.

The RRED Division is hosting another biannual Knowledge Exchange Symposium on April 19. Knowledge Exchange Symposia provide a collegial forum for all staff and presenters to share program ideas and information for possible local implementation or development of better practices. Sessions continue to be well attended and appreciated.

Respectfully submitted,

Original signed by

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

Sudbury & District Health Unit
STATEMENT OF REVENUE & EXPENDITURES
For The 2 Periods Ending February 29, 2016

Cost Shared Programs

	Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOHLTC - General Program	14,893,000	2,482,167	2,482,167	(0)	12,410,833
MOHLTC - Unorganized Territory	813,000	135,500	135,500	0	677,500
MOHLTC - VBD Education & Surveillance	65,000	10,833	10,833	0	54,167
MOHLTC - SDWS	106,000	17,667	17,667	(0)	88,333
MOHLTC - CINOT Expansion	24,800	4,133	4,133	0	20,667
Municipal Levies	6,807,155	1,134,527	1,134,527	(0)	5,672,628
Municipal Levies - Small Drinking Water Syst	47,222	7,870	7,870	0	39,352
Municipal Levies - VBD Education & Surveill	21,646	3,608	3,608	(0)	18,038
Municipal Levies - CINOT Expansion	10,503	1,751	1,751	(1)	8,752
Interest Earned	85,000	10,413	10,413	0	74,587
Total Revenues:	\$22,873,326	\$3,808,468	\$3,808,469	\$(1)	\$19,064,857
Expenditures:					
Corporate Services:					
Corporate Services	4,150,845	779,087	704,522	74,565	3,446,323
Print Shop	211,219	39,041	26,421	12,620	184,798
Espanola	92,204	14,539	18,391	(3,853)	73,812
Manitoulin	125,708	20,025	22,521	(2,496)	103,187
Chapleau	98,585	15,569	14,783	785	83,801
Sudbury East	16,486	2,748	2,735	13	13,751
Volunteer Services	6,838	1,265	183	1,081	6,655
Total Corporate Services:	\$4,701,884	\$872,273	\$789,557	\$82,715	\$3,912,327
Strategic Engagement					
Strategic Engagement	506,341	78,044	79,399	(1,356)	426,942
Total Strategic Engagement:	\$506,341	\$78,044	\$79,399	\$(1,356)	\$426,942
Clinical and Family Services:					
General	1,041,498	160,556	140,003	20,553	901,495
Clinical Services	1,217,881	187,137	168,190	18,947	1,049,691
Branches	342,399	52,777	46,755	6,022	295,644
Family	648,589	99,811	96,648	3,163	551,941
Risk Reduction	98,302	33,629	39,552	(5,923)	58,750
Intake	306,216	47,129	45,567	1,561	260,649
Clinical Preventative Services - Outreach	139,150	21,578	26,248	(4,670)	112,903
Sexual Health	940,742	147,904	139,269	8,635	801,472
Influenza	0	0	(195)	195	195
HPV	0	0	(2,627)	2,627	2,627
Dental - Clinic	805,584	103,940	97,678	6,263	707,906
CINOT Expansion - Clinic	35,303	0	0	0	35,303
Family - Repro/Child Health	1,165,023	179,970	128,745	51,226	1,036,279
Total Clinical Services:	\$6,740,688	\$1,034,431	\$925,834	\$108,598	\$5,814,854
Environmental Health:					
General	771,116	113,388	105,818	7,569	665,298
Environmental	2,676,862	444,260	423,943	20,317	2,252,919
Vector Borne Disease (VBD)	86,585	14,211	3,854	10,357	82,731
Small Drinking Water System	178,200	27,426	23,771	3,655	154,429
Total Environmental Health:	\$3,712,763	\$599,285	\$557,386	\$41,899	\$3,155,377
Health Promotion:					
General	1,089,021	168,861	178,766	(9,905)	910,255
School	1,413,698	217,793	200,991	16,802	1,212,707
Healthy Communities & Workplaces	180,720	28,010	25,739	2,270	154,981
Branches - Espanola / Manitoulin	295,926	45,607	46,796	(1,189)	249,130
Nutrition & Physical Activity	1,288,172	201,341	159,609	41,732	1,128,563
Branches - Chapleau / Sudbury East	304,286	46,894	46,130	764	258,156
Injury Prevention	460,061	70,977	58,131	12,846	401,930
Tobacco By-Law	360,655	55,779	40,033	15,746	320,622
Alcohol and Substance Misuse	292,207	45,182	27,265	17,916	264,942
Total Health Promotion:	\$5,684,746	\$880,444	\$783,460	\$96,983	\$4,901,286
RRED:					
General	1,511,663	258,555	230,663	27,893	1,281,001
Health Equity Office	15,240	3,825	2,185	1,640	13,055
Total RRED:	\$1,526,903	\$262,380	\$232,847	\$29,533	\$1,294,056
Total Expenditures:	\$22,873,326	\$3,726,857	\$3,368,484	\$358,373	\$19,504,842
Net Surplus/(Deficit)	\$0	\$81,612	\$439,985	\$358,373	

Sudbury & District Health Unit 2010-2015

Cost Shared Programs

STATEMENT OF REVENUE & EXPENDITURES

Summary By Expenditure Category

For The 2 Periods Ending February 29, 2016

	BOH Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:					
Funding	22,873,326	3,808,468	3,845,492	(37,024)	19,027,834
Other Revenue/Transfers	926,201	107,206	173,692	(66,486)	752,509
Total Revenues & Expenditure Recoveries:	23,799,527	3,915,674	4,019,184	(103,510)	19,780,343
Expenditures:					
Salaries	15,861,372	2,468,011	2,338,943	129,068	13,522,429
Benefits	4,290,477	662,890	673,183	(10,293)	3,617,294
Travel	282,080	39,013	8,645	30,368	273,435
Program Expenses	847,461	186,628	141,003	45,625	706,458
Office Supplies	70,683	12,570	8,680	3,891	62,003
Postage & Courier Services	71,975	9,996	4,100	5,895	67,875
Photocopy Expenses	67,256	11,522	5,489	6,033	61,767
Telephone Expenses	57,755	9,626	10,287	(662)	47,468
Building Maintenance	352,858	76,310	73,361	2,948	279,497
Utilities	195,840	36,640	37,566	(926)	158,273
Rent	221,384	36,897	38,911	(2,014)	182,473
Insurance	103,774	92,065	91,232	833	12,542
Employee Assistance Program (EAP)	34,969	7,828	7,605	223	27,364
Memberships	30,027	5,679	4,114	1,565	25,913
Staff Development	110,760	19,526	10,189	9,337	100,571
Books & Subscriptions	16,750	2,792	534	2,258	16,216
Media & Advertising	125,886	22,266	4,039	18,227	121,847
Professional Fees	300,729	22,588	24,185	(1,597)	276,544
Translation	47,300	7,883	6,249	1,634	41,051
Furniture & Equipment	16,130	2,688	2,704	(16)	13,426
Information Technology	694,060	100,643	88,179	12,465	605,881
Total Expenditures	23,799,527	3,834,062	3,579,199	254,863	20,220,327
Net Surplus (Deficit)	0	81,612	439,985	358,373	

Sudbury & District Health Unit

SUMMARY OF REVENUE & EXPENDITURES

For the Period Ended February 29, 2016

100% Funded Programs

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
Pre/Postnatal Nurse Practitioner	704	139,000	1,079	137,921	0.8%	Dec 31	16.7%
GSPS - Community Drug Strategy	705		23,989	(23,989)	#DIV/0!	Dec 31	16.7%
SFO - Electronic Cigarette Act - New Nov./15	723	36,700	16,081	20,619	43.8%	Mar 31/16	0.0%
SFO -TCAN - Prevention	724	97,200	(106)	97,306	-0.1%	Dec 31	16.7%
SFO - Tobacco Control Area Network - TCAN	725	285,800	39,022	246,778	13.7%	Dec 31	16.7%
SFO - Local Capacity Building: Prevention & Protection	726	259,800	29,862	229,938	11.5%	Dec 31	16.7%
SFO - Tobacco Control Coordination	730	100,000	15,746	84,254	15.7%	Dec 31	16.7%
SFO - Youth Engagement	732	80,000	11,078	68,922	13.8%	Dec 31	16.7%
Infectious Disease Control	735	479,100	81,672	397,428	17.0%	Dec 31	16.7%
LHIN - Falls Prevention Project & LHIN Screen	736	110,000	108,586	1,414	98.7%	Mar 31/16	91.7%
MOHLTC - Special Nursing Initiative	738	180,500	26,597	153,903	14.7%	Dec 31	16.7%
MOHLTC - Northern Fruit and Vegetable Funding	743	150,100	108,962	41,138	72.6%	Mar 31/16	66.7%
Beyond BMI - LDCP	747	143,023	3,969	139,054	2.8%	Dec 31	16.7%
Food Safety - Haines Funding	750	36,500	723	35,777	2.0%	Dec 31	16.7%
Triple P Co-Ordination	766	5,943	11,796	(5,853)	198.5%	Dec 31	16.7%
Healthy Babies Healthy Children	778	1,476,897	230,499	1,246,398	15.6%	Dec 31	16.7%
Healthy Smiles Ontario (HSO)	787	406,300	49,296	357,004	12.1%	Dec 31	16.7%
Anonymous Testing	788	59,393	50,708	8,685	85.4%	Mar 31/16	91.7%
MHPS- Aboriginal Diabetes	792	175,000	133,892	41,108	76.5%	Mar 31/16	91.7%
Total		4,221,256	943,451	3,277,805			

The Premier of Ontario

Legislative Building, Queen's Park
Toronto, Ontario M7A 1A1



La première ministre de l'Ontario

Édifice de l'Assemblée législative, Queen's Park
Toronto (Ontario) M7A 1A1

March 8, 2016

Dr. Penny Sutcliffe
Medical Officer of Health and Chief Executive Officer
Sudbury and District Health Unit
1300 Paris Street
Sudbury, Ontario
P3E 3A3

SUDBURY & DISTRICT HEALTH UNIT	
Medical Officer of Health and CEO	
MAR 11 2016	
Environ Health	RRD
CFS	SEU
Corporate Services	Board
Head Office	Committee
File () Circulate () Return () F.Y.I ()	

Dear Dr. Sutcliffe:

Thank you for your letter in which you set out the Board of Health's resolution regarding legislation to enforce infection prevention and control practices within invasive personal service settings. I appreciate your keeping me informed of the board's activities.

I note that you have sent a copy of the board's resolution to my colleague the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care. I trust that the minister will also take the board's views into consideration.

Thank you again for the information.

Sincerely,

A handwritten signature in cursive script, reading "Kathleen Wynne".

Kathleen Wynne
Premier

c: The Honourable Dr. Eric Hoskins



March 15, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
premier@ontario.ca

Dear Premier Wynne,

Re: Legislation to enforce infection prevention and control practices within invasive personal service settings under the Health Protection and Promotion Act

At its meeting held on March 9, 2016, the Board of Health for the Peterborough County-City Health Unit considered correspondence from the Haliburton, Kawartha, Pine Ridge District Health Unit regarding the above noted matter.

The Board echoes the recommendations outlined in their letter (attached) and it is our hope that you will consider enacting legislation for infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording in the *Provincial Offences Act*.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Dr. David Williams, Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Boards of Health



21 January 2016

The Hon. Kathleen Wynne
Premier of Ontario
Legislative Building - Queen's Park
Toronto ON M7A 1A1

Re: Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings under the *Health Protection and Promotion Act*

Dear Premier Wynne

Ontario has no legislation regulating infection prevention and control practices to minimize the risk of blood borne disease transmission from practices/procedures performed at invasive Personal Service Settings (PSS). The PSS Protocol under Ontario Public Health Standards (OPHS) govern the activities of Public Health Units regarding PSS infection control such as causing one inspection per year for invasive services which is the same frequency for non-invasive PSS such as a hair salon.

Public Health Inspectors (PHIs), in accordance with the OPHS and best practices, inspect invasive PSS without provincial legislation that outlines legal requirements for infection control needs and operator responsibilities. Infection prevention and control practices are a major component of assessing invasive PSS to minimize the transmission risks of blood-borne disease.

Invasive PSS such as tattoo/body modification establishments or other invasive PSS require extra attention and time for PHIs to mitigate risk to the public by ensuring operators have adequate infection prevention and control practices in place. The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit views the importance of public health regulations to minimize the risk of blood-borne disease transmission from invasive personal service settings.

The Haliburton, Kawartha, Pine Ridge District Board of Health therefore urges the Government of Ontario to enact legislation for infection prevention and control requirements for invasive PSS under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act*.

Sincerely

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

Mark Lovshin
Board of Health Chair

.../2

PROTECTION · PROMOTION · PREVENTION



HEAD OFFICE

200 Rose Glen Road
Port Hope, Ontario L1A 3V6
Phone · (905) 885-9100
Fax · (905) 885-9551



BRIGHTON OFFICE

Box 127
35 Alice Street
Brighton, Ontario K0K 1H0
Phone · (613) 475-0933
Fax · (613) 475-1455



HALIBURTON OFFICE

Box 570
191 Highland Street, Unit 301
Haliburton, Ontario K0M 1S0
Phone · (705) 457-1391
Fax · (705) 457-1336



LINDSAY OFFICE

108 Angeline Street South
Lindsay, Ontario K9V 3L5
Phone · (705) 324-3569
Fax · (705) 324-0455

Page 2

The Hon. Kathleen Wynne

Encl. 2

Cc:

The Honourable Eric Hoskins, Minister of Health and Long-Term Care

Ms. Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock

Mr. Lou Rinaldi, MPP, Northumberland-Quinte West

Mr. Patrick Brown, MPP, Simcoe North – Leader of the Progressive Conservative Party of Ontario

Ms. Andrea Horwath, MPP, Hamilton Centre – Leader of the New Democratic Party of Ontario

Dr. David Williams, Chief Medical Officer of Health

Board of Health Chairs

Association of Local Public Health Agencies

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT BOARD OF HEALTH RESOLUTION

- TITLE:** Enactment of Legislation to enforce infection prevention and control practices within invasive Personal Service Settings (PSS) under the *Health Protection and Promotion Act*.
- SPONSOR:** Haliburton, Kawartha, Pine Ridge District Health Unit
- WHEREAS** Ontario has no legislation governing infection prevention and control practices to minimize the risk of blood borne disease transmission from practices/procedures performed at invasive Personal Service Settings (PSS); and
- WHEREAS** The Personal Service Setting Protocol under the *Ontario Public Health Standards* (OPHS) governs the activities of public health units regarding PSS infection control; and
- WHEREAS** The OPHS mandate one inspection per year for invasive personal service settings, which is the same frequency for non-invasive PSS such as a hair salon; and
- WHEREAS** Public Health Inspectors (PHIs), in accordance with the OPHS and best practices, inspect invasive PSS without provincial legislation that outlines legal requirements for infection control needs and operator responsibilities; and
- WHEREAS** Infection prevention and control practices are a major component of assessing invasive PSS to minimize the transmission risks of blood-borne disease; and
- WHEREAS** Invasive PSS such as tattoo/body modification establishments or other invasive PSS require extra attention and time for PHIs to mitigate risk to the public by ensuring operators have adequate infection prevention and control practices in place.

NOW THEREFORE BE IT RESOLVED that the Haliburton, Kawartha, Pine Ridge District Board of Health strongly recommends and urgently requests the Government of Ontario to enact legislation implementing infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act*.

AND FURTHER that the Haliburton, Kawartha, Pine Ridge District Board of Health strongly recommends and urgently requests that the Association of Local Public Health Agencies advocate to the Premier of Ontario and the Minister of Health and Long-Term Care, to enact legislation implementing infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act*.

March 24, 2016

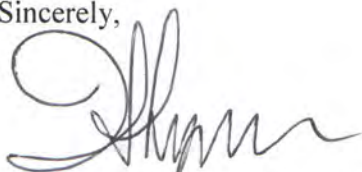
The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Wynne:

Re: Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached resolution #11-16 from Sudbury and District Health Unit regarding the enactment of legislation to enforce Infection Prevention and Control (IPAC) practices within Invasive Personal Service Settings. A motion to endorse this resolution was passed.

Sincerely,



Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

Encl.

Working together for a healthier future for all.

101 17th Street East, Owen Sound, Ontario N4K 0A5 www.publichealthgreybruce.on.ca

519-376-9420

1-800-263-3456

Fax 519-376-0605

February 22, 2016

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

Dear Minister Hoskins:

Subject: Environmental Health Program Funding – BOH Resolution #BOH/2016/01/13

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/13:

Whereas, the Board of Health is responsible to oversee the implementation of the Ontario Public Health Standards (OPHS), related protocols/guidelines and Health Protection and Promotion Act (HPPA) and related regulations, and

Whereas, the Board of Health works towards improvement of the overall health of the population through surveillance, health promotion, disease prevention, health protection and enforcement of provincial public health policy, and legislation, and

Whereas, the Board of Health supports the Province of Ontario enacting new policy and legislation which will improve the health of the population, and

Whereas, recent changes to provincial policy and new legislation has resulted in the expansion of the Environmental Health program mandate in recent years, and

Whereas, in 2014 the Skin Cancer Prevention Act (Tanning Beds) went into effect and public health inspectors (PHIs) were required to complete education visits of tanning bed establishments and respond to future public complaints with these facilities, and

Whereas, the Recreational Water Protocol was updated by the Ministry of Health and Long-Term Care in 2014 and included a broadening of the definition of a public beach which resulted in doubling the number of municipal public beaches that require annual water sampling, and

Whereas, in 2015, the Ministry of Health and Long-Term Care released the new Infection Prevention and Control Lapse Disclosure Guidance document requiring the Health Unit to actively investigate public complaints related to infection prevention and control (IPAC) in regulated health care settings where previously the Health Unit was not mandated, and

Whereas, in 2017, the Ministry of Health and Long-Term Care advises that menu labelling requirements will come into force for certain restaurants and will require PHIs to enforce, and

Whereas, recent amended environmental health protocols require the disclosure of public facility inspection reports to the public on request and resulting in increased workload for Health Unit staff, and

Whereas, the challenge is implementing new policy and legislation that comes often without any additional resources and where current Environmental Health program staff are already at full capacity implementing existing mandated programs, and

Whereas, the challenge is implementing new policy and legislation that comes often without any support for staff training,

Now Therefore Be It Resolved, that the Board of Health for the North Bay Parry Sound District Health Unit endorse the following actions to support the Environmental Health program in implementing new provincial public health policy and legislation:

- 1) Encourage the Ontario Ministry of Health and Long-Term Care to provide dedicated, predictable recurring funding to public health units for the purpose to enhance Environmental Health program field staff and management capacity to implement new provincial public health policy and legislation;
- 2) Encourage the Ontario Ministry of Health and Long-Term Care to fund an additional 2.0 full-time equivalent (FTE) public health inspectors in the Environmental Health program;
- 3) Encourage the Ontario Ministry of Health and Long-Term Care to adopt as standard policy for providing of training to public health staff whenever new provincial public health policy and legislation is implemented; and
- 4) Encourage the Ministry of Health and Long-Term Care to develop a staffing model for health units to use to determine adequate levels of environmental health staffing which include field staff, supervisory staff and management staff necessary to fully implement provincial environmental health policy and legislation.

Furthermore Be It Resolved, that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.

Sincerely,



James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

C: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Linda Stewart, Executive Director, Association of Local Public Health agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member Municipalities (31)

March 24, 2016

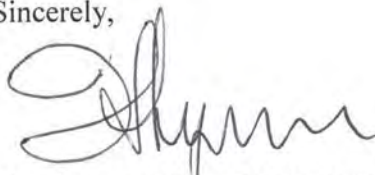
The Honourable Dr. Eric Hoskins
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins:

Re: Environmental Health Program Funding

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached resolution #BOH/2016/01/13 from North Bay Parry Sound District Health Unit regarding the Environmental Health Program Funding. A motion to endorse this resolution was passed.

Sincerely,



Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Ontario Boards of Health
Ontario Medical Officers of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies

Encl.

Working together for a healthier future for all.

101 17th Street East, Owen Sound, Ontario N4K 0A5 www.publichealthgreybruce.on.ca

519-376-9420

1-800-263-3456

Fax 519-376-0605

February 22, 2016

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

Dear Minister Hoskins:

Subject: Environmental Health Program Funding – BOH Resolution #BOH/2016/01/13

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/13:

Whereas, the Board of Health is responsible to oversee the implementation of the Ontario Public Health Standards (OPHS), related protocols/guidelines and Health Protection and Promotion Act (HPPA) and related regulations, and

Whereas, the Board of Health works towards improvement of the overall health of the population through surveillance, health promotion, disease prevention, health protection and enforcement of provincial public health policy, and legislation, and

Whereas, the Board of Health supports the Province of Ontario enacting new policy and legislation which will improve the health of the population, and

Whereas, recent changes to provincial policy and new legislation has resulted in the expansion of the Environmental Health program mandate in recent years, and

Whereas, in 2014 the Skin Cancer Prevention Act (Tanning Beds) went into effect and public health inspectors (PHIs) were required to complete education visits of tanning bed establishments and respond to future public complaints with these facilities, and

Whereas, the Recreational Water Protocol was updated by the Ministry of Health and Long-Term Care in 2014 and included a broadening of the definition of a public beach which resulted in doubling the number of municipal public beaches that require annual water sampling, and

Whereas, in 2015, the Ministry of Health and Long-Term Care released the new Infection Prevention and Control Lapse Disclosure Guidance document requiring the Health Unit to actively investigate public complaints related to infection prevention and control (IPAC) in regulated health care settings where previously the Health Unit was not mandated, and

Whereas, in 2017, the Ministry of Health and Long-Term Care advises that menu labelling requirements will come into force for certain restaurants and will require PHIs to enforce, and

Whereas, recent amended environmental health protocols require the disclosure of public facility inspection reports to the public on request and resulting in increased workload for Health Unit staff, and

Whereas, the challenge is implementing new policy and legislation that comes often without any additional resources and where current Environmental Health program staff are already at full capacity implementing existing mandated programs, and

Whereas, the challenge is implementing new policy and legislation that comes often without any support for staff training,

Now Therefore Be It Resolved, that the Board of Health for the North Bay Parry Sound District Health Unit endorse the following actions to support the Environmental Health program in implementing new provincial public health policy and legislation:

- 1) Encourage the Ontario Ministry of Health and Long-Term Care to provide dedicated, predictable recurring funding to public health units for the purpose to enhance Environmental Health program field staff and management capacity to implement new provincial public health policy and legislation;
- 2) Encourage the Ontario Ministry of Health and Long-Term Care to fund an additional 2.0 full-time equivalent (FTE) public health inspectors in the Environmental Health program;
- 3) Encourage the Ontario Ministry of Health and Long-Term Care to adopt as standard policy for providing of training to public health staff whenever new provincial public health policy and legislation is implemented; and
- 4) Encourage the Ministry of Health and Long-Term Care to develop a staffing model for health units to use to determine adequate levels of environmental health staffing which include field staff, supervisory staff and management staff necessary to fully implement provincial environmental health policy and legislation.

Furthermore Be It Resolved, that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.

Sincerely,



James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

C: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Linda Stewart, Executive Director, Association of Local Public Health agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member Municipalities (31)



February 25, 2016

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

Dear Minister Hoskins:

The board of health for Peterborough County-City Health Unit recently received a staff report on the Herpes Zoster Vaccine, at our request. As individual board members, we are aware of both the serious complications of Herpes Zoster reactivation, or “Shingles”, and the significant cost of the vaccine. We are also aware that the currently available vaccine, Zostavax II™, produced by Merck Canada Inc., appears to have a limited length of time where it is considered protective.

The burden of illness associated with Herpes Zoster reactivation is considerable, with a lifetime risk of 30%. For persons over 80 years of age, the incidence has been estimated to be 8.4/1,000. The debilitating neurogenic pain syndrome that can occur following shingles, called post-herpetic neuralgia, occurs in 20% of all cases, but increases to more than a third of octogenarians.

The Provincial Infectious Diseases Advisory Committee (PIDAC) for Ontario released a report in 2013 which examined several options for a publicly funded vaccine program for herpes zoster. PIDAC found that the vaccine was cost-effective under a wide range of assumptions, particularly for adults aged 65-70 years of age. PIDAC recommended that the provision of the vaccine for 65 year olds, as this is also the age eligibility for the pneumococcal polysaccharide vaccine. Providing the vaccine to 60 year olds, as currently recommended by the National Advisory Committee on Immunization (NACI) would be more expensive but also more equitable, as all persons for whom the vaccine is recommended by NACI would be eligible.

We understand that there is a new vaccine currently in development that may present a much more effective and longer lasting option. The availability of this promising vaccine would only enhance the economic evaluations that have already been done.

We call upon you and your government to seriously consider adding the herpes zoster vaccine to the list of publicly funded vaccines available to Ontario’s adults. Immunization continues to be one of our most effective tools in the prevention of disease and promotion of health, and this remains true through-out the life cycle, including into our later years.

We appreciate your consideration of this important addition as you move forward with Vision 20/20, the modernization of our provincial immunization system.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at

cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
M.P.P. Jeff Leal, Peterborough
M.P.P. Laurie Scott, Haliburton-Kawartha Lakes-Brock
Ontario Boards of Health
Association of Local Public Health Agencies

March 24, 2016

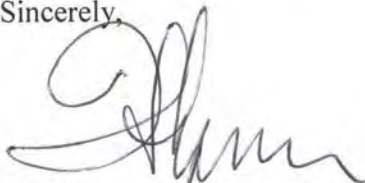
The Honourable Dr. Eric Hoskins
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Hoskins:

Re: Herpes Zoster Vaccine

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached correspondence from Peterborough County-City Health Unit regarding the Herpes Zoster Vaccine. A motion to endorse this correspondence was passed.

Sincerely,



Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Ontario Boards of Health
Association of Local Public Health Agencies

Encl.

Working together for a healthier future for all.

101 17th Street East, Owen Sound, Ontario N4K 0A5 www.publichealthgreybruce.on.ca

519-376-9420

1-800-263-3456

Fax 519-376-0605



February 25, 2016

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

Dear Minister Hoskins:

The board of health for Peterborough County-City Health Unit recently received a staff report on the Herpes Zoster Vaccine, at our request. As individual board members, we are aware of both the serious complications of Herpes Zoster reactivation, or "Shingles", and the significant cost of the vaccine. We are also aware that the currently available vaccine, Zostavax II™, produced by Merck Canada Inc., appears to have a limited length of time where it is considered protective.

The burden of illness associated with Herpes Zoster reactivation is considerable, with a lifetime risk of 30%. For persons over 80 years of age, the incidence has been estimated to be 8.4/1,000. The debilitating neurogenic pain syndrome that can occur following shingles, called post-herpetic neuralgia, occurs in 20% of all cases, but increases to more than a third of octogenarians.

The Provincial Infectious Diseases Advisory Committee (PIDAC) for Ontario released a report in 2013 which examined several options for a publicly funded vaccine program for herpes zoster. PIDAC found that the vaccine was cost-effective under a wide range of assumptions, particularly for adults aged 65-70 years of age. PIDAC recommended that the provision of the vaccine for 65 year olds, as this is also the age eligibility for the pneumococcal polysaccharide vaccine. Providing the vaccine to 60 year olds, as currently recommended by the National Advisory Committee on Immunization (NACI) would be more expensive but also more equitable, as all persons for whom the vaccine is recommended by NACI would be eligible.

We understand that there is a new vaccine currently in development that may present a much more effective and longer lasting option. The availability of this promising vaccine would only enhance the economic evaluations that have already been done.

We call upon you and your government to seriously consider adding the herpes zoster vaccine to the list of publicly funded vaccines available to Ontario's adults. Immunization continues to be one of our most effective tools in the prevention of disease and promotion of health, and this remains true through-out the life cycle, including into our later years.

We appreciate your consideration of this important addition as you move forward with Vision 20/20, the modernization of our provincial immunization system.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at

cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
M.P.P. Jeff Leal, Peterborough
M.P.P. Laurie Scott, Haliburton-Kawartha Lakes-Brock
Ontario Boards of Health
Association of Local Public Health Agencies

FONOM

The Federation of Northern Ontario Municipalities

March 8, 2015

Dr. Penny Sutcliffe, Chief Medical Officer of Health and Chief Executive Officer
Sudbury & District Health Unit
1300 Paris Street
Sudbury, ON
P3E 3A3

Dear Dr. Sutcliffe,

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

The Federation of Northern Ontario Municipalities (FONOM) held its regular meeting of the Board of Directors on January 15, 2016 in which resolution #55-15 from the Sudbury & District Board of Health was discussed.

Kindly be advised that FONOM supported the resolution to encourage the Province of Ontario to take action to reduce the exposure of second-hand smoke in multi-unit housing.

Yours sincerely,



Alan Spacek
President

SUDBURY & DISTRICT HEALTH UNIT Medical Officer of Health and CEO			
MAR 16 2016			
Environ Health	_____	RRCD	_____
CFS	_____	SEU	_____
Corporate Services	_____	Board	_____
Health Promotion	_____	Committee	_____
File () Circulate () Return () F.Y.I ()			



March 21, 2016

The Honourable Ted McMeekin
Ontario Minister of Municipal Affairs and Housing
777 Bay Street, 17th Floor
Toronto, ON
M5G 2E5

Dear Minister McMeekin,

On March 18, 2016, the Porcupine Health Unit Board of Health passed the following resolution:

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;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Porcupine Health Unit support 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 (AMO), the Federation of Northern Ontario Municipalities (FNOM) and Porcupine Health Unit municipalities for their information and support.

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

Yours very truly,



Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

email: info4you@porcupinehu.on.ca
Website: www.porcupinehu.on.ca

Branch Offices: Cochrane, Hearst,
Hornepayne, Iroquois Falls,
Kapuskasing, Matheson,
Moosonee, Smooth Rock Falls

February 22, 2016

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

Dear Minister Hoskins:

Subject: Bill 139: Smoke-Free Schools Act – BOH Resolution #BOH/2016/01/11

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/11:

Whereas, tobacco use is the leading cause of preventable death and disability in Canada (Ministry of Health and Long-Term Care, 2010), and

Whereas, the number of daily and occasional cigarette smokers in the North Bay Parry Sound District Health Unit is 7% higher than the provincial average (25.8% vs. 18.7%; NBPSDHU, 2014), and

Whereas, Bill 139: Smoke-Free Schools Act introduced by MPP Todd Smith is slated for third reading in the Ontario Legislature this year, and

Whereas, Bill 139: Smoke-Free Schools Act includes a prohibition on the sale of any tobacco products in schools, increased fines for offenders caught selling illegal tobacco, and increased suspension periods of driver's licenses for people convicted of using a vehicle for unauthorized delivery/transportation of illegal tobacco, sharing the proceeds of disposition of forfeited property with police forces if they were involved in the investigation, a requirement that the Government establish a public education program about the health risks associated with the use of tobacco, and

Whereas, the illegal sale of contraband cigarettes undermines public health's efforts to reduce smoking rates and protect children and youth from the dangers of smoking, and

Whereas, higher tobacco taxes have been identified as the most effective strategy to reduce smoking prevalence and Ontario has one of the lowest tobacco tax rates in Canada (Smoke-Free Ontario Scientific Advisory Committee, 2010; Ontario Tobacco Research Unit, 2015), and

Whereas, plain and standardized packaging is an effective counter measure to the tobacco industry's use of packaging as an important part of tobacco promotion, and

Whereas, Bill 139: Smoke-Free Schools Act has been endorsed by the Canadian Cancer Society, the Heart & Stroke Foundation, and the Ontario Campaign Against Tobacco (OCAT),

Now Therefore Be It Resolved, that the Board of Health for the North Bay Parry Sound District Health Unit support Bill 139: Smoke-Free Schools Act and that legislation for plain and standardized cigarette packaging and higher tobacco taxes be considered by all levels of government, and

Furthermore Be It Resolved, that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, the Association of Local Public Health Agencies (alpha), MPP Todd Smith (Prince Edward-Hastings), MPP Victor Fedeli (Nipissing), MPP Norm Miller (Parry Sound-Muskoka), Premier Kathleen Wynne, and Ontario Boards of Health.

Sincerely,



James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

C: Todd Smith, MPP, Prince Edward-Hastings
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
Hon. Kathleen Wynne, Premier of Ontario
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

March 24, 2016

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

Dear Minister Hoskins:

Re: Bill 139: Smoke-Free Schools Act

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached resolution #BOH/2016/01/11 from North Bay Parry Sound District Health Unit regarding Bill 139: Smoke-Free Schools Act. A motion to endorse this resolution was passed.

Sincerely,

A handwritten signature in black ink, appearing to read "H. Lynn". The signature is fluid and cursive, with a large initial "H" and a long, sweeping underline.

Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: Hon. Kathleen Wynne, Premier of Ontario
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Ontario Boards of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies

Encl.

Working together for a healthier future for all.

101 17th Street East, Owen Sound, Ontario N4K 0A5 www.publichealthgreybruce.on.ca

519-376-9420

1-800-263-3456

Fax 519-376-0605



The Regional
Municipality
of Durham

Corporate Services
Department -
Legislative Services

605 ROSSLAND RD. E.
PO BOX 623
WHITBY ON L1N 6A3
CANADA

905-668-7711
1-800-372-1102
Fax: 905-668-9963

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

February 8, 2016

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

RE: **Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated January 12, 2016 re: Cannabis Regulation and Control (Our File No. P00)**

SUDBURY & DISTRICT HEALTH UNIT	
Medical Officer of Health and CEO	
FEB 16 2016	
Environ Health	_____
Clinical Services	_____
Corporate Services	_____
Health Promotion	_____
RRCD	_____
Board	_____
Committee	_____
Circulate	()
F.Y.I.	()

Honourable Prime Minister, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on January 27, 2016, Council adopted the following recommendations of the Committee:

- A) That the correspondence dated December 1, 2015 from the Sudbury & District's Medical Officer of Health, urging the Government of Canada to adopt a public health approach if it proceeds with its election commitment to legalize, regulate and restrict access to marijuana be endorsed;
- B) That the Federal government and province provide additional funding to municipalities to help offset any higher social costs resulting from legalization of marijuana; and a copy of the resolution be provided to Federation of Canadian Municipalities, Association of Municipalities of Ontario, local MPs and MPPs; and
- C) That the Prime Minister of Canada, Minister of Health, Minister of Justice and Attorney General of Canada, Durham MPPs, alPHA and all Ontario boards of health be so advised.

Attached is a copy of the Memorandum from Dr. Robert Kyle, Commissioner and Medical Officer of Health dated January 12, 2016 regarding Cannabis Regulation and Control.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

"Service Excellence
for our Communities"

If this information is required in an accessible format, please contact the Accessibility Co-ordinator at 1-800-372-1102 ext. 2009.

- c: The Honourable Jane Philpott, Minister of Health
 The Honourable Jody Wilson-Raybould, Minister of Justice and
 Attorney General of Canada
 Joe Dickson, MPP (Ajax/Pickering)
 Whitby/Oshawa Constituency Office
 The Honourable Tracy MacCharles, MPP, (Pickering/
 Scarborough East)
 Granville Anderson, MPP (Durham)
 Jennifer French, MPP (Oshawa)
 Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
 Mark Holland, MP (Ajax)
 Mr. Erin O'Toole, MP (Durham)
 Jamie Schmale MP (Haliburton/Kawartha Lakes/Brock)
 Kim Rudd, MP (Northumberland/Peterborough South)
 Dr. Colin Carrie MP(Oshawa)
 Jennifer O'Connell, MP (Pickering/Uxbridge)
 Celina Caesar-Chavannes MP (Whitby)
 L. Stewart, Executive Director, Association of Local Public
 Health Agencies (aLPHa)
 P. Vanini, Executive Director, Association of Municipalities of
 Ontario (AMO)
 B. Carlton, Chief Executive Officer, Federation of Canadian
 Municipalities (FCM)
 Ontario Boards of Health
 R.J. Kyle, Commissioner & Medical Officer of Health

February 12, 2016

The Right Honourable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, Ontario K1A 0A6

Dear Prime Minister Trudeau,

Re: Cannabis: A Public Health Approach

At its meeting on January 21, 2016, the Middlesex-London Board of Health approved Report No.003-16 and its Appendix, supporting a public health approach to cannabis policy, including a strong framework of strict regulations to minimize health and social harms.

After receiving this report, the following motion was passed:

Moved by: Mr. Stephen Turner

Seconded by: Mr. Trevor Hunter

That the Board of Health for Middlesex-London:

- 1) authorize staff to advocate for an evidence-based public health approach to Cannabis in the context of legalization, including strict regulation for the non-medical use of cannabis, as well as its production, distribution, product promotion and sale; and*
- 2) establish baseline data and mechanisms to monitor local use of cannabis in the coming years; and*
- 3) forward this report and appendices to the Association of Local Public Health Agencies, the Ontario Public Health Association, Ontario Boards of Health, the Ontario Minister of Health and Long-Term Care, the federal Minister of Health, and other elected officials as appropriate.*

We applaud the Liberal government's commitment to developing an evidence based approach to cannabis regulation and control, and advocate for a strong public health focus in this regard.

Sincerely,



Jesse Helmer
Chair, Middlesex-London Board of Health



Dr. Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health & CEO

Page 62 of 182

Cc:

Hon. Eric Hoskins, Ontario Minister of Health
Hon. Jane Philpott, Minister of Health
Hon. Kathleen Wynne, Premier of Ontario
Bill Blair, MP Scarborough-Southwest, Parliamentary Secretary to the Minister of Justice and Attorney General of Canada
Bev Shipley, MP Lambton-Kent-Middlesex
Irene Mathysen, MP London-Fanshawe
Karen Vecchio, MP Elgin-Middlesex-London
Kate Young, MP London-West
Peter Fragiskatos, MP London-North Centre
Deb Matthews, MPP London-North Centre
Jeff Yurek, MPP Elgin-Middlesex-London
Monte McNaughton, MPP Lambton-Kent-Middlesex
Peggy Sattler, MPP London-West
Theresa Armstrong, MPP London-Fanshawe
Daniel Cho Program and Policy Assistant, Ontario Public Health Association
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director Ontario Public Health Association
All Ontario Boards of Health

Encl.

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2016 January 21

CANNABIS: A PUBLIC HEALTH APPROACH

Recommendation

It is recommended that the Board of Health:

- 1. authorize staff to advocate for an evidence-based public health approach to Cannabis in the context of legalization, including strict regulation for the non-medical use of cannabis, as well as its production, distribution, product promotion and sale; and*
- 2. establish baseline data and mechanisms to monitor local use of cannabis in the coming years; and*
- 3. forward this report and appendices to the Association of Local Public Health Agencies, the Ontario Public Health Association, Ontario Boards of Health, the Ontario Minister of Health and Long-Term Care, the federal Minister of Health, and other elected officials as appropriate.*

Key Points

- Canada has one of the highest rates of cannabis use in the world.
- Police associations and public health organizations have expressed support for a new approach, and the federal government has indicated that they will legalize cannabis in their current mandate.
- Cannabis use is associated with a variety of health harms. The most concerning occur among youth and chronic heavy users.
- A public health approach to cannabis policy is recommended, including a strong policy framework of strict regulations to minimize health and social harms.

Background

In July 2015, staff reported to the Board of Health on work being undertaken to develop an evidence-based position on cannabis policy (see [Report No. 047-15](#) from July).

Canada has one of the highest rates of cannabis use in the world with over 40% of Canadian adults having used cannabis in their lifetime. In Ontario, it is the most widely consumed illicit drug, with youth and young adults having the highest rates of use. The debate about the regulation of cannabis for non-medical use has been ongoing for decades in Canada and has gained interest with the election of the new Liberal government. Despite decades of legislation and international conventions aimed at eliminating cannabis, use has continued to increase globally. In response, various countries have adjusted or are in the process of adjusting their approach to cannabis legislation and control.

Portugal decriminalized the possession of all drugs for personal use in 2001 while implementing a national drug strategy at the same time. In 2013, Uruguay became the first country to legalize the personal use and sale of cannabis. In the United States, 15 states have decriminalized the possession of small amounts for personal use and in 2012 Colorado and Washington State became the first two states to legalize recreational use of cannabis, followed by Alaska, Washington DC and Oregon.

A comprehensive review of what cannabis is, prevalence of use, history of law related to cannabis, cannabis associated harms, synopsis of trends away from prohibition and positions of other Canadian agencies can be found in the attached report, Cannabis: A Public Health Approach (see [Appendix A](#)).

Public Health Approach

While the scientific evidence suggests that cannabis has a smaller public health impact than alcohol and tobacco, cannabis is associated with health risks which generally increase with frequent heavy consumption and use at an early age. Public health considerations include cannabis impaired driving, effects on youth brain development and mental health, respiratory system effects, use during pregnancy and risk of dependence. Criminalization of cannabis possession and use has not reduced use and has paradoxically resulted in increased health and social harms.

A public health approach addresses the public health concerns of cannabis use while aiming to eliminate or reduce the health and social harms resulting from its criminal prohibition. The Canadian Public Health Association (CPHA) asserts that a public health approach based on principles of social justice, attention to human rights and equity, evidence informed policy and practice and addressing the underlying determinants of health is the preferred approach to criminalization.

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in its field. In 2014, following extensive review of the research, CAMH scientific staff released the report "Cannabis Policy Framework" concluding that Canada requires a strong policy framework for cannabis, recommending legalization with strict regulations.

The policy framework by CAMH is consistent with the views of other agencies such as Canadian Public Health Association (CPHA) and the Canadian Centre on Substance Abuse (CCSA). Middlesex London Health Unit recommends an approach to cannabis policy that is consistent with CAMH. This recommended approach is also consistent with the Colorado Department of Public Health and Environment's public health framework for legal recreational marijuana. The federal government's approach to changing the legal framework around cannabis has also received support from such policing organizations as the Canadian Association of Chiefs of Police.

Conclusion

While there are recognized and important health harms to cannabis use, these are modest in comparison to the health impacts of other drugs such as alcohol and tobacco. Despite prohibition, prevalence of the recreational use of cannabis has increased, and moreover, criminal prohibition has resulted in well documented health and social harms. The Ontario Public Health Standards mandates boards of health to reduce the frequency, severity and impact of substance misuse; with regards to cannabis, criminal prohibition is a barrier to effectively meet these objectives.

In the context of coming legalization, strict regulation for the non-medical use of cannabis, i.e. a public health approach to cannabis production, distribution, product promotion and sale, is recommended to best prevent and reduce health and social harms associated with cannabis use. This approach acknowledges that cannabis is not a benign substance and that policy built upon evidence-based regulations and controls is the recommended best approach to minimize the risks and harms associated with use.

The report was prepared by Ms. Mary Lou Albanese, Manager and Ms. Rhonda Brittan, Public Health Nurse, Healthy Communities and Injury Prevention Team.



Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards:
Prevention of Injury and Substance Misuse Standard Requirement #2.

February 22, 2016

The Honourable Deb Matthews
Deputy Premier
President of the Treasury Board
Minister Responsible for the Poverty Reduction Strategy
Room 4320
99 Wellesley Street West
Toronto, ON M7A 1W3

Dear Minister Matthews,

As the Minister responsible for the Ontario Poverty Reduction Strategy, I am writing to inform you of the resolutions passed on January 27, 2016 at the North Bay Parry Sound District Health Unit Board of Health meeting. These resolutions focus on increasing incomes in Ontario in an effort to reduce food insecurity and poverty rates.

According to the 2015 Nutritious Food Basket data, the cost of healthy eating for a family of four in the North Bay Parry Sound District is approximately \$837 per month. When this amount is combined with local rent rates and compared to several income scenarios, it is clear that those receiving social assistance and earning minimum wage do not have enough money for all the costs of living, including nutritious food. Our 2015 Cost of Healthy Eating Report and associated infographic include more information on these income scenarios and are included in this package for your reference.

Household food insecurity is defined as inadequate or insecure access to food because of financial constraints. Food insecurity greatly impacts health and wellbeing, which makes it a serious public health problem. Adults who are food insecure have poorer self-rated health and are more likely to suffer from chronic conditions such as diabetes, high blood pressure and anxiety. Children who experience food insecurity have an increased risk of developing asthma and depression in adolescence and early adulthood. In addition, being food insecure is strongly associated with being a high cost health care user. Research clearly highlights poverty as the root cause of food insecurity.

The most common community level response to food insecurity is food charity programs, including food banks and soup kitchens. While food charity is well meaning, it does not decrease food insecurity. The North Bay Parry Sound District Health Unit Board of Health has endorsed the Ontario Society of Nutrition Professionals in Public Health's (OSNPPH) [Position Statement on Responses to Food Insecurity](#), highlighting food charity as an ineffective and counterproductive response to food insecurity and calling for the implementation of a basic income guarantee as a long term solution to truly address poverty in Ontario.

The North Bay Parry Sound District Health Unit Board of Health also endorsed the [resolution](#) passed by the Association of Local Public Health Agencies (aLPHa) in June 2015, endorsing the concept of a basic income guarantee as a policy option for reducing poverty, and calling on federal and provincial representatives to prioritize joint federal-provincial consideration and investigation into a basic income guarantee.

We recognize improvements have been made in recent years to social assistance programs, and minimum wage has been increased. However, this is just the beginning in addressing food insecurity. Our

local data indicates more must be done to increase incomes and reduce poverty in Ontario in an effort to promote good health for all. Thank you in advance for taking the time to review this information and please consider the resolutions passed by the NBPSDHU Board of Health.

Sincerely,



James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

Attachments (3)

C: Hon. Eric Hoskins Minister of Health and Long-Term Care (MOHLTC)
Hon. Helena Jaczek, Minister of Community and Social Services
Hon. Kathleen Wynne, Premier of Ontario
Anthony Rota, MP, Nipissing-Timiskaming
Tony Clement, MP, Parry Sound-Muskoka
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
Ontario Society of Nutrition Professionals in Public Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Member Municipalities
Ontario Boards of Health

**NORTH BAY PARRY SOUND DISTRICT HEALTH UNIT
BOARD OF HEALTH**

RESOLUTION

DATE: January 27, 2016

MOVED BY:

John Stopper

RESOLUTION: #BOH/2016/01/10

SECONDED BY:

CRIS Jull

Whereas, The Nutritious Food Basket Survey results show that many low-income individuals and families do not have enough money for nutritious food and other basic living expenses,¹ and

Whereas, The Board of Health for the North Bay Parry Sound District Health Unit recognizes the impact of adequate income on food security and other social determinants of health,

Whereas, food charity programs do not address the root cause of food insecurity, which is poverty,³

Whereas, a basic income guarantee would ensure all citizens would have an income sufficient to meet basic needs and live with dignity, regardless of work status,

Now Therefore Be it Resolved, That the Board of Health for the North Bay Parry Sound District Health Unit endorse the Association of Local Public Health Agencies (alPHA) resolution titled Public Health Support for a Basic Income Guarantee⁴, and

Furthermore Be It Resolved, That the Board of Health for the North Bay Parry Sound District Health Unit endorse the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Position Statement on Responses to Food Insecurity², and

Furthermore Be it Resolved, That the Board of Health for the North Bay Parry Sound District Health Unit urge the Ontario government to prioritize the investigation into a basic income guarantee, and increase minimum wage and social assistance rates, indexed with inflation to reflect the costs of living including the ability to purchase nutritious food, and

Furthermore Be It Resolved, That the Board of Health for the North Bay Parry Sound District Health Unit continue to support the efforts of employees and community stakeholders that play a role in addressing food insecurity through social determinants of health work, and

Furthermore Be It Resolved, that the Board of Health for the North Bay Parry Sound District Health Unit provide correspondence of these resolutions to district municipalities, Ontario Society of Nutrition Professionals in Public Health (OSNPPH), Association of Local Public Health Agencies (alPHA), the Honourable Anthony Rota (Nipissing-Timiskaming), the Honourable Tony Clement (Parry Sound-Muskoka), Victor Fedeli, MPP (Nipissing), Norm Miller, MPP (Parry Sound-Muskoka) Premier Kathleen Wynne, Deputy Premier Deb Matthews, the Honourable Helena Jaczek (Minister of Community and Social services) and the Honourable Dr. Eric Hoskins (Minister of Health and Long-Term Care).

CARRIED:

✓

DEFEATED:



AS AMENDED:

CHAIRPERSON:

CONFLICT OF INTEREST DECLARED AND SEAT(S) VACATED:

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

RECORDED VOTE:

- | | |
|------|----------|
| For: | Against: |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |
| 6. | 6. |
| 7. | 7. |
| 8. | 8. |
| 9. | 9. |
| 10. | 10. |

The 2015 Cost of Healthy Eating: North Bay Parry Sound District

What is the Nutritious Food Basket?

The Nutritious Food Basket is a provincial survey tool that is used to calculate the cost of a basic nutritious diet. Each year, the North Bay Parry Sound District Health Unit conducts the survey with twelve grocery stores across the district to price food items that represent a basic healthy diet according to Canada's Food Guide and Canadian purchasing patterns. The results of the Nutritious Food Basket survey are then compiled into the annual Cost of Healthy Eating Report.

The list of 67 food items does not include processed and convenience foods, snack foods, or household non-food items such as cleaning products, toothpaste and toilet paper. The survey also assumes that people have the skills and ability to access, prepare and store food. The survey does not consider the additional costs of eating out or special occasions such as holiday or birthday celebrations.

Year after year the results of the survey continue to show that for many low income households in our district it may not be possible to pay rent, bills such as utilities and telephone, and buy nutritious food.

What is the cost of healthy eating in the North Bay Parry Sound District?

In 2015, the cost for a family of four to eat a basic healthy diet for one week was \$193.30 or \$837.03 a month.

2015 Income Scenarios in the North Bay Parry Sound District

- A 40 year old single man on Ontario Works with a total monthly income of \$752.00 paying \$550.00 per month in rent (which may or may not include heat and hydro) would need \$281.10 to maintain the cost of a nutritious diet. This person would have a remaining income of -\$79.10 per month.
- A single mother with a son and daughter on Ontario Works with a total monthly income of \$2006.00 paying \$896.00 per month in rent (which may or may not include heat and hydro) would need \$632.92 to maintain the cost of a nutritious diet. This person would have \$477.08 remaining per month.
- A family of four on Ontario Works with a total monthly income of \$2,214.00 paying \$1,131.00 per month in rent (which may or may not include heat and hydro) would need \$837.03 to maintain the cost of a nutritious diet. This family would have \$245.97 remaining per month.
- A single man on an Ontario disability support program with a total monthly income of \$1,205.00 paying \$720.00 per month in rent (which may or may not include heat and hydro) would need \$281.10 to maintain the cost of a nutritious diet. This person would have \$203.90 remaining per month.
- A 75 year old single woman on an old age security/guaranteed annual income with a total monthly income of \$1556.00 paying \$720.00 per month in rent (which may or may not include heat and hydro) would need \$204.88 to maintain the cost of a nutritious diet. This person would have \$631.12 remaining per month.

- A minimum wage earner with a family of four with a total monthly income of \$2,900.00 paying \$1,131.00 per month in rent (which may or may not include heat and hydro) would need \$837.03 to maintain the cost of a nutritious diet. This person would have \$931.97 remaining per month.
- A family of four with the Ontario median income of \$6,952.00 paying \$1,131.00 per month in rent (which may or may not include heat and hydro) would need \$837.03 to maintain the cost of a nutritious diet. This family would have \$4983.97 remaining per month.

Monthly income includes additional benefits and credits. A family of four consists of a man and a woman, both age 35, a boy age 14, and a girl age 8. The Health Unit can provide references for income calculations. Please contact Erin Reyce, RD at 705-474-1400 ext 2532 for further information.

The scenarios above only account for monthly rent and a basic healthy diet. Other monthly expenses may include heat, hydro, childcare, transportation costs, insurance, prescriptions, dental care, telephone, costs associated with school and other unexpected costs.

Even with careful planning and budgeting low income families are unable to cover all of their necessary expenses and afford a basic healthy diet. In these situations food becomes a discretionary expense. People may skip meals or fill up on less nutritious foods, resulting in poor diets.

In 2013, 12.5% of households were food insecure in Ontario.¹ Families with children are greatly affected, with local data showing that 1 in 3 families with children are food insecure.² The source of household income is also important. 68% of households reliant on social assistance experience food insecurity.¹ 61% of food insecure households in Ontario were reliant on employment wages¹. These numbers demonstrate that current social assistance and minimum wage rates do not reflect the true costs of living.

How does income impact health?

Household food insecurity is defined as inadequate or insecure access to food because of financial constraints. Poverty is the root cause of food insecurity.³

Food insecurity greatly impacts health and wellbeing. Adults who are food insecure have poorer self-rated health and are more likely to suffer from chronic conditions such as diabetes, high blood pressure and anxiety. Children who experience food insecurity have an increased risk of developing asthma and depression in adolescence and early adulthood.¹ In addition, being food insecure is strongly associated with being a high cost health care user.³

What is the solution?

Community responses to food insecurity such as food banks and meal programs provide some low income individuals and families temporary hunger relief. However, they do not address the root problem, which is poverty. These programs will never be enough to truly address food insecurity.

The only long term solution to food insecurity is to reduce poverty rates. Many groups are calling on governments to investigate the implementation of a basic income guarantee (also known as guaranteed annual income) which would ensure adequate income for all, regardless of work status.

Advocacy efforts to provincial and federal governments are needed to support policy change to improve the social safety net, and in turn, promote health and wellbeing for all, including:

- More stable employment opportunities (i.e. full time employment opportunities with medical benefits)
- The investigation of a basic income guarantee for all
- Immediate increased minimum wage and social assistance rates to reflect the actual cost of living and indexed annually to inflation

Additional Resources

- PROOF, Research to Identify Policy Options to Reduce Food Insecurity: <http://nutritionalsciences.lamp.utoronto.ca/>
- Basic Income Canada Network http://www.basicincomecanada.org/about_basic_income
- Ontario Society of Nutrition Professionals in Public Health – Position Statement on Responses to Food Insecurity <http://www.osnp-ph.on.ca/news/membership/news/osnp-ph-releases-position-statement-on-responses-to-food-insecurity>
- Ontario Poverty Reduction Strategy: <http://www.ontario.ca/home-and-community/realizing-our-potential-poverty-reduction-strategy-2014-2019>
- Do the math challenge: <http://dothemath.thestop.org/>
- Call 705-474-1400 or 1-800-563-2808 and ask to speak with a Public Health Dietitian

References:

1. Tarasuk, V, Mitchhell, A, Dachner, N. (2015). *Household food insecurity in Canada, 2013*. Toronto: Research to identify policy options to reduce food insecurity (PROOF). Retrieved from <http://nutritionalsciences.lamp.utoronto.ca/>
2. North Bay Parry Sound District Health Unit. (2014). *NutriSTEP® Screening - 2013*. North Bay, ON: North Bay Parry Sound District Health Unit.
3. Ontario Society of Nutrition Professionals in Public Health. (2015). *Position Statement on Responses to Food Insecurity*. Retrieved from http://www.osnp-ph.on.ca/upload/membership/document/position-statement-2015-final_1.pdf#upload/membership/document/position-statement-2015-final.pdf

The Cost of Healthy Eating

North Bay Parry Sound 2015

\$837

Local monthly cost to feed a family of 4.



Household food insecurity =

- Not enough money to buy healthy food

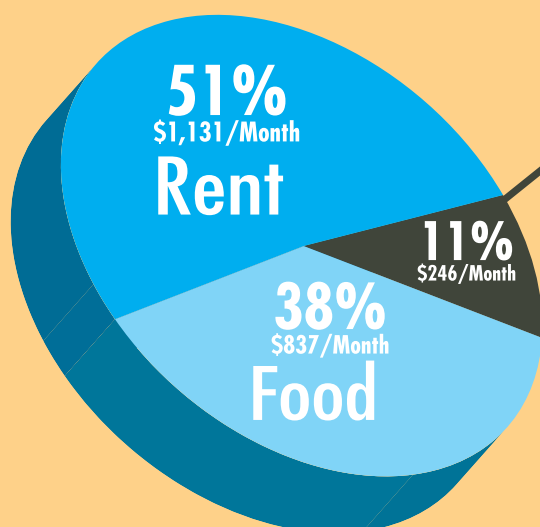
- Higher rates of: Diabetes
Heart disease
Depression
High blood pressure



1 in 8 Ontario households are food insecure.

Social assistance rates are inadequate.

For a family of four on Ontario Works in our district:

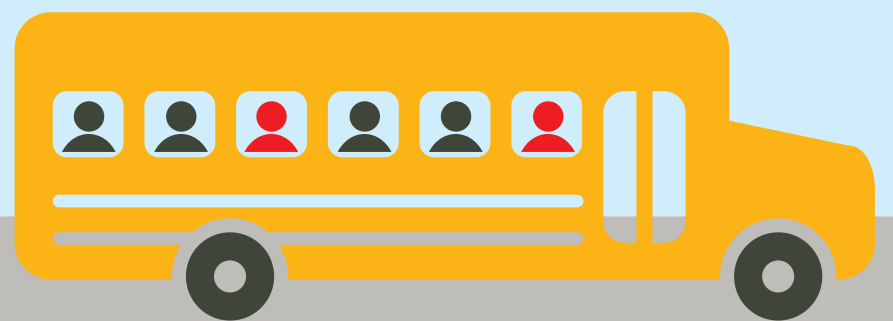


Left For

Utilities
Telephone
Childcare
Transportation
Clothing
Insurance
School costs
Etc...



61% of food insecure households in Ontario have income from employment.



1 in 3 households with children in our district struggle to put food on the table.

Poverty is the root cause of food insecurity.

“Implement a guaranteed annual income.”



“Health benefits for all.”

“Strengthen employment standards to reduce unstable employment and improve working conditions.”

“Increase social assistance rates.”



What can you do? Share these messages. Learn about food insecurity and poverty. Support programs that increase access to healthy food. Talk to your local MP and MPP.

Learn more

www.myhealthunit.ca

@NBPSDHealthUnit

facebook.com/NorthBayParrySoundDistrictHealthUnit

North Bay Parry Sound District
Health Unit

Le coût d'une alimentation saine

dans la région de North Bay Parry Sound - 2015

837 \$

Le coût moyen pour
nourrir une famille
de 4 par mois.



L'insécurité alimentaire d'un foyer signifie

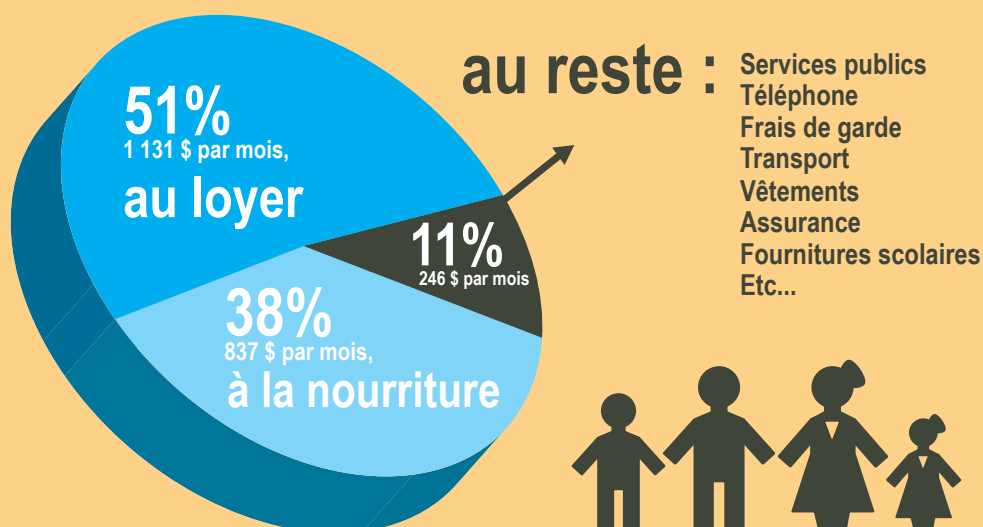
- Pas assez d'argent pour acheter des aliments nutritifs
- Des taux plus élevés de :
 - diabète
 - maladies cardiaques
 - dépression
 - tension artérielle élevée



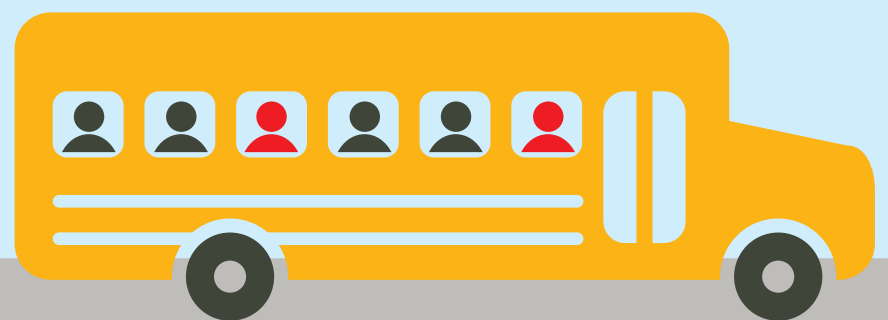
1 ménage sur 8 en Ontario se trouve en situation d'insécurité alimentaire.

Les taux d'aide sociale sont trop faibles.

Une famille de quatre dans notre district recevant du soutien du programme Ontario au travail consacre :



61% des ménages se trouvant en situation d'insécurité alimentaire en Ontario ont des revenus d'emploi.



1 ménage sur 3 comptant **des enfants** dans notre district a du mal à nourrir la famille.

La pauvreté est la cause première de l'insécurité alimentaire.

« Mettez sur pied un revenu annuel garanti. »



« Assurance-maladie pour tous. »

« Renforcez les normes d'emploi pour réduire les emplois précaires et améliorer les conditions de travail. »

« Augmentez les taux d'aide sociale. »



Que pouvez-vous faire? Transmettez ces messages. Renseignez-vous sur l'insécurité alimentaire et la pauvreté. Appuyez les programmes qui améliorent l'accès aux aliments nutritifs. Parlez à votre député fédéral et provincial local.

Pour en savoir plus

www.myhealthunit.ca

@NBPSDHealthUnit

facebook.com/NorthBayParrySoundDistrictHealthUnit



Bureau de santé
du district de North Bay-Parry Sound

March 2, 2016

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

Dear Minister Duclos:

I am writing today on behalf of Wellington-Dufferin-Guelph Public Health to request that the federal government study the merits of a basic income guarantee as a policy option for reducing poverty and as a measure to improve the health of all Canadians. Wellington-Dufferin-Guelph Public Health's Board of Health believes that health equity is an important part of building healthy communities which is why we urge you to give serious consideration to a basic income guarantee.

Income inequities are increasing in Canada as described in a number of recent reports, including a report released by Wellington-Dufferin-Guelph Public Health in 2011. The Low Income Measure (LIM) revealed that 11.4 percent of households in Wellington-Dufferin-Guelph (WDG) were low income. The rate of low-income households in WDG ranged widely among communities from 4.6 to 19.8 percent. Although just under 7 percent of children in WDG were living in households with low income, the rate in one Guelph neighbourhood was over 30 percent.

Another well-documented fact is that poverty has considerable negative impacts on health. Income may be the most important determinant of health as it influences health-related living conditions. A Wellesley Institute report presented compelling evidence that low income almost inevitably ensures poor health and significant health inequity in Canada. Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis and heart disease, and to live with a disability. The report, *Poverty Is Making Us Sick* offered a comparison between the highest and lowest-income quintiles among Canadians and found that the lowest quintile had double the rates of diabetes and heart disease than those in the highest one. Those in the lowest quintile were 60 percent more likely to have two or more chronic conditions, four times more likely to live with disability, and three times less likely to have additional health and dental coverage.



Research conducted across multiple countries found that countries with higher rates of income inequality had higher levels of health and social problems across all income levels. This pattern was consistent and included health issues such as mental illness, higher levels of obesity and lower life expectancy, educational achievements such as math and literacy scores, and community issues such as violence.

There has been widespread support for an investigation into and consideration of a basic income guarantee for all Canadians. In the public health sector, resolutions have been passed by the Association of Local Public Health Agencies (alPHA) and the Ontario Public Health Association (OPHA). Prior to the last federal election, the Canadian Public Health Association released a fact sheet calling on the next federal government to take leadership in adopting a national strategy to provide all Canadians with a basic income guarantee.

Support for a basic income guarantee has also emerged from municipalities. In December of 2015, the City of Kingston passed a resolution advocating for the federal and provincial governments to consider, investigate and develop a basic income guarantee for all Canadians. The City of Kingston resolution was forwarded to all municipalities in Ontario with a request that they consider supporting the initiative. To date the resolution has been endorsed by the cities of Cornwall, Belleville, Pelham, Peterborough and Welland.

Wellington-Dufferin-Guelph Public Health's strategic directions include "health equity" and "building healthy communities." Both of these strategic directions are intended to support advocacy efforts for the investigation into and consideration of a basic income guarantee for all Canadians. We urge you to move the government's intentions from the well-documented evidence in a number of recent reports to action, by studying the merits of a basic income guarantee. Poverty results in poor health and a basic income guarantee is a cost-effective policy option that will impact the lives and health of the poorest Canadians.

Sincerely,

Doug Auld, Board of Health Chair
Wellington-Dufferin-Guelph Public Health

Attachment: Basic Income Guarantee Board of Health Report

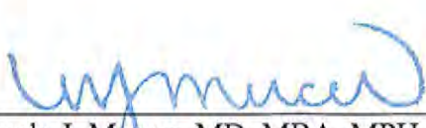


- cc. The Right Honourable Justin Trudeau, Prime Minister of Canada
The Honourable Kathleen Wynne, Premier of Ontario
Dr. David Williams, Ontario Chief Medical Officer of Health
Linda Stewart, Association of Local Public Health Agencies
Pegeen Walsh, Ontario Public Health Association
Ontario Boards of Health
Wellington-Dufferin-Guelph Members of Parliament
Wellington-Dufferin-Guelph Members of Provincial Parliament
Waterloo Wellington Local Health Integration Network
Central West Local Health Integration Network
Brock Carlton, Chief Executive Officer, Federation of Canadian Municipalities
Wellington-Dufferin-Guelph Municipalities

Report to: Board of Health
Submitted by: Dr. Nicola Mercer, Medical Officer of Health & CEO
Prepared by: Jennifer MacLeod, Manager, Health Analytics
Approved by: Andrea Roberts, Director, Family Health & Health Analytics
Subject: BASIC INCOME GUARANTEE

RECOMMENDATION(S)

- (a) That the Board of Health send a letter to the Minister of Families, Children and Social Development requesting that the federal government study the merits of a basic income guarantee as a policy option for reducing poverty and as a measure to improve the health of all Canadians.



Nicola J. Mercer, MD, MBA, MPH, FRCPC
Medical Officer of Health & CEO

EXECUTIVE SUMMARY

A Basic Income Guarantee is intended to ensure universal income security.¹ There are currently individuals and families who are living in poverty in Wellington County, Dufferin County and the City of Guelph.² There have been widespread advocacy efforts to support an investigation into and consideration of a Basic Income Guarantee for all Canadians. Pilot studies have demonstrated that Basic Income Guarantee initiatives can achieve intended outcomes.³

BACKGROUND

Basic Income Guarantee (BIG) is an income transfer from government to citizens that is not tied to labour market participation.¹ The objective of basic income guarantee is universal income security.¹ A basic income guarantee ensures that income for all individuals is at a level that is sufficient to meet basic needs and live with dignity, regardless of work status.⁴ There are different models of basic income guarantee and it is known by other names such as Guaranteed Annual Income (GAI), Basic Annual Income, Guaranteed Liveable Income, and Citizen's Income.⁴ A Basic Income Guarantee has the potential to alleviate or even eliminate poverty.⁵

One of the proposed models of Basic Income Guarantee is the negative income tax model (NIT). The NIT model depends on the tax system to administer income. Within this model there are three basic elements:

1. The benefit level – which delineates the maximum benefit payable to an individual
2. The reduction rate – which is the amount by which the benefit is decreased for additional income that exceeds the maximum allowable level
3. The break-even rate – which is the amount of income at which an individual will receive no benefit because the reduction rate has reached 100%⁶

Glen Hodgson, Chief Economist of the Conference Board of Canada stated that there are solid economic, fiscal and social reasons to give a guaranteed annual income serious consideration. He outlined three main advantages:

1. Its approach to addressing poverty would reduce public administration by streamlining existing social welfare programs into one universal system. The system used would be the already existing tax system.
2. Earned income for the working poor could be taxed at low marginal rates. This would provide a strong incentive for recipients to work to earn additional income.
3. Through reducing the prevalence of poverty, a guaranteed annual income could create better health outcomes and therefore reduce health care spending.⁷

Senator Hugh Segal has enumerated other compelling reasons to support a Basic Income Guarantee. He believes that it will result in supporting people to become productive, taxpaying, full participants in our economic mainstream. In contrast, continued societal poverty will result in “serious economic, stability and social cohesion costs that are not sustainable.” In addition, he points out that a Basic Income Guarantee would result in

significant economic savings from reducing the administration costs of current systems.⁸

A Basic Income Guarantee has many advantages over minimum wage. It is financed through the tax and transfer system. Those who earn more money pay more for it. It is available whether an individual is working or not. In contrast the minimum wage is only of benefit to those who have a job and the cost of minimum wage is borne entirely by employers. As a result, employers may hire fewer workers or provide fewer hours of work.⁹

In 2011 it was estimated by the National Council of Welfare that it would cost \$12.6-billion to top up the 3.5 million Canadians living under the poverty line. At that time the amount was less than five percent of the federal budget. It was also less than half the cost imposed on the economy by poverty and its effects.¹⁰ Allowing poverty to continue is far more expensive than investing to improve the economic well-being of those who are impoverished.⁴ The cost of poverty has been estimated at 5.5 to 6.6 percent of Canada's Gross Domestic Product (GDP). This is attributed to costs of health care, criminal justice and lost productivity. Canada's GDP is currently in the range of \$1.5-\$2.0 trillion a year. As a percentage of the current GDP, poverty costs are calculated to be in the range of \$82-\$132 billion per year.⁴

*"Given that basic income is designed primarily to bring individuals out of poverty, it has the potential to reduce the substantial, long-term social consequences of poverty, including higher crime rates and fewer students achieving success in the educational system."*⁴

The Low Income Measure After Tax (LIM-AT) identifies individuals living in households with an income that is lower than 50% of the median adjusted income for all households of the same size in that year. The adjustment for household size reflects that fact that a household's needs increase as the number of household members increases, although not by the same proportion per additional member. For 2010, the LIM-AT threshold for a household of two people was \$27,521. That same year, the LIM-AT threshold for a household of four people was \$38,920.¹¹

Living below this threshold is an indication of poverty. There are individuals and families who are living in poverty in Dufferin County, Wellington County, and the City of Guelph. The National Household Survey data shows that 10.5% percent of WDG residents live in low income circumstances as measured by the LIM-AT (10.1% in Dufferin County, 8.4% in Wellington County and 12.1% in the City of Guelph).² Since 2008, Ontario Works caseloads at the County of Wellington and Dufferin County have risen by approximately 60% and 42%, respectively.^{12, 13}

Poverty has a negative and lasting impact on health and well-being. Income may be the most important determinant of health as it influences health related living conditions.¹⁴ A Wellesley Institute report presented compelling evidence that low income almost inevitably ensures poor health and significant health inequity in Canada.¹⁵ People living in poverty use health services more frequently and often are more seriously sick or injured. Low income results in poor health and is attributable to 20% of total health care spending in Canada.¹⁶ Children who live in low income households are particularly affected. They are more likely to have a range of

health problems throughout their life, even if their socioeconomic status changes later in life.¹⁶ Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis, and heart disease, and to live with a disability. The Wellesley Institute study, *Poverty Is Making Us Sick* offered a comparison between the highest and lowest income quintiles among Canadians and found that the lowest quintile had double the rates of diabetes and heart disease than those in the highest one. Those in the lowest quintile were 60% more likely to have two or more chronic conditions, four times more likely to live with disability, and three times less likely to have additional health and dental coverage.¹⁵

Research conducted across multiple countries found that countries with higher rates of income inequality had higher levels of health and social problems across all income levels. This pattern was consistent and included health issues such as mental illness, higher levels of obesity and lower life expectancy, educational achievements such as math and literacy scores, and community issues such as violence.¹⁷

Politicians have acknowledged the benefits of a Basic Income Guarantee. The Senate of Canada in 2009 released a report on poverty which called for a study on the costs and benefits of a basic income supplement.¹⁸ Conservative Senator Hugh Segal has long been a proponent of a Basic Income Guarantee. In 2012 he wrote that, “if the federal tax system topped up everyone who was beneath the poverty line to above it, there would be no Canadians eligible for provincial welfare.” As a result the lowest income Canadians “would not occupy homeless shelters, prisons, court rooms and mental hospitals disproportionately to their percentage of the population, because they would be liberated from poverty-caused pathologies by having a basic income guarantee.”¹⁹

At a 2014 convention, Liberal party members passed a policy resolution pledging to create a basic annual income. Priority Resolution 100: Creating a Basic Annual Income to be Designed and Implemented for a Fair Economy resolves “that a Federal Liberal Government work with the provinces and territories to design and implement a Basic Annual Income in such a way that differences are taken into consideration under the existing Canada Social Transfer System.”²⁰

Minister of Families, Children and Social Development, Jean-Yves Duclos, a veteran economist, has a mandate to come up with a poverty-reduction strategy for Canada. He stated that he appreciates the principles behind the idea of a guaranteed income, “greater simplicity for the government, greater transparency on the part of families, and greater equity for everyone.”²¹

There have been widespread advocacy efforts to support an investigation into and consideration of a Basic Income Guarantee for all Canadians. Public Health agencies recognize that poverty and income inequality have well-established relationships with adverse health outcomes. In the Public Health sector, resolutions have been passed by the Association of Local Public Health Agencies (alPHA) and the Ontario Public Health Association (OPHA), calling for governments to “prioritize joint federal-provincial consideration and investigation into a basic income guarantee, as a policy option for reducing poverty and income insecurity and for providing opportunities for those in low income.”²⁶ Prior to the last federal election the

Canadian Public Health Association released a fact sheet calling on the next federal government to take leadership in adopting a national strategy to provide all Canadians with a basic income guarantee.²²

In a 2014 report the Canadian Association of Social Workers proposed the development of a basic income to encourage pan-Canadian income, social and health equity.²³ In August 2015, prior to the Federal election, members of the Canadian Medical Association passed a motion in support of a basic income guarantee.²⁴ The motion passed with a sizeable majority.

Support for a Basic Income Guarantee has also emerged from municipalities. In December of 2015 the City of Kingston passed a resolution advocating for the federal and provincial governments to consider, investigate and develop a basic income guarantee for all Canadians. The City of Kingston resolution was forwarded to all municipalities in Ontario with a request that they consider supporting the initiative. To date the resolution has been endorsed by the cities of Cornwall, Belleville, Pelham, Peterborough and Welland.⁴

ANALYSIS/RATIONALE

One of the only major studies on Basic Income Guarantee in a high-income country that examined outcomes beyond labour market effects was conducted in Canada in the 1970s. This study, “MINCOME”, was conducted in the province of Manitoba between 1974 and 1979. The research design involved selecting families from two communities: the city of Winnipeg, and the small rural community of Dauphin, Manitoba. A unique design element in the study was that Dauphin was a saturation site; everyone was entitled to participate in the study. About a third of Dauphin families qualified for MINCOME stipends at any point in time. Families from other small, rural communities were selected as study controls for the Dauphin families.³

One of the advantages of the saturation site was that it reproduced the conditions that would be present in a universal program. It was believed that this would result in a greater ability to understand administrative and community outcomes in a less artificial environment. In addition, a saturation site can result in a “social multiplier effect” - outcomes that are stronger than one might expect because the broader community benefitted from changing social circumstances.³ Details of the MINCOME stipend are described:

“The Dauphin cohort all received the same offer: a family with no income from other sources would receive 60% of Statistics Canada low-income cut-off (LICO), which varied by family size. Every dollar received from other sources would reduce benefits by fifty cents. All benefits were indexed to the cost of living. Families with no other income and who qualified for social assistance would see little difference in their level of support, but for people who did not qualify for welfare under traditional schemes – particularly the elderly, the working poor, and single, employable males – MINCOME meant a significant increase in income. Most important for an agriculturally dependent town with a lot of self-employment, MINCOME offered stability and predictability; families knew they could count on at least some support,

no matter what happened to agricultural prices or the weather. They knew that sudden illness, disability or unpredictable economic events would not be financially devastating.”³

At the end of the four-year study virtually no analysis was done by project staff, and a final report was not produced. This is attributed to a change in the intellectual and economic climate. There were also changes in both the federal and provincial governments.³

Dr. Evelyn Forget, an economist and professor at the University of Manitoba, conducted an analysis of the MINCOME study in 2009 and published her findings in 2011. She was interested in determining what impact MINCOME may have had on population health. The results were impressive. The MINCOME study demonstrated higher rates of school completion (Figure 1), and a reduction in hospitalizations (Figure 2).²⁵

Figure 1

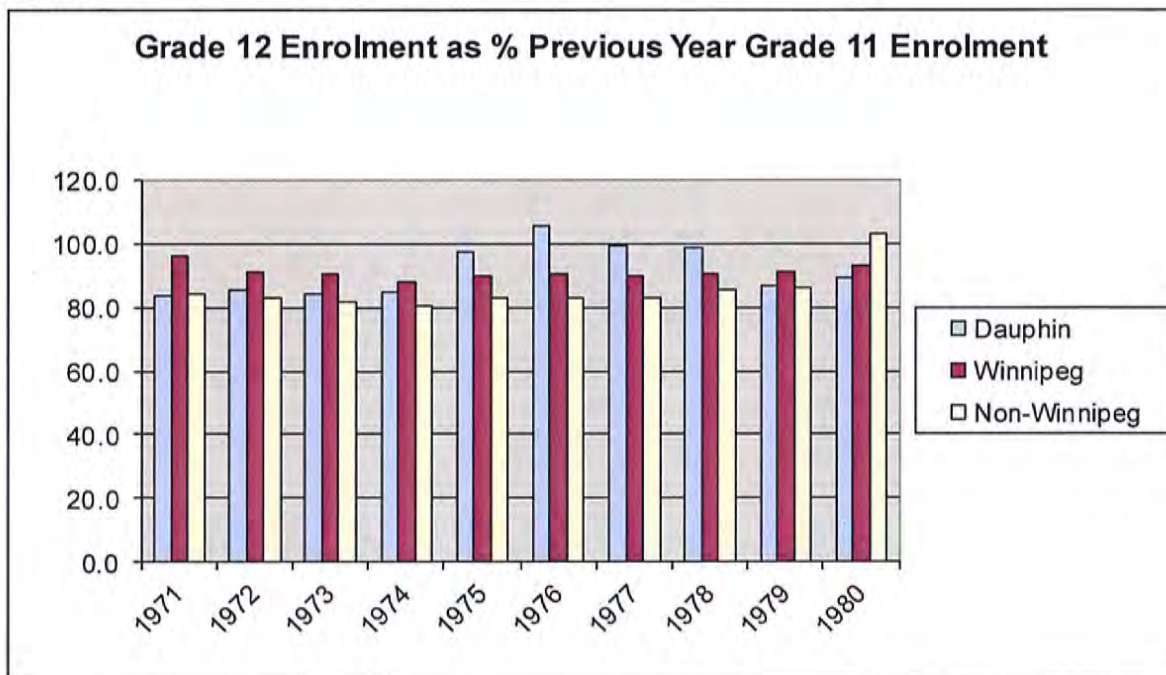
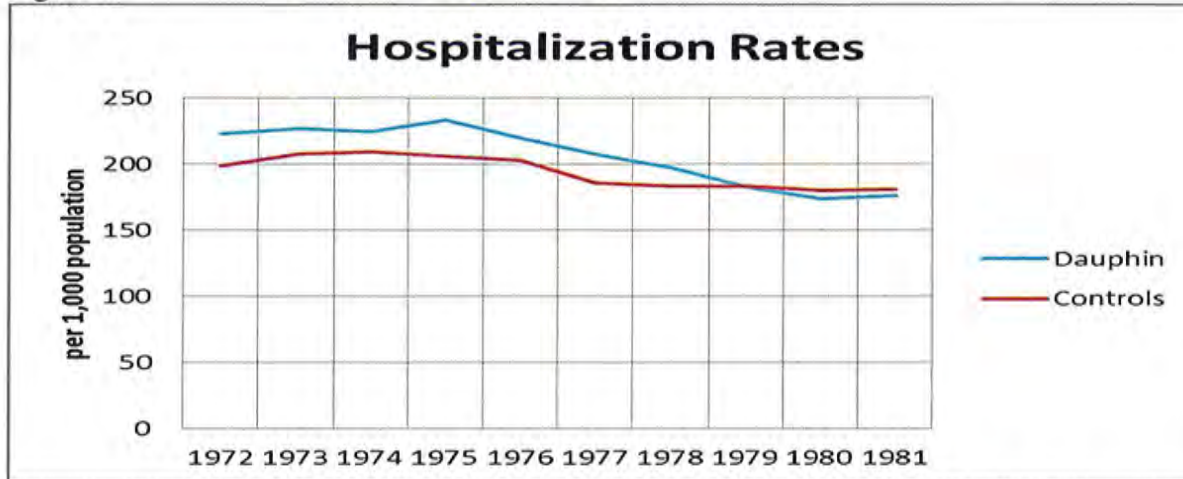


Figure 2



The results of Dr. Forget's analysis of the MINCOME study concluded that the findings suggest that a Guaranteed Annual Income, implemented broadly in society, may improve health and social outcomes at the community level.³ Dr. Forget has been invited by the federal Liberals to review the findings of this Canadian study at pre-budget hearings.²⁶

ONTARIO PUBLIC HEALTH STANDARD

"Addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. Effective public health programs and services consider the impact of the determinants of health on the achievement of intended health outcomes." (p.2)²⁷

WDGPH STRATEGIC COMMITMENT

Health Equity

Our programs and services use health equity principles to reduce or eliminate health differences in our communities.

Building Healthy Communities

We will work with communities to support the health and well-being of everyone.

HEALTH EQUITY

A Basic Income Guarantee will ensure that all individuals living below an identified income threshold will be supported at a level that is sufficient to meet basic needs. There is strong evidence that reducing poverty will result in improved long term health outcomes.

APPENDICES

None.

REFERENCES

1. Pasma, C., and Mulvale, J. Income Security for All Canadians: Understanding Guaranteed Income. Ottawa: Basic Income Earth Network Canada; 2009. Available from:
http://www.cpj.ca/files/docs/Income_Security_for_All_Canadians.pdf
2. Statistics Canada. National Household Survey (NHS) Profile. 2011 National Household Survey. Ottawa. 2013.
3. Forget, E. The Town With No Poverty: Using Health Administration Data to Revisit Outcomes of a Canadian Guaranteed Annual Income Field Experiment. University of Manitoba. [Internet]. 2011 [cited 2016 Feb 16] Available from:
[http://public.econ.duke.edu/~erw/197/forget-cea%20\(2\).pdf](http://public.econ.duke.edu/~erw/197/forget-cea%20(2).pdf)
4. Basic Income Canada Network. [Internet]. 2016 [cited 2016 Feb 4]. Available from:
<http://www.basicincomecanada.org>
5. Young, M., and Mulvale, J. Possibilities and Prospects: The Debate Over a Guaranteed Income. Ottawa: Canadian Centre for Policy Alternatives; 2009. Available from:
<https://www.policyalternatives.ca/publications/reports/possibilities-and-prospects>
6. Hyndman B, Simon L. Basic income guarantee: backgrounder. alpha-OPHA Health Equity Workgroup; 2015
7. The Conference Board of Canada. A Big Idea Whose Time Has Yet to Arrive: A Guaranteed Annual Income [Internet]. 2011 [Updated 2011 Dec 15; Cited 2016 Feb 21]. Available from:
http://www.conferenceboard.ca/economics/hot_eco_topics/default/11-12-15/a_big_idea_whose_time_has_yet_to_arrive_a_guaranteed_annual_income.aspx
8. Segal, H. Why Guaranteeing the Poor an Income Will Save Us All In the End. [Internet] [Updated 2013 June 8; cited 2016 Feb 21]. Available from:
http://www.huffingtonpost.ca/hugh-segal/guaranteed-annual-income_b_3037347.html
9. National Post. Andrew Coyne: Guarantee a minimum income, not a minimum wage [Internet] [Updated 2015 Jun 10; Cited 2016 Feb 21]. Available from:
<http://news.nationalpost.com/news/canada/canadian-politics/andrew-coyne-guarantee-a-minimum-income-not-a-minimum-wage>

10. National Council of Welfare Reports. The Dollars and Sense of Solving Poverty. Volume #130. [Internet]. 2011 [Cited 2016 Feb 21]. Available from: http://publications.gc.ca/collections/collection_2011/cnb-ncw/HS54-2-2011-eng.pdf
11. Statistics Canada. National Household Survey. Table 3.2 Low-income measures thresholds (LIM-AT, LIM-BT and LIM-MI) for households of Canada, 2010 [Internet]. 2016 [Updated 2016 Apr 1; cited 2016 Feb 23]. Available from: <https://www12.statcan.gc.ca/nhs-enm/2011/ref/dict/table-tableau/t-3-2-eng.cfm>
12. Corporation of the County of Wellington. 2014 Ontario works caseload profile. [Internet] [cited 2016 Feb 16]. Available from: http://www.wellington.ca/en/socialservices/resources/Ontario_Works/2014_Caseload_Profile.pdf
13. Wellington-Dufferin-Guelph Public Health. Ontario Nutritious Food Basket report. Guelph, Ontario; 2015.
14. Mikkonen J, Raphael D. Social determinants of health: the Canadian facts. Toronto: York University School of Health Policy and Management; 2010, 12.
15. Lightman E, Mitchell A, Wilson B. Poverty is making us sick: a comprehensive survey of income and health in Canada. The Wellesley Institute; 2008.
16. Wellington-Dufferin-Guelph Public Health. Addressing social determinants of health in Wellington, Dufferin and Guelph: a public health perspective on local health, policy, and program needs. Guelph, Ontario; 2013
17. Wilkinson R, Pickett K. The spirit level: why equality is better for everyone. London: Penguin Books; 2009.
18. Eggleton A, Segal H. In from the margins: a call to action on poverty, housing and homelessness. The Standing Senate Committee on Social Affairs, Science and Technology; 2009.
19. Segal, H. Scrapping Welfare: The case for guaranteeing all Canadians an income above the poverty line. Literary Review of Canada. [Internet]. 2012 [Cited 2016 Feb 21]. Available from: <http://reviewcanada.ca/magazine/2012/12/scrapping-welfare/>
20. Liberal Party of Canada. Resolution 100. [Internet].[Cited 2016 Feb 21]. Available from: <https://www.liberal.ca/policy-resolutions/100-priority-resolution-creating-basic-annual-income-designed-implemented-fair-economy/>
21. Globe and Mail. Guaranteed income has merit as a national policy, minister says. [Internet]. [Updated 2016 Feb 5; Cited 2016 Feb 21]. Available from: <http://www.theglobeandmail.com/news/politics/guaranteed-income-has-merit-as-a->

[national-policy-minister-says/article28588670/](#)

22. Canadian Public Health Association. Public health matters: basic income guarantee. [Internet]. 2015 [cited 2016 Feb 04]. Available from: <http://www.cpha.ca/en/election2015/1.aspx>
23. Canadian Association of Social Workers (CASW). Promoting equity for a stronger Canada: the future of Canadian social policy; 2014.
24. Canadian Medical Association. Resolutions Adopted (confirmed) 148th Annual Meeting of the Canadian Medical Association Aug. 24-26, 2015. Halifax, NS. Available from: https://www.cma.ca/Assets/assets-library/document/en/about-us/gc2015/resolutions-passed-at-gc_final_english.pdf
25. Forget, E., Equalizing opportunity: Can a guaranteed annual income help level the playing field for kids? Presentation at St. Michaels Hospital, Toronto, ON.
26. Globe and Mail. Liberals invite guaranteed-income expert to speak at pre-budget hearings. [Internet]. [Updated 2016 Feb 19; Cited 2016 Feb 21]. Available from: <http://www.theglobeandmail.com/news/politics/ottawa-invites-guaranteed-income-expert-to-speak-at-pre-budget-hearings/article28806760/>
27. Ontario. Ministry of Health and Long-Term Care. Ontario public health standards. Toronto, ON: Queen's Printer for Ontario; 2008 [revised 2014 May 1; cited 2014 May 1]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf [PDF].

March 21, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Room 281, Main Legislative Building
Queen's Park
Toronto, ON
M7A 1A1

Dear Premier Wynne,

On March 18, 2016, the Porcupine Health Unit Board of Health passed the following resolution:

THAT the Board of Health for the Porcupine Health Unit support Thunder Bay District Health Unit's resolution # 50-2015, and The Corporation of the Town of Iroquois Falls resolution # 2015-307, requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires;

AND THAT this resolution be forwarded to the Premier of Ontario, Ministers responsible for Health and Long-Term Care, Community Safety and Correctional Services, Aboriginal Affairs, Northern Development and Mines, Natural Resources and Forestry, the Association of Local Public Health Agencies (alPHA), local area Members of Provincial Parliament and Ontario Boards of Health.

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

Yours very truly,



Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

email: info4you@porcupinehu.on.ca
Website: www.porcupinehu.on.ca

Branch Offices: Cochrane, Hearst,
Hornepayne, Iroquois Falls,
Kapuskaing, Matheson,
Moosonee, Smooth Rock Falls

March 18, 2016

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

Dear Minister Hoskins:

Re: Petition to Update Ontario Fluoridation Legislation

I am writing as Chair of the Windsor-Essex County Board of Health in support of changes to Ontario fluoridation legislation-amendments to the Fluoridation Act and the Ontario Municipal Act to make the fluoridation of municipal drinking water mandatory in all municipal water systems across Ontario (see attached petition).

On December 18, 2014 our Board of Health passed a resolution (see attached) recommending the Province of Ontario amend the regulations of the Safe Drinking Water Act to require community water fluoridation for all municipal water systems (when source-water levels are below the Health Canada-recommended Level of 0.7 mg/L) to prevent dental caries .

Because fluoridation is a safe, equitable, effective and cost-effective way to improve the oral health of everyone in our community, and water fluoridation is effective against dental cavities even when other sources of fluoride, such as toothpastes and topical fluorides are used, I urge you to support mandatory community water fluoridation that will extend this protection to all Ontario residents.

I thank you in advance for your consideration of this significant public health issue.

Sincerely,



Gary McNamara, Chairperson
Windsor-Essex County Board of Health

F:\Gary Kirk\Letters\2016\CWF Letter to Min Hoskins -2016 March 18-final.docx

Attachments: Community Water Fluoridation Petition
Windsor-Essex County Board of Health Community Water Fluoridation Resolution

Continued to page 2

Letter to The Honourable Dr. Eric Hoskins

March 18, 2016

Page 2

cc: The Honourable Bob Delaney, Member, Standing Committee on Justice Policy
Ted McMeekin, Ministry of Municipal Affairs and Housing
Dr. Bob Bell, Deputy Minister, Ministry of Health and Long-Term Care
Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Martha Greenberg, Assistant Deputy Minister (A), Ministry of Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Roselle Martino, Executive Director, Ministry of Health and Long-Term Care
Paulina Salamo, Director (A), Public Health Standards, Practice & Accountability Branch
Laura Pisko, Director, Health Promotion Implementation Branch
Dr. David Williams, Chief Medical Officer of Health of Ontario
The Honourable Tracy MacCharles, Minister of Children and Youth Services
Pat Vanini, Executive Director, Association of Municipalities of Ontario (AMO)
Monika Turner, Director of Policy, AMO
Dr. Vic Kutcher, President, Ontario Dental Association
Dr. Charles Frank and Dr. Lesli Hapak, Board Members, Ontario Dental Association
Dr. Edward Socilotto, President, Essex County Dental Society
Dr. Peter Cooney, Canadian Oral Health Advisor, Public Health Agency of Canada
Tracey Ramsey, NDP MP for Essex
Cheryl Hardcastle, NDP MP for Windsor-Tecumseh
Brian Masse, NDP MP for Windsor-West
Dave Van Kesteren, MP for Chatham-Kent-Leamington
France Gelinas, MPP, NDP Critic, Health and Long-Term Care
Lisa Gretzky, MPP, Windsor West
Taras Natyshak, MPP, Essex
Percy Hatfield, MPP, Windsor-Tecumseh
Rick Nicholls, MPP, Chatham-Kent-Essex
Ontario Boards of Health
Windsor-Essex County Board of Health
Dr. Gary Kirk, Medical Officer of Health and CEO, Windsor-Essex County Health Unit

Petition to the Ontario Legislative Assembly

Update Ontario Fluoridation Legislation

WHEREAS scientific studies conducted during the past 70 years have consistently shown that community water fluoridation is a safe and effective means of preventing dental decay, and is a public health measure endorsed by more than 90 national and international health organizations, including the Ontario Chief Medical Officer of Health, and the Ontario Dental Association, **and**

WHEREAS recent experience in Canadian cities that have removed fluoride from drinking water has led directly to a dramatic increase in tooth decay, **and**

WHEREAS the Ontario Ministry of Health and Long-Term Care urges support for amending the *Fluoridation Act* to ensure community water fluoridation is mandatory, **and**

WHEREAS the Ontario Ministry of Municipal Affairs and Housing urges support for the removal of provisions allowing Ontario municipalities to cease drinking water fluoridation, or fail to start drinking water fluoridation, from the *Ontario Municipal Act*,

WE the undersigned, petition the Legislative Assembly of Ontario as follows:

THAT the **Premier of Ontario** direct the Ministries of Municipal Affairs and Housing, and Health and Long-Term Care to amend all applicable legislation and regulations to make the fluoridation of municipal drinking water mandatory in *all* municipal water systems across the Province of Ontario before the end of the first session of the current Ontario Parliament.

Name (Printed)	Home Address and E-Mail Address	Signature

Please mail or deliver (*do not fax*) the **original** signed petition (*no copies*) to your Member of Provincial Parliament, or

Bob Delaney
Member of Provincial Parliament
Mississauga-Streetsville
2000 Argentia Road; Plaza 4, Suite 220
Mississauga ON L5N 1W1

**WINDSOR-ESSEX COUNTY
BOARD OF HEALTH**

Resolution Recommendation

December 18, 2014

Issue:

Community water fluoridation promotes good (oral) health, and the optimal concentration of fluoride in drinking water is essential to the health of Ontarians by minimizing tooth decay, and helping restore tooth enamel.

Background:

Dental caries, also known as tooth decay or cavities, is one of the most prevalent chronic diseases in humans. Dental caries affect 60 to 90 per cent of school children and the vast majority of adults in most industrialized countries (World Health Organization, 2003). Among five to seventeen year olds, dental decay is five times as common as asthma and seven times as common as hay fever (U.S. Public Health Service, 2000). In Canada, 57 per cent of children, and 59 per cent of adolescents and 96 per cent of adults have been affected by tooth decay (Health Canada, 2010). In children, early tooth loss caused by dental decay can result in failure to thrive, impaired speech development, absence from and inability to concentrate in school, and reduced self-esteem (Office of Disease Prevention and Health Promotion, 2000).

Oral health care is a critical component of health care and must be included in the design of community programs. The World Health Organization states that oral health is an important part of overall health, and a determinant of quality of life (World Health Organization, 2003). Prevention is critical to good oral health, and tooth decay is almost always easily preventable.

Community water fluoridation is recognized as the single most effective public health measure to prevent tooth decay and was listed by the Centres for Disease Control in the top ten greatest public health achievements of the 20th century. In her report, *Oral Health, More than just Cavities, A Report by Ontario's Chief Medical Officer of Health*, April 2012, Dr Arlene King, states that all Ontarians should have access to optimally fluoridated drinking water. "It is my view that the improvements to oral health in Ontario as a result of our publicly funded oral health programs would be undermined by the removal of fluoridation from the water supply" (King, 2012).

From a public health perspective, an advantage of providing fluoride at a population level is that it benefits all residents served by community water supplies (Petersen, 2003). As well water fluoridation does not rely on individual compliance with health recommendations and therefore removes barriers around poor compliance or limited access. Population level intervention ensures all socioeconomic sectors of the population can be reached, notably those with limited access to preventive dentistry. There is mounting evidence for the role of fluoridation in reducing disparities in dental caries (cavities) that are related to the social determinants of health. Fluoridation is highly effective and can reach and benefit large populations. Other preventive services such as fluoridated toothpaste, fluoride mouth rinses, fluoride varnish, and sealants may be less accessible to those without private dental insurance, or those living on low incomes (King, 2012).

continued to page 2

Fluoridation of Ontario's drinking water supplies is a safe and cost-effective and efficient population health intervention. Studies have shown that fluoridated drinking water reduces the number of cavities in children's teeth by up to 60 per cent and in their permanent teeth by up to 35 per cent (American Dental Association, 2005). As well, a number of studies have shown a positive cost-benefit analysis for community water fluoridation (National Collaborating Centre for Environmental Health, 2014).

Many major health organizations support community water fluoridation including the WHO, the CDC, Health Canada, the Public Health Agency of Canada, the Canadian Dental Association and the Canadian Medical Association. An expert panel convened by Health Canada in 2007 recommended adopting a level of 0.7 mg/L as the optimal target concentration for fluoride in drinking water, which prevent excessive intake of fluoride through multiple sources of exposure. In 2010 Health Canada recommended an optimal concentration of fluoride in drinking water of 0.7 mg/L to promote dental health.

Opponents to fluoridation claim it causes harm to individuals. A known health consequence is fluorosis (an alteration of the appearance of the tooth enamel). Other health outcomes suspected to be associated with community water fluoridation have not been supported by the scientific literature. Anti-fluoridation advocacy efforts targeting various Ontario communities are costly in terms of time and resources to city and municipal councils, Boards of Health, MOH's, public health professionals as well as other dental professionals.

Therefore, let it be moved that:

WHEREAS the relationship between poor oral health and poor physical and mental health is clear; and

WHEREAS the relationship between poor oral health and risks associated with childhood development are known; and

WHEREAS individuals in the community of lower socio-economic status suffer a more significant burden of poor health; and

WHEREAS Windsor-Essex has a higher than average number of individuals living in low income compared to the province; and

WHEREAS providing fluoride via community water offers the positive benefits equally for everyone in the community; and

WHEREAS global health experts and evidence support community water fluoridation to prevent tooth decay;

THEREFORE BE IT RESOLVED that the Windsor Essex County Health Unit recommends that the Province of Ontario amend the regulations of the Safe Drinking Water Act to require community water fluoridation for all municipal water systems (when source-water levels are below the Health Canada-recommended level of 0.7 mg/L) to prevent dental caries.



Information Break

Feb. 23, 2016

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.

Patients First Response Activities

alPHa has drafted its initial response to the government's discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. The draft response contains nine recommendations and will be reviewed by members at the face-to-face meetings on February 25 with the Boards of Health Section and Council of Ontario Medical Officers of Health. On February 26 the alPHa Board will meet to discuss the draft response. Many thanks to Karen Singh and Dr. Brent Moloughney as well as members who provided feedback into our response plan.

[Read the Patients First discussion paper here](#)

[Read alPHa's news release here](#)

[View results of alPHa's member survey on Patients First here](#)

Final Program for Risk Management Workshop II

The final program for alPHA's sold out Risk Management workshop on February 24 is now available. Corinne Berinstein of the Ontario Treasury Board Secretariat will once again lead attendees through an informative, interactive session that will help them build a healthy risk management culture in their own organizations and provide practice in identifying, assessing and mitigating risks at the health unit level.

[View the final program for February 24 here](#)

New Acting President of alPHA

Dr. Valerie Jaeger, alPHA's Vice President, has taken on the Acting President role for the association until June. Former alPHA president Lorne Coe stepped down from his position after recently winning the Whitby-Oshawa provincial byelection. alPHA congratulates Lorne, and looks forward to continue working on members' behalf under Valerie's leadership. A new president will be appointed at the June AGM.

New Chief Medical Officer of Health for Ontario

The Ontario government appointed Dr. David Williams as the new Chief Medical Officer of Health (CMOH) for the province, effective February 16. He had been the Acting CMOH since July 2015. Prior to that, he was the medical officer of health for the Thunder Bay District Health Unit. Congratulations to David from alPHA and your public health colleagues.

[Read the news release on the CMOH appointment here](#)

Calgary Fluoridation Cessation Study

This February, two journals published a study showing increased tooth decay rates among Calgary children after that city stopped fluoridating its drinking water in 2011. The study generated much media interest and was reported on by many outlets and newspapers of record. Below are links to two papers from the study.

[Read the Community Dentistry & Oral Epidemiology paper here](#)

[Read the International Journal for Equity in Health paper here](#)

Upcoming Events

February 24, 2016 - alPha Risk Management Session II, Novotel Toronto Centre, 45 The Esplanade, Toronto.

February 25, 2016 - Boards of Health Section Meeting (full day) & COMOH Meeting (full day), Novotel Toronto Centre, 45 The Esplanade, Toronto.

April 4-6, 2016 - [TOPHC 2016](#), Collaborate.Innovate.Transform, Allstream Centre, Toronto, Ontario. Registration now open.
[Click on this brochure to learn about Early Bird rates and more.](#)
[Click here for TOPHC program information.](#)

June 5, 6 & 7, 2016 - alPha Annual General Meeting and Conference - 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.
[Click here for Notices and Calls.](#)

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.

This email was sent to lerouxh@sdhu.com from the Association of Local Public Health Agencies (info@alphaweb.org).
To stop receiving email from us, please UNSUBSCRIBE by visiting:
<http://www.alphaweb.org/members/EmailOptPreferences.aspx?id=15240578&e=lerouxh@sdhu.com&h=79bb32e21dd7a1f1046a63fd606510f60acfa78>

1

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



Information Break

March 10, 2016

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.

Patients First Response Activities

On February 29 alPHA submitted its response to the government's discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. The letter makes five key recommendations to Minister Hoskins on strengthening patient care in Ontario from the public health perspective, and seeks further opportunities to engage with him and his staff on the Patients First discussion.

[Read alPHA's response to the Patients First discussion paper here](#)

[Read the Patients First discussion paper here](#)

[Read alPHA's news release here](#)

[View results of alPHA's member survey on Patients First here](#)

Deputy Minister of Health and Long-Term Care, Dr. Bob Bell, met with alPHA's members on February 25 to discuss Ontario's health transformation agenda. It was a lively session marked by frank comments and questions from attendees, with some of the discussion being used to inform alPHA's response to the Patients First paper.

[Read alPHA's thank you letter to the DM here](#)

Risk Management Work Shop II

Many thanks to those who attended alPHA's second Risk Management workshop on February 24 in Toronto. Attendees learned how to build a healthy risk management culture in their own organizations and practiced identifying, assessing and mitigating health unit risks. Special thanks to the alPHA Risk Management Working Group, who organized this event, and Corinne Berinstein of the Treasury Board Secretariat for consulting and facilitating.

alPHA 2016 Fitness Challenge

It's time again to gear up for alPHA's Annual Fitness Challenge to health unit employees. This year the Challenge takes place on Thursday, May 5, 2016. Health units across Ontario will go head to head with each other to see which organization can involve the most number of staff in physical activity for 30 minutes on May 5. At stake is a lovely award (not to mention staff pride) that will be presented to the winning health unit at the alPHA Annual Conference.

[Learn more about the 2016 Fitness Challenge here](#)

Ontario Pilot on Basic Income Guarantee

In the February 25 budget announcement, the provincial government indicated plans to fund a basic income pilot project as part of its poverty reduction strategy. alPHA will be writing a letter of support to government on this encouraging initiative, with reference to its own resolution endorsed last year by members calling for government support of a basic income guarantee. Many thanks to associate medical officer of health Dr. Lisa Simon of Simcoe Muskoka District Health Unit for leading advocacy efforts on this topic.

[Read alPHA's 2015 resolution on a basic income guarantee](#)

[Learn more about the 2016 Ontario Budget](#)

Correspondences

alPHA has written a number of letters to government, including support for the Canadian Senate's recent recommendations to address obesity. alPHA has also submitted a recommendation that the Public Health Expert Panel include alPHA's Acting President Dr. Valerie Jaeger as a member.

[Read alPHA's latest correspondences here](#)

alPHA 30th Anniversary

alPHA turns 30 this year, hence the refreshed logo at the top of this column. We will be celebrating this milestone at the June annual conference. Stay tuned for further information!

Upcoming Events

April 4-6, 2016 - [TOPHC 2016](#),
Collaborate.Innovate.Transform, Allstream Centre,
Toronto, Ontario. [Register before March 18](#).
[Click here for TOPHC program information](#)

June 5, 6 & 7, 2016 - alPha Annual General Meeting
and Conference - 30th Anniversary, Novotel
Toronto Centre, 45 The Esplanade, Toronto,
Ontario.
[Click here for Notices and Calls](#)

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.

This email was sent to lerouxh@sdhu.com from the Association of Local Public Health Agencies (info@alphaweb.org).
To stop receiving email from us, please UNSUBSCRIBE by visiting: <http://www.alphaweb.org/members/EmailOptPreferences.aspx?id=15240578&e=lerouxh@sdhu.com&h=79bb32e21dd7a1f1046a63fd606510f60acfa781>
Please note that if you unsubscribe, you will no longer receive notices, important announcements, and correspondence from alPha.



Information Break

March 30, 2016

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.

Proceedings of Risk Management Work Shop II

A summary of the presentations and discussion that took place at alPHA's second Risk Management Work Shop held on February 24 is now available for viewing by clicking the link below. Many thanks to those who attended and presented in helping us to deliver another successful learning event.

[Read the February 24 Risk Management Work Shop proceedings and presentations here](#)

Ontario Government Report on Patients First Action Plan

The province has released a progress report on its investments into the Ontario health system since February 2015. The Patients First: Action Plan Progress Report summarizes activities in four key areas, including access, services, health information for the public, and patient protection.

[Read the Ontario Government news release here](#)
[Read Year One Results - Patients First Action Plan for Health Care here](#)

Correspondences

alPHA has written a number of letters to government, including support for federal infrastructure funding and the Ontario 2016 Spring Budget.

[Read alPHA's latest correspondences here](#)

Severe Asthma Conference - May 6 & 7

On **May 6th** and **May 7th**, 2016, the Asthma Society of Canada will be holding its Third Annual Conference, *Fighting for Breath*, to examine the health, social and economic issues related to Severe Asthma. Interested health unit staff can find more information on the event at www.fightingforbreath.ca

Upcoming Events

April 4-6, 2016 - [TOPHC 2016](#), Collaborate.Innovate.Transform, Allstream Centre, Toronto, Ontario. **Registration now closed.** [Click here for TOPHC program information](#)

June 5, 6 & 7, 2016 - alPHA Annual General Meeting and Conference - 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario. [Click here for Notices and Calls](#)

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.

This email was sent to lerouxh@sdhu.com from the Association of Local Public Health Agencies (info@alphaweb.org). To stop receiving email from us, please UNSUBSCRIBE by visiting: <http://www.alphaweb.org/members/EmailOptPreferences.aspx?id=15240578&e=lerouxh@sdhu.com&h=79bb32e21dd7a1f1046a63fd606510f60acfa781>. Please note that if you unsubscribe, you will no longer receive notices, important announcements, and correspondence from alPHA.

March 16, 2016

Dear Penny:

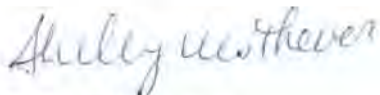
Please consider this my formal acknowledgement that I will be retiring from my position as Director, Clinical and Family Services effective June 30, 2016. My last day in the office will be May 30, 2016 as I will be on vacation from May 30 to June 30.

Penny, my 26 + years working at the Sudbury & District Health Unit has been an amazing journey. I was fortunate to work in many different program areas and positions and have been privileged to work with an incredible group of public health professionals during that time.

I will be forever grateful for your leadership and support as well as that of the Executive Committee and the Board of Health. Together your progressive and visionary leadership has made my public health experience one I will never forget.

Thank you so much for your mentorship and friendship throughout my years with the health unit.

Kind regards,



Shelley Westhaver

23/3/16

Please share c'
cc + board



Advertisement



Ignite your future with innovative programs at Ryerson University.



Work With a System that is 91.4% Accurate With The Odds At Your Favor, You Are Guaranteed To Win.



Did You Know Why China Has So Many Billionaires? Their Secret Of Wealth Is Finally Out!

THE GLOBE AND MAIL

February 19, 2016

Why did Calgary cave to chemophobes over fluoridation?

By ANDRÉ PICARD

The city has followed a disturbing trend by municipalities to reject fluoridation for non-scientific and conspiracy-driven reasons.

When Calgary city council decided to end water fluoridation in 2011, one outcome was clear: The number of cavities in children was going to go up.

Five years later, we have the hard evidence that the perfectly predictable has indeed come to pass.

A study¹ published in the journal Community Dentistry and Oral Epidemiology shows that Grade 2 students in Calgary had an average of 3.8 more cavities in 2013-14 than they did in 2004-05. In Edmonton (which continued to fluoridate its water), during the same time period, the number of dental caries (or cavities) increased by 2.1, on average.

In other words, ending fluoridation is not the sole reason oral health has deteriorated, but it is a significant factor.

So, why did Calgary city councilors make a decision that has caused a lot of children unnecessary pain and that will cost their parents a good chunk of change in dental bills?

They essentially bought into the unscientific rantings and overblown fears of a small but loud minority of self-centered chemophobes.

There are four principal arguments raised by opponents of fluoridation:

- Fluoride is a "chemical" that is poisoning people;
- By putting fluoride in municipal water, people are being treated against their will;
- Adding fluoride is a waste of tax dollars because you can get fluoride elsewhere;
- There is a growing scientific "controversy" about the safety of fluoride.

None of these arguments hold any water (fluoridated or otherwise), but let's examine them anyhow.

Yes, fluoride is a poison – in the same way that salt is a poison. If you ingest too much of it, you can get sick and even die.

Toxicity depends on dose, and fluoride is added to water in minute quantities – about 0.7 parts per million. By comparison, toothpaste contains up to 1,500 parts per million of fluoride.

To get fluoride poisoning from tap water, you would have to drink a couple thousand litres of water without peeing – and if you did that, fluoride would be the least of your problems.

Adding fluoride to water is a cost-effective way of preventing one of the most common diseases on Earth – dental caries. People are being "forced" to ingest fluoride in the same way emission controls "force" them to breathe clean air.

The American Dental Association estimates that every \$1 spent on fluoridation saves about \$50 in the cost of dental treatment – a good return on investment.

It costs a little less than \$1 a person to fluoridate municipal drinking water – about \$750,000 in Calgary. Without question, the greatest beneficiaries are low-income children. Research shows that, for a variety of reasons – chief among them poor access to dental care and poor diets – these kids tend to have dismal oral health, including more cavities, that has life-long repercussions.

When it cut the fluoridation program, Calgary city council allocated the savings to an "anti-cavity program" aimed at poor children. About 3,000 kids were treated – an average cost of \$250 per child – and only after they had cavities and were in pain.

The reason cavities are on the rise even in cities that do fluoridate water, like Edmonton, is that the number of families with dental insurance is falling, there are many new immigrants who have never had access to dental care or fluoridated water, and more people are drinking (non-fluoridated) bottled water.

The biggest myth is that there is growing "controversy" about fluoride. There is not. What there is is a trend by municipalities to reject fluoridation for non-scientific and conspiracy-driven reasons.

Today, fewer than 45 per cent of Canadians drink fluoridated water. In some provinces, like Quebec, fewer than 3 per cent of citizens have the benefits of fluoridation. (And it's not a coincidence that Quebec has the highest rate of dental caries.)

Alberta was once a leader, with 75 per cent of homes having access to fluoridated water but, in recent years, that number has plummeted by half.

When fluoridation was first introduced – about 60 years ago – the impact was immediate and dramatic. The public health measure reduced cavities by about 50 per cent. Today, the gap in dental caries between fluoridating and non-fluoridating communities is much less because of better access to dentists and the promotion of preventive measures such as brushing and flossing.

But the benefits of fluoridation still far outweigh the risks. Politicians – in Calgary and elsewhere – should grit their teeth and fluoridate, in the name of science and child health.

References

1. onlinelibrary.wiley.com/doi/10.1111/cdoe.12215/abstract

The Globe and Mail, Inc.



The Globe and Mail Inc. All Rights Reserved. Permission granted for up to 5 copies. All rights reserved.

You may forward this article or get additional permissions by typing http://license.icopyright.net/3.8425?icx_id=28814768 into any web browser. The Globe and Mail, Inc. and The Globe and Mail logos are registered trademarks of The Globe and Mail, Inc. The iCopyright logo is a registered trademark of iCopyright, Inc.

WORKPLACE HEALTH

putting health on your agenda

Healthy Weights

Spring / Summer 2016

Does the workplace have a role?

Absolutely! A healthy weight is important in all environments – including the workplace. Canadians spend the majority of their day at work. Finding a balance between the demands of the workplace and taking care of one's self can be difficult. A workplace environment that encourages and models healthy behaviours helps to support employees in adopting healthy behaviours and to reach for their best weight.

A healthy weight is the weight your body is naturally when you regularly enjoy a healthy, balanced lifestyle which includes eating well, moving well, sleeping well, and feeling well. Weight is only one indicator of health and a healthy weight is different for everyone.

How can your workplace adopt healthier behaviours and help employees reach for their best weight? In this issue, you will discover the relationship a healthy weight can play in employees' lives and how to take the focus off weight, and instead promote a holistic, weight-neutral approach to health and well-being.



Inspired by the popular TV show “The Biggest Loser”, many employers and employees implement and participate in weight loss challenges and competitions in the workplace in an effort to make the workplace healthier.

Did you know?

Weight loss challenges have a 90-95% failure rate and can lead to several negative consequences:

- unhealthy attitudes about one’s body, such as weight concerns and poor body image
- dysfunctional eating behaviours, such as chronic dieting, skipping meals, and fear of food
- negative feelings towards physical activity
- weight cycling (repeated gain and loss of weight)
- weight bias and stigma
- low staff morale
- psychological consequences, such as feelings of shame, anxiety, and depression
- significant health consequences, such as high blood pressure, high cholesterol, stress fractures, and a host of other potential psychological and physiological consequences

Definitions:

Weight bias is the negative attitudes, beliefs and judgments toward individuals affected by excess weight or obesity. Common examples include the belief that people affected by excess weight or obesity are less competent, lazy, unsuccessful, unintelligent, and undisciplined.

Weight discrimination is more than having negative attitudes: it can include acting or behaving unfairly or unequally towards people with excess weight. Examples of discrimination can range from saying hurtful things to avoiding, ignoring, or rejecting an individual, as well as making offensive remarks, taking part in cyber-bullying or physically attacking someone.

Weight loss challenges don’t work and actually result in more problems than solutions!

How your workplace can support healthy weights

Make small, realistic changes to behaviours and environments that help support employees to reach for their best. Set employees up for success by providing opportunities to eat well, move well, sleep well, and feel well using a health-centred approach.

Eat Well

- Offer a variety of healthy foods in workplace cafeterias and vending machines.
- Provide common areas for eating with others.
- Provide a fridge and microwave.
- Encourage employees who are on the road to bring a small cooler with ice and stock with healthier snacks for when they stop to eat. Yogurt, boiled eggs, veggies with hummus, and baby carrots are great on-the-go options.

Move Well

- Promote “at-work” activities:
 - ✓ take the stairs rather than the elevator
 - ✓ organize a walking club for break times
 - ✓ organize walking meetings
 - ✓ stand for 60 to 90 seconds for every hour spent seated
- Promote active transportation:
 - ✓ encourage walking or biking to work - this can also reduce demand for employee parking
 - ✓ provide a secure location so that employees can park their bicycle
 - ✓ provide an area where employees can shower and change before work

Sleep Well

- Explore the creation of policies and procedures for recognizing workplace fatigue.
- Make natural lighting a focal point in your workplace to help regulate normal biological processes.
- If possible, explore schedule changes such as forward and quickly rotating shifts, flexible working conditions, and exposure to light and dark.

Feel Well

- Include language on weight bias and discrimination in organizational policies.
- Promote acceptance of all body types, shapes, and sizes.
- Create a mentally healthy workplace by reducing or eliminating stressors and providing access to counselling or Employee Assistance Programs.

The Canadian Obesity Network, Sudbury Chapter allows members to network and work collaboratively to improve the lives of Canadians affected by obesity. If you or your workplace are interested in finding out more, visit:

Facebook: <https://www.facebook.com/CONSudbury/>

Email: con-ysb@obesitynetwork.ca

Things to Remember

Take the focus off weight and focus on healthy behaviours and well-being. Invest in approaches that help employees find acceptance with their bodies, food, and movement. Consider the following tips to get started in your workplace:

DO	DON'T
DO focus on lifestyle and how a person feels.	DON'T focus on weight or measurements.
DO provide a variety of nutritious choices. Encourage employees to pay attention to and trust their feelings of hunger and fullness.	DON'T put limitations and restrictions on foods.
DO recognize and celebrate the different body shapes and sizes.	DON'T put emphasis on an "ideal" body type/shape.
DO provide incentives to encourage employees to eat well and get active.	DON'T offer incentives or rewards for weight loss.
DO participate in and provide opportunities for pleasurable and fun physical activity.	DON'T encourage strict physical activity for excessive weight loss.
DO encourage social support and growth toward a positive relationship with your body.	DON'T put emphasis on social competitions for weight loss.
DO define success as having a better quality of life, higher energy levels, a positive attitude about oneself and improved overall health.	DON'T let food and weight be a cause of stress.
DO develop a genuine culture of health where everyone from the top down models and commits to healthy behaviours. Evaluate wellness initiatives. Explore what worked well, what did not work, and if you reached your goal(s).	DON'T be invisible.

Creating healthy workplaces benefits everyone.

Resources:

Healthy body weight: workplace health: <https://www.sdhu.com/health-topics-programs/workplace-health/healthy-body-weight-workplace-health>

Creating a healthy workplace nutrition environment: <https://www.sdhu.com/professionals/employers-workplaces/creating-healthy-workplace-nutrition-environment>

7 steps to developing a successful healthy workplace program: <https://www.sdhu.com/professionals/employers-workplaces/7-steps-developing-successful-healthy-workplace-program>

Comprehensive workplace health promotion approach <https://www.sdhu.com/professionals/employers-workplaces/comprehensive-workplace-health-promotion-approach>

Workplace Health and Wellness Program – Getting started: http://www.ccohs.ca/oshanswers/psychosocial/wellness_program.html

Launching and sustaining a workplace wellness program: <http://www.healthyalberta.com/653.htm>



Sudbury & District

Health Unit

Service de
santé publique

Workplace Wellness Team
Sudbury & District Health Unit
1300 Paris Street
Sudbury, ON P3E 3A3

705.522.9200, ext. 290
workplaceteam@sdhu.com
Espanola: 705.222.9202
Chapleau: 705.860.9200

Manitoulin: 705.370.9200
Sudbury East: 705.222.9201
Toll-free: 1.866.522.9200

LA SANTÉ AU TRAVAIL

inscrire la santé à votre agenda

printemps / été 2016

Poids sain

Le milieu de travail a-t-il un rôle à jouer?

Absolument! Un poids sain est important dans tous les environnements, y compris le milieu de travail. Les Canadiens passent la majeure partie de leur journée au travail, alors il peut être difficile de trouver un équilibre entre les exigences professionnelles et les soins à prodiguer à soi-même. Un milieu de travail qui encourage et favorise des comportements sains aide à soutenir les employés dans l'adoption de ces comportements et leur quête pour trouver leur « meilleur poids ».

Un poids sain est le poids que votre corps affiche naturellement lorsque vous jouissez régulièrement d'un mode de vie sain et équilibré qui inclut les éléments suivants : bien manger, bien bouger, bien dormir et se sentir bien. Le poids ne constitue qu'un seul indicateur de la santé et un poids sain varie d'une personne à l'autre.

Comment votre milieu de travail peut-il adopter des comportements sains et aider les employés dans leur quête pour trouver leur « meilleur poids »? Dans ce numéro, vous découvrirez le rôle qu'un poids sain peut jouer dans la vie des employés et comment l'employeur peut détourner l'attention du poids et favoriser plutôt une approche holistique envers la santé et le bien-être qui demeure neutre sur le plan du poids.



Inspirés par l'émission de télévision populaire « Biggest Loser », beaucoup d'employeurs et d'employés mettent en œuvre des défis et des concours de perte de poids en milieu de travail et y participent afin de rendre le milieu de travail plus sain.

Le saviez-vous?

Les défis de perte de poids ont un taux d'échec de 90 à 95 % et peuvent entraîner plusieurs conséquences négatives :

- des attitudes malsaines envers son corps telles que les préoccupations liées au poids et une mauvaise image corporelle;
- des comportements alimentaires dysfonctionnels tels que le régime chronique, le fait de sauter des repas et la peur de la nourriture;
- des sentiments négatifs face à l'activité physique;
- le cycle du poids (un gain et une perte de poids répétés);
- des préjugés et une stigmatisation à l'égard du poids;
- une baisse du moral du personnel;
- des conséquences psychologiques telles que les sentiments de honte, l'anxiété et la dépression;
- des conséquences importantes pour la santé telles que l'hypertension artérielle, un taux élevé de cholestérol, des fractures de stress et une série d'autres conséquences psychologiques et physiologiques potentielles.

Définitions :

Les **préjugés à l'égard du poids** sont des attitudes, des croyances et des jugements négatifs envers les gens qui présentent un surpoids ou qui sont atteints d'obésité. Parmi les exemples courants, on note la croyance que les gens qui ont un surpoids ou de l'obésité sont paresseux et moins compétents, qu'ils ne réussissent pas et qu'ils manquent d'intelligence et d'autodiscipline.

La **discrimination à l'égard du poids** n'est pas seulement le fait d'avoir des attitudes négatives; cela peut inclure d'agir ou de réagir de façon injustes envers les gens qui ont un surpoids. Les comportements discriminatoires peuvent aller de dire des choses blessantes jusqu'à éviter, ignorer ou rejeter une personne, ainsi que faire des remarques désagréables, de la cyberintimidation ou des attaques physiques.

Les défis de perte de poids ne fonctionnent pas et créent plus de problèmes que de solutions!

Comment votre milieu de travail peut appuyer le poids sain

Faites de petits changements réalistes au niveau du comportement et de l'environnement qui aident les employés à réaliser leur plein potentiel. Favorisez la réussite des employés en leur donnant l'occasion de bien manger, de bien bouger, de bien dormir et de se sentir bien en adoptant une approche axée sur la santé.

Bien manger

- Offrez une gamme d'aliments sains dans les cafétérias et les distributeurs automatiques en milieu de travail.
- Proposez des aires communes pour permettre aux employés de manger ensemble.
- Fournissez un réfrigérateur et un four à micro-ondes.
- Encouragez les employés sur la route à apporter une petite glacière remplie de collations santé lorsqu'ils arrêtent pour manger. Le yogourt, les œufs à la coque, les légumes avec du houmous et les petites carottes sont d'excellents choix pour manger sur le pouce.

Bien bouger

- Faites la promotion des activités « au travail » :
 - ✓ utilisez les escaliers au lieu de l'ascenseur;
 - ✓ organisez un club de marche pendant les pauses;
 - ✓ organisez des réunions où les participants marchent;
 - ✓ restez debout pendant 60 à 90 secondes pour chaque heure passée assis.
- Favorisez le transport actif :
 - ✓ encouragez les employés à se rendre au travail à pied ou à vélo – cela peut également réduire la demande de stationnements qui leur sont destinés;
 - ✓ offrez aux employés un endroit sécuritaire pour stationner leur vélo;
 - ✓ offrez un endroit où les employés peuvent prendre une douche et se changer avant de travailler.

Bien dormir

- Envisagez la création de politiques et de procédures pour reconnaître la fatigue au travail.
- Éclairez votre milieu de travail avec la lumière naturelle pour aider à réguler les processus biologiques normaux.
- Si possible, modifiez l'horaire des postes en faisant la rotation vers l'avant et la rotation rapide et songez à offrir des conditions de travail flexibles et à alterner l'exposition à la lumière et à l'obscurité.

Se sentir bien

- Incluez des dispositions sur les préjugés et la discrimination à l'égard du poids dans les politiques de l'organisation.
- Favorisez l'acceptation de tous les types, formes et tailles de corps.
- Créez un milieu de travail favorable à la santé mentale en réduisant ou en éliminant les facteurs de stress et en donnant accès à des services de counseling et à des Programmes d'aide aux employés.

Le Réseau canadien en obésité, section de Sudbury, facilite le réseautage et la collaboration des membres afin d'améliorer la vie des Canadiens et des Canadiennes touchés par l'obésité. Si vous ou votre milieu de travail désirez en savoir plus, consultez les ressources suivantes :

Facebook : <https://www.facebook.com/CONSudbury/>

Courriel : con-ysb@obesitynetwork.ca

Points à retenir

Détournez l'attention du poids et concentrez-vous sur les comportements sains et le bien-être. Favorisez des approches qui aident les employés à accepter leur corps, les aliments et l'activité physique. Tenez compte des conseils suivants pour votre milieu de travail :

À FAIRE	À NE PAS FAIRE
Concentrez-vous sur le mode de vie et la façon dont une personne se sent.	Ne vous concentrez pas sur le poids ou les mesures du corps.
Offrez une gamme de choix nutritifs. Encouragez les employés à prêter attention et à faire confiance aux sensations de faim et de satiété.	N'imposez pas de limites et de restrictions concernant les aliments.
Reconnaissez et célébrez les différentes formes et tailles de corps.	Ne mettez pas l'accent sur un type ou une forme de corps « idéal ».
Offrez des mesures incitatives pour encourager les employés à bien manger et à mener une vie active.	N'offrez pas de mesures incitatives ou de récompenses pour la perte de poids.
Fournissez des occasions d'activité physique agréable et amusante et participez-y.	N'encouragez pas une activité physique stricte pour une perte de poids excessive.
Encouragez le soutien social et le développement personnel pour parvenir à entretenir une relation positive avec votre corps.	Ne mettez pas l'accent sur les compétitions sociales pour perdre du poids.
Définissez le succès par le fait d'avoir une meilleure qualité de vie, un niveau d'énergie plus élevé, une attitude positive envers soi-même et une meilleure santé globale.	Ne laissez pas les aliments et le poids être une source de stress.
Créez une véritable culture de la santé où les employés de tous les échelons de l'organisme s'engagent à adopter des comportements sains. Évaluez les initiatives de bien-être afin de mesurer à quel point vous avez atteint ou non vos objectifs. Examinez ce qui a bien fonctionné et ce qui n'a pas fonctionné.	Ne soyez pas invisible.

La création d'un milieu de travail sain bénéficie à tout le monde.

Ressources :

Poids sain : Santé en milieu de travail : <https://www.sdhu.com/fr/sujets-et-des-programmes-de-sante/sante-au-travail/poids-sain-sante-en-milieu-de-travail>

Créer un environnement favorable à la saine alimentation en milieu de travail : <https://www.sdhu.com/fr/professionnels/employeurs-et-lieux-de-travail/creer-un-environnement-favorable-la-saine-alimentation-en-milieu-de-travail>

Sept étapes pour élaborer un programme de santé efficace en milieu de travail : <https://www.sdhu.com/fr/professionnels/employeurs-et-lieux-de-travail/sept-etapes-pour-elaborer-un-programme-de-sante-efficace-en-milieu-de-travail>

Approche complète de promotion de la santé en milieu de travail : <https://www.sdhu.com/fr/professionnels/employeurs-et-lieux-de-travail/approche-complexe-de-promotion-de-la-sante-en-milieu-de-travail>

Programme santé et mieux-être en milieu de travail – Point de départ : http://www.cchst.ca/oshanswers/psychosocial/wellness_program.html

Launching and sustaining a workplace wellness program (Lancement et administration d'un programme de mieux-être en milieu de travail) : <http://www.healthyalberta.com/653.htm> (en anglais seulement)



Sudbury & District

Health Unit

Service de
santé publique

Équipe La santé au travail
Service de santé publique
de Sudbury et du district
1300, rue Paris
Sudbury ON P3E 3A3
705.522.9200, poste 290
workplaceteam@sdhu.com

Espanola : 705.222.9202
Chapleau : 705.860.9200
Manitoulin : 705.370.9200
Sudbury-Est : 705.222.9201
Sans frais : 7.866.522.9200

APPROVAL OF CONSENT AGENDA

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

**SUDBURY & DISTRICT HEALTH UNIT
BOARD OF HEALTH MANUAL**

INFORMATION

APPROVED BY:	Board of Health	CATEGORY:	Board of Health Structure & Function
DATE:	O: June 18, 2015 R:	SECTION:	Finance Standing Committee of the Board of Health
NUMBER:	C-II-11	SUBJECT:	Terms of Reference
PAGE:	1 of 2		

**BOARD OF HEALTH FINANCE STANDING COMMITTEE
TERMS OF REFERENCE**

Purpose:

The purpose of the Finance Standing Committee on behalf of the Board is generally to ensure that the Board conducts itself according to the principles of ethical financial and management behaviour and is efficient and effective in its use of public funds by giving oversight to the SDHU's accounting, financial reporting and audit practices.

Reporting Relationship:

The Finance Standing Committee reports to the Board of Health.

Membership:

Membership must be assigned annually by majority vote of the full Board.

- Board of Health members (3)
- Medical Officer of Health/Chief Executive Officer
- Director of Corporate Services
- Manager, Accounting Services
- Board Secretary

Chair: As elected annually by the committee at the first meeting of the Finance Committee of the Board of Health

Only Board of Health members have voting privileges. All staff positions are all ex officio.

Responsibilities:

The Finance Committee of the Board of Health is responsible for the following:

1. Reviewing financial statements and strategic overview of financial position.
2. Reviewing the annual cost-shared and 100% funded program budgets, for the purposes of governing the finances of the Health Unit.
3. Reviewing the annual financial statements and auditor's report for approval by the Board.
4. Reviewing annually the types and amounts of insurance carried by the Health Unit.
5. Reviewing periodically administrative policies relating to the financial management of the organization, including but not limited to, procurement, investments, and signing authority.
6. Monitoring the Health Unit's physical assets and facilities.

All actions taken by the Finance Standing Committee must be reported to the full Board at its next scheduled meeting.

**SUDBURY & DISTRICT HEALTH UNIT
BOARD OF HEALTH MANUAL**

INFORMATION

APPROVED BY:	Board of Health	CATEGORY:	Board of Health Structure & Function
DATE:	O: June 18, 2015 R:	SECTION:	Finance Standing Committee of the Board of Health
NUMBER:	C-II-11	SUBJECT:	Terms of Reference
PAGE:	2 of 2		

Committee Proceedings:

The rules governing the procedures of the Board shall be observed by the Finance Standing Committee insofar as applicable.

The Committee will meet twice yearly, normally in April/May and September/October. Additional meetings may be called at the discretion of the Chair.

Meetings are held at the health unit at a time mutually agreed upon by the committee, with the option of teleconferencing.

An agenda is developed by the Chair with the support of the Medical Officer of Health/Chief Executive Officer and distributed by the Secretary one week in advance of a scheduled meeting, whenever possible.

Meeting minutes, recommendations and supporting documentation are forwarded by the Secretary to the Board for inclusion in the agenda of the next Board meeting.

Closed session minutes are taken by the Recording Secretary. In the event the Recording Secretary is excused from the closed session, the Chair or designate must document the proceedings. Closed session minutes must be approved at a subsequent meeting of the Board Finance Standing Committee.

APPOINTMENT TO BOARD FINANCE STANDING COMMITTEE

(2015 Board Membership: Carolyn Thain; Claude Belcourt; René Lapierre)

MOTION: THAT the Board of Health appoint the following individuals to the Board Finance Standing Committee for the year 2016:

1. _____, Board member at large
2. _____, Board member at large
3. _____, Board member at large
4. **Medical Officer of Health/Chief Executive Officer**
5. **Director, Corporate Services**
6. **Manager, Accounting Services**
7. **Board Secretary**

SUDBURY & DISTRICT HEALTH UNIT

Medical Officer of Health/Chief Executive Officer

Division: Corporate Services
Supervisor: Board of Health
Original date: June 1995
Reviewed date: ~~October 2015~~ March 2016

SUMMARY

Reporting directly to the Board of Health, the Medical Officer of Health/Chief Executive Officer (herein after referred to as MOH) is responsible to the Board for the management and administration of all Sudbury & District Health Unit (SDHU) programs and services and for upholding the Health Protection and Promotion Act (HPPA) and any other Act as relevant. The Medical Officer of Health directs all employees and persons whose services are engaged by the Board of Health. The Medical Officer of Health is also the Chief Executive Officer of the SDHU.

DUTIES

A. Operational Responsibilities

Chief Executive Officer

- i. provides overall direction and management of the health unit, its resources and services, subject to the general supervision of, and within the policy guidelines of the Board of Health.
- ii. implements all public health programs, and such other programs or services as are indicated by local health needs and as approved by the Board of Health.
- iii. chairs all meetings of the Executive Committee; attends all meetings of the Board of Health and sub-committees; sits ex-officio on standing, special staff or Board committees as specified in committee terms of reference.
- ~~iv.~~ prepares annual report and monthly reports for each Board of Health meeting and annual reports for the Board of Health.
- ~~v.~~ eEnsures administrative practices that support transparency and accountability
- ~~iv-vi.~~ Demonstrates supports a culture of organizational effectiveness and due diligence in exercising day to day responsibilities.
- ~~vii.~~ ensures that measurement and monitoring strategies are put in place to provide evidence for evidence-based decision-making and continuous quality improvement.

Epidemiologist/Community Health Planner

- i. applies expertise in epidemiology to identifying community health issues and program/service gaps.
 - ii. advises on and/or plans and develops appropriate programs or services to respond to these gaps, along with relevant evaluation of such developments.
- Risk Management/Public Health & Preventive Medicine Consultant
- i. ensures that community public health hazards are adequately anticipated and prevented where possible and/or are promptly and adequately investigated and controlled should they develop.
 - ii. consults with and advises other practitioners, health care agencies, community groups and government agencies with respect to current appropriate measures directed toward disease prevention, health protection and promotion.

Best Practice/Evidence-Based Practitioner

- i. ensures that current relevant research methodologies are applied in determining the need for new community health programs and in evaluating the effectiveness of established or new programs.
- ii. makes available to other appropriate community agencies, where feasible, the resources of the health unit in research activities relevant to community health.
- iii. applies the results of relevant research in acting as a community catalyst and advocate for community health policies and activities.

Teacher and Information Source

- i. is available to health unit staff as a teaching resource for in-service education, and to community groups and agencies on issues relevant to community health.
- ii. ensures that current reliable information on community health issues is provided to the media and other information sources.
- iii. Enforcer of Public Health Statutes and Legislation
- iv. upholds, interprets and administers, within the limits provided by statute, all pertinent federal and provincial regulations and municipal by-laws.

B. Human Resources Responsibilities

- In compliance with current legislation, responsible for establishing, maintaining and implementing policies and procedures for effective human resource management, recruitment, development, appraisal and deployment throughout the Health Unit.
- Responsible for the direct supervision of each Division Director, the Associate Medical Officer of Health, Associate Director, Strategic Engagement and the Executive Assistant to Medical Officer of Health/Secretary to Board of Health.

- Ensures that the Board of Health is apprised of the human resources complement to meet organizational objectives.
- Coaches, mentors and conducts performance appraisals on assigned staff. Provides leadership, supervision, support and consultation to individual employees concerning work related matters.
- Ensures appropriate professional development system through divisional and organizational staff development plans.
- Ensures that the workplace is compliant with the Occupational Health and Safety Act and its regulations and that conduct and activities of the SDHU are in accordance with the Act.
- In compliance with current legislation, responsible for ensuring that systems are established and maintained to protect the privacy of health information, and functions as the Health Information Custodian under current legislation.

C. Financial Resource Responsibilities

- Ensures, through the Director of Corporate Services, the preparation of all annual budgets by assigned staff, and their final review by the Finance Executive Committee. Approves annual budget for recommendation to the Board of Health for its approval.
- Ensures the development and implementation of a regular system of reporting on the status of all budgets to appropriate directors and management and the reporting of overall health unit budgets.
- Ensures the implementation of financial systems and controls that are consistent with government guidelines and standards, the Public Health Funding and Accountability Agreement and Board of Health by-laws and policies, and which are consistent with acceptable accounting practices.

D. Organizational Responsibilities

- Responsible for the development of the health unit strategic plan, vision, mission and goals and objectives.
- Responsible for organization performance monitoring and improvement planning relating to SDHU accountability agreement indicators and targets.
- Responsible for the development of program planning and evaluation processes, consistent with existing standards and Board of Health expectations.
- Reflects the SDHU's mission, vision, philosophy, and strategic priorities in day-to-day work.
- Keeps the Board of Health apprised of salient events and issues.
- Demonstrates professional conduct and communication in interactions with others.

- Demonstrates strong interpersonal skills including: effective problem solving, conflict resolution, negotiation and mediation skills.
- Maintains professional competence via appropriate continuing education and self-directed study.
- Focuses on building community relationships, networks and coalitions and provides consultation specific to health unit programs.
- Applies appropriate technology to comprehensive programming (i.e. use of computerized health information and resources)

E. Contacts Community and Stakeholder Engagement

- Acts as principal information source to the community on community health matters and Health Unit programs and policies, including for example, health care professionals and institutions, the education sector, community health and social service agencies and planning bodies, municipal authorities and the general public.
- Ensures engagement with community issues and events that impact on health by various means including participating on appropriate committees, councils, etc., as an official health unit representative and ensuring the designation of appropriate health unit staff from assigned programs to community committees, councils, etc.
- Ensures is aware of and contributes to the public health system by participating in public health-related local, regional and provincial committees, associations, societies, etc.
- Ensures maintenance of Royal College certification and ongoing competence in Public Health & Preventive Medicine and epidemiology through attendance at workshops, seminars, courses and through self-directed learning.

F. Occupational Health and Safety Responsibilities

Ensures that workplace conduct and activities are in accordance with the *Occupational Health and Safety Act*.

- Serves as a role model by working in compliance with the Act and regulations
- Demonstrates the use of protective equipment or clothing to workers and provides education regarding the appropriate use of same
- Monitors worker compliance with the Act and regulations, and the use of protective devices and clothing as required by the employer
- Conducts regular inspections of the work area
- Investigates the report of any violations of the Act, defective equipment, workplace hazard or incident and implements appropriate corrective action
- Identifies and advises workers of actual or potential health and safety hazards, including written instructions when appropriate

- Ensures health and safety training and annual review of health and safety is completed for direct reports
- Takes every precaution reasonable in the circumstances for the protection of workers

SPECIFICATIONS

- Current licence to practice medicine in Ontario.
- Fellowship in Public Health & Preventive Medicine from the Royal College of Physicians and Surgeons of Canada.
- Minimum four years' experience in public health and preventive medicine.
- Minimum of two years leadership experience, particularly in a public health setting.
- Demonstrated superior leadership, planning and interpersonal skills, in particular negotiating solutions and making decisions.
- Demonstrated knowledge of community organizations and resources.
- Demonstrated computer skills with experience in word processing, presentation software, email, internet/intranet usage, spreadsheets and database software.
- Knowledge of current practice in relation to ethical issues.
- Knowledge and understanding of pertinent federal, provincial and municipal legislation, regulations and guidelines.
- Demonstrated ability to function cooperatively in a multi-disciplinary field.
- Eligible for joint appointment with affiliated universities.
- Maintains current Ontario driver's license and has access to a reliable vehicle in order to fulfill position requirements.
- Advanced oral and written proficiency in English is essential.
- Advanced oral and written proficiency in French is an asset.

MOH/CEO POSITION DESCRIPTION

MOTION: BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the revised position description for the Medical Officer of Health/Chief Executive Officer, dated March 2016.

MOH/CEO RENEWAL EMPLOYMENT CONTRACT

MOTION: WHEREAS the term of the current employment contract agreement for the Medical Officer of Health/CEO for the Sudbury & District Health Unit is until December 31, 2016; and

Whereas the Board of Health is required to provide notice in order to commence negotiations for a renewal agreement no later than two months prior to the expiry of the agreement; and

WHEREAS the Board of Health Executive Committee has historically reviewed the MOH/CEO contract agreement; and

WHEREAS the Board of Health Executive Committee Terms of Reference stipulate that the Executive Committee of the Board of Health may, from time to time, be assigned responsibilities by the Board of Health in areas such as: policy, personnel, and property; and

WHEREAS responsibilities assigned to the Board of Health Executive Committee must be delegated by majority vote of the full Board;

THEREFORE BE IT RESOLVED THAT the Board of Health assign to the Board of Health Executive Committee the responsibility to engage in discussions with the MOH/CEO regarding a renewal agreement, execute an updated employment contract with the MOH/CEO and report back to the Board of Health following execution of the updated agreement.

N O T I C E

2016 ANNUAL GENERAL MEETING

NOTICE is hereby given that the 2016 Annual General Meeting of the **ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES** will be held at the Novotel Toronto Centre hotel, 45 The Esplanade, Toronto, Ontario, on **Monday, June 6, 2016 at 8:00 AM** at the *2016 Annual Conference*, for the following purposes:

1. To consider and approve the minutes of the 2015 Annual General Meeting in Ottawa, Ontario;
2. To receive and adopt the annual reports from the President, Executive Director, Section Chairs and others as appropriate;
3. To consider and approve the Audited Financial Statement for 2015-2016;
4. To appoint an auditor for 2016-2017; and
5. To transact such other business as may properly be brought before the meeting.

DATED at Toronto, Ontario, February 1, 2016.

BY THE ORDER OF THE BOARD OF DIRECTORS.



Linda Stewart
Executive Director

CALL FOR BOARD OF HEALTH NOMINATIONS 2016-2017 & 2017-2018 alPHA BOARD OF DIRECTORS



*alPHA is accepting nominations for **four** Board of Health representatives from the following regions for the following terms on its Board of Directors:*

1. Central East 2. North East 3. North West	2 year term <i>(i.e. June 2016 to June 2017 and June 2017 to June 2018)</i>
4. East	1 year term <i>(this is to fill an in-term resignation from June 2016 to June 2017)</i>

See the attached appendix for boards of health in each of these regions.

Each position will fill a seat on the Boards of Health Section Executive Committee and a seat on the alPHA Board of Directors.

Qualifications:

- *Active member of an Ontario Board of Health or regional health committee;*
- *Background in committee and/or volunteer work;*
- *Supportive of public health;*
- *Able to commit time to the work of the alPHA Board of Directors and its committees;*
- *Familiar with the Ontario Public Health Standards and its Organizational Standards.*

An election to determine the two representatives will be held at the Boards of Health Section Meeting on June 7 during the 2016 alPHA Annual Conference, Novotel Toronto Centre Hotel, 45 The Esplanade, Toronto, Ontario.

*Nominations close **4:30 PM, Monday, May 30, 2016.***

Why stand for election to the alPHA Board?

- Help make alPHA a stronger leadership organization for public health units in Ontario;
- Represent your colleagues at the provincial level;
- Bring a voice to discussions reflecting common concerns of boards of health and health unit management across the province;
- Expand your contacts and strengthen relationships with public health colleagues;
- Lend your expertise to the development of alPHA position papers and official response to issues affecting all public health units; and
- Learn about opportunities to serve on provincial ad hoc or advisory committees.

What is the Boards of Health Section Executive Committee of alPHA?

- This is a committee of the alPHA Board of Directors comprising seven (7) *Board of Health representatives*.
- It includes a Chair and Vice-Chair who are chosen by the Section Executive members.
- Members of the Section Executive attend all alPHA Board meetings and participate in teleconferences throughout the year.

How long is the term on the Boards of Health Section Executive/alPHA Board of Directors?

- A full term is two (2) years with no limit to the number of consecutive terms.
- Mid-term appointments will be for less than two years.

How is the alPHA Board structured?

- There are 22 directors on the alPHA Board:
 - 7 from the Boards of Health Section
 - 7 from the Council of Ontario Medical Officers of Health (COMOH)
 - 1 from each of the 7 Affiliate Organizations of alPHA, and
 - 1 from the Ontario Public Health Association Board of Directors.
- There are 3 committees of the alPHA Board: Executive Committee, Boards of Health Section Executive, and COMOH Executive.

What is the time commitment to being a Section Executive member/Director of alPHA?

- Full-day alPHA Board meetings are held in person 4 times a year in Toronto; a fifth and final meeting is held at the June Annual Conference.
- Boards of Health Section Executive Committee teleconferences are held 5 times throughout the year.
- The Chair of the Boards of Health Section Executive participates on alPHA Executive Committee teleconferences, which are held 5 times a year.

Are my expenses as a Director of the alPHA Board covered?

- Any travel expenses incurred by an alPHA Director during Association meetings are *not* covered by the Association but are the responsibility of the Director's sponsoring health unit.

How do I stand for consideration for appointment to the alPHA Board of Directors?

- Submit a completed Form of Nomination and Consent along with a biography of your suitability for candidacy and a copy of the motion from your Board of Health supporting your nomination to alPHA by **May 30, 2016**.

Who should I contact if I have questions on any of the above?

- Susan Lee, alPHA, Tel: (416) 595-0006 ext. 25, E-mail: susan@alphaweb.org

Board of Health Vacancies on alPHa Board of Directors

alPHa is accepting nominations for **four** Board of Health representatives to fill positions on its 2016-2017 and 2017-2018 Board of Directors from the following regions and for the following terms:

1. Central East 2. North East 3. North West	2 year term (i.e. June 2016 to June 2017 and June 2017 to June 2018)
4. East	1 year term (this is to fill an in-term resignation from June 2016 to June 2017)

See below for boards of health in these regions.

Each position will fill a seat on the Boards of Health Section Executive Committee and a seat on the alPHa Board of Directors.

An election will be held at alPHa's annual conference in June to determine the new representatives (one from each of the regions below).

If you are an active member of a Board of Health/Regional Health Committee who is interested in running for a seat, please consider standing for nomination.

Central East Region

Boards of health in this region include:

Durham
Haliburton Kawartha Pine Ridge
Peel
Peterborough
Simcoe-Muskoka
York

North East Region

Boards of health in this region include:

Algoma
North Bay-Parry Sound
Porcupine
Sudbury
Timiskaming

Continued on next page

North West Region

Boards of health in this region include:

Northwestern
Thunder Bay

East Region

Boards of health in this region include:

Eastern Ontario
Hastings & Prince Edward
Kingston, Frontenac Lanark & Addington
Leeds Grenville
Ottawa
Renfrew

FORM OF NOMINATION AND CONSENT
alPHA Board of Directors 2016-2017 & 2017-2018

_____, a Member of the Board of Health of
 (Please print nominee's name)

_____, is HEREBY NOMINATED
 (Please print health unit name)

as a candidate for election to the alPHA Board of Directors for the following Boards of Health Section Executive seat from (*choose one using the list of Board of Health Vacancies on previous pages*):

- | | |
|------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Central East Region (2 year term) | <input type="checkbox"/> East Region (1 year term) |
| <input type="checkbox"/> North East Region (2 year term) | |
| <input type="checkbox"/> North West Region (2 year term) | |

SPONSORED BY:

1) _____
 (Signature of a Member of the Board of Health)

2) _____
 (Signature of a Member of the Board of Health)

Date: _____

I, _____, HEREBY CONSENT to my nomination
 (Signature of nominee)

and agree to serve as a **Director of the alPHA Board** if appointed.

Date: _____

IMPORTANT:

- Nominations close **4:30 PM, May 30, 2016** and must be submitted to alPHA by this deadline.
- A **biography** of the nominee outlining their suitability for candidacy, as well as a **motion passed by the sponsoring Board of Health** (i.e. record of a motion from the Clerk/Secretary of the Board of Health) must also be submitted along with this nomination form on separate sheets of paper by the deadline.
- E-mail the completed form, biography and copy of Board motion by **4:30 PM, May 30, 2016** to Susan Lee at susan@alphaweb.org

Number of Votes Eligible for Resolutions Session Per Health Unit

<i>HEALTH UNITS</i>	<i>VOTING DELEGATES</i>
Toronto*	20
POPULATION OVER 400,000	7
Durham	
Halton	
Hamilton	
Middlesex-London	
Niagara	
Ottawa	
Peel	
Simcoe-Muskoka	
Waterloo	
York	
POPULATION OVER 300,000	6
Windsor-Essex	
POPULATION OVER 200,000	5
Wellington-Dufferin-Guelph	
POPULATION UNDER 200,000	4
Algoma	
Brant	
Chatham-Kent	
Eastern Ontario	
Elgin-St.Thomas	
Grey Bruce	
Haldimand-Norfolk	
Haliburton, Kawartha, Pine-Ridge	
Hastings-Prince Edward	
Huron	
Kingston, Frontenac, Lennox and Addington	
Lambton	
Leeds, Grenville and Lanark	
North Bay-Parry Sound	
Northwestern	
Oxford	
Perth	
Peterborough	
Porcupine	
Renfrew	
Sudbury	
Thunder Bay	
Timiskaming	

* total number of votes for Toronto endorsed by membership at 1998 Annual Conference

Health Unit population statistics taken from: Statistics Canada. [2011 Census. Census Profile.](#)

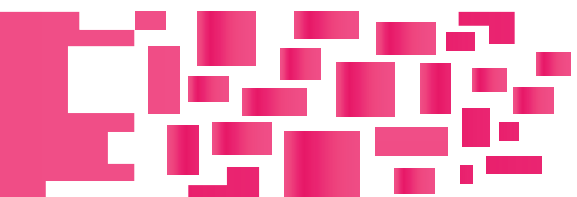
2016 ALPHA ANNUAL GENERAL MEETING AND CONFERENCE

MOTION: WHEREAS the SDHU has a modest travel budget to cover remuneration, registration, travel, meals, and accommodation as per the Board Manual Policy and Procedure I-I-10, permitting Board members to attend official Board of Health functions; and

WHEREAS the SDHU is allocated four votes at the Annual General Meeting; and

THEREFORE, BE IT RESOLVED THAT in addition to the Medical Officer of Health, the following Board member(s) attend(s) the 2016 alPha Annual General Meeting as voting delegates for the Sudbury & District Board of Health:

Strategic Priorities: Narrative Report



Performance
Monitoring Plan

2013
2017

April 2016



Sudbury & District

Health Unit

Service de
santé publique

Introduction

The Sudbury & District Health Unit's (SDHU) 2013–2017 Strategic Plan includes five Strategic Priorities that represent areas of focus. These priorities steer the planning and delivery of public health programs and services, learning activities, and partnerships. This Narrative Report is provided to the Board of Health three times a year as a component of the 2013–2017 Performance Monitoring Plan.

Division Directors seek out program or service narrative topics from staff at key points throughout the year. Selected narratives are then reported to the Board of Health in the spring, summer, and fall of every year. It's important to note that narratives do not reflect a specific reporting timeline. Rather, they represent an ongoing monitoring component of our 2013–2017 Strategic Plan.

A Bike Giveaway to Children in an Identified Neighbourhood

Of all childhood adventures, receiving a bicycle is by far one of the most profound. A bicycle provides the first opportunity for independence and adventure while fostering development and self-growth.

In March 2016, the Health Unit partnered with community stakeholders and volunteers to develop a bike giveaway initiative. This follows on a successful similar initiative that was held in July of 2015. Prior to the 2015 event, pre-owned and discarded bicycles were collected, repaired, and at the event, the bicycles were ‘upcycled’ to fifteen children whose families may not have the means to acquire a bicycle.

Children not only received a bicycle, but were also provided a helmet, safety information, and an opportunity to meet the Greater Sudbury Police Bike Patrol. The initiative was successful due to the diversity of the partnerships and the strong commitment and contributions by all involved to meet an identified community need. The SDHU will continue to collaborate with community partners should they seek out to implement similar initiatives in the future.



Strategic Priority: Champion and lead equitable opportunities for health

- Advocate for policies that address health equity
- Reduce social and economic barriers to health
- Address a broad range of underlying factors that impact health
- Support all communities to reach their full health potential

Ramsey Lake Main Beach Receives International Blue Flag Award

With support from the Health Unit, the City of Greater Sudbury successfully received the Foundation for Environmental Education's internationally recognized Blue Flag award. Main Beach on Ramsey Lake was awarded the Blue Flag in 2015 by meeting strict criteria and complying with guidelines within the following categories:

- Environmental education and information
- Water quality
- Environmental management
- Safety and services

The Health Unit supported the City of Greater Sudbury in its application for this award by providing municipal staff with weekly beach water quality sampling results confirming that the beach water met provincial bacteriological standards. Weekly inspections of the sand on the beach area were also conducted to verify that the beach area was clean, safe, and free of hazards.

Strategic Priority: Strengthen relationships

- Invest in relationships and innovative partnerships based on community needs and opportunities
- Help build capacity with our partners to promote resilience in our communities and neighbourhoods
- Monitor our effectiveness at working in partnership
- Collaborate with a diverse range of sectors



Implementation of New Processes Leads to Improvements for Parents and Schools

In order to help parents report vaccinations to the Health Unit to comply with the Immunization of School Pupils Act, the Vaccine Preventable Diseases Programming staff and the Strategic Engagement Unit recently used feedback from parents and schools to make the process clearer and easier. Specific changes to the process include:

- changes to parent letters
- the creation of information packages for principals and fact sheets for parents
- a new online process that allows parents and guardians to report their child's vaccinations
- the development of a social media campaign

Information about the new process was shared with all school boards and media outlets. The improvements increased communication, transparency, and awareness of the Immunization of School Pupils Act. The Health Unit hopes to continue to build on existing relationships with parents and schools. We are committed to working in partnership with individuals, and with the school community utilizing community evidence to promote, protect, and prevent disease in our community.



Strategic Priority: Strengthen evidence-informed public health practice

- Implement effective processes and outcomes to use and generate quality evidence
- Apply relevant and timely surveillance, evaluation, and research results
- Exchange knowledge internally and externally

Supporting the LaCloche Area Community With an Early Years Screening Day for Families

The Health Unit partners with the LaCloche Area Service Provider Network (LASPN) in Espanola to provide families access to services to which they would typically not have access. On May 27, 2015, the LASPN hosted an Early Years Screening Day for the early identification and prevention of child development issues. This event was open to all families in the area with children between the ages 0 to 5 years. Approximately 20 families were provided with education and screening on services related to dental hygiene, car seat safety, NutriStep®, hearing, Triple P (Positive Parenting Program), preschool speech and language, and immunization. Referrals were provided to children who were found to have developmental delays or difficulties.

Each family received an information package that described children's services and programs. Additional information for those seeking access to childcare subsidy was also available. The event was well received by area residents and partners, and the screening day will continue to be offered on an annual basis. Planning for this year's event is underway and will take place on May 11, 2016.

Strategic Priority: Support community actions promoting health equity

- Facilitate diverse community engagement
- Support awareness, education, advocacy and policy development at local, provincial, and federal levels
- Tailor programs and services to reflect community voices and needs
- Seek community input on issues that impact health equity



4

Staff Develop Meaning to the Strategic Plan Values

The Health Unit approved five guiding principles for the implementation of the 2013–2017 Strategic Plan, one of which outlined the need for staff to develop meaning to the Strategic Plan values. To meet this, in 2016, activities that ask staff to provide an example of how they demonstrate our values in action will be implemented. This builds on the success of the work that was implemented in the past year.

In 2015, the Strategic Plan Committee created and coordinated awareness activities to promote the values. Staff were encouraged to participate in a number of activities through the use of whiteboards, Inside Edition (the internal newsletter) and surveys. As a result of the activities, staff have an increased awareness of the values, and they have developed meaning to these values. For example, in the survey that was distributed to staff, they related the word ‘responsibility’ to the value accountability.

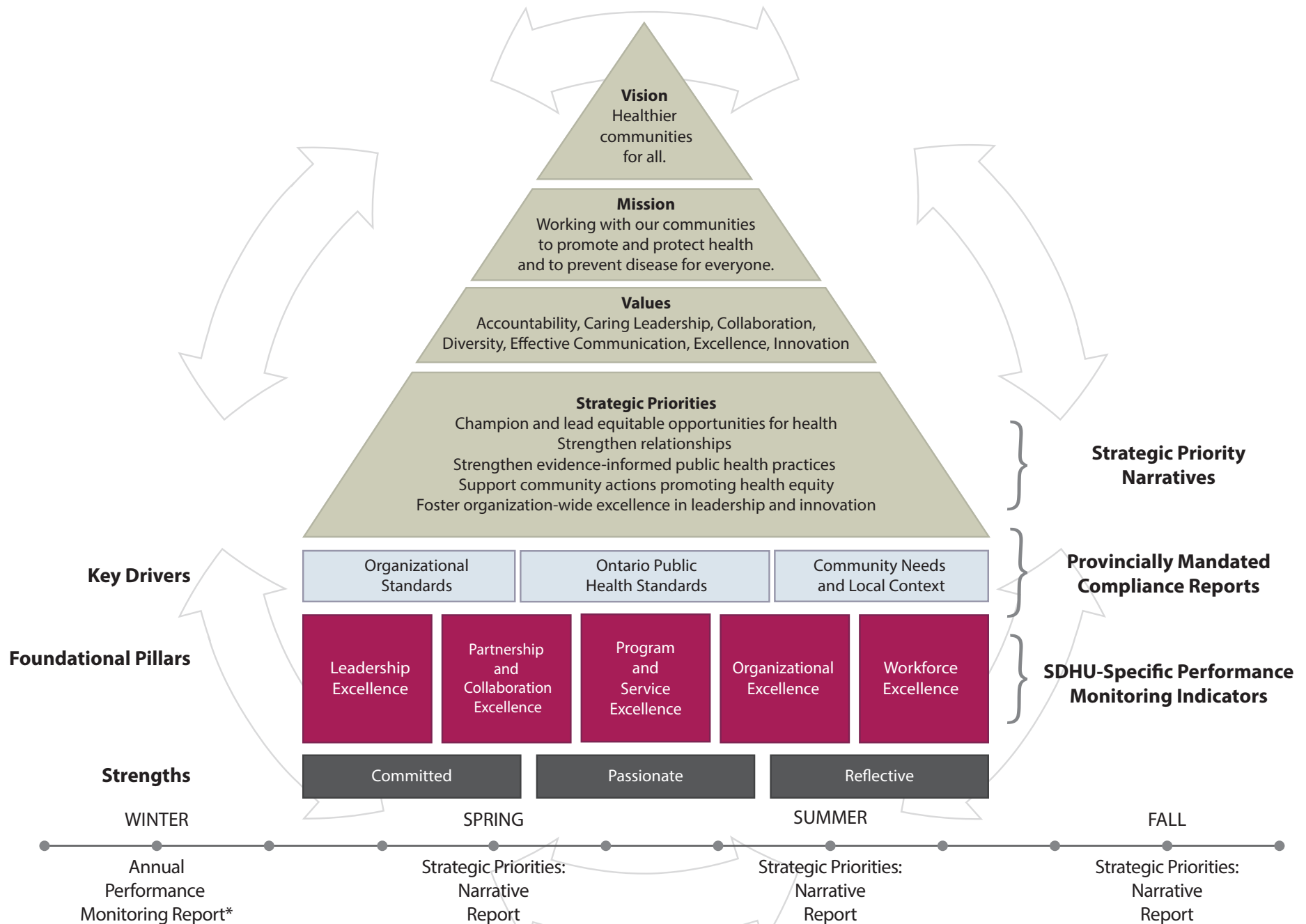
In efforts to report back to the staff, the information gathered from the activities were included in seven interactive videos (one for each value), which were shared with staff and posted on our YouTube channel.



Strategic Priority: Foster organization-wide excellence in leadership and innovation

- Cultivate a skilled, diverse, and responsive workforce
- Promote staff engagement and support internal collaboration
- Invest resources wisely
- Build capacity to support staff and management core competencies
- Ensure continuous improvement in organizational performance
- Promote a learning organization

2013–2017 Sudbury & District Board of Health Strategy Map



* Includes Strategic Priority Narratives “roll-up”, Organizational Standards Compliance Report, Accountability Indicator Compliance Report, and SDHU-Specific Performance Monitoring Indicators Report

Briefing Note

To: R. Lapierre, Board Chair, Sudbury & District Board of Health
From: Dr. P. Sutcliffe, Medical Officer of Health and Chief Executive Officer
Date: April 13, 2016
Re: Minister of Health and Long-Term Care (MOHLTC) Patient's First Discussion Paper

☐ For Information

☐ For Discussion

☒ For a Decision

Issue:

This briefing note provides updates on actions pursuant to Board of Health motion 03-16 supporting Sudbury & District Board of Health engagement with constituent municipalities, the Federation of Northern Ontario Municipalities and the North East LHIN concerning the December 17, 2015, MOHLTC discussion paper, *Patients First*. It also recommends next steps for northeast collaboration and further engagement.

Recommended Action:

THAT the Sudbury & District Board of Health seek to collaborate with the boards of health for Porcupine, Timiskaming, Algoma and North Bay Parry Sound to engage further with the North East LHIN for the purposes of relationship building and exploring the potential implications for the northeast of the proposals in *Patients First*; and

THAT to this end, an initial meeting be sought between the respective Board of Health Chairs and Medical Officers of Health/Chief Executive Officers and the Board and Chief Executive Officer for the North East LHIN.

Background:

- It is expected that legislation will be tabled in spring 2016 to action the proposals outlined in *Patients First*.
- At the April 2016 provincial public health convention, TOPHC, the Minister of Health and Long-Term Care, Eric Hoskins, signaled his strong support for the public health-related proposals within *Patients First*.

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

-
- The Association of Local Public Health Agencies, alPha, has responded to Patients First (attached) and its board is actively discussing various scenarios and responses.
 - Locally, meetings have occurred with the SDHU Board Chair and Sudbury Mayor, Brian Bigger (second vice president for FONOM), the FONOM Board and with NE LHIN representatives.
 - There is interest and support among northeastern MOH/CEO colleagues to act collectively to further engage with the NE LHIN. The FONOM Board was also supportive of this approach and has offered to write a letter of support, highlighting the need for both groups to work together to ensure that northern concerns are taken into consideration.
 - The purpose of engagement with the NE LHIN at this time would be to build and strengthen relationships, explore the potential implications, issues and concerns for public health of the proposals within Patients First, and to further orient LHIN leadership to the public health system and functions.

Contact:

Dr. P. Sutcliffe, MOH/CEO

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

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

February 29, 2016

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

Dear Minister Hoskins:

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations, the Association of Local Public Health Agencies (alPHA) is pleased to provide comment on the Ministry of Health and Long-Term Care discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. We received and reviewed the paper with much interest and anticipation. There is much to consider from a local public health perspective. We offer our preliminary comments herein and will be very pleased to engage further as the government's work progresses to strengthen patient-centred health care in Ontario.

We note the fact that how a "problem" is defined will greatly inform the solutions that are considered.

Patients First conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care. One solution to this problem is to better integrate population health within the health system, specifically through establishing closer linkages between LHINs and public health units. We are aware of recent work exploring the use of the population health approach in health system planning (CIHI 2014) and appreciate the merits of this work in contributing to health system sustainability. Further, we believe that local public health has valuable expertise to offer in this area. Indeed this approach is one of the five actions for health promotion as set out in the 1986 Ottawa Charter for Health Promotion.

A wider problem is improving and supporting the health and health equity of Ontarians which is effectively the mandate of the Ontario public health system. A solution to this problem would be to support and strengthen the public health system which works on all five Ottawa Charter actions for health promotion. The public health system understands that although access to a quality health care system is a determinant of individual and population health, it is a relatively minor determinant as compared with social and economic circumstances that create opportunities for health, mediated by factors such as education, food security, physical activity opportunities, social networks, effective coping strategies, etc. The public health system is that part of the overall health system that is specifically mandated to work with both health and non-health sector partners to act on these determinants and create opportunities for health for all.

We are concerned that some of the *Patients First* proposals regarding public health may have the unintended consequence of eroding the capacity of the public health system to improve the health of Ontarians through our intersectoral work on the determinants of health.

At the same time, we firmly hold that public health can assist in reorienting the health care system and see this as a valuable contribution of public health to the problems of health care system sustainability as set out in *Patients First*. We also hold that health care system sustainability is achieved by ensuring a strong public health system that can stem the tide of need; focusing on healthy people first.

In the recommendations that follow, we list and briefly describe what we present are the conditions necessary to achieve both. That is, to ensure that public health is able to contribute to the reorientation of the health care system so that population and public health priorities inform health care planning, funding and delivery, while at the same time protecting public health's ability to work upstream to promote and protect the health of all Ontarians.

Recommendations

1. **Funding and Accountability** – Provincial Public Health Funding and Accountability Agreements (PHFAA) must continue to be directly negotiated between local boards of health and the MOHLTC.
 - a. A direct relationship mitigates against the threat of resource reallocation (financial and functional) to the acute care system as has been evidenced in the experience of other regions with integrated health systems.
 - b. The direct relationship ensures that common Ministry principles and standards are upheld and implemented for all boards, further ensuring that all Ontarians benefit equitably from the public health system.
 - c. The direct relationship with the Ministry is needed to maintain the independent voice of public health at LHIN tables; otherwise public health would be advising on health resource allocation and also be a resource recipient.
2. **Independent Voice of Boards of Health** – Boards of health must be maintained as defined in the Health Protection and Promotion Act, directly accountable to the Minister of Health.
 - a. Boards of health must continue as entities with an independent voice with roles and responsibilities as set out in statute, standards and accountability agreements.
 - b. Municipal representation on boards of health ensures invaluable connections with decision makers and staff in non-health sectors where there is scope of authority over key determinants of health (e.g. bylaws, built environment, social services, child care, planning, long term care, drinking water, recreational facilities, first responders, etc.).
 - c. For certain boards of health (e.g. single tier and regional boards), local government is the de facto board of health, creating governance issues if required to report to an appointed LHIN board.
 - d. Ways to strengthen boards of health should be explored; this should form part of the work of the Expert Panel following the report of the Institute on Governance (IOG).

3. **Integration of Local Population and Public Health Planning with Other Health Services** – The Ontario Public Health Standards and Ontario Organizational Standards, as required, should be modified to require boards of health to align their work and ensure that population and public health priorities inform LHIN health planning, funding and delivery. Reciprocal amendments should be made to the LHIN legislation (or other mandate documents as appropriate) to require LHIN boards to ensure that population and public health priorities inform LHIN health planning, funding and delivery. aPHa looks forward to participating in the following activities.
 - a. Identification of the enabling policies and structures to ensure an effective relationship between the medical officer of health and LHIN leadership.
 - b. The identification of the resources and funding required for public health to effectively engage in this work.
4. **Process for Determining Respective Roles** – The respective roles of local public health and LHINs (and other system players involved with population and public health including the Population and Public Health Division, MOHLTC, the Capacity Planning and LHIN Support, Health Analytics Branch, MOHLTC and Public Health Ontario) must be determined through a transparent, inclusive and deliberative process that is informed by evidence. We maintain that this is a key role of the proposed Expert Panel.
 - a. It must be recognized that the work for public health as described in *Patients First* is additional to public health's core functions and mandate and the related resources must be identified to accommodate this work to ensure that public health capacity to promote and protect health and improve health equity is not eroded.
 - b. There is an important distinction between providing population health information and translating this information into planning, funding and delivery decisions for acute care and other downstream services. It should not be assumed that the latter is a public health competency.
5. **Geographic Boundaries** – LHIN boundaries should be re-configured to align with municipal, local public health, education and social service boundaries to support their relationships with local public health and population health and health care system planning.

Local public health appreciates that a population health approach to health system planning is an emerging paradigm that may contribute to the sustainability of the health care system. Local public health also agrees with the *Patients First* discussion document that the public health system has expertise that may support such a reorientation of the health care system. Simply put, however, we must ensure that this “fix” to the health care system does not “break” the public health system.

We are committed to engaging in a thoughtful change management process with you that minimizes system disruption, mitigates risks associated with system instability and fosters balance between the systems intended to treat illness and the systems intended to prevent disease and promote health. To this end, we look forward to ongoing dialogue with government on the issues addressed in this letter. We trust that this will take place in many ways, including our participation in the proposed Expert Panel. We remain available for further consultation and are eager to pursue next steps.

In closing, I would reiterate that we are committed to finding win-wins so that Ontarians can continue to benefit from a strong and effective public health system while knowing that a quality health care system is there for them when they need it.

Sincerely,

A handwritten signature in black ink, appearing to read "Jaeger".

Dr. Valerie Jaeger,
President

Copy: Dr. David Williams, Chief Medical Officer of Health
Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister of Health and Long-Term Care
Nancy Naylor, Associate Deputy Minister of Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Board of Health Chairs
Medical Officers of Health



February 18th, 2016

The Honourable Dr. Eric Hoskins, M.P.P.
Minister of Health and Long-Term Care
10th floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister:

RE: Ontario Minister of Health and Long-Term Care's discussion paper: *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*

At its regular meeting on February 8, 2016, the Board of Health for the City of Ottawa Health Unit approved the recommendations included in [*Towards Better Outcomes for Communities and Patients: Protecting and Leveraging Public Health in Ontario's Proposed Health System Transformation*](#) report, a copy of which is attached. This report is in response to your discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* discussion paper. The Board approved the following motion, as amended:

That the Board of Health for the City of Ottawa Health Unit:

- 1. Receive for information the Ministry of Health and Long-Term Care's discussion paper entitled: *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* (Document 1);**
- 2. Approve that the Chair of the Board of Health submit this report to the Minister of Health and Long-Term Care and write a letter to the Minister of Health and Long-Term Care outlining the key considerations for successful health system transformation, as outlined in the report:**
 - a) Leverage the Role of Public Health**
 - b) Maintain Independent Governance and Accountability**
 - c) Protect Public Health Funding**
 - d) Strategically Integrate Population Health Priorities, Assessment, and Surveillance; and**
 - e) Enhance Public Health Capacity**

3. Approve that the Chair of the Board of Health include in the letter, referenced in Recommendation 2, a recommendation that Boards of Health be afforded ex-officio representation on Local Health Integration Networks (LHIN) Boards in order to effectively influence priority setting, and also recommend that public health representation from Boards of Health be included on the Expert Panel outlined in the Ministry's *Patients First* report;
4. Approve that the Chair of the Board of Health, subject to the approval of Recommendations 2 and 3, forward the letter referenced in recommendations 2 and 3 and this report to all Ontario Boards of Health, Ottawa City Council, the Association of Municipalities of Ontario (AMO), Association of Local Public Health Agencies (aLPHa), the Champlain LHIN, and local Members of Provincial Parliament, as part of the Ministry's consultations on their proposals included in the *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* report;
5. Recommend that the Chair of the Board of Health, and the Medical Officer of Health consult with the Ottawa City Council representative for AMO, regarding municipal perspectives around the proposed changes in governance and funding; and,
6. Direct staff to contribute to the Ministry's consultations, as required.

The Ottawa Board of Health welcomes and supports enhanced integration of population and public health planning into local health system decision making. However, there are potential risks, including the diversion of prevention and health promotion resources, the erosion of important local partnerships, and the loss of the municipal share of funding, which must be considered and, ideally, mitigated, as the government moves towards implementation of these proposals.

The [*Towards Better Outcomes for Communities and Patients: Protecting and Leveraging Public Health in Ontario's Proposed Health System Transformation*](#) report provides an overview of the key principles that we hold must be considered and addressed in order to ensure that proposed changes to Ontario's healthcare system lead to an improvement in population health and patient outcomes.

In addition, as the Ministry of Health and Long-Term Care advances its health transformation agenda, the Ottawa Board of Health proposes that a whole of government approach, at the municipal, provincial and federal level, be enhanced to



advance policies and programs that address the social determinants of health and to address inequities in health outcomes.

We appreciate the importance of transforming the health care system in Ontario to achieve better outcomes for communities and patients, and we welcome the engagement you have initiated with Boards of Health.

We have initiated discussions with local Members of Provincial Parliament to this affect and I would be delighted to continue this discussion with you at any time.

Sincerely,



Councillor Shad Qadri
Chair, Board of Health for the City of Ottawa Health Unit

Encl.

Cc: The Honourable Bob Chiarelli, M.P.P., Ottawa West-Nepean
The Honourable Madeleine Meilleur, M.P.P., Ottawa-Vanier
The Honourable Yasir Naqvi, M.P.P., Ottawa Centre
Mr. Grant Crack, M.P.P., Glengarry-Prescott-Russell
Mr. John Fraser, M.P.P., Ottawa South
Ms. Marie-France Lalonde, M.P.P., Ottawa-Orléans
Mr. Jack MacLaren, M.P.P., Carleton-Mississippi Mills
Ms. Lisa MacLeod, M.P.P., Nepean-Carleton

Dr. Isra Levy, Medical Officer of Health for the City of Ottawa Health Unit
Ms. Gillian Connelly, Secretary, Board of Health for the City of Ottawa Health Unit
Ottawa City Council
Ottawa Board of Health
Association of Municipalities of Ontario
Association of Local Public Health Agencies
Champlain Local Health Integration Network
Ontario Boards of Health

February 18, 2016

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

Dear Minister Hoskins

RE: *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*

At its meeting held today, February 18, 2016, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit considered a report from the Medical Officer of Health (copy attached) and endorsed the following recommendations:

THAT the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit request that the Minister of Health and Long-Term Care ensure that public health units continue to be directly funded by the Province;

THAT the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit request that the Minister of Health and Long-Term Care ensure that the Population and Public Health Division of the Ministry of Health and Long-Term Care maintain responsibility for accountability agreements with public health units;

THAT should the proposed changes for public health units as outlined in the Patients First Discussion paper be implemented then the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit endorse recommendations made to the Toronto Board of Health as follows:

PROTECTION · PROMOTION · PREVENTION

□
HEAD OFFICE
200 Rose Glen Road
Port Hope, Ontario L1A 3V6
Phone · (905) 885-9100
Fax · (905) 885-9551

□
BRIGHTON OFFICE
Box 127
35 Alice Street
Brighton, Ontario K0K 1H0
Phone · (613) 475-0933
Fax · (613) 475-1455

□
HALIBURTON OFFICE
Box 570
191 Highland Street, Unit 301
Haliburton, Ontario K0M 1S0
Phone · (705) 457-1391
Fax · (705) 457-1336

□
LINDSAY OFFICE
108 Angeline Street South
Lindsay, Ontario K9V 3L5
Phone · (705) 324-3569
Fax · (705) 324-0455

.../2

1. The Board of Health request the Minister of Health and Long-Term Care to ensure a continued strong role for public health in keeping people healthy by:
 - a. Maintaining independent governance of the local public health sector by boards of health;
 - b. Strengthening comprehensive provincial standards for public health through the current review of the Ontario Public Health Standards, especially for healthy public policy and other programs that keep people healthy;
 - c. Ensuring that any provincial funding directed to local boards of health by Local Health Integration Networks cannot be reallocated to other health services and that there is a transparent budget process;
2. The Board of Health request the Minister of Health and Long-Term Care to mandate a formal relationship between LHINs and senior representatives of the healthcare, municipal, education, social service and voluntary sectors as well as the Medical Officer of Health to support population health planning and service coordination in order to improve health equity and address social determinants of health; and
3. The Board of Health request the Minister of Health and Long-Term Care to provide the necessary resources to LHINs and Boards of Health to support collaboration on population health planning of health services;
4. The Board of Health request the Minister of Health and Long-Term Care to create transparent accountability indicators and targets for LHINs which include population health and health equity; and

THAT the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit request the Minister of Health and Long-Term Care to adjust LHIN boundaries to create geographic alignment with the boundaries of municipalities, school boards, and public health units.

.../3

The Honourable Eric Hoskins

February 18, 2016

Page 3 of 3

The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health therefore strongly urges the Ministry of Health and Long-Term Care to include these recommendations in any implementation of the *Patients First: Proposal to Strengthen Patient-Centred Health Care in Ontario*.

Sincerely

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

Original signed by Mr. Lovshin

Mark Lovshin
Board of Health Chair

Attachment

March 7, 2016

Association of Local Public Health Agencies
Suite 1306
2 Carlton Street
TORONTO, ON M5B 1J3

Dear Ontario Boards of Health:

Re: Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

On February 26, 2016 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached 'Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document'. The following motion was passed:

Motion No: 2016-19

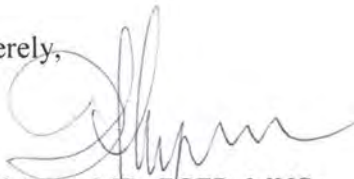
Moved by: David Shearman

Seconded by: Laurie Laporte

"That the Grey Bruce Board of Health does endorse the Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document."

Carried.

Sincerely,



Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey

Encl.

Working together for a healthier future for all.

101 17th Street East, Owen Sound, Ontario N4K 0A5 www.publichealthgreybruce.on.ca

519-376-9420

1-800-263-3456

Fax 519-376-0605



Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

February 2016

For More Information:

Drew Ferguson

Public/Media Relations Coordinator

Grey Bruce Health Unit

101 17th Street East Owen Sound ON N4K 0A5

519-376-9420 ext. 1269

d.ferguson@publichealthgreybruce.on.ca

Grey Bruce Health Unit Brief in Response to Patients First Discussion Document

This brief specifically addresses Section Four of the *Patients First* discussion document, titled *Stronger Links Between Public Health and Other Health Services*.

This brief is comprised of two components. The first looks at the population health approach taken by Public Health and issues that arise. The second section provides a Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

THE ISSUE

The initial statement ***Public health has historically been relatively disconnected from the rest of the health care system*** is at the core of this discussion.

The focus of the LHIN-based health care is on individual patient care, service provision and costs. In essence, it is sickness care.

Public Health has a different role than the sickness care system. Our focus is “upstream” through prevention of disease and illness, staying well.

Public Health’s population health approach aims to improve the health of the entire population. It considers the things that influence our health both inside and outside the health care system. It recognizes that at every stage of life, our health is affected by complex interwoven fabric of factors referred to as 'determinants of health'. These include Housing; Income; Social Status; Social Support Networks; Education and Literacy; Employment/Working Conditions; Social Environments; Physical Environments; Personal Health Practices and Coping Skills; Healthy Child Development; Biology and Genetics; Health Services; Gender; and Culture. These factors do not exist in isolation. Rather, the combined influence of these factors determines our health.

This is profoundly different from the health care system’s view of population health. The health care system’s approach to population health is to provide interventions to specific, identifiable groups whose needs are greatest and it is taken that, by extension, this will improve overall population health.

A Public Health-based, population health strategy addresses the factors contributing to disease in the population as a whole. That goes beyond behaviour and lifestyle approaches. Working at the population health level does not translate well to the individual. Using alcohol misuse as an example, greater societal gain is achieved from a small change within the larger population than by addressing the problem on an individual basis. Referred to as the ‘prevention paradox’; preventive measures, through strategies such as policy development, that address health equity or social determinants of health, that bring benefit at the population level, offers little to the individual. Public Health is virtually invisible to the public. In the population health model, success is marked by a non-event.

Public Health is the ounce of prevention. In terms of health funding, Public Health is small potatoes accounting for about 1.4 per cent of the province's over-all health budget. When limited funding for population health initiatives is balanced against individual care, the scale invariably tips to individual care. Referred to as the, "tyranny of the acute", when limited resources are in play, the demands of sick person will always take precedent over the need to better the health of the larger population. The public have a preoccupation with acute and medical care, as that affects them directly.

In identifying the current situation, Section Four states that ***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.***

Given that reality, it would be unrealistic to expect a relatively small Public Health sector to have much influence on the larger and more powerful set of illness care-oriented priorities. As seen in other jurisdictions, the larger culture of illness care will steer Public Health to a more clinical orientation and away from population health. As a result, the already scarce Public Health resources are diverted to acute, primary and long-term care issues (e.g., emergency room diversion strategies).

The role with respect to the regulatory functions performed by Public Health is not addressed in the *Patients First* discussion. These roles do not align well with health care and speak to the "disconnect from the rest of the health care system" as. Areas including safe drinking water, beach water testing, food premise inspections, personal service setting inspections (aesthetic/tattoo etc.), tobacco by-law enforcement, environmental hazards, and emergency preparedness are all significant components of the Public Health portfolio. The transfer and monitoring of accountability and performance in these regulatory areas is a substantial undertaking for LHINs. Additionally, it would seem redundant to require 14 independent LHINs to provide universal regulatory and performance oversight in these non-healthcare areas.

Further to this discussion of accountability and performance, it should be noted that population health does not lend itself easily to quick measurements as compared to acute care. It is easy to count ER visits, but as we have seen with the shift towards tobacco de-normalization, results are often incremental and can take decades.

The LHINs are defined by health-care referral patterns where the patient goes. Owen Sound patients go to London, Blue Mountains patients go to Collingwood and Barrie, Dundalk patients go to Shelburne and Orangeville. Public Health is defined by municipal boundaries. The two do not align. The current proposal puts the Grey Bruce Health Unit in three LHINs; the majority in the South West LHIN, Southgate in the Waterloo Wellington LHIN and Town of Blue Mountains the North Simcoe Muskoka LHIN. The implications of these over-lapping alignments require clarification.

QUESTIONS FOR DISCUSSION

The following provides the Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

How can public health be better integrated with the rest of the health system?

Should it be? As described, the healthcare system is sickness care, the system comes into play once you become ill; Public Health is all about maintain and extending wellness. That question could well be reversed to ask how the rest of the health system can better integrate with Public Health. This would have the health care system acknowledge and adopt a population health approach as fundamental to all significant health issues. By necessity, this is a long-term approach re-directing the focus towards health and not just health care.

What connections does public health in your community already have?

Grey Bruce Health Unit has filaments that thread throughout our community. The list is extensive; these connections can be characterized as being with:

- upper and lower tier municipal partnerships and working groups. We perform regulatory roles but also focus on planning and policy for healthy communities
- health care, primary care/health care and a wide range of health professionals, providing materials, knowledge and resources
- community and community groups supporting capacity in the community around specific issues
- school boards, from frontline services such as dental screening and immunization, to issue specific initiatives such as youth mental health, to broader healthy school initiatives
- post-secondary institutions
- First Nations communities
- Plains Communities, also known as Amish and Mennonite communities
- federal and provincial ministries
- agriculture and veterinary, producer and consumer groups, industry, and
- the community at large.

What additional connections would be valuable?

Many of the areas of public health involvement, including the provision of clinical services, reflect ongoing or historic gaps on a population-wide basis. This has been particularly true for the more vulnerable populations. One of the emerging roles for the Grey Bruce Health Unit is to

identify capacity within a community and seek out the resources and links that can help empower populations or communities to take steps to improve their own health and wellbeing. These types of partnerships may provide examples of collaborative models between primary care and Public Health.

As noted, health inequities and the broader social determinants of health are often outside the immediate scope of healthcare services. In this regard, LHINs not only need to work with Public Health but they should also develop formal relationships with the municipal, social services, housing, education, and voluntary sectors to support service integration. As the Ottawa Charter for Health Promotion suggests, health services should be expanded to include building healthy public policy, creating supportive environments, strengthening community action and supporting development of personal skills.

What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

The Ministry plan 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.***

A direct role by the Medical Officers of Health in informing or influencing decisions would provide a public health link to healthcare systems. Offering the potential to bring a population health view to health issues and the planning of healthcare services. This can only be achieved with the Medical Officer of Health's routine participation in the executive management team and at the Board level. Experience from other jurisdiction has shown that success requires a strong and interested health sector leadership combined with strong public health leadership and epidemiological capacity. Public health's involvement in providing a population health perspective can only be achieved by design and cannot be left to the discretion of individual LHINs or their Boards.

Without a formal or direct influence on budgets, programs and staffing, it might fall to the Medical Officers of Health to be the lone voice for Public Health. The challenge being to mitigate adverse impacts on Public Health including loss of funding, fragmentation of capacity, diversion of staff through re-orientation to clinical issues, and barriers to engagement with community and municipal partners.



March 31, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
premier@ontario.ca

The Honourable Dr. Eric Hoskins
Minister, Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
ehoskins.mpp@liberal.ola.org

Dear Premier Wynne and Minister Hoskins

Re: Patients First Discussion Paper

At its meeting held on March 9, 2016, the Board of Health for the Peterborough County-City Health Unit passed the following resolution:

“WHEREAS the discussion paper Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care, by establishing links between LHINs and public health which can occur through identifying new roles and responsibilities that do not require changes in the funding or governance of public health in Ontario; and

WHEREAS the wider problem of improving and supporting the health and health equity of Ontarians is mandated to the public health system, through the Health Protection and Promotion Act that has created local boards of health and has made them accountable for the delivery of public health programs and services as required by the Ontario Public Health Standards and the Ontario Public Health Organizational Standards, and

WHEREAS the direct relationship with the province ensures that the same principles and standards are upheld and implemented for all boards of health, further ensuring that all Ontarians benefit equitably from the public health system; and

WHEREAS municipal and First Nation representation on boards of health ensure valuable connections with decision makers and staff to support local healthy public policy; and

WHEREAS evidence from other jurisdictions where public health funding has been integrated regionally with funding for the rest of the health care system shows that opportunities for system improvement is often not realized and unintended risks to public health have arisen:

BE IT THEREFORE RESOLVED that the board of health for the Peterborough County-City Health Unit calls upon the province of Ontario to ensure a continued strong role for public health in keeping people healthy by

- maintaining independent governance of the public health sector by local boards of health; and
- maintain its direct and transparent funding of local boards of health; and
- continue to directly negotiate Provincial Public Health Funding and Accountability Agreements (PHFAA) with local boards of health.

Local municipal and First Nation Councils are called upon to endorse this motion and advise Premier Kathleen Wynne, Minister of Health and Long Term Care, the Honourable Eric Hoskins, and local MPPs, Minister of Agriculture and Rural Affairs Jeff Leal, and Laurie Scott, in writing."

Moved:	Mr. Andy Sharpe
Seconded:	Chief Phyllis Williams
Motion carried.	(M-2016-032)

On behalf of our communities, the Board of Health would like to thank you for the opportunity to provide input on the discussion paper. Our concerns echo those of other public health units, it is our hope that the Province will consider these recommendations.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at

cc: MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Association of Local Public Health Agencies
Ontario Boards of Health

PATIENTS FIRST: PUBLIC HEALTH AND THE NE LHIN

MOTION: **THAT the Sudbury & District Board of Health seek to collaborate with the boards of health for Porcupine, Timiskaming, Algoma and North Bay Parry Sound to engage further with the North East LHIN for the purposes of relationship building and exploring the potential implications for the northeast of the proposals in Patients First; and**

THAT to this end, an initial meeting be sought between the respective Board of Health Chairs and Medical Officers of Health/Chief Executive Officers and the Board and Chief Executive Officer for the North East LHIN.

Strengthening Ontario's Smoking and Vaping Laws

**Proposed changes to regulations made under the
*Smoke-Free Ontario Act and Electronic Cigarettes Act, 2015***

**Public Consultation Paper
March 10, 2016**

Table of Contents

Purpose.....	3
Feedback.....	3
Summary	4
Background	5
Proposal.....	5
1. Expand no smoking rules to apply to medical marijuana	6
Issue	6
Proposed approach.....	6
Discussion	7
2. Prohibit the use of e-cigarettes – including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes – in all enclosed public places, enclosed workplaces, and other specified outdoor areas.....	7
Issue	7
Proposed Approach	8
Discussion	9
3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes	9
Issue	9
Proposed approach.....	9
Discussion	10
4. Expand the definition of “e-cigarette” to include “e-substance”	10
Issue	10
Proposed approach.....	11
Discussion	11
5. Expand the list of places where e-cigarettes are prohibited from sale.....	11
Issue	11
Proposed approach.....	11
Discussion	12
6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.	12
Issue	12
Proposed approach.....	12
Discussion	13

Purpose

This consultation paper aims to solicit feedback from businesses, retailers, employers, health care facilities, public health experts, medical marijuana users, physicians, medical organizations, and the general public on the impacts of the Ministry of Health and Long-Term Care's proposal to strengthen Ontario's smoking and e-cigarette (vaping) laws.

This paper outlines the ministry's proposal to make changes to Ontario's smoking and vaping laws that would restrict where people can smoke medical marijuana and vape an e-cigarette, where e-cigarettes can be sold, and how e-cigarettes can be displayed and promoted.

Feedback

Your feedback and comments will inform the development of proposed amendments to Ontario Regulation 48/06¹ made under the *Smoke-Free Ontario Act* (SFOA)² and Ontario Regulation 337/15³ made under the *Electronic Cigarettes Act, 2015* (ECA)⁴.

Comments on this public consultation paper are welcome until **April 24, 2016** and can be provided in three different ways:

- Complete the Response Form provided on the Regulatory Registry in connection with this paper at <http://www.ontariocanada.com/registry>.
- Email comments directly to SFOA-ECA-Consultations@ontario.ca quoting this paper "Strengthening Ontario's Smoking and Vaping Laws"
- Mail comments to:
Population and Public Health Division
Ministry of Health and Long-Term Care
777 Bay Street, Suite 1903, 19th Floor
Toronto, ON M7A 1S5

Please note that all comments received from organizations, including individuals indicating an affiliation with an organization, will be considered public information and may be used and disclosed by the ministry to help in developing its final proposal.

¹ Ontario Regulation 48/06 made under the *Smoke-Free Ontario Act* can be found here - <https://www.ontario.ca/laws/regulation/060048>

² The *Smoke-Free Ontario Act* can be found here - <https://www.ontario.ca/laws/statute/94t10>

³ Ontario Regulation 337/15 made under the *Electronic Cigarettes Act, 2015* can be found here: <https://www.ontario.ca/laws/regulation/150337>

⁴ The *Electronic Cigarettes Act, 2015* can be found here - <https://www.ontario.ca/laws/statute/15e07>

Comments from individuals who do not indicate an affiliation will also be considered public and will be used and disclosed by the ministry to help in developing its final proposal. However, any personal information, such as names or contact details, would be removed prior to disclosure of the comments.

Summary

The Ministry of Health and Long-Term Care (the “ministry”) is committed to improving the health and wellness of Ontarians. In May 2015, the *Making Healthier Choices Act, 2015*⁵ received Royal Assent, strengthening the *Smoke-Free Ontario Act* by banning the sale of certain flavoured tobacco products, and increasing the maximum fines for youth-related sales offences. The *Making Healthier Choices Act, 2015* also created new legislation - the *Electronic Cigarettes Act, 2015* – to regulate the sale, use, display, and promotion of e-cigarettes.

On January 1, 2016, provisions in the *Electronic Cigarettes Act, 2015* came into force, which prohibit the sale or supply of e-cigarettes to persons who are less than 19 years old.

The ministry is considering further legislative and regulatory amendments that would strengthen smoking and e-cigarettes laws. This proposal is outlined below:

1. Expand “no smoking rules” to apply to medical marijuana;
2. Prohibit the use of e-cigarettes - including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes – in all enclosed public places, enclosed workplaces, and other specified outdoor areas;
3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes;
4. Expand the definition of “e-cigarette” to include “e-substance”;
5. Expand the list of places where e-cigarettes are prohibited for sale;
6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

If approved, this proposal would have a variety of impacts on the public, businesses and employers in Ontario. The ministry is interested in hearing from stakeholders about these impacts, and welcomes continued input.

⁵ The *Making Healthier Choices Act, 2015* can be found here - http://www.ontla.on.ca/bills/bills-files/41_Parliament/Session1/b045ra.pdf

Background

Electronic cigarettes

E-cigarettes are an emerging trend in Ontario. Concerns have been raised about the potential negative health effect of e-cigarettes. The World Health Organization recommends taking precautionary action on e-cigarettes, and jurisdictions around the world have put into place restrictions to protect people from potential health impacts. In Ontario, the government has also taken precautionary measures to protect people, especially youth, from exposure to e-cigarettes and potential harms through restrictions on e-cigarette sales to minors, restrictions on where e-cigarettes can be used, restrictions on where e-cigarettes can be sold, and restrictions on how they can be displayed and promoted in stores.

Medical marijuana

Possession of marijuana is a criminal offence under the federal *Controlled Drugs and Substances Act*. However, the federal government provides access to a legal source of marijuana for medical purposes under its *Marihuana for Medical Purposes Regulations* (MMPR) made under the *Controlled Drugs and Substances Act*. Health Canada has not approved marijuana as a therapeutic product.

In order to obtain marijuana for medical purposes, a person must have a medical document from a physician and obtain medical marijuana from a licensed producer. As of September 2015, there are just over 30,000 clients in Canada who were registered with licensed producers of marijuana under federal regulation.

Evidence about the use, forms, and effectiveness of medical marijuana is still evolving. Although methods of consuming marijuana are also rapidly evolving, smoking is the most common form of consumption⁶. People can also consume medical marijuana using a vaporizer, which is considered an “e-cigarette” under the *Electronic Cigarettes Act, 2015*.

While there are some laws that impact where a medical marijuana user may smoke, vape, or ingest marijuana for medical purposes, such as the *Liquor Licence Act* and driving laws, they do not address the specific forms of smoking or vaping in public places.

Proposal

The following summary outlines and explains the proposed rules to strengthen smoking and e-cigarette laws in Ontario. The ministry is soliciting feedback on how these rules

⁶ Canadian Centre on Substance Abuse. “Clearing the Smoke on Cannabis: Respiratory Effects of Cannabis Smoking.” J. Diplock and D. Plecas. 2015

would affect you and how they can be improved to protect the health of Ontarians. Note that the final regulation may be different from what is in this proposal.

1. Expand no smoking rules to apply to medical marijuana

Issue

Ontario's *Smoke-Free Ontario Act* (SFOA) currently only applies to tobacco. It includes prohibitions on the smoking of tobacco in all enclosed public spaces and enclosed workplaces (including movie theatres and restaurants) and a number of outdoor public spaces (including playgrounds, restaurant/bar patios). It does not address the smoking of marijuana or other substances.

There are few laws, such as liquor license and driving laws, which address where a medical marijuana user may smoke, vape, or ingest marijuana for medical purposes.

Proposed approach

The ministry is proposing to amend the SFOA and Ontario Regulation 48/06 made under the SFOA to establish that the "no smoking" rules apply to medical marijuana. This would provide reasonable and precautionary safeguards to employees, customers and bystanders from exposure to medical marijuana smoke.

This would mean that smoking medical marijuana would be illegal in the following locations in which the smoking of tobacco is prohibited:

- Enclosed public places (e.g. shopping malls, theatres, schools)
- Enclosed workplaces (e.g. retail stores, office buildings, factories)
- Schools and school grounds
- Common areas in condominiums, apartment buildings and university/college campuses
- Child care centres within the meaning of *Child Care and Early Years Act, 2014*
- Places where home child care is provided within the meaning of the *Child Care and Early Years Act, 2014*, whether or not children are present
- Reserved seating areas of outdoor sports or entertainment venues
- Motor vehicles while another person who is less than 16 years old is present
- Restaurant and bar patios
- Sheltered areas with a roof and more than two walls
- Children's playgrounds
- Publicly owned sporting areas
- Nine meters from any entrance or exit of a public hospital, private hospital, psychiatric facility, long-term care home, and independent health facility

- Outdoor grounds of public hospitals, private hospitals and psychiatric facilities
- Outdoor grounds of certain government of Ontario office buildings

However, under the proposal, a specific exemption would permit smoking medical marijuana in:

- Scientific research and testing facilities;

Other exemptions in the SFOA for smoking tobacco would not apply to medical marijuana, i.e. designated guest rooms in hotels, motels and inns, controlled smoking areas in residential care facilities (e.g. long-term care homes), and traditional use of tobacco by Aboriginal persons.

The proposal, if approved and implemented, would continue to be enforced by inspectors appointed under the SFOA. These inspectors are employees of local public health units.

Discussion

This proposal would have different impacts on medical marijuana users, employees, businesses, retailers, employers, hospitals, residential care facilities, and public health units.

- How would this proposal impact your current practices or policies?
Do you have specific suggestions to improve this proposal?

2. Prohibit the use of e-cigarettes - including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes –in all enclosed public places, enclosed workplaces, and other specified outdoor areas

Issue

Though not yet in force, Ontario's *Electronic Cigarettes Act, 2015* and its regulation contain provisions that would prohibit the use of e-cigarettes (i.e. vaping) in enclosed workplaces, enclosed public places and a number of other prescribed places (e.g. restaurant and bar patios, playgrounds).

E-cigarettes are a relatively new and quickly evolving technology; the evidence concerning their potential health effects and implications for tobacco control efforts is in its early stages. The restrictions under the *Electronic Cigarettes Act, 2015* ensure that Ontarians are protected from the potential harms that vapour exposure could have on their health.

Vaporizers, which are considered e-cigarettes under the *Electronic Cigarettes Act, 2015*, can be used to consume medical marijuana. The current regulation, Ontario

Regulation 337/15, made under the ECA (which is not yet in force) includes an exemption for medical marijuana users, which would permit them to use an e-cigarette for medical marijuana in places where vaping is otherwise prohibited.

Proposed Approach

The ministry is proposing that vaping be prohibited in enclosed workplaces, enclosed public places, and other prescribed places. This would protect employees, customers and bystanders from any potential harms associated with exposure to e-cigarettes – no matter the substance being vaped. This proposal would require a change to the regulation.

This would mean that using an e-cigarette (vaping), including the use of a vaporizer to consume medical marijuana, would be prohibited in the following places:

- Enclosed public places (e.g. shopping malls, theatres, schools)
- Enclosed workplaces (e.g. retail stores, office buildings, factories)
- Schools and school grounds
- Common areas in condominiums, apartment buildings and university/college campuses
- Child care centres within the meaning of *Child Care and Early Years Act, 2014*
- Places where home child care is provided within the meaning of the *Child Care and Early Years Act, 2014*, whether or not children are present
- Reserved seating areas of outdoor sports or entertainment venues
- Motor vehicles while another person who is less than 16 years old is present
- Restaurant and bar patios
- Sheltered areas with a roof and more than two walls
- Children's playgrounds
- Publicly owned sporting areas
- Nine meters from any entrance or exit of a public hospital, private hospital, psychiatric facility, long-term care home, and independent health facility
- Outdoor grounds of public hospitals, private hospitals and psychiatric facilities
- Outdoor grounds of certain government of Ontario office buildings

However, under this proposal, specific exemptions for e-cigarettes would permit e-cigarette use/vaping, including the use of a vaporizer to consume medical marijuana, in the following places:

- Scientific research and testing facilities;
- Designated outdoor areas on hospital grounds and on the grounds of specific government of Ontario office properties (to be phased out by January 1, 2018).

The exemption permitting the use of e-cigarettes in theatrical stage productions under specified conditions, would not apply to vaping medical marijuana.

Note that under the ministry's proposal, there would not be an exemption to permit testing/sampling of e-cigarette devices or products in stores that sell e-cigarettes. Under this proposal, e-cigarette use inside stores would be prohibited, as stores are considered enclosed workplaces and enclosed public places. However, stores could continue to be able to display, promote and provide informational material about e-cigarettes under conditions that protect children and youth from exposure. (More details are provided under issue 6, with regard to Display and Promotion.)

The proposal, if approved and implemented, would be enforced by inspectors appointed under the ECA. These inspectors are employees of local public health units.

Discussion

This proposal would have different impacts on medical marijuana users, employees, businesses, retailers, employers, hospitals, residential care facilities, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes

Issue

As of January 1, 2016, Ontario's *Electronic Cigarettes Act, 2015* prohibits the sale or supply e-cigarettes to a person who is less than 19 years old. It also prohibits the sale or supply of e-cigarettes to a person who appears to be less than 25 years old without asking the person for identification and being satisfied that the person is at least 19 years old.

Vaporizers, which are considered e-cigarettes under the *Electronic Cigarettes Act, 2015*, can be used to consume medical marijuana. The current regulation (which is not yet in force) made under the *Electronic Cigarettes Act, 2015* includes an exemption for medical marijuana users and would permit a minor to buy or obtain an e-cigarette for medical marijuana purposes.

Proposed approach

The ministry is proposing to change the regulation to specify that a parent, guardian or caregiver would be permitted to *supply* (but not sell) an e-cigarette to a minor to consume medical marijuana, if the minor is authorized to possess medical marijuana under federal law.

As noted above, the ECA is enforced by inspectors appointed under the Act, who are employees of local public health units.

Discussion

This proposal would have different impacts on medical marijuana users, medical marijuana licensed producers, parents, guardians, caregivers, health care providers, physicians, hospitals, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

4. Expand the definition of “e-cigarette” to include “e-substance”

Issue

As of January 1, 2016, Ontario’s *Electronic Cigarettes Act, 2015* prohibits the sale or supply e-cigarettes to a person who is under 19 years old and to a person who appears to be less than 25 years old without proof of identification. The ECA also contains provisions, which are not yet in force, which would restrict the display and promotion of e-cigarettes in places where they are sold.

Under the ECA,

“electronic cigarette” means any of the following:

1. A vaporizer or inhalant-type device, whether called an electronic cigarette or any other name, that contains a power source and heating element designed to heat a substance and produce a vapour intended to be inhaled by the user of the device directly through the mouth, whether or not the vapour contains nicotine.
2. A component of a device described in paragraph 1
3. Any other prescribed device or product.

The current definition of e-cigarette is a device designed to heat a substance. There is some confusion around whether the substance being heated in an e-cigarette (e.g. e-liquid) is a component of the device, and whether or not the substance is covered by the Act’s restrictions on selling, displaying and promoting e-cigarettes.

Proposed approach

The ministry is proposing to clarify by regulation that the definition of “electronic cigarette” in the ECA includes “e-substance”; i.e. any substance manufactured or sold for use in an e-cigarette device (e.g. e-liquid).

This would mean that businesses selling e-cigarettes would not be able to sell or supply an e-substance to a minor. In addition, businesses would not be able to display and promote e-substances, except under certain circumstances (see Issue 6 “Prescribe conditions under which a business selling e-cigarettes could display or promote products”).

As noted above, the *Electronic Cigarettes Act, 2015* is enforced by inspectors appointed under the Act who are employees of local public health units.

Discussion

This proposal would have different impacts on businesses that sell e-cigarettes or any substance meant to be used in an e-cigarette, as well as on e-cigarette users and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

5. Expand the list of places where e-cigarettes are prohibited from sale

Issue

Though not yet in force, Ontario’s *Electronic Cigarettes Act, 2015* contains provisions that would prohibit the sale of electronic cigarettes in public hospitals, private hospitals, psychiatric facilities, long-term care homes, pharmacies, and grocery stores containing pharmacies. Ontario’s *Smoke-Free Ontario Act* also prohibits the sale of tobacco in these places.

However, the *Smoke-Free Ontario Act* also prohibits the sale of tobacco in additional places set out in regulation, such as post-secondary institution campuses, independent health facilities, schools and school grounds (including private schools), child care centres, places where home child care is provided, and certain Government of Ontario office buildings.

Proposed approach

To ensure comparable rules for where tobacco and e-cigarettes may be sold, the ministry is proposing to prescribe the following additional places as places where e-cigarettes cannot be sold:

- Independent health facilities
- Schools and school grounds, including private schools
- Campuses of post-secondary institutions including universities and colleges,
- Child care centres within the meaning of the *Child Care and Early Years Act, 2014*
- Places where home child care is provided within the meaning of the *Child Care and Early Years Act, 2014*, whether or not children are present.
- Certain office buildings owned by the Government of Ontario and prescribed in the regulation under the *Smoke-Free Ontario Act*.

As noted above, the ECA is enforced by inspectors appointed under the Act who are employees of local public health units.

Discussion

This proposal would have different impacts on e-cigarette users, e-cigarette retailers, schools, colleges, universities, businesses, health care providers, physicians, hospitals, residential care facilities, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

Issue

Though not yet in force, Ontario's *Electronic Cigarettes Act, 2015* contains provisions that would:

- prohibit the display of e-cigarettes in a way that would permit a consumer to view or handle an e-cigarette before purchasing it in a store; and
- prohibit the promotion of e-cigarettes at places where e-cigarettes or tobacco products are sold or offered for sale.

These restrictions would protect the well-being of children and youth by limiting their exposure to e-cigarette products.

Proposed approach

The ministry is proposing to permit certain signs/documents to be made available to inform the public that they have e-cigarettes for sale, and educate customers about the types of e-cigarettes available for sale and how to use them.

Signs/documents would need to meet the following conditions:

- A maximum of three (3) signs referring to e-cigarettes and/or e-cigarette product accessories. These signs must:
 - not exceed 968 square centimeters;
 - have a white background with black text;
 - not provide any information about a brand of e-cigarette (including its components and e-substances).
- Documents listing brands, specifications, instructions, or other details about products available for sale, could only be made available for viewing:
 - inside the store;
 - to adults over 19 years of age

The ministry is also proposing to permit the display and promotion of e-cigarette products (but not the testing or sampling of e-cigarettes) in places where they are sold, provided that the following conditions are met:

- Owner must inform its local public health unit in writing that it wishes to operate under the exemption;
- Products and promotional material must not be visible from the outside of the store;
- Individuals under the age of 19 would not be permitted to enter the shop;
- Customers could only access the store from outdoors or from areas in an enclosed shopping mall;
- Store could not be a thoroughfare (e.g. kiosk in a mall corridor).

As noted above, the ECA is enforced by inspectors appointed under the Act who are employees of local public health units.

Discussion

This proposal would have different impacts on e-cigarette users, e-cigarette retailers, distributors, manufacturers, and public health units.

- How would this proposal impact your current practices or policies?
- Do you have specific suggestions to improve this proposal?

STRENGTHENING ONTARIO'S SMOKING AND VAPING LAWS

MOTION: WHEREAS as strong regulatory environment is essential for effective tobacco control as supported by the World Health Organization Framework Convention on Tobacco Control; and

WHEREAS Sudbury & District Board of Health motion 54-15 calls for a public health framework for the anticipated legalization of cannabis; and

WHEREAS the Sudbury & District Board of Health motion #57-14 calls for enhanced public health measures in the manufacturing, quality, promotion and sale of e-cigarettes; and

WHEREAS the proposed changes to regulations made under the Smoke Free Ontario Act and Electronic Cigarettes Act, 2015 as described in the MOHLTC Public Consultation Paper, March 10, 2016 further strengthen the tobacco regulatory framework, and are consistent with Board of Health motions regarding cannabis and e-cigarettes, and include following:

1. Expand no smoking rules to apply to medical marijuana;
2. Prohibit the use of e-cigarettes – including the use of vaporizers to consume medical marijuana and testing in stores that sell e-cigarettes – in all enclosed public places, enclosed workplaces, and other specified outdoor areas;
3. Permit parents, guardians and caregivers to supply e-cigarettes to minors for medical marijuana purposes;
4. Expand the definition of “e-cigarette” to include “e-substance”;
5. Expand the list of places where e-cigarettes are prohibited from sale;
6. Establish rules for the display and promotion of e-cigarettes at places where they are sold.

THEREFORE be it resolved that the Sudbury & District Board of Health fully endorse the proposals as described in the March 10, 2016 MOHLTC Public Consultation Paper.

COMMUNITY WATER FLUORIDATION

MOTION: WHEREAS tooth decay remains the most common chronic disease in Canadian Children; and

WHEREAS water fluoridation is the most cost-effective, safe and internationally recognized method to prevent dental decay and to ensure that citizens receive the benefits of reduced dental decay; and

WHEREAS children living in fluoridated communities in Ontario have less tooth decay than children living in non-fluoridated communities and the effect tends to be maximized among children from lower socioeconomic groups; and

WHEREAS dental treatment costs are substantially higher than the costs of preventing dental disease; and

WHEREAS a recently introduced bill by a Member of Provincial Parliament supports community water fluoridation, and calls for changes to the Fluoride Act and other relevant legislation to support mandatory fluoridation of municipal drinking water; and

WHEREAS the decision on April 11, 2016 of the Council of the Township of Nairn and Hyman to discontinue the practice of fluoridating its community water supply is expected to result in a negative impact on the oral health among residents; and

WHEREAS the Sudbury & District Board of Health has consistently supported the principle and administration of community water fluoridation in Sudbury and districts;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health reaffirm its support for community water fluoridation and advocate for the implementation of provincial regulation mandating community water fluoridation; and

FURTHER THAT this motion be shared with relevant area municipalities, dental associations, community stakeholders, boards of health, the Minister of Health and Long-Term Care and the Chief Medical Officer of Health.

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/>

All Board members are encouraged to complete the Board of Health meeting evaluation following each regular Board meeting:

<https://fluidsurveys.com/surveys/sdhu/board-monthly-meeting-evaluation/>

ADJOURNMENT

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