



Sudbury & District Board of Health

Thursday, February 16, 2017

SDHU Boardroom

1300 Paris Street

Sudbury & District Board of Health Meeting - February 16, 2017

Sudbury & District Board of Health Meeting #02-17

1.0 CALL TO ORDER

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

Agenda - February 16, 2017

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4.0 DELEGATION / PRESENTATION

i) 2016 Year-In Review

Sandra Laclé, Director, Clinical and Family Services Division

Stacey Laforest, Director, Environmental Health Division

Megan Dumais, Director, Health Promotion Division

Renée St Onge, Director, Resources, Research, Evaluation and Development (RRED) Division

a. 2016 Highlights by the Numbers Infographic

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5.0 CONSENT AGENDA

i) Minutes of Previous Meeting

a. First Meeting, January 19, 2017

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ii) Business Arising From Minutes

None

iii) Standing Committees

None

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

a. MOH/CEO Report, February 2017

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v) Correspondence

a. Ontario Public Health Modernization Review

Letter from the Windsor-Essex County Board of Health to the Ontario Public Health Standards Modernization Committee Executive Steering Committee dated January 18, 2017

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b. Marijuana Controls Under Bill 178, Smoke-Free Ontario Amendment Act, 2016

Letter from the Grey Bruce Board of Health to the Minister of Health and Long-Term Care dated February 7, 2017

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vi) Items of Information

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AGENDA – SECOND MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT
THURSDAY, FEBRUARY 16, 2017 – 1:30 P.M.

- 1. CALL TO ORDER**
- 2. ROLL CALL**
- 3. REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST**
- 4. DELEGATION / PRESENTATION**
 - i) 2016 Year-In Review**
 - a. *2016 Highlights by the Numbers* Infographic
 - b. Presentation by:
 - Sandra Laclé, Director, Clinical and Family Services Division
 - Stacey Laforest, Director, Environmental Health Division
 - Megan Dumais, Director, Health Promotion Division
 - Renée St Onge, Director, Resources, Research, Evaluation and Development (RRED) Division
- 5. CONSENT AGENDA**
 - i) Minutes of Previous Meeting**
 - a. First Meeting – January 19, 2017
 - 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, February 2017
 - v) Correspondence**
 - a. Ontario Public Health Modernization Review**
 - Letter from the Windsor-Essex County Board of Health to the Ontario Public Health Standards Modernization Committee Executive Steering Committee dated January 18, 2017
 - b. Marijuana Controls Under Bill 178, Smoke-Free Ontario Amendment Act, 2016**
 - Letter from the Grey Bruce Board of Health to the Minister of Health and Long-Term Care dated February 7, 2017

vi) Items of Information

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|--|--------------------------------------|
| a. alPHa Information Break | February 2, 2017 |
| b. Canada's Chief Public Health Officer's Annual Report: <i>Health Status of Canadians 2016: A Report of the Chief Public Health Officer</i> | |
| c. Update: Health System Integration | January 27, 2017
February 3, 2017 |
| d. SDHU Submission for Pre-Budget Consultation | February 2017 |
| e. 2017 alPHa Annual General Meeting and Conference | |

APPROVAL OF CONSENT AGENDA

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

6. NEW BUSINESS

i) Opioids

- Presentation by Dr. A. Zbar, Associate Medical Officer of Health
- Letter from the Peterborough Board of Health to the Chief Medical Officer of Health dated February 2, 2017
- Community Drug Strategy Greater Sudbury 2016 Progress Report

OPIOID USE IN SUDBURY & DISTRICT

MOTION: WHEREAS the Sudbury & District Board of Health is alarmed by the rise in opioid-related harms as evidenced by a tripling of the number of opioid prescriptions in Canada over the past decade and the growing number of opioid-related poisonings presenting to Ontario emergency departments; and

WHEREAS within Greater Sudbury indicators of harmful opioid use exceed those for the province, including the rates of opioid users, opioid maintenance therapy use, high strength opioid use, opioid-related emergency department visits, hospital visits and hospital deaths; and

WHEREAS federal and provincial governments have signed a Joint Statement of Action committed to addressing the burden of opioid-related harms in Canada and, recently, Ontario announced a provincial opioid strategy that includes modernizing opioid prescribing and monitoring, improving the treatment of pain and enhancing addiction supports and harm reduction; and

WHEREAS the Community Drug Strategy for the City of Greater Sudbury, of which the Sudbury & District Health Unit is a leading member, supports Ontario's opioid strategy and is committed to implementing the strategy within the local context;

THEREFORE BE IT RESOLVED the Sudbury & District Board of Health congratulate the Ontario Minister of Health and Long-Term Care and the Chief Medical Officer of Health, as the province's first Provincial Overdose Coordinator, and request that the new provincial plan be further developed with targets, deliverables and timelines that are supported by regular communication to stakeholders and partners such as boards of health; and

FURTHER THAT the Sudbury & District Board of Health urge the federal Minister of Health to similarly communicate and promptly implement the federal opioid strategy.

ii) Part VIII - Ontario Building Code Fee Increases

- Briefing Note from Dr. Sutcliffe, Medical Officer of Health and Chief Executive Officer to the Board Chair dated February 9, 2017
- Revised Board Manual G-I-50 By-Law 01-98

AMENDMENT TO FEE SCHEDULE "A" TO BY-LAW 01-98

MOTION: WHEREAS the Board of Health is mandated under the Ontario Building Code (O. Reg. 332/12), under the Building Code Act to enforce the provisions of this Act and the Building Code related to sewage systems; and

WHEREAS program-related costs are funded through user fees on a cost-recovery basis; and

WHEREAS the fees charged by the Board of Health have not been increased since 2011; and

WHEREAS the proposed fees are necessary to address increased program associated operational and delivery costs;

THEREFORE BE IT RESOLVED THAT the Board of Health approve the amended fees within Schedule "A" and that the appendix of Board of Health By-law 01-98 be correspondingly updated; and

FURTHERMORE THAT this fee schedule shall come into effect immediately.

- iii) **SDHU 2013 – 2017 Performance Monitoring Plan and Annual Performance Monitoring Report**
- Presentation by Krista Galic, Specialist, Quality & Monitoring
 - 2016 Performance Monitoring Report, February 2016

SDHU 2016 PERFORMANCE MONITORING REPORT

MOTION: WHEREAS the Sudbury & District Board of Health is working toward achieving its vision of Healthier Communities for All; and

WHEREAS the 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 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 2016 Performance Monitoring Report.

- iv) **Board of Health Finance Standing Committee Terms of Reference**
- Revised Board Manual Information Sheet C-II-11

BOARD OF HEALTH FINANCE STANDING COMMITTEE TERMS OF REFERENCE

MOTION: THAT the Board of Health, having reviewed the revised Information C-II-11, approve the contents therein for inclusion in the Board of Health Manual.

7. ADDENDUM

ADDENDUM

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

8. ANNOUNCEMENTS / ENQUIRIES

Please remember to complete the Board Evaluation following the Board meeting:

9. ADJOURNMENT

ADJOURNMENT

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



Sudbury & District

Health Unit

Service de
santé publique

2016 Highlights by the numbers

The Sudbury & District Health Unit is a progressive public health agency committed to improving health and reducing social inequities in health through evidence-informed practice.

Our Mission—**Working with our communities to promote and protect health and to prevent disease for everyone**—is reflected in all of our programs and services.

In **2016**, the Health Unit continued to meet the public health needs of the community by:

Inspecting

3 608

food premises.

Collaborating with partner agencies to support vulnerable and marginalized individuals to improve their living and housing conditions. Responding to

413

health hazard complaints.

Issuing

13

blue-green algae advisories.

WARNING

Setting **299** mosquito traps, and trapping **20 370** mosquitoes to track West Nile virus.



Investigating

37

enteric outbreaks.



Responding to **54** internal and external requests for data related to population health assessment and surveillance, and providing **32** consultations on topics such as communicable diseases, demographics, determinants of health, maternal health, chronic disease, and mental health.

Offering placements to **101** students from **6** post-secondary institutions, representing **9** disciplines, and resulting in **7 557** hours of experience.



Reaching **1 534 563** Facebook users and generating **282 700** Twitter impressions.



Responding to

395

requests for information received through the Health Unit's website.



Promoting the *You Can Create Change* health equity campaign: **20** Facebook ads reaching **94 933** people and **53** tweets generating **21 620** impressions.

**YOU CAN
CREATE CHANGE.**

Responding to

3 880

calls received through the Health Information Line on topics such as immunization, infection control, and reportable diseases.

Providing **537** children access to the oral health preventive program to help keep their teeth and gums healthy. Children received:

- individual assistance in taking care of their teeth
- fluoride varnish
- pit and fissure sealants

Promoting the *Breastfeeding Challenge* and welcoming

97

mothers, joined by their families, to breastfeed or hold their babies skin-to-skin for the event.

Giving out

844 929

needles through the Harm Reduction Supplies and Services Program.

Providing sexual health services to **6 149** clients at the Health Unit's Rainbow Centre site (Greater Sudbury) and to **767** clients at other office sites throughout the districts of Sudbury and Manitoulin.

Facilitating **527** activities related to chronic disease and injury prevention in schools, reaching **11 765** school community members, with topics ranging from mental health, healthy eating, healthy weights, and physical activity to ultraviolet radiation, injury prevention, sexual health, tobacco use, and substance misuse.

Working with **78** active volunteers who provided over **850** hours of service.

Thank you!



Offering academic detailing to

32

primary care providers on *Canada's Low-Risk Alcohol Drinking Guidelines* and the *Alcohol Screening, Brief Intervention and Referral* tool used for alcohol misuse prevention.

Educating

200

secondary students on Manitoulin Island about the dangers of texting and driving.

ONTARIO
TXT • L8R

Offering

186

appointments at the Quit Smoking Clinic.

Distributing

4 338

home safety checklists during Falls Prevention month.



**MINUTES – FIRST MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM
THURSDAY, JANUARY 19, 2017, AT 1:30 P.M.**

BOARD MEMBERS PRESENT

Maigan Bailey
Robert Kirwan
Paul Myre
Mark Signoretti

Janet Bradley
René Lapierre
Ken Noland
Carolyn Thain

Jeffery Huska
Richard Lemieux
Rita Pilon

BOARD MEMBERS REGRETS

Stewart Meikleham

STAFF MEMBERS PRESENT

Megan Dumais
Rachel Quesnel

Nicole Frappier
Dr. P. Sutcliffe

Stacey Laforest

R. QUESNEL PRESIDING

1.0 CALL TO ORDER

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

- i) **Letter from the Sudbury & District Board of Health Chair to the Minister of Health and Long-Term Care dated December 21, 2016, Recommending Reappointment for Sudbury & District Board of Health member, J. Bradley**

The Public Appointments Secretariat has been notified of J. Bradley's interest in a reappointment as a provincial appointee on the Sudbury & District Board given her term expires February 21, 2017. A letter of support for her reappointment has been submitted by the Board Chair.

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

There were no declarations of conflict of interest.

4.0 ELECTION OF OFFICERS

APPOINTMENT OF CHAIR OF THE BOARD

Following a call for nominations for the position of Chair of the Board, René Lapierre was nominated.

There being no further nominations, the nomination for the Sudbury & District Board of Health Chair for 2017 was closed. R. Lapierre accepted the nomination. The following was announced:

THAT THE Sudbury & District Board of Health appoints René Lapierre as Board for the year 2017.

R. LAPIERRE PRESIDING

APPOINTMENT OF VICE-CHAIR OF THE BOARD

Following a call for nominations for the position of Vice-Chair of the Board, Jeffery Huska was nominated.

There being no further nominations, the nomination for the Sudbury & District Board of Health Vice-Chair for 2017 was closed. Jeffery Huska accepted his nomination. The Board Chair announced:

THAT the Sudbury & District Board of Health appoints Jeffery Huska as Vice-Chair for the year 2017.

APPOINTMENTS TO THE BOARD EXECUTIVE COMMITTEE

Following a call for nominations for three positions of Board Member at Large to the Board Executive Committee, Paul Myre, Janet Bradley, Mark Signoretti, and Ken Noland were nominated.

There being no further nominations, the nominations for the Board Executive Committee for the year 2017 was closed. The four nominees accepted their nominations. A paper vote was conducted and results handed to the Chair. The Chair announced:

THAT the Sudbury & District Board of Health appoints the following individuals to the Board Executive Committee for the year 2017:

- 1. Paul Myre, Board Member at Large***
- 2. Janet Bradley, Board Member at Large***
- 3. Ken Noland, Board Member at Large***
- 4. René Lapierre, Chair***
- 5. Jeffery Huska, Vice-Chair***
- 6. Medical Officer of Health/Chief Executive Officer***
- 7. Director, Corporate Services***
- 8. Secretary Board of Health (ex-officio)***

APPOINTMENTS TO THE FINANCE STANDING COMMITTEE OF THE BOARD

Following a call for nominations for three positions of Board Member at Large to the Finance Standing Committee of the Board, Carolyn Thain, Mark Signoretti, and Paul Myre were nominated.

There being no further nominations, the nominations for the Finance Standing Committee of the Board for the year 2017 was closed. The three nominees accepted their nominations. The Chair announced:

THAT the Sudbury & District Board of Health appoints the following individuals to the Finance Standing Committee of the Board for the year 2017:

- 1. Carolyn Thain, Board Member at Large**
- 2. Mark Signoretti, Board Member at Large**
- 3. Paul Myre, Board Member at Large**
- 4. Medical Officer of Health/Chief Executive Officer**
- 5. Director, Corporate Services**
- 6. Manager, Account Services**
- 7. Secretary Board of Health**

5.0 DELEGATION / PRESENTATION

i) No Time to Wait: Healthy Kids in the Sudbury and Manitoulin Districts Report Card Progress Update

- Paula Ross, Public Health Nutritionist, Nutrition Physical Activity Action Team, Health Promotion Division

Today's presentation was to provide Board members with an update on the progress the SDHU has made over the last three years since the release of its *No Time to Wait: Healthy Kids in the Sudbury and Manitoulin Districts Report Card* in 2013 and to highlight next steps. Copies of the 2013 report card were available for the Board members next to the Boardroom display.

P. Ross began by noting that childhood obesity is a complex health issue that has major implications for society.

Board members were reminded that in 2012, the provincial government struck a Healthy Kids Panel (HKP) that consisted of multi-sectoral experts to inform the development of a strategy that would reduce childhood obesity in Ontario by 20% over five years. The SDHU was extremely proud to have Dr. Sutcliffe participate on the HKP as the only local public health representative. Following the release of the HKP recommendations in 2013 which included a comprehensive three-pronged strategy, the SDHU undertook a process of self-reflection and evaluated its efforts and actions against the HKP recommendations through a *Healthy Kids in Sudbury and Manitoulin Districts* report card with a resulting Grade B.

Key SDHU actions that have taken place since the release of this local report card were outlined. These focus on starting all kids on the path to health, changing the food environment, and creating healthy communities. In order to have the greatest positive impact on child health, concerted, coordinated and collaborative efforts across all sectors of society have been important.

Over the next 2-3 years, the SDHU will continue to work with community partners and encourage their involvement in a community wide evaluation that will be more comprehensive and inclusive.

Questions were entertained and P. Ross was thanked for her presentation.

6.0 CONSENT AGENDA

There were no consent agenda items identified for discussion.

- i) Minutes of Previous Meeting**
 - a. Eighth Meeting – November 24, 2016
- ii) Business Arising From Minutes**
 - None
- iii) Report of Standing Committees**
 - None
- iv) Report of the Medical Officer of Health / Chief Executive Officer**
 - a. MOH/CEO Report, January 2017
- v) Correspondence**
 - a. Association of Municipalities of Ontario (AMO) and Alcohol Policy**
 - Correspondence from the Northwestern Health Unit to alPHA dated November 1, 2016
 - b. 2016 Ontario Public Health Standards Modernization Review**
 - Letter from the Board of Health for Grey Bruce Health Unit to the Ontario Public Health Standards Modernization Committee and Executive Steering Committee dated November 25, 2016
 - c. Bill 5 – Greater Access to Hepatitis C Treatment Act, 2016**
 - Letter from the Board of Health for Peterborough Public Health to the Minister of Health and Long-Term Care dated November 28, 2016

d. Oral Health Programs for Low-Income Adults and Seniors

- Letter from the County of Lambton Board of Health to the Minister of Health and Long-Term Care dated December 8, 2016

e. Nutritious Food Basket

- Email from the Premier of Ontario to Dr. Sutcliffe dated November 22, 2016
- Letter from the North Bay Parry Sound District Board of Health to the Ministers of Health and Long-Term Care, Community and Social Services as well as Housing, Poverty Reduction Strategy dated November 25, 2016
- Letter from the Durham Region Health Unit to the Premier of Ontario dated December 14, 2016
- Letter from the Township of Nairn and Hyman to the Premier of Ontario dated December 16, 2016, supporting the Sudbury & District Board of Health motion 50-16

f. Student Nutrition Programs

- Letter from the Durham Region Health Unit to the Prime Minister dated December 14, 2016

g. Marketing of Food and Beverages to Children, Support for Bill S-228 and Bill C-313

- Letter from the Durham Region Health Unit to the Prime Minister dated December 14, 2016
- Letter from Huron County Board of Health to the Federal Health Minister dated December 8, 2016
- Letter from Middlesex-London Board of Health to the Federal Minister of Health dated December 13, 2016

h. aPHa Update for 2017

- i. Email and 2017 aPHa Update from the North East regional representative on the Board of Health Executive/aPHa Board of Directors

i. Manitoulin Drug Strategy

- i. Letter from the Municipality of Central Manitoulin to the Sudbury & District Health Unit dated November 29, 2016

j. Health Hazards of Gambling

- i. Letter from the North Bay Parry Sound District Board of Health to the Minister of Health and Long-Term Care dated December 5, 2016

k. Immunization Program Funding

- i. Letter from the Huron County Board of Health to the Minister of Health and Long-Term Care dated January 5, 2017

vi) Items of Information

- a. alPHa Information Break December 8, 2016
January 10, 2017
- b. 2016 Financial Controls Checklist
- c. Report: *Board Learning and Information Session, Strengthening Indigenous Relationships* November 9, 2016

01-17 APPROVAL OF CONSENT AGENDA

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

CARRIED

It was clarified that the financial control checklist was introduced by the Ministry as part of the 2015 Program Based Grant (PBG) process and submitted with the Board Chair's signature along with our 2015 PBG request. For 2016, the checklist was requested as part of our quarterly financial reporting. New to the process is the requirement to insert on the form the date of the Board meeting at which it is shared.

The objective of the checklist per Ministry is to provide boards of health with an informative tool to be assured of key internal controls. The financial controls checklist deals mainly with the day-to-day operating financial processes of the organization. It helps provide the board assurance that the organization has adequate financial controls in place and practice. It is being shared for the Board's information and will be brought forward to the next Board Finance Standing Committee in the context of its discussion of the organization's management financial policies and practices.

Board members are pleased to see the ongoing advocacy taking place throughout the province as it relates to all aspects of the nutritious food baskets.

Dr. Sutcliffe clarified that the immunization rates referenced in the January Board report are not lower than the numbers reported at the same time last year. End of season will be also be compared with last year's end of season.

7.0 NEW BUSINESS

i) Sudbury & District Board of Health Meeting Attendance

- Summary – 2016

The Board attendance summary is shared with the Board on an annual basis for review and information and makes reference to the relevant Board policies. It was clarified that there is currently one provincial appointment vacancy.

ii) Board Survey Results from Monthly Board Meeting Evaluations

- 2016 Evaluation Summary Results

A roll up of the evaluation results from the regular Board meetings in 2016 is shared for information and discussion. There were no questions or discussion.

iii) 2016 Board Annual Self-Survey Results

- 2016 Board Self-Evaluation Summary Results

Every year, Board members are asked to complete a board self-evaluation survey which covers three components:

1. Individual Performance Compliance with Individual Roles and Responsibilities as a Board of Health member
2. Board of Health Processes Effectiveness of Policy and Process
3. Overall Performance of the Board of Health

Results are shared with the Board for information and discussion. There were no questions or discussion.

iv) Electronic Cigarettes Act

Dr. Sutcliffe noted that the proposed motion includes some background and has similar principles to the disclosure of tobacco-related enforcement activity.

**02-17 INCLUSION OF ELECTRONIC CIGARETTES ACT VENDOR
CONVICTIONS WITHIN EXPANSION OF PROACTIVE DISCLOSURE
SYSTEM**

Moved by Lemieux – Myre: WHEREAS the Minister of Health and Long-Term Care has requested that all boards of health make transparency a priority objective in business plans and develop reporting practices to make information readily available to the public; and

WHEREAS the Sudbury & District Board of Health is committed to public transparency; and

WHEREAS the Sudbury & District Board of Health endorsed motion 36-15 (Expansion of Proactive Disclosure System) at its September 17, 2015, meeting; and

WHEREAS, inclusion of enforcement-related activities pertaining to the Electronic Cigarettes Act (2015), would further improve transparency by enhancing public access to inspection findings;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the inclusion of enforcement-related activities pertaining to electronic cigarette vendors within the expanded proactive disclosure system; and

THAT the following be the Board policy on the release of enforcement and inspection information pertaining to the Electronic Cigarettes Act:

- 1. Charges: Statistical information on charges (i.e. no identifying information) is released to the Sudbury & District Board of Health at its regularly scheduled meetings.***
- 2. Convictions: Convictions related to electronic cigarette vendor infractions are posted on the Sudbury & District Health Unit website as soon as possible following the conviction and for a period of 12 months from the date on which the conviction was rendered.***
- 53. Requests for information not posted on website: Requests for information not posted on the website are considered on an individual basis in accordance with Health Unit policy and the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA); and***

FURTHER THAT Board of Health Disclosure Information Sheet F-IV-10 be correspondingly updated.

CARRIED with friendly amendment

v) Anti-Contraband Tobacco Campaign

- Slide Deck by the Physicians for Smoke-Free Canada
- Algoma Board of Health Anti-Contraband Tobacco Campaign Resolution 2016-109 dated November 23, 2016

Dr. Sutcliffe noted that dense slides developed by the Physician for Smoke-Free Canada are being shared to inform the Board of the work that has been done in this area. The Algoma Board's resolution is also attached to today's agenda package.

Dr. Sutcliffe described the impacts of contraband tobacco campaigns and strategies from the tobacco industry.

03-17 ANTI-CONTRABAND TOBACCO CAMPAIGN

Moved by Myre – Lemieux: WHEREAS the Sudbury & District Board of Health has reviewed information indicating that recent anti-tobacco contraband campaigns from the National Coalition Against Contraband Tobacco and the Ontario Convenience Store Association were supported

by the tobacco industry with the intention of blocking tobacco excise tax increases and regulation of tobacco products generally; and

WHEREAS Ontario municipalities including the City of Greater Sudbury have endorsed such campaigns without being informed of tobacco industry support; and

WHEREAS municipalities within the SDHU service area are longstanding advocates for measures to protect the public from exposure to environmental tobacco smoke;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health advise area municipalities of this information and urge municipalities to not endorse tobacco industry supported campaigns; and

THAT the Sudbury & District Board of Health request municipalities to call on the Ontario Ministry of Finance to raise tobacco excise taxes and enhance enforcement activities designed to reduce the presence of contraband tobacco in Ontario communities; and

FURTHERMORE THAT this resolution be shared with municipal councils, local MPPs, the Ontario Ministry of Finance, the Association of Local Public Health Agencies, Ontario public health units, and the Ontario Campaign for Action on Tobacco.

CARRIED

vi) Cannabis Regulation and Control

- Letter from the Simcoe Muskoka District Health Unit to the Minister of Health and Long-Term Care dated December 15, 2016

Dr. Sutcliffe noted that there is the ability within the current legislative regulations to prescribe certain substances for which regulations would be applicable. The proposed motion advocates that these would be subject to the same restrictions as tobacco. It is felt to be an important control measure to protect health.

Discussion ensued regarding the possibility of municipalities establishing municipal by-laws prior to provincial measures being put in place, similar to the municipal tobacco by-laws being put in place prior to having provincial laws.

Further questions were entertained and the Board consented to a friendly amendment to include municipalities as community partner in the last paragraph.

04-17 CANNABIS REGULATION AND CONTROL

Moved by Thain – Pilon: WHEREAS the Final Report of the Task Force on Cannabis Legalization and Regulation, A Framework for the Legalization and Regulation of Cannabis, recommended to the federal government that

current restrictions on public smoking of tobacco products be extended to the smoking of cannabis products and to cannabis vaping products; and

WHEREAS the recently amended Smoke Free Ontario Act permits certain products and substances to be prohibited under the regulatory framework of the Act; and

WHEREAS Sudbury & District Board of Health motion #54-15 called for a public health approach to the forthcoming cannabis legalization framework, including strict health-focused regulations to reduce the health and societal harms associated with cannabis use; and

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

WHEREAS by prohibiting the smoking of all cannabis in all places where the smoking of tobacco is prohibited, children, youth and adults in our communities will result in reduced public and second-hand exposure to cannabis;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health call for the inclusion of marijuana (medicinal and recreational) as a prescribed product or substance under the Smoke Free Ontario Act; and

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

CARRIED with friendly amendment

vii) Sugar Sweetened Beverages and Menu Labelling

- Position of Dietitians of Canada – Taxation and Sugar-Sweetened Beverages, February 2016

The proposed motion is a call to endorse a well researched position paper that addresses the impact of sugar-sweetened beverages on children. The motion also speaks to the effective practice of taxation and positive impacts of policies which aim

to decrease the consumption of sugar-sweetened beverages. The position statement effectively addresses potential critiques of increased taxation.

It was acknowledged that this is only one element of a comprehensive strategy that needs to be put in place to address obesity and, for today's motion, childhood obesity. Dietitians chose to develop this specific position statement knowing other strategies are as important and also being explored. It was pointed out that the Healthy Kids Community Challenge (HKCC) places a strong emphasis on the use of community water.

Dr. Sutcliffe referenced the Ontario Public Health Standards which establish the minimum requirements for fundamental public health programs and services to be delivered by Ontario's 36 boards of health. It is unknown whether the current review for the modernization of the OPHS will expand its reach to include elder programs/services.

**05-17 SUPPORT FOR THE POSITION OF DIETITIANS OF CANADA ON
TAXATION AND SUGAR-SWEETENED BEVERAGES AS PART OF A
COMPREHENSIVE HEALTHY EATING APPROACH**

Moved by Pilon – Noland: WHEREAS obesity results from a complex interaction of many factors including genetic, social and environmental; and

WHEREAS 32% of Canadian children and youth have excess weight or obesity; and

WHEREAS intake of sugar-sweetened beverages is one of the dietary factors leading to increased rates of overweight and obesity; and

WHEREAS children with high intakes of sugar sweetened beverages are 55% more likely to have obesity or excess weight in comparison to those with low intakes; and

WHEREAS available evidence suggests that policy efforts which decrease the consumption of sugar sweetened beverages have the potential to positively impact the health of Canadians; and

WHEREAS the Dietitians of Canada position statement on Taxation and Sugar-Sweetened Beverages identifies sugar-sweetened beverage taxation as a public health intervention with potential positive health impact, especially when combined with further policy efforts; and

WHEREAS Dietitians of Canada recommends that an excise tax of at least 10-20% be applied to sugar sweetened beverages sold in Canada; and

WHEREAS a number of influential Canadian national organizations support a tax on sugar sweetened beverages including the Association of Local Public Health Agencies, the Childhood Obesity Foundation, Heart and Stroke Foundation of Canada, Chronic Disease Prevention Alliance of Canada, and the Canadian Diabetes Association;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the Position of Dietitians of Canada on Taxation and Sugar-Sweetened Beverages, and urge the federal government to implement an excise tax on sugar-sweetened beverages; and

FURTHER THAT copies of this motion be shared with key provincial and national stakeholders.

CARRIED

8.0 ADDENDUM

06-17 ADDENDUM

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

CARRIED

DECLARATION OF CONFLICT OF INTEREST

There are no declarations of conflict of interest.

i) Basic Income Pilot Survey

Board members are invited to complete the public consultation survey to reiterate the SDHU's strong support for the Ontario basic income pilot.

ii) Public Health Expert Panel

- Letter from the Minister of Health and Long-Term Care dated January 18, 2017
- Minister's Expert Panel on Public Health Mandate
- Expert Panel on Public Health: Panel Member Biographies

On January 28, 2017, the Minister of Health and Long-Term Care announced the establishment of the Public Health Expert Panel, its mandate and membership.

Dr. Sutcliffe recapped the events since the *Patients First: Action Plan for Health Care* was released in December 2015 which led to the passing of Bill 41: *The Patients First Act, 2016*.

There are 16 workstreams at the provincial level working through implementation which is expected to take place on May 1, 2017. Dr. Sutcliffe participates on the Public

Health Work Stream which is examining the Patients First Act as it relates to Boards, MOH and linkages with the LHIN.

One of four pillars of the Patients First initiative related to strengthening connections between population and public health and the rest of our health system, and establishing the expert panel on public health. The work of the Public Health Expert Panel will include a review of various operational models for the integration of public health into the broader health system and the development of options and recommendations that will best align with the principles of health system transformation, enhance relationships between public health, LHINs and other public sector entities and improve public health capacity and delivery.

The Minister has defined what will be within scope and out of scope for the Expert Panel which will be co-chaired by the Chief Medical Officer of Health.

Questions were entertained and the Board commented that it is unfortunate that the Expert Panel does not have northern Ontario representation.

9.0 IN CAMERA

07-17 IN CAMERA

Moved by Bailey – Thain: That this Board of Health goes in camera.

Time: 2:44 p.m.

CARRIED

- Labour relations or employee negotiations

10.0 RISE AND REPORT

08-17 RISE AND REPORT

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

Time: 2:59 p.m.

CARRIED

The Board Vice-Chair reported that one labour relations/employee negotiations item was discussed. The follow in-camera motion was entertained upon the Rise and Report:

09-17 APPROVAL OF BOARD IN-CAMERA MEETING NOTES

Moved by Bailey – Noland: THAT this Board of Health approve the meeting notes of the November 24, 2016, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the Municipal Freedom of Information and Protection of Privacy Act.

CARRIED

11.0 ANNOUNCEMENTS / ENQUIRIES

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

The date of alPHa symposium is February 23 to 24, 2017, in Toronto. Board members interested in attending are asked to contact R. Quesnel.

12.0 ADJOURNMENT

10-16 ADJOURNMENT

Moved by Myre – Lemieux: THAT we do now adjourn. Time: 2:55 p.m.

CARRIED

(Chair)

(Secretary)

Medical Officer of Health/Chief Executive Officer Board of Health Report, February 2017

Words for thought

Health Status of Canadians 2016: Report of the Chief Public Health Officer

How healthy are we?

- Canadians are living longer than ever with an **average life expectancy** of 82 years, although life expectancy in Canada is not the same for everyone.
- More babies are being born with a **low birth weight** than in the past. A higher proportion of babies with a low birth weight are born to mothers under the age of 20, and between the ages of 35 to 49 years.
- The proportion of Canadians who reported a **strong sense of community belonging** in 2014 was lowest among those aged 20 to 34 years.
- Almost 90 % of Canadians **reported feeling in good to excellent health**—the highest proportion of people among G7 countries.
- At 70 %, most Canadians considered their mental health to be either very good or excellent in 2014. People living in lower income households had lowered **perceived mental health**.

What is influencing our health?

- The gap between the highest and lowest **income** groups is widening. Men and women are now equally likely to have a low income.
- More Canadians are completing their **high school and post-secondary education** than ever before—in 2015, 90% finished high school and 66% were a post-secondary graduate.
- Canadians with the lowest incomes report the highest rates of **core housing need and food insecurity**. In 2011, 29% of women single-parent households were in core housing need and 54% of First Nations on-reserve households reported food insecurity in 2008/2010.
- The vast majority of Canadians do not meet recommended levels of **physical activity** with 9 out of 10 children and youth not meeting the Canadian Physical Activity Guidelines.
- The proportion of Canadians who **smoke** is decreasing, but over 4 million Canadians currently smoke.
- **Immunization** rates for measles and DPT in Canada are below national immunization coverage goals of 97% by age 2.

How are we unhealthy?

- **Cancer** continues to be the leading cause of death in Canada.
- In 2014, Canadians with the lowest income were twice as likely to report living with **cardiovascular disease** than those of the highest income.
- The proportion of Canadians 20 years and older with **diabetes** almost doubled between 2000 and 2011—up from 6% to 10%.
- The proportion of Canadians reporting having been **injured** in the previous year increased to 16% in 2014 from 13% in 2003. An estimated 20% to 30% of seniors fall each year in Canada.
- The proportion of Canadians saying they had been diagnosed with a **mood disorder** increased from 5% in 2003 to 8% in 2014.
- In 2011, just over 340 000 Canadians, were diagnosed with **dementia**, representing an estimated 2% of the Canadian population aged 40 years and older.
- **Tuberculosis** rates for Indigenous and foreign-born populations in Canada are higher than the overall Canadian population. Rates are almost 50 times higher for the Inuit.

Source: Health Status of Canadians 2016: Report of the Chief Public Health Officer
Date: 2016

Chair and Members of the Board,

In keeping with the “by the numbers” theme for this month’s Board of Health meeting, the above statistics from the most recent Report of the Chief Public Health Officer paint a comprehensive picture of Canadians’ health status. Interestingly and certainly of no surprise to Board of Health members, the majority of the factors that influence our health lie outside of the health care system. These factors include income, education, and our social and physical environments. As we think about health system sustainability (over 40% of most provincial budgets are allocated to health care), we must work to optimize these determinants of health. In our pre-budget consultation submission, included in the February Board package, we make the case that investing in public health is investing in productivity and engagement, creating a virtuous cycle of health and the economy for our communities.

GENERAL REPORT

1. Board Updates

Board Chair, R. Lapierre, and Board member, M. Bailey, will be attending the alPHa’s Winter 2017 Symposium, on February 23, 2017, in Toronto along with Dr. Sutcliffe, Dr. Zbar, and S. Laclé. Our Board members will also participate in the alPHa Board Section meeting on February 24, 2017.

alPHa will be holding its 2017 Annual General Meeting (AGM) and Conference on June 11, 12, and 13 at the Chatham-Kent John D. Bradley Convention Centre, Chatham, Ontario. Board members interested in attending are asked to pencil these dates in their calendars. A motion will be included on the April Board agenda relating to Board attendance for the AGM.

We have not yet heard from the province regarding reappointment for provincial appointee, J. Bradley. Her current term expires February 21, 2017.

The Joint Board/Staff Performance Monitoring Working Group met on January 24, 2017, to review the draft 2016 Performance Monitoring Report. Board representation on this working group include C. Thain, R. Pilon and J. Bradley. The final report is included in today’s Board meeting agenda package.

Did You Know: That the PowerPoint presentations for every Board meeting delegation is available in BoardEffect. It can be found under the *Libraries—Sudbury & District Board of Health workroom—Board Delegations/Presentations* folder. The presentations are normally posted the day of the Board meeting.

2. Finance

The required forms for the submission of the 2017 Program-based Grant request are being prepared for submission. The grant request reflects the Board of Health approved cost-shared operating budget. Boards of health were advised to plan for no growth funding for 2017.

The SDHU audit is scheduled to commence March 6, 2017, and conclude by March 20, 2017. KPMG is conducting the audit for this year. The current due date for submission of the audited financial statements and annual reconciliation report to the Ministry is April 28, 2017.

3. Strategic Planning

Planning is currently underway for the development of the next SDHU Strategic Plan. The Board of Health Executive Committee is meeting on February 16 to review and approve the engagement plan and process and to provide input, which will help scope out the next Strategic Plan. Board of Health members will be kept apprised of progress over time and will have the opportunity to be engaged at various stages throughout the process.

4. SDHU Visual Identity

To align with the work on strategic planning, the SDHU is currently reviewing its visual identity and client service standards. Once the review is complete, relevant recommendations will be brought forth to the Board of Health for approval.

5. Local and Provincial Meetings

On January 20, 2017, I attended a Practice and Evidence Program Standards Advisory Committee (PEPSAC) meeting, which marked the completion of the Committee's mandate. As a reminder, the mandate was to recommend a set of evidence-based program standards reflective of current accepted practice in the areas of health protection and health promotion. When PEPSAC began last January, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* had just been released for feedback and consultation. Over the past year, PEPSAC has provided an ongoing forum for the interchange of ideas and perspectives about the role of public health and has been instrumental in the provision of advice with respect to the proposed changes to the modernized Standards for Public Health Programs and Services. The Committee formally met eight times including throughout the summer months. PEPSAC members also participated in many meetings of program-specific sub-groups. The Ministry extended thanks to the committee members for the openness, honesty and professionalism that was shown during this past year. It is expected that the draft Standards will be shared for consultation with the field sometime this month.

I participated in a North East Regional Quality Table meeting on January 25; a CCO Prevention Advisory Committee teleconference on January 26 as well as an alPHa Board meeting in Toronto on February 3.

I have been asked to Co-Chair the Northern Ontario Health Equity Steering Committee, which meets monthly.

A Public Health Working Group teleconference was held on February 8. This is a working group of the Trilateral First Nations Health Senior Officials Committee (TFNHSOC).

On February 13, I, along with SDHU staff, will attend the *Moving Upstream* session hosted by the City of Greater Sudbury.

6. Regulatory Health Protection Reporting

Control of Infectious Diseases: During the month of January, four sporadic enteric cases and one infection control complaint were investigated. Eight enteric outbreaks were declared in institutions.

Food Safety: In January, staff issued three special event food service permits to various organizations for events serving approximately 550 attendees.

Through Food Handler Training and Certification Program sessions offered in January, 56 individuals were certified as food handlers.

Health Hazard: In January, 29 health hazard complaints were received and investigated. Three of these complaints involved marginalized populations.

Ontario Building Code: During the month of January, six renovation applications were received.

Rabies Prevention and Control: 18 rabies-related investigations were carried out in the month of January.

Safe Water: During January, 16 residents were contacted regarding adverse private drinking water samples. Public health inspectors investigated three regulated adverse water sample results. Additionally during the month of January, one boil water advisory and one drinking water advisory were issued. Furthermore, one boil water order was rescinded.

I am pleased to commend to you the following sections of my report which provide the statistical highlights in public health programming and services for the 2016 year. In contrast to the usual MOH/CEO report, which describes various aspects of Health Unit programming, this “**the year by the numbers**” report provides a snapshot of the scope and volume of our work.

CLINICAL & FAMILY SERVICES DIVISION

Control of Infectious Diseases

Universal Influenza Immunization Program (UIIP)

42 293 doses of seasonal influenza vaccine distributed to health care providers
2 557 doses of vaccine administered by the SDHU at community and office-based clinics
1 clinic at HSN was provided and **322** influenza vaccinations were given to members of the community
53 pharmacies took part in UIIP

Respiratory Outbreaks

15 outbreaks in long-term care homes (Influenza A, RSV, Coronavirus and unknown)

School Immunization Program

1 365 Grade 7 students completed the hepatitis B series
1 825 Grade 7 students received meningococcal vaccine
864 eligible female students completed the HPV vaccine series

TB Control Program

1 792 TB tests performed

Publicly and Non-publicly Funded Vaccines

12 847 vaccines administered

Nurse On Call – CID

3 880 calls on topics such as immunization, infection control, and reportable diseases

Growing Family Health Clinic

777 client appointments

119 prenatal and postnatal appointments

338 appointments for children aged 0–6 years

Sexual Health, Sexually Transmitted Infections and Blood-borne Infections (including HIV)

6 149 client visits at the Rainbow Centre office
3 791 sexual health calls includes inquiries on a variety of sexual health and sexually transmitted infection topics and follow up. Does not include calls made for service coordination.

1 031 nominal HIV tests completed

131 anonymous HIV tests completed

1 162 total HIV tests/people

342 point-of-care HIV tests completed

392 client visits in Sudbury schools and agency outreach

767 client visits in district offices and school outreach

202 online tests

Sexual Health Promotion

3 095 pamphlets and promotional items distributed

45 presentations and consultations to **1 711** participants

4 media campaigns

6 interactive displays

Healthy Babies Healthy Children (HBHC) Program

1 984 live births in the Sudbury and Manitoulin districts in 2015

87% of new moms were screened to identify those who would benefit from further services
300 families supported with ongoing home visiting

916 women attended breastfeeding clinics at the Sudbury and Val Caron clinic sites

27% of pregnant women are screened prenatally to determine if they would benefit from HBHC services

HBHC Information Line

1 879 total number of calls with over 50% of those being in the area of breastfeeding

Oral Health

1 082 calls received for assistance, emergency care, and general information

128 walk-in visits seeking assistance for treatment or access to services

8 269 children screened during school screening clinics

484 children referred for urgent care

230 children participated in school-based preventive services

307 children participated in Health Unit-based preventive care

378 children enrolled for emergency assistance

188 high school students participated in voluntary dental screening program

639 Indigenous children participated in dental screening programs located in daycares, elementary schools, and health centres

Family Health

Child Health

Baby Friendly designation was achieved for a term of five years

216 parents participated in Triple P Program interventions

30 families and partners and **55** stakeholders participated in Fetal Alcohol Spectrum Disorder event

97 mothers and family took part in the Breastfeeding Challenge at Science North

6 clients participated in the A Breastfeeding Companion program

46 breastfeeding mothers attended the face-to-face support group implemented in Greater Sudbury
680 prenatal packages delivered to health care provider offices
199 pregnant women and their support persons attended prenatal classes
128 pregnant women registered for online prenatal
3 teens and their carers participated in a community trial delivery of PEERS program for social skills development
382 community as client interactions on prenatal and child health topics (e.g. breastfeeding, safe sleep, healthy eating and child safety, and injury prevention) in partnership with agencies that work with priority populations

Academic Detailing - Alcohol Screening

134 clinicians received a personal invitation letter by mail.
32 of these clinicians (23%) participated in an AD session
21 of these clinicians received two AD visits on the same topic.

Substance Misuse/Harm Reduction

1 Community Drug Strategy website launched with the Greater Sudbury Police Service

1 Drug Strategy approved by the Manitoulin Harm Reduction Sub-Committee of the Manitoulin Addictions and Mental Health Committee

1 Drug Strategy consultation meeting held in Sudbury East

Needle Exchange Program

12 624 client visits
844 929 needles given out
550 083 needles taken in
65% needle return rate
103 calls were received regarding used needle and syringe sightings in the community
3 948 needles and syringes were found and picked up in the community
6 775 inhalation kits were distributed
39 305 condoms were distributed

CORPORATE SERVICES DIVISION

Volunteer Resources

78 active volunteers
36 new volunteers
864 volunteer hours of services provided

ENVIRONMENTAL HEALTH DIVISION

Food Safety

3 608 inspections of food premises
270 complaint investigations
16 charges: **3** closure orders issued
58 food handler training courses
901 food handlers certified
17 food recalls: **2 574** recall inspections
706 special events food service permits
21 999 disclosure website hits
980 consultations and inquiries

Safe Water

Drinking Water

20 boil water orders
8 drinking water advisories
2 drinking water orders
13 blue-green algae advisories
742 adverse drinking water reports investigated
329 bacteriological samples taken
433 consultations and inquiries
47 complaint investigations: **31** for blue-green algae

70 Small Drinking Water System (SDWS) risk assessments completed

70 SDWS directives completed

159 SDWS consultations and inquiries

Recreational Water

35 beaches inspected weekly

404 beach inspections

2 173 bacteriological samples taken

1 beach temporarily posted

6 blue-green algae beach advisories

156 pool inspections

50 spa inspections

3 pool or spa closure orders issued

128 bacteriological samples taken

Chronic Disease Prevention –

Comprehensive Tobacco Control

Smoke-Free Ontario Act and Electronic Cigarettes Act Enforcement

491 youth access inspections

16 sales or supply charges issued

7 warning letters issued to retailers/vendors

311 display and promotion inspections

232 school compliance inspections

14 charges: smoking on school property

48 charges: smoking in the workplace

14 charges: smoking on hospital property

1 charge: CGS smoking By-Law

41 complaints investigated

136 consultations and inquiries

Health Hazard

413 complaint investigations

- **138** mould complaints
- **92** insects, cockroaches, birds
- **50** housing complaints
- **38** rodents, vermin
- **11** sewage backup, spills
- **14** heating complaints
- **9** garbage and waste
- **61** miscellaneous complaints

1 order issued

718 consultations and inquiries

51 arena air quality inspections

4151 calls or office visits to the duty officer

1107 calls to the after-hours line (24/7)

Control of Infectious Diseases

37 enteric outbreaks investigated

875 people ill

110 sporadic enteric cases investigated

154 consultations and inquiries

Rabies

337 animal exposure incidents investigated

11 animal specimens submitted

No positive cases of rabies

23 individuals received post-exposure prophylaxis

1 order to produce an animal issued

230 consultations and inquiries

Vector-borne Diseases

299 mosquito traps set

20 370 mosquitoes trapped

7 198 mosquitoes speciated

495 mosquito pools tested

➤ **272** for Eastern Equine Encephalitis

➤ **223** for West Nile virus

No positive mosquito pools for WNV/EEE

23 ticks submitted: **One** positive for bacteria causing Lyme disease

No human cases of WNV, EEE, or Lyme disease

Infection Control

12 institutional infection control meetings

302 inspections in institutional settings

587 inspections in settings where there is a risk of blood exposure

300 consultations and inquiries

30 complaint investigations

Environmental Health Policy

Extreme Weather Alerts

5 heat warnings issued

Built Environment

11 plans and proposals reviewed

Emergency Response

123 staff received respirator fit testing

Participated in **3** municipal emergency exercises

Part 8 – Land Control

1 724 inspection activities
274 sewage system permits issued
38 consent applications processed
182 renovation applications processed
39 mandatory maintenance inspections completed

25 private sewage complaints investigated
1 charge issued
1 724 consultations and inquiries
2 community information sessions
84 file search requests
84 copy of record requests

HEALTH PROMOTION DIVISION

Chronic Disease Prevention – Comprehensive Tobacco Control

542 inquiries to the Tobacco Information Line
186 appointments to the Quit Smoking Clinic
27 participants attended three STOP on the Road sessions
42 participants attended 7 group cessation information sessions, along with a presentation for at-risk youth on prevention and cessation
25 health care providers provided Minimal Contact Intervention (MCI) information
145 attendees at two smoke-free movies
2 424 people reached through social media
Supported a number of campaigns (Would U Rather, Memorable Mondays, Party without the Smoke) including implementing 3 runs of our youth cessation campaign
5-poster series on Indigenous tobacco use went out to almost all schools (French and English), 20 community partners, 10 provincial partners. **400** brochures were distributed through conferences and displays

Exposure to Ultraviolet Radiation and Early Detection of Cancer

Breast cancer screening presentation shared with **3** community health centres
30 women participated in Mammoth, a breast cancer screening event
516 reached by Facebook post “Myth Fractures” about Sun Safety
65 people were screened by a dermatologist
Shade canopies positioned at events reaching more than **300** community members

Healthy Eating

344 people attended a total of **11** presentations on food systems and food security
2 presentations on sugar sweetened beverages
1 district office arena piloting healthy canteen menu
429 community members participated in food literacy programming within their community
4 presentations on food security in workplaces, with a reach of **44**

Healthy Weights

72 participants attended **5** presentations on mental health promotion
100 junior summer camp supervisors trained on weight bias and bullying
10 workshops on weight bias and mental health were provided to **140** adult influencers of children and youth (including parents, coaches, child care supervisors and Healthy Kids Community Challenge steering committee members)
1 Public Health Prevention Series on the role of primary health care in the prevention of weight related issues delivered to **9** clinicians
2 diabetes conferences through the Diabetes Prevention Program with a reach of **210**
Diabetes Prevention Program staff joined various Indigenous Health Agencies in Sudbury to host the Sudbury Wellness event, led by the Metis Nations of Ontario. **10** health and wellness organizations provided an audience of **100** with health-related information.

Physical Activity

228 pairs of skates were collected and **397** were donated through **7** skate exchange events in Sudbury in 2016. Skate exchange activities occurred in **6** other communities (French River, St-Charles, Warren, Espanola, Mindemoya, Little Current).
4 workshops hosted on Physical Literacy 301, with an audience of **83** representing **4** sectors (education, sport & recreation, health and early childhood education)
6 organizations represented in Active Sudbury, a multi-sectoral group focused on the development of physical literacy in Sudbury
70 community members involved in sustainable mobility and built environment initiatives
SDHU participation on the review of **2** strategic plans and **2** municipal planning documents

Prevention of Injury and Substance Misuse

315 car seats inspected at **19** car seat clinics and **3** Baby Rides
24 car seat technicians trained
5 car seat safety presentations held in Espanola and Manitoulin Island
12 community stakeholders engaged in a Sudbury Child Passenger Safety initiative
8 bus backs, **55** interior bus panels, **3** road signs promoting the Vulnerable Road User campaign
Texting and Driving study presented at **1** provincial conference

200 Manitoulin Island secondary school students educated about the danger of texting and driving
80 texting and driving radio messages in Manitoulin
210 students educated on bicycle helmet safety in Sudbury East. **12** helmets and **50** vouchers distributed
150 students educated on bicycle helmet safety in Manitoulin and **150** helmets distributed
15 helmet vouchers distributed in Espanola.
1 100 ATV resources were distributed in Sudbury East

Falls Prevention in Older Adults

36 430 educational resources distributed
4 338 Home Safety Checklists distributed during Falls Prevention month in November
3 900 medication cleanout bags distributed
37 Stand-Up delivery sessions supported
21 new Stand-Up facilitators trained, **6** facilitators received refresher training
2 regional falls prevention campaigns implemented
74 community partners engaged in a district-wide falls prevention coalition
190 attendees at regional falls prevention conference held in October
5 Northeast health units and the NELHIN engaged in regional planning
Supporting **3** Age-friendly communities

Alcohol Misuse Prevention

32 primary care providers detailed on Canada's Low-Risk Alcohol Drinking Guidelines (LRADG) and the Alcohol Screening, Brief Intervention and Referral (SBIR) tool
267 people reached through **3** information booths and *Pour Challenges* to promote Canada's LRADG **1** LRADG training presentation to **113** people
1 webinar presentation on the development of the SDHU's Alcohol Strategy
1 consult and written contribution to the development of Ontario's Alcohol Policy
22 250 individuals reached and **63** participants in the *Alcohol, Let's Get Real* social media challenge
1 provincial-wide campaign with **28** health units – *Rethink Your Drinking*
1 promotional video for *Rethink Your Drinking*

School Health

527 total activities related to OPHS standards and advancing our goal of building resilient school communities were provided within schools, reaching **11 765** school community members (school staff, parents, students and community partners)

236 activities were related to chronic disease prevention, including **138** related to healthy eating/healthy weights, **30** related to sexual health, **18** related to tobacco prevention, **13** related to injury prevention, **23** related to physical activity, **6** related to substance misuse, **8** related to UVR, reaching **4 559** school community members
250 activities were related to building resilient school communities, reaching **6 432** school community members
14 activities took place related to mental health, reaching **539** school community members
25 activities reached **476** post-secondary students and faculty members, which focused on healthy eating, alcohol misuse, and resiliency
15 sessions took place with staff and students from alternative schools, including **9** food skills sessions with students, and **6** staff development sessions with teachers
121 schools (all) are serviced by an assigned public health nurse
133 presentations were delivered on various topics including resiliency, healthy eating, healthy weights, sexual health, mental health, and injury prevention, reaching **5 242** school community members
53 training sessions and workshops were delivered to adult influencers, reaching **1442** adults in school communities
29 activities engaged youth on topics such as tobacco use prevention, healthy eating, and resiliency

Northern Fruit and Vegetable Program

16 347 students received fruits and vegetables weekly for **20** weeks as part of the Northern Fruit and Vegetable Program. **72** elementary schools from Sudbury and each district office participated in the program

Workplace Health

2 workplace health presentations delivered to **220** people
2 consults on workplace health initiatives
6 requests for lunch and learn presentations and workshops on workplace health topics
14 individuals representing **9** workplaces attended the workplace health network meeting
690 Workplace health newsletters distributed to **360** workplaces
580 pedometers borrowed by **6** workplaces
3 205 workplace health resources distributed based on requests received through the Workplace Health Line
1 promotional radio ad to promote Canada's Healthy Workplace Month

Smoke-Free Ontario (*northeast regional activities*)

All **7** TCANs and **10** NGO partners participated in Freeze the Industry – Plain and Standardized Packaging, reaching **2 339** people through social media by June 2016
35 participants attended the Plain and Standard Packaging Spring Summit
32 participants attended the Plain and Standard Packaging fall training
20 participants from the Northeast attended TCAN Prevention planning meeting
42 participants attended a webinar on a regional cessation services evaluation tool.
17 TCAN members participated in a knowledge exchange session on increasing quit attempts in the NE region.
Ad campaign for Smoke-Free Multi-Unit housing included television and cinema ads as well as a social media campaign.
10 515 page views for Smoke-Free Movies (smokefreemovies.ca) as of June 2016
5 public health units participated in World No Tobacco Day, reaching **31 595** people through social media

RESOURCES, RESEARCH, EVALUATION AND DEVELOPMENT (RRED) DIVISION

Population Health Assessment and Surveillance

SDHU Population Health Profile (full report, summary report, executive summary): analysis of most currently available data for mortality rates, leading causes of death, health care utilization, cardiovascular disease, cancer, and health behaviours and risks

28 Population Health Assessment and Surveillance team-Indicator Reports for internal use on more than 111 indicators

54 internal and external data requests, and 32 consultations on topics such as communicable diseases, demographics, determinants of health, maternal health, chronic disease, mental health, etc.

1 800 SDHU area residents were surveyed by Rapid Risk Factor Surveillance System (RRFSS)—1 000 as part of the regular SDHU cycles and an additional 800 surveys to provide information at each district office area level

Number of other surveillance activities: seasonal bi-weekly or weekly Acute Care Enhanced Surveillance (ACES) reports, daily school absenteeism reports, quarterly reportable diseases internal reports

Research, Evaluation, and Needs Assessments

16 research and evaluation projects where RRED acts in a lead or consultation role, including: *City of Greater Sudbury Healthy Kids Community Challenge: Overall evaluation*

3 research projects funded by the Louise Picard Public Health Research Grant

6 new proposals reviewed by the Research Ethics Review Committee

1 needs assessment

60 web surveys

155 consults on development of methodology or approach for research, evaluation, or needs assessment

Knowledge Exchange

2 Knowledge Exchange Symposiums

8 Knowledge Exchange Sessions

24 conference or external meeting presentations and workshops

7 publications (research and evaluation reports, journal or newsletter articles, fact sheets, and surveillance reports)

Contribution to **3** rapid reviews of evidence or reviews of literature

Information Resource Centre

81 interlibrary loans

4 literature searches

Professional Practice and Development

Academic Affiliations

5 faculty appointments with the Northern Ontario School of Medicine (NOSM)

2 joint-appointments as Adjunct Professor with Laurentian University and **1** joint-appointment as Public Health Consultant with the SDHU

Student Placements

101 students from **6** post-secondary institutions representing **9** disciplines

7 557 hours of student placement experience

7 undergraduate medical students from NOSM

3 postgraduate medical students from the NOSM Preventive & Community Medicine Program

2 NOSM dietetic interns

2 Masters in Public Health student

1 student orientation sessions

1 preceptor appreciation event

76 staff and **7** teams in preceptor roles

Staff Development

9 staff initiation and **1** staff orientation session in addition to mandatory training requirements for all employees

9 lunch and learn sessions (hosted by Nutrition Working Group, Workplace Wellness Committee, and Clinic and Family Services)

Division, Manager Professional Practice and Development)

13 management development sessions (**6** in person and **7** externally hosted webinars)
105 cross-divisional development opportunities (**9** in person and **96** via webinar)
3 division specific development webinars offered.
99 externally hosted staff development webinars/teleconferences offered to staff

Strategic Planning

Promotion of the 2013–2017 Strategic Plan Values through internal activities (use of the whiteboards, Inside Edition, ceiling decals)
4 Strategic Plan Values promotional videos created and shared with staff and the public

Performance Monitoring

1 *SDHU Performance Monitoring Report* presented to the Board of Health (part of the 2013–2017 Performance Monitoring Plan)
3 *Strategic Priorities Narrative Reports* presented to the Board of Health and shared with external community partners
Monitoring of indicators to measure the SDHU's performance as an organization and to further demonstrate our commitment to excellence and accountability; collection of performance monitoring data for 2016
Compliance with the Ontario Public Health Organizational Standards
Reporting of the Public Health Accountability Agreement Indicators

Committee Work and Partnerships

Participation on:
4 national committees, **13** provincial committees, and **16** local or regional committees, e.g. City of Greater Sudbury Community Safety and Well-being Planning Committee, Sudbury Data Consortium, Public Health Ontario's Ethics Review Board

Health Equity Knowledge Exchange and Resource Team

You Can Create Change Campaign

8 images, **1** video created and distributed via social media including:
20 Facebook ads with **94 933** people reached,
53 Twitter messages with **21 620** impressions
5 internal staff engagement sessions
8 external partner engagement sessions

External

10 presentations (**18** including the *You Can Create Change Campaign* engagement sessions), **21** requests for health equity resources, **13** consultations, **18** partner support instances (e.g. grant writing, evaluation support, community events), **8** requests for the adaptation of SDHU health equity resources

Internal

24 instances of staff support, **30** consultations, **3** presentations (**8** including the *You Can Create Change Campaign* engagement sessions), **2** health equity stories created and distributed highlighting program health equity examples

STRATEGIC ENGAGEMENT UNIT (SEU)

SEU Support and Consultations

263 resource review and approval requests
69 media releases issued
150 media requests processed by SEU staff

Electronic and Social Media Reach

1 534 563 Facebook users reached
282 700 Twitter impressions
395 requests for information received through the Health Unit's website www.sdhu.com

Respectfully submitted,

Original signed by

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

January 18, 2017

The Ontario Public Health Standards Modernization Committee
Executive Steering Committee
c/o Jackie Wood, Director, Planning and Performance Branch
College Park, 777 Bay Street, Suite 1903
Toronto, ON M7A 5S5

Dear Ms. Wood:

2016 Ontario Public Health Standards Modernization/Review

At the December 15, 2016 meeting of the Windsor Essex County Board of Health, Board members agreed to provide support to the Grey Bruce Board of Health recommending that the Ministry of Health and Long-Term Care, Population Health and Public Health Division, adopt a "Health in all Policy" approach when reviewing the current Ontario Public Health Standards.

A better co-ordination of efforts through a cross-sectoral approach to program delivery, along with engaging a broader array of strategic partnerships, will contribute to the successful development and implementation of policies, services and evidence-based standards.

WECHU is pleased to see that the Committee is working to collaborate across sectors to reach a common goal towards strategies that result in the modernization of the Ontario Public Health standards to effectively utilize public health resources in our communities.

Sincerely,



Gary McNamara
Chair, Windsor-Essex County Board of Health



Gary M. Kirk, MPH, MD
CEO & Medical Officer of Health

c: Paulina Salamo, MOHLTC
Ontario Boards of Health
Association of Local Public Health Agencies

February 7, 2017

The Honourable Dr. Eric Hoskins
Minister – Minister's Office
Ministry of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor St
Toronto, Ontario
M7A 2C4

Dear Minister Hoskins:

Re: Marijuana controls under Bill 178, Smoke-Free Ontario Amendment Act, 2016

On January 27, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached letter from the Simcoe Muskoka District Health Unit regarding the Marijuana controls under Bill 178, Smoke-Free Ontario Amendment Act, 2016. The following motion was passed:

Motion No: 2017-3

Moved by: Mitch Twolan Seconded by: Mike Smith

“THAT the Board of Health for the Grey Bruce Health Unit support the recommendations from Simcoe Muskoka District Health Unit regarding the inclusion of marijuana (medicinal and recreational) as a prescribed product under Bill 178, Smoke-Free Ontario Amendment Act, and as such, prohibit the smoking of all marijuana in all places where the smoking of tobacco is prohibited.”

Carried.

Sincerely,



Christine Kennedy, MSc, MS, DPhil, MD, CCFP, FRCPC
Medical Officer of Health
Grey Bruce Health Unit

Working together for a healthier future for all.

Cc: Chief Medical Officer of Health of Ontario
Ontario Boards of Health
Association of Local Public Health Agency
Ontario Public Health Association

Encl.



Information Break

February 2, 2017

This 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.

Program for alPHA Winter 2017 Symposium - Feb. 23

A draft program for the Winter 2017 Symposium in Toronto is now available for viewing (click link below). As alPHA members anticipate the release of the updated Ontario Public Health Standards, the Association's February 23rd session will feature guest presentations on the updates as well as a facilitated discussion led by public health consultant Brent Moloughney. On February 24, COMOH and the Boards of Health Section will hold meetings to discuss current issues and activities. Pre-registration for all meetings on the 23rd and 24th are required if attending.

[View program, registration and hotel details here](#)

[Register for the Symposium / Section Meetings here](#)

Patients First Update

On January 27, the Province issued an update on the work supported by the *Patients First Act, 2016* and health system integration.

[Read the Jan. 27 provincial update on Health System Integration](#)

The Minister of Health and Long-Term Care announced the establishment of the Public Health Expert Panel on January 18. The panel's role will be to "advise on structural and organizational factors that will improve the integration of population and public health into the health system, deepen the partnerships between local boards of health and LHINs, and improve public health capacity and delivery within a transformed and integrated health system." Chaired by Ontario chief medical officer of health David Williams, the Panel's membership includes, among others, alPHA president Valerie Jaeger and Wellington-Dufferin-Guelph MOH Nicola Mercer. Carol Timmings from Toronto Public Health is also a Panel member.

Advocacy Activities

Board of Health Budgets - alPha has written the Minister of Health and Long-Term Care regarding concerns over 2016 board of health budgets.

Basic Income Guarantee - alPha has joined with the Ontario Public Health Association (OPHA) and Public Health Ontario (PHO) in responding to Senator Hugh Segal's work on [*Finding a Better Way: A Basic Income Pilot Project for Ontario*](#).
[Download alPha's response on Basic Income Pilot Consultation](#)

Items of Public Health Interest

[Heart & Stroke's 2017 Report on the Health of Canadians](#) (released Feb. 1, 2017)

[Eileen de Villa Appointed Toronto's New Medical Officer of Health](#) (Jan. 31)

[Projects with Indigenous Partners to Reduce Poverty](#) (Jan. 19)

[New Provincial Supports to Help Ontarians Quit Smoking](#) (Jan. 18)

[Ontario Proposes Fee for Bottling Water Companies](#) (Jan. 18)

alPhaWeb Feature: Correspondences

alPha has written letters on a number of issues to various government officials on a range of public health issues, including community water fluoridation, Ministerial Mandate Letters, and more (click below and scroll down the opened page).

[View alPha's list of recent correspondences](#)

Upcoming Events - Mark your calendars!

February 23 & 24, 2017 - alPha Winter Symposium, DoubleTree by Hilton Hotel Toronto Downtown, Toronto, Ontario. Program, registration and hotel details [here](#).

March 29-31, 2017 - [TOPHC 2017](#): Global challenges. Local Solutions. Allstream Centre, Toronto. Early bird registration deadline: [February 12](#).

June 11, 12 & 13, 2017 - 2017 alPHa Annual General Meeting and Conference: *Driving the Future of Public Health*, Chatham-Kent John D. Bradley Convention Centre, Chatham, Ontario. [Click here](#) for the Notice of Annual General Meeting and calls for resolutions, Distinguished Service Award Nominations, and Board of Health Nominations to alPHa Board.

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 quesnelr@sdhu.com from the Association of Local Public Health Agencies (info@alphaweb.org).

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



Health Status of Canadians 2016

A REPORT OF THE CHIEF
PUBLIC HEALTH OFFICER

Également disponible en français sous le titre:

État de santé des Canadiens 2016 : Rapport de l'administrateur en chef de la santé publique

To obtain additional information, please contact :

Public Health Agency of Canada
Address Locator 0900C2
Ottawa ON K1A 0K9

Tel.: 613-957-2991
Toll free: 1-866-225-0709
Fax: 613-941-5366
TTY: 1-800-465-7735

Email: publications@hc-sc.gc.ca

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Publication date: December 2016

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Cat: 978-0-660-05480-3

ISSN: HP5-121/2016E-PDF

Pub: 160227



A message from Canada's Chief Public Health Officer

Health is fundamental to our quality of life and to Canada's prosperity in the world. I think most Canadians would agree that their health and the health of their loved ones is what matters most to them.



Using a collection of health indicators to monitor the health status of a population helps us understand areas where we are doing well and those areas where we can improve. This report tells us Canadians are experiencing good health on a number of measures—almost 90 percent of Canadians reported having good to excellent health. If you **feel** healthy, then you likely **are** healthy. Canada's average life expectancy of 82 years ranks us as among the healthiest nations in the world. A long life-expectancy reflects well on many social and environmental factors in Canada that influence our health.

There are some worrisome trends. Over a relatively short period of time, the proportion of Canadians living with diabetes has almost doubled from 6% in 2000 to 10% in 2011. This is a concern as we know that more Canadians living with type 2 diabetes is linked to a higher proportion of people with an unhealthy diet, low physical activity and higher rates of overweight and obesity—which are all associated with higher rates of other diseases and conditions.

In addition, some Canadians are not as healthy as others or are at higher risk for poor health outcomes.

- In 2008/2010, more than half of First Nations households on reserve reported not having access to enough safe, affordable and nutritious food;
- In 2011, almost a third of women single-parent households reported living in housing that was not adequate, not affordable and/or not suitable;
- Between 1991 and 2006, men in the lowest income group died of cancer at a rate more than double that of women in the highest income group; and,
- In 2014, the rate of new or retreatment cases of tuberculosis was almost 50 times higher in the Inuit population than in the Canadian population overall.

This snapshot is a useful tool to help bring us closer to narrowing health gaps in Canada and preventing illness in the most vulnerable.

Ultimately, my hope is that this report provides a glimpse to all Canadians about the health of our country while illustrating how many different factors interact to makes us healthy.

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Acknowledgments

Many individuals and organizations have contributed to the development of Health Status of Canadians 2016: A Report of the Chief Public Health Officer.

I would like to express my appreciation to the consultants who provided invaluable expert advice:

- Dr. David Mowat, Canadian Partnership Against Cancer;
- Dr. Daryl Pullman, Memorial University;
- Dr. Elizabeth Saewyc, University of British Columbia
- Dr. Jeff Reading, University of Victoria;
- Dr. John Frank, University of Edinburgh;
- Dr. Michael Routledge, Chief Provincial Public Health Officer, Manitoba;
- Dr. Peter Donnelly, President and Chief Executive Officer of Public Health Ontario, and;
- Dr. Peter Glynn, Health Systems Consultant

In addition, I would also like to recognize contributions made by partners and stakeholders who were consulted on the report under tight timelines, including: Drs. Louise Pelletier, Beth Jackson and Malgorzata Goshia Miskurka as well as Alain Demers, Catherine Pelletier, Cynthia Robitaille, Karen Roberts and Louise McRae, from the Public Health Agency of Canada's Health Promotion and Chronic Disease Prevention Branch; Jennifer Pennock and Lyne Cantin from the Infectious Disease Prevention and Control Branch; Bill Martin, Cameron Coulby, Grace Huang, Heather Tait, Isabelle Ouellet, Jessica Dwyer, Julie Stokes, Kathleen Lydon-Hassen, Kerri Watkins, Nany Grimard-Ouellette, Sabrina Chung, Veeran-Anne Singh and Victoria Smith from Health Canada's First Nations and Inuit Health Branch, and; Dr. Ricardo Batista-Moliner.

I would also like to sincerely thank members of my report unit and support staff: Dr. Stephanie Rees-Tregunno, Michael Halucha, Judith O'Brien, Rhonda Fraser, Meheria Arya, Fatimah Elbarrani, Crystal Stroud, Michelle MacRae and Lori Engler-Todd.

Key messages

HEALTH STATUS OF CANADIANS 2016

HOW HEALTHY ARE WE?

- Canadians are living longer than ever with an **average life expectancy** of 82 years, although life expectancy in Canada is not the same for everyone.
- More babies are being born with a **low birth weight** than in the past. A higher proportion of babies with a low birth weight are born to mothers under the age of 20 and between the ages of 35 to 49 years.
- The proportion of Canadians who reported a **strong sense of community belonging** in 2014 was lowest among those aged 20 to 34 years.
- Almost 90% of Canadians **reported feeling in good to excellent health** – the highest proportion of people among G7 countries.
- At 70%, most Canadians considered their mental health to be either very good or excellent in 2014. People living in lower income households had lowered **perceived mental health**.

WHAT IS INFLUENCING OUR HEALTH?

- The gap between the highest and lowest **income** groups is widening. Men and women are now equally likely to have a low income.
- More Canadians are completing their **high school and post-secondary education** than ever before—in 2015, 90% finished high school and 66% were a post-secondary graduate.
- Canadians with the lowest incomes report the highest rates of **core housing need and food insecurity**. In 2011, 29% of women single-parent households were in core housing need and 54% of First Nations on-reserve households reported food insecurity in 2008/2010.

- The vast majority of Canadians do not meet recommended levels of **physical activity** with 9 out of 10 children and youth not meeting the Canadian Physical Activity Guidelines.
- The proportion of Canadians who **smoke** is decreasing, but just under 4 million Canadians currently smoke.
- **Immunization** rates for measles and DPT in Canada are below national immunization coverage goals of 97% by age 2.

HOW ARE WE UNHEALTHY?

- **Cancer** continues to be the leading cause of death in Canada.
- In 2014, Canadians with the lowest income were twice as likely to report living with **cardiovascular disease** than those of the highest income.
- The proportion of Canadians 20 years and older with **diabetes** almost doubled between 2000 and 2011 - up from 6% to 10%.
- The proportion of Canadians reporting having been **injured** in the previous year increased to 16% in 2014 from 13% in 2003. An estimated 20% to 30% of seniors fall each year in Canada.
- The proportion of Canadians saying they had been diagnosed with a **mood disorder** increased from 5% in 2003 to 8% in 2014.
- In 2011, just over 340,000 Canadians were diagnosed with **dementia**, representing an estimated 2% of the Canadian population aged 40 years and older.
- **Tuberculosis** rates for Indigenous and foreign-born populations in Canada are higher than the overall Canadian population. Rates are almost 50 times higher for the Inuit.

From: Patients First [<mailto:PatientsFirst@ontario.ca>]

Sent: January-27-17 3:57 PM

To: Undisclosed recipients:

Subject: Update: Health System Integration / Mise à jour: Intégration du système de santé



Pour voir une version française de ce courriel, svp défiler vers le bas.

To see a French version of this email, please scroll down.

Hello colleagues,

We are pleased to share this update on the work supported by the *Patients First Act, 2016*. You will also find this update archived at this [link](#). You may also be interested in the answers to some Frequently Asked Questions at this [link](#).

You can count on regular emails like this as your source of ongoing information and updates, which can also be shared with staff members, local stakeholders and other stakeholders and colleagues.

Enabling the Health Care We Need Today and Planning for Tomorrow

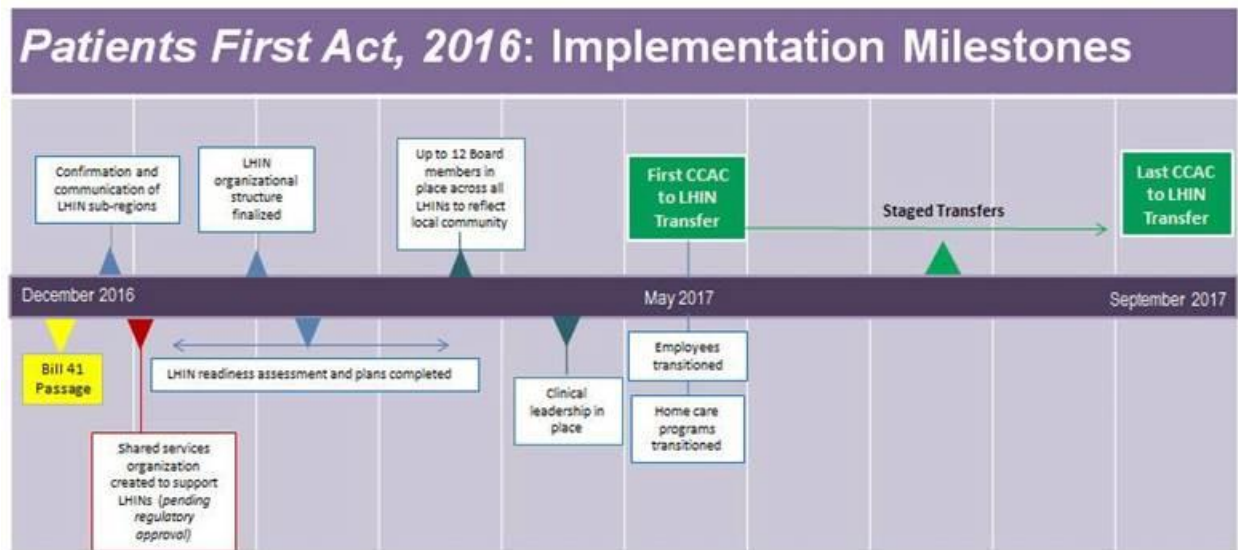
Writing in the January 16th edition of the *New Yorker* magazine, Dr. Atul Gawande describes the [*Heroism of Incremental Care*](#) and advocates for a change in emphasis from hospital-based medicine to community-based primary care in Western health systems.

Using examples from his career as an eminent cancer surgeon, Gawande describes how we have built and outfitted high technology hospitals that excel in “find it and fix it” urgent treatment for trauma, heart attacks, cancer and other acute problems. However, Dr. Gawande argues, the next generation of medical advances will depend on longer term observation, tweaking medications and treatments, counseling to change behaviour in people with chronic disease, and providing social and medical services that allow frail, elderly people to live in dignity.

Dr. Gawande is describing the necessary changes in health systems that many jurisdictions around the world are pursuing, including those the Patients First Action Plan will deliver in Ontario. The *Patients First Act* and the work it supports are important steps forward in this plan. Ontario excels at delivering high-quality care in a cost-effective hospital system. However, as Gawande emphasizes, the real challenge in improving our system lies outside hospital walls.

[Read more here.](#)

Implementation Updates



Patients First Act, 2016: Implementation Milestones

Partners across the health care system are working together on the work supported by the Patients First Act.

To oversee implementation planning, a joint Steering Committee has been set up with Ministry of Health and Long-Term Care (ministry) and LHIN executive leadership. The ministry is also regularly meeting with LHIN Board Chairs, CCAC CEOs, CCAC Board Chairs and external advisors to obtain their valued input. The ministry, LHINs and CCACs are communicating regularly and collaborating with all local health care partners.

Implementation is focused on ensuring a smooth transition of home and community care service delivery and management from CCACs to the LHINs through collaborative project planning, focus on continuity of care, and increasing partnership.

Some particular areas of focus are:

- Patient and family engagement
- French language services
- Indigenous engagement
- Primary care
- Home and community care
- Public health
- Workforce planning
- Leadership and management
- Governance, accountability and performance measurement, change management and ongoing communications

LHINs will be supported to build their capacity to successfully undertake their enhanced role in the health care system. This includes embedding clinical leads in the LHINs to support better planning and integration of patient care locally and working to successfully transition home and community care services and staff from CCACs to the LHINs.

One key priority underway is collaboration between the ministry, LHINs, CCACs and health care partners on capacity and readiness planning and activities to prepare for a smooth and seamless transition. Readiness assessments and capacity building are underway in all LHINs to inform a staged transition to the new LHIN in Spring/Summer 2017.

The ministry is also working with Patient and Family Advisory Councils across Ontario to seek advice and benefit from existing best practices in order to expand patient engagement activities and support the creation of Patient and Family Advisory Councils in all LHINs. Some meetings are already scheduled, however please feel free to reach out to us through this email address if you feel there is a particular group we should be engaging with.

What the work supported by the Patients First Act WILL Do:

- 1) It will reduce management costs by 8%. These savings will be reinvested in providing more care.
- 2) It will eliminate a layer of administration by winding down CCACs and transferring frontline workers to the LHINs.
- 3) Ontarians will continue to have freedom to choose their doctor. Access to a primary care provider close to home will be made easier through a single phone number.
- 4) Planning primary and home and community care with a sub-region lens (by community) will allow family doctors and nurse practitioners to better navigate services for their patients.
- 5) Ontario's Patients First: Action Plan for Health Care emphasizes access to health services. This includes the comprehensive, holistic primary care advocated by Ontario primary care stakeholders. New doctors and existing fee-for-service doctors will be encouraged to provide this type of care for their patients. We are recruiting 480 new family doctors annually to provide the ongoing, relationship-based care that evidence shows improves quality of life, extends life expectancy and prevents chronic conditions.
- 6) By planning services at the community level through a sub-region lens, family doctors and nurse practitioners will be better able to connect their patients with specialist services, community rehabilitation and mental health services.
- 7) Bringing public health specialists to the LHIN planning table will allow better coordination and understanding of the population health needs in each community.
- 8) The planning of primary care and home and community services will pay special attention to the needs of Indigenous and Francophone Ontarians. Indigenous

Ontarians, Francophone Ontarians, community leaders and health care providers are collaborating with us to ensure health care services are culturally appropriate and meet the principles of reconciliation.

- 9) Through the assessment of the capacity of health resources across the sub-regions, we will ensure that investments are focused where the need is greatest to improve the equity of health for all citizens.
- 10) Implementing these changes will achieve the Triple Aim of: improving the patient experience, improving overall health of the whole population and improving the sustainability and cost effectiveness of our publicly funded system.

What the work supported by the Patients First Act WILL NOT Do:

- 1) It does not increase bureaucracy. Just the opposite – it removes a layer of administration within the CCACs and decreases management costs by 8%.
- 2) It does not put the confidentiality of personal health information at risk. The Information and Privacy Commissioner provided advice and recommendations for amendments to the Act. The amendments were made and the Commissioner is satisfied that health information is properly protected.
- 3) It does not mean that doctors will need to spend more time on administration or filling in forms. It simply means that patients and the LHINs should be informed if the doctor is closing their office for a long absence or retiring.
- 4) It does not mean that Ontarians will need to change doctors or home care providers. LHIN regional planning will make services more understandable and accessible. If a patient wants to leave their community to get care this is their right.
- 5) It does not mean that hospitals will receive less funding. Hospital leaders realize that these changes will help them provide more effective service because strong community services will reduce some demand for non-acute care in the hospital. Resources will be deployed more effectively.
- 6) It does not mean that planning of health services will be centralized to the Ministry of Health and Long-Term Care. All care planning will be informed by Patient and Family Advisory Committees and clinical leaders in each LHIN, and will take into account the unique needs and care patterns in each community.

More Updates Coming

You can expect regular updates like this as we move forward together.

And you'll hear from us soon about our next Webinar, which is planned for February. That will provide another opportunity to share updates and ask questions.

Please Stay in Touch

We value your feedback, and we want to provide the information you need. If you have questions or comments, please send an email to patientsfirst@ontario.ca. To join our email list and receive these updates, please send an email to patientsfirst@ontario.ca.

En français:

Chers collègues,

Nous sommes heureux de partager cette mise à jour sur le travail soutenu par la *Loi de 2016 donnant la priorité aux patients*. Vous trouverez également cette mise à jour archivée en cliquant sur ce [lien](#). Certaines réponses qui se trouvent dans la foire aux questions accessible en cliquant sur ce [lien](#) pourraient aussi vous intéresser.

Des courriels comme celui-ci vous seront transmis régulièrement afin de vous donner de l'information et des mises à jour, que vous pourrez partager avec les membres de votre personnel, les intervenants locaux et autres intervenants et collègues.

Mise en oeuvre des soins de santé nécessaires aujourd'hui et planification pour demain

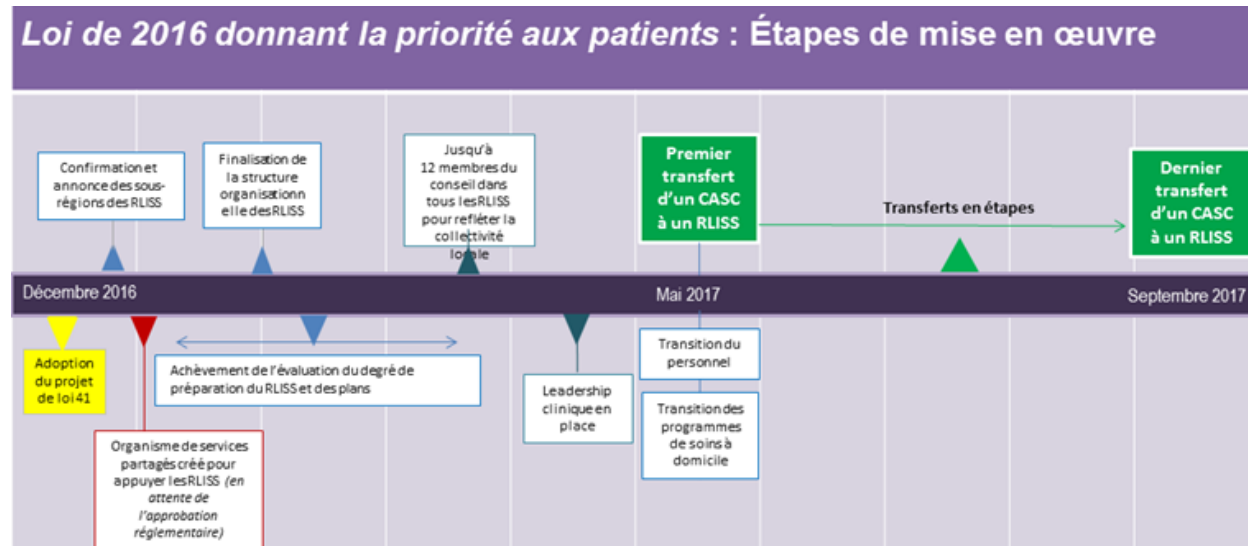
Dans un article paru dans l'édition du 16 janvier du magazine New Yorker et intitulé *Heroism of Incremental Care*, le D^r Atul Gawande décrit ce qu'il appelle l'héroïsme des soins complémentaires et milite pour que l'accent soit désormais mis sur les soins primaires communautaires plutôt que sur la médecine hospitalière dans les systèmes de santé occidentaux.

À l'aide d'exemples tirés de sa propre carrière d'éminent chirurgien du cancer, le D^r Gawande explique comment nous avons bâti des hôpitaux outillés de technologies de pointe qui excellent dans le traitement urgent des traumatismes, des infarctus, du cancer et d'autres problèmes aigus selon le mode « trouver le problème et y remédier ». Cependant, selon le D^r Gawande, la prochaine génération d'avancées médicales se fondera sur l'observation à long terme, les rajustements de médicaments et de traitements, les conseils visant à modifier le comportement des gens ayant des maladies chroniques, et la prestation de services sociaux et médicaux qui permettent aux personnes âgées et de santé fragile de vivre dans la dignité.

Le D^r Gawande décrit les changements nécessaires aux systèmes de santé que plusieurs collectivités publiques dans le monde cherchent à concrétiser, y compris celles que le plan d'action Priorité aux patients réalisera en Ontario. La *Loi de 2016 donnant la priorité aux patients* et le travail qu'elle favorise sont d'importants pas en avant dans le déploiement de ce plan. L'Ontario excelle à offrir des soins de qualité supérieure dans un système hospitalier rentable. Cependant, comme le souligne le D^r Gawande, le véritable défi pour améliorer notre système se trouve à l'extérieur des murs des hôpitaux.

[En lire plus.](#)

Mises à jour sur la mise en oeuvre



Loi de 2016 donnant la priorité aux patients: etapes de mise en oeuvre

Les partenaires de l'ensemble du système de santé collaborent au travail soutenu par la *Loi de 2016 donnant la priorité aux patients*.

Afin de superviser la planification de la mise en oeuvre, un comité directeur a été créé avec le ministère de la Santé et des Soins de longue durée (ministère) et les hauts dirigeants des RLSS. Le ministère rencontre aussi régulièrement les présidents des conseils d'administration des RLSS, les directeurs généraux des CASC, les présidents des conseils d'administration des CASC et des conseillers externes afin d'obtenir leurs observations utiles. Le ministère, les RLSS et les CASC communiquent ensemble régulièrement et collaborent avec l'ensemble des partenaires locaux en santé.

La mise en oeuvre se concentre à garantir une transition harmonieuse de la prestation et de la gestion des services de soins à domicile et en milieu communautaire des CASC aux RLSS grâce à une planification en collaboration de ce projet, axée sur la continuité des soins et à un partenariat plus grand.

Voici certains domaines où un accent particulier est mis :

- la mobilisation des patients et des familles;
- les services en français;
- la mobilisation autochtone;
- les soins primaires;
- les soins à domicile et en milieu communautaire;
- la santé publique;
- la planification de la main-d'oeuvre;
- la direction et la gestion;

- la gouvernance, la responsabilisation et la mesure du rendement, la gestion du changement et la communication continue.

Les RLISS seront appuyés alors qu'ils renforcent leur capacité pour entreprendre avec succès leur rôle accru au sein du système de santé. Cela inclut le fait d'intégrer les dirigeants des soins cliniques dans les RLISS afin de soutenir une meilleure planification et une meilleure intégration des soins aux patients à l'échelle locale et de travailler à une transition réussie des services et du personnel de soins à domicile et en milieu communautaire des CASC aux RLISS.

Actuellement, notre principale priorité est la collaboration entre le ministère, les RLISS, les CASC et les partenaires de la santé concernant la planification de la capacité et de l'état de préparation et les activités pour préparer une transition harmonieuse et unifiée. Les évaluations de l'état de préparation et le renforcement de la capacité sont en cours dans tous les RLISS afin d'orienter une transition par étape vers les nouveaux RLISS au printemps et à l'été 2017.

Le ministère travaille également avec les conseils consultatifs des patients et des familles de tout l'Ontario pour recueillir leur avis et tirer profit des pratiques exemplaires existantes afin d'accroître les activités de mobilisation des patients et de favoriser la création de conseils consultatifs des patients et des familles dans tous les RLISS. Certaines rencontres sont déjà prévues, mais nous vous invitons à communiquer avec nous au moyen de cette adresse courriel si vous pensez que nous devrions rencontrer un groupe particulier.

Ce que FERA le travail appuyé par la Loi de 2016 donnant la priorité aux patients :

- 1) Il réduira les coûts de gestion de 8 pour cent. Ces économies seront réinvesties dans la prestation de davantage de soins.
- 2) Il éliminera un niveau administratif en procédant à la réduction progressive des activités des CASC et en transférant les travailleurs de première ligne aux RLISS.
- 3) La population ontarienne continuera de pouvoir choisir librement son médecin. Accéder à un fournisseur de soins primaire plus près de chez soi sera plus facile grâce à un numéro de téléphone unique.
- 4) La planification des soins primaires et des soins à domicile et en milieu communautaire avec une perspective sous-régionale (par collectivité) permettra aux médecins de famille et au personnel infirmier praticien de mieux naviguer pour leurs patients parmi les services.
- 5) Le plan d'action de l'Ontario *Priorité aux patients : Plan d'action en matière de soins de santé* met l'accent sur l'accès aux services de santé. Cela comprend les soins primaires complets et holistiques que défendent les intervenants de soins primaires ontariens. Les nouveaux médecins et les médecins actuellement payés à l'acte seront encouragés à offrir à leurs patients ce type de soins. Nous recrutons 480 nouveaux médecins de famille annuellement afin d'offrir les soins

continus et basés sur une relation qui, selon les preuves, améliorent la qualité de vie, prolongent l'espérance de vie et préviennent les maladies chroniques.

- 6) En planifiant les services à l'échelle communautaire au moyen d'une perspective sous-régionale, les médecins de famille et le personnel infirmier praticien pourront mieux aiguiller leurs patients vers des services de spécialistes et des services de réadaptation et de santé mentale en milieu communautaire.
- 7) L'ajout de spécialistes de la santé publique à la table de planification du RLSS permettra une meilleure coordination et une meilleure compréhension des besoins en santé de la population au sein chaque collectivité.
- 8) La planification des soins primaires et des services à domicile et en milieu communautaire accordera une attention particulière aux besoins de la population ontarienne autochtone et francophone. La population ontarienne autochtone, la population ontarienne francophone, les dirigeants communautaires et les fournisseurs de soins de santé collaborent avec nous afin de garantir que les services de santé sont culturellement adaptés et respectent les principes de la réconciliation.
- 9) Grâce à l'évaluation de la capacité des ressources en santé des différentes sous-régions, nous nous assurerons que les investissements sont concentrés là où les besoins sont les plus grands afin d'améliorer l'équité en matière de santé pour l'ensemble des citoyens.
- 10) Le déploiement de ces changements concrétisera le triple objectif suivant : améliorer l'expérience du patient, améliorer la santé générale de toute la population et améliorer la viabilité et la rentabilité de notre système financé par les deniers publics.

Ce que NE FERA PAS le travail appuyé par la Loi de 2016 donnant la priorité aux patients :

- 1) Il n'augmentera pas la bureaucratie. C'est tout le contraire. Il élimine un niveau administratif au sein des CASC et diminue les coûts de gestion de 8 pour cent.
- 2) Il ne met pas la confidentialité des renseignements personnels sur la santé en danger. Le Commissaire à l'information et à la protection de la vie privée a fourni des conseils et des recommandations afin de modifier le projet de loi. Ces modifications y ont été apportées et le commissaire est convaincu que les renseignements sur la santé sont désormais protégés de façon convenable.
- 3) Cela ne signifie pas que les médecins devront passer plus de temps à faire des tâches administratives ou à remplir des formulaires. Cela veut simplement dire que les patients et les RLSS devraient être informés si un médecin ferme son cabinet pour une absence prolongée ou parce qu'il prend sa retraite.
- 4) Cela ne veut pas dire que les Ontariennes et les Ontariens devront changer de médecin ou de fournisseur de soins à domicile. La planification régionale des RLSS rendra les services plus compréhensibles et accessibles. Si un patient souhaite quitter sa collectivité pour obtenir des soins, c'est son droit.

- 5) Cela ne veut pas dire que les hôpitaux recevront moins de financement. Les dirigeants d'hôpitaux réalisent que ces changements les aideront à fournir des services plus efficaces, puisque des services communautaires plus forts réduiront en partie la demande pour des soins de courte durée à l'hôpital. Les ressources seront déployées plus efficacement.
- 6) Cela ne veut pas dire que la planification des services de santé sera centralisée au ministère de la Santé et des Soins de longue durée. Toute la planification des soins sera orientée par les comités consultatifs des patients et des familles et les dirigeants des soins cliniques de chaque RLSS, et se fondera sur les besoins et des modèles de soins particuliers de chaque collectivité.

D'autres mises à jour seront proposées

Vous pouvez vous attendre à recevoir des mises à jour régulières comme celle-ci au fur et à mesure que nous progressons ensemble.

Vous entendrez aussi parler de nous bientôt concernant notre prochain webinaire, qui devrait se dérouler en février. Cela représentera une autre occasion de partager des mises à jour et de poser des questions.

Restons donc en contact.

Nous souhaitons recevoir vos commentaires et nous voulons vous transmettre l'information dont vous avez besoin. Si vous avez des questions ou des commentaires, veuillez envoyer un courriel à patientsfirst@ontario.ca. Si vous souhaitez faire partie de notre liste de diffusion et recevoir ces mises à jour, veuillez envoyer un courriel à patientsfirst@ontario.ca.

From: Patients First [<mailto:PatientsFirst@ontario.ca>]

Sent: Friday, February 3, 2017 9:39 AM

To: Patients First <PatientsFirst@ontario.ca>

Subject: Update: Health System Integration / Mise à jour: Intégration du système de santé



Pour voir une version française de ce courriel, svp défiler vers le bas.

To see a French version of this email, please scroll down.

We are pleased to share this update on the work supported by the *Patients First Act, 2016*. You will also find this update archived at this [link](#). You may also be interested in the answers to some Frequently Asked Questions at this [link](#).

You can count on regular emails like this as your source of ongoing information and updates, which can also be shared with staff members, local stakeholders and other stakeholders and colleagues.

LHIN Sub-Regions

Ontario is home to nearly 14 million people spread across a vast geography, representing different walks of life. As the province continues to focus on transforming the health care sector, an emerging priority is to ensure that health care planning is supported through mechanisms that take into account the diverse geographic, population and demographic needs to deliver quality care in an effective and efficient manner.

LHIN sub-regions are local planning regions that will serve as the focal point for improved health system planning, performance improvement and service integration. Sub-regions have been in place informally in LHINs for many years and they are now being formalized. They will be the avenue for local improvement and innovation with the common objective of improving the patient experience.

The rationale for sub-regions is based on a significant body of research, experience and advice. LHINs range in population size from about one to two million residents; although the development of LHINs enabled a more community-focused lens for health care planning and improvement, we know there remains significant diversity within LHIN boundaries. For example, in the North East LHIN the needs of the James and Hudson

Bay Coasts sub-region, with a population size of 7,100, significantly differ from the needs of the Sudbury-Manitoulin-Parry Sound sub-region, with a population size of 229,900.

North East LHIN Sub-Region Map



We also know through our [Health Links](#) initiative that targeting health care improvement efforts at a smaller scale can enable better identification of population health needs, can foster improved patient and family engagement and can improve collaboration among providers within the circle of care. Further, advice from the [Expert Advisory Committee on Strengthening Primary Health Care in Ontario](#) recommended smaller geographies as a means of structuring our primary care sector around the needs of populations.

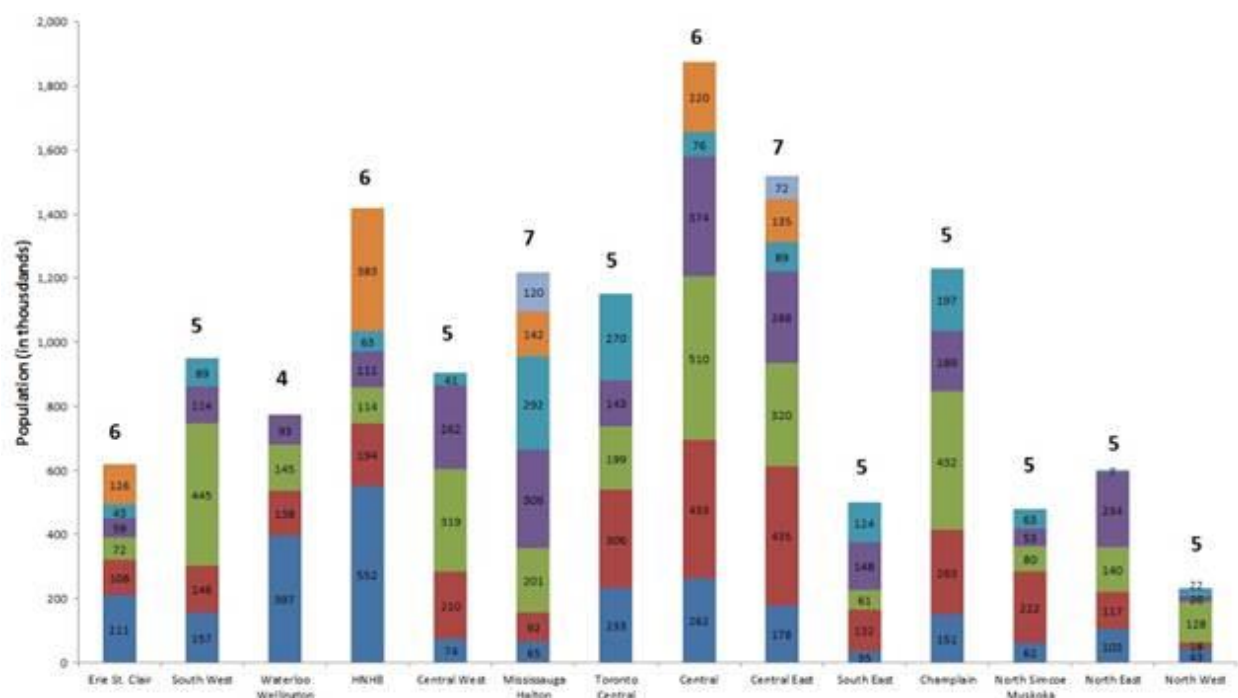
Sub-regions are not another layer of bureaucracy. They are instead simply a better way for LHINs to plan and improve health services in a manner that is more in line with the diverse needs of communities across the province.

For each sub-region, the LHIN will ensure there is a person responsible as the administrative lead on planning, plus a clinical lead – a doctor or nurse practitioner who already provides primary care in the community and will provide their clinical expertise to the LHIN. This clinical lead will work with other local doctors and health service providers to inform the LHIN's planning and help ensure that health service providers address local clinical trends and needs. The sub-region planning lens will also help ensure better equity of health services, with opportunities to address issues like communities where there might currently be higher rates of chronic disease and challenges in access to health resources.

LHIN sub-regions do not mean that people need to change the way they access care. They will not have to find a new primary care provider, choose a different hospital nor seek out home and community care services differently. In fact, LHIN sub-regions are based in part on existing care patterns, not creating new ones.

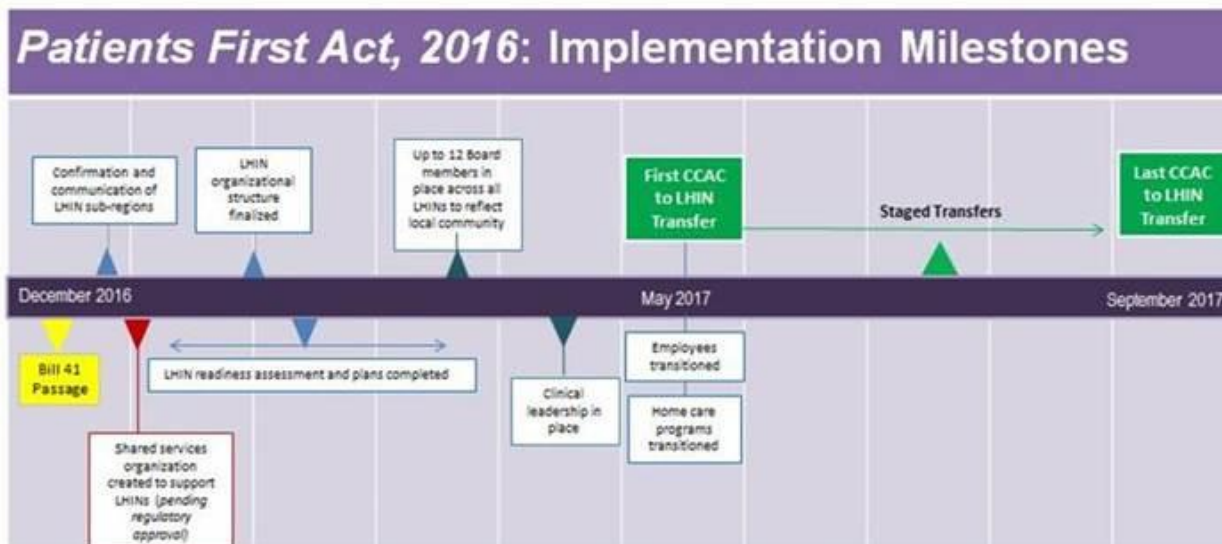
To arrive at the sub-regions, LHINs spent the summer and fall engaging patients, families, providers and other community partners locally. The ministry also consulted with our Indigenous partners, French language stakeholders, municipal sector and others. Based on consultation and looking at existing care patterns, each LHIN recommended between 4 and 7 sub-regions. In total, there are 76 sub-regions, a number that reflects the diversity of Ontario and its local needs. The median population size of LHIN sub-regions is about 140,000 and each LHIN sub-region typically has at least one acute care hospital, on average 150 primary care practices as well as home and community care service providers. We may see LHIN sub-region geographies evolve over time as we gather more experience, as LHINs continue to engage their communities and as improvement efforts take hold.

The Number and Size of Sub-Regions in Ontario



What's next? The formalization of sub-regions is the platform upon which system improvements will take hold. From a planning perspective, LHINs and partners can expect detailed, local analysis of population health, service utilization patterns, capacity considerations and other data points. From an improvement and integration perspective, sub-regions will be the locus for local innovations, be they focused on improving connections between primary care and home care, access to specialists or ensuring newcomers receive the care they need.

We invite you to take a look at LHIN websites to see these sub-regions. We value your input going forward on how we can use these new geographies to put patients first.



Patients First Act, 2016: Implementation Milestones

More Updates Coming

You can expect regular updates like this as we move forward together.

And you'll hear from us soon about our next Webinar, which is planned for February. That will provide another opportunity to share updates and ask questions.

If you have questions or comments, please send an email to patientsfirst@ontario.ca. To join our email list and receive these updates, please send an email to patientsfirst@ontario.ca.

En français:

À tous les collègues,

Nous avons le plaisir de vous présenter cette mise à jour sur les travaux réalisés en vertu de la *Loi de 2016 donnant la priorité aux patients*. Vous pourrez également trouver cette mise à jour archivée en cliquant sur ce [lien](#). Vous souhaitez peut-être aussi consulter les réponses de la foire aux questions que vous trouverez sous ce [lien](#).

Vous pouvez compter sur des courriels comme celui-ci qui constitue une source continue d'information et de mises à jour, et que vous pouvez transmettre à des membres du personnel, des intervenants locaux, ainsi qu'à d'autres intervenants et collègues.

Sous-régions des RLISS

L'Ontario compte une population de près de 14 millions de personnes réparties sur un vaste territoire et provenant de tous les milieux. Alors que la province continue de mettre l'accent sur la transformation du secteur des soins de santé, une nouvelle

priorité consiste à s'assurer que la planification des soins de santé repose sur des mécanismes qui doivent tenir compte des différents besoins géographiques, humains et démographiques dans le but d'offrir des soins de qualité de manière efficace et adéquate.

Les sous-régions des RLISS assurent la planification locale et deviendront le point de mire qui nous permettra de mieux planifier notre système de santé, d'accroître son rendement et d'assurer l'intégration des services. Les sous-régions existent de manière officieuse dans les RLISS depuis plusieurs années et sont en voie d'être officialisées. Elles représenteront un moyen de procéder à des améliorations et à des innovations locales dans un but commun qui consiste à améliorer l'expérience du patient.

La raison d'être des sous-régions repose sur un ensemble important de recherches, d'expériences et de conseils. La taille de la population au sein des RLISS est comprise entre un et deux millions de résidents environ, même si leur création a permis d'axer davantage la planification et l'amélioration des soins de santé sur les besoins de la communauté, nous savons qu'une diversité considérable subsiste toujours à l'intérieur des frontières des RLISS. Dans le RLISS du nord-est, par exemple, les besoins des gens vivant dans la sous-région sur les côtes des baies de James et d'Hudson, dont la population atteint 7 100 habitants, diffèrent considérablement de ceux des habitants dans la sous-région de Sudbury-Manitoulin-Parry Sound qui compte une population de 229 900 habitants.

Carte de la sous-région du RLISS du nord-est



Nous savons également, grâce à notre initiative des [Maillons santé](#), qu'en concentrant nos efforts d'amélioration des soins de santé à plus petite échelle, il devient possible de mieux identifier les besoins en santé de la population, de favoriser un engagement accru de la part des patients et des membres de leurs familles et d'améliorer la collaboration entre des fournisseurs qui font partie du cercle des soignants. De plus, le [Comité consultatif d'experts sur les soins de santé primaires en Ontario](#) a recommandé qu'on réduise la taille des régions géographiques dans le but de structurer notre secteur des soins primaires autour des besoins des populations.

Les sous-régions ne constituent pas un niveau additionnel de bureaucratie. Il s'agit simplement d'une meilleure façon pour les RLIS de planifier et d'améliorer les services de santé de manière à mieux répondre aux besoins des différentes communautés de la province.

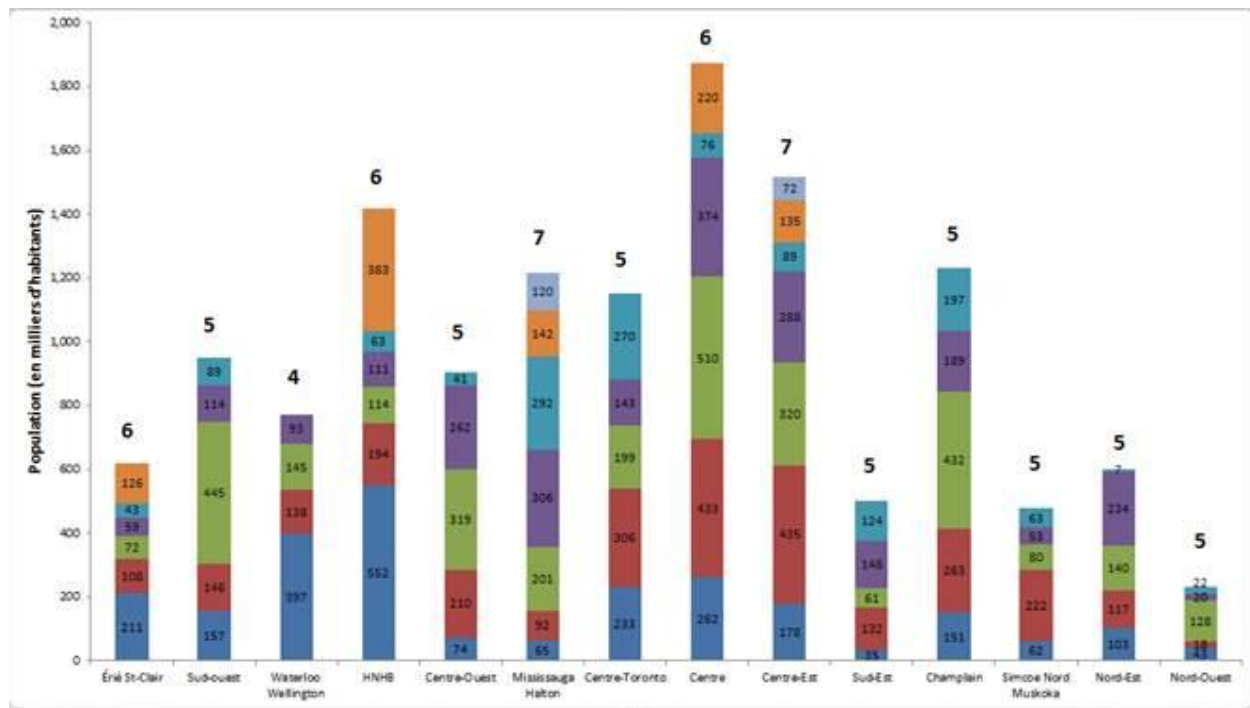
Pour chaque région, le RLIS garantira qu'on puisse compter sur une personne responsable qui dirige les fonctions administratives, comme la planification, et sur un responsable des soins cliniques, tels un médecin ou une infirmière praticienne qui dispensent déjà des soins primaires dans la communauté et qui feront profiter le RLIS de leur expertise sur le plan clinique. Le responsable des soins cliniques collaborera avec les autres médecins locaux ainsi qu'avec les fournisseurs de soins de santé pour alimenter ainsi le processus de planification du RLIS et contribuer à assurer que les fournisseurs de services de santé réagissent aux tendances et répondent aux besoins cliniques locaux. Le volet de la planification par sous-région nous aidera également à améliorer l'équité des services de santé en nous permettant de nous attaquer, par exemple, au problème des communautés où l'on constate peut-être à l'heure actuelle des taux plus élevés de maladies chroniques et une difficulté d'accès aux ressources en santé.

Les sous-régions du RLIS ne signifient aucunement que les gens devront modifier leur façon de se prévaloir des soins. Ceux-ci n'auront pas à trouver un nouveau fournisseur de soins primaires, à choisir un autre hôpital ou à procéder différemment pour obtenir des soins à domicile ou des services de santé communautaires. En fait, les sous-régions du RLIS reposent en partie sur les modèles de soins actuels et non sur la création de nouveaux modèles.

Les RLIS en sont arrivés à ce besoin de créer des sous-régions, alors que leurs responsables ont passé l'été et l'automne à consulter les patients, les familles, les fournisseurs et les autres partenaires communautaires à l'échelle locale. Le ministère a également consulté nos partenaires autochtones, les intervenants francophones, le secteur municipal et d'autres instances. Partant du résultat de ces consultations et d'un examen des modèles de soins déjà existants, chaque RLIS a recommandé la création de 4 à 7 sous-régions. On dénombre en tout 76 sous-régions et ce nombre reflète la diversité de l'Ontario et de ses besoins locaux. La population médiane des sous-régions des RLIS compte tout près de 140 000 habitants, alors que chaque sous-région du réseau possède habituellement au moins un hôpital de soins de courte durée, en moyenne 150 pratiques de soins primaires, ainsi que des fournisseurs de soins à domicile et de services de soins communautaires. Nous pouvons constater qu'au fur et à mesure que nous acquérons de l'expérience, l'aspect géographique des sous-régions

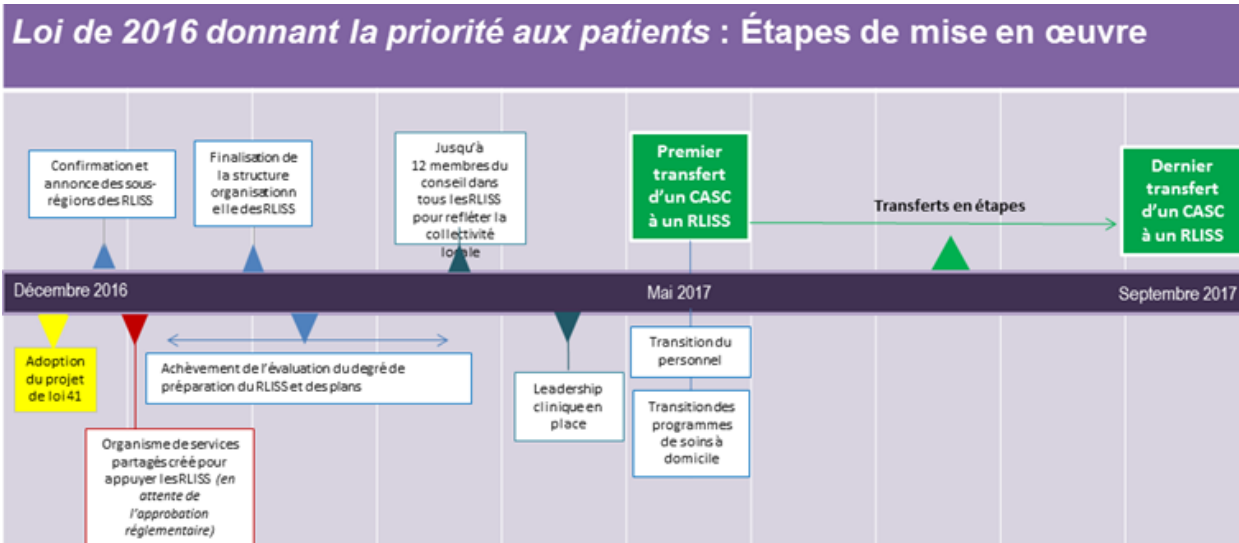
des RLIS évolue avec le temps, alors que ces réseaux continuent d'impliquer leurs communautés et que les efforts d'amélioration portent leurs fruits.

Nombre et taille des sous-régions en Ontario



Quelle sera la suite? L'officialisation des sous-régions constitue la plate-forme qui servira de pierre angulaire aux améliorations de notre système. Du point de vue de la planification, les RLIS et les partenaires peuvent s'attendre à une analyse locale détaillée de la santé de la population, des habitudes en matière d'utilisation des services, des aspects en lien avec la capacité, ainsi que d'autres points de données. Du point de vue de l'amélioration et de l'intégration, les sous-régions représenteront le point de mire de l'innovation locale alors qu'elles s'efforceront principalement d'améliorer les liens entre les soins primaires et l'accès aux spécialistes ou les mesures visant à s'assurer que les nouveaux arrivants bénéficient des soins dont ils ont besoin.

Nous vous invitons à consulter les sites Web des RLIS pour connaître les sous-régions. Nous vous encourageons à donner votre opinion sur la façon dont nous pouvons exploiter ces nouvelles divisions géographiques pour mettre le patient au premier plan.



Loi de 2016 donnant la priorité aux patients: étapes de mise en œuvre

D'autres mises à jour suivront

Vous pouvez vous attendre à recevoir régulièrement des mises à jour comme celle-ci au fur et à mesure que nous progressons.

De plus, nous vous parlerons bientôt de notre prochain webinaire qui doit avoir lieu en février. Celui-ci représentera pour nous une autre occasion de vous présenter des mises à jour et pour vous, de nous poser vos questions.

Enfin, si vous avez des questions ou des commentaires, faites-nous parvenir un courriel à l'adresse patientsfirst@ontario.ca. Pour vous inscrire à notre liste d'envoi par courriel, écrivez-nous à l'adresse patientsfirst@ontario.ca.



2017 PRE-BUDGET CONSULTATION: INVESTING IN PUBLIC HEALTH



SUDBURY & DISTRICT HEALTH UNIT 1300 Paris Street, Sudbury, ON, P3E 3A3

Executive Summary

Ontario's government seeks to create jobs and grow its economy. It seeks a health care system that is high-quality, cost-effective and sustainable. Investing in public health creates a return on investment in health outcomes and contributes to a sustainable health care system over the long term. It is an investment that goes beyond health care by contributing to a healthier, more productive population to grow and benefit from Ontario's economy.

Public health addresses the social determinants of health (SDOH), the "conditions in which people are born, grow, live, work, and age and are driven by inequities in the distribution of power, money and resources in society" (1). The SDOH account for the majority of what makes Canadians healthy or unhealthy. By preventing and modifying risk factors for disease through strong partnerships with both the health care and non-health care sectors, public health works to ensure that all Ontarians, regardless of age, orientation or socioeconomic status, have the opportunities to life a healthy life.

Currently, Ontario's health care system is facing a dire set of challenges including a slowing global economy, expensive end-of-life care, an aging population, working-age adults squeezed with demands to provide both child and parental care, increasing prevalence of non-communicable diseases (NCDs) and a widening wealth gap (2). NCDs account for nearly 80% of deaths in Ontario and the burden is shouldered most heavily by those who are socioeconomically deprived (2–5).

The *Patients First Act* aims to address many of Ontario's health care challenges, yet the role of public health remains unclear. Two directions can be taken: "downstream integration" or "upstream with collaboration". The first would see public health contributing through integration with health care, analyzing population health-level data to prepare for, plan and manage patient needs and service provision. However, the experience from other provinces and countries highlights that public health is most effective when it works "upstream". This second option involves working with health care and non-health care sectors to advocate, design implement and evaluate policies and programs that prevent diseases and their risk factors and promote and protect health, before people become patients in the first place.

The downstream approach may help achieve the health care system Ontario seeks, however, health care accounts for less than a quarter of what makes us healthy or unhealthy (6). Addressing the SDOH through a collaborative upstream approach would yield a much greater return on investment that also extends to growing Ontario's economy.

The status quo is an untenable situation for our province's health care system. Poor health outcomes harm the economy through decreased worker productivity. The opportunities for health are not the same for all Ontarians and it is particularly the socioeconomically disadvantaged who will be unable to participate and benefit from the returns of Ontario's economy. Public health works to address the health of all Ontarians and is positioned to do more. It is the right investment for our health and economy.

Strategic Context

Health: current roles of public health and health care

Sam is 58 years old and has poorly-controlled diabetes and cardiovascular disease. Sam has a part-time job that is sedentary and does not pay enough to buy fresh vegetables and fruits. Sam has visited the emergency room twice in the past month for angina and has missed nearly one week of work.

Ontario's health care workers all know a Sam. They know that if nothing changes, more visits can be expected. They work hard to ensure that Sam has access to timely and high quality care.

Public health knows many Sams and that not all of them have the same opportunities for health. We know that if nothing changes, many more Sams are on their way. We are working hard so that their workplace culture promotes physical and mental health, that they have access to affordable and nutritious food, and that they live, work and play in communities that promote active, healthy living and protect against disease.

Health is at the heart of both public health and health care and each approach them differently. Health care uses an array of diagnostic and treatment options to care for each patient. While important, accessible and quality health care accounts for under a quarter of what makes Canadians healthy or unhealthy (6). The social determinants of health (SDOH), what public health works to address, account for *at least* half. The SDOH are the "conditions in which people are born, grow, live, work, and age and are driven by inequities in the distribution of power, money and resources in society" (1). When conditions are poor, good health is harder to achieve, particularly for the most deprived. Addressing these issues involves "levelling up" the health outcomes of those who are deprived to meet those who are least deprived. This necessitates working with health care through strong partnerships with municipalities, school boards, policy and planning departments and community services (7).

Public health and health care address health at different stages. Health care treats the individual through primary prevention (preventing disease through modifying the individual's existing risk factors), secondary prevention (early detection and treatment of the individual's disease), tertiary prevention (preventing the worst outcomes from the disease) and supporting those at the end of life (7,8). Public health, on the other hand, addresses health at the population level by working to understand population health and acting on this knowledge through health promotion and disease prevention (9). We work in the areas of primary prevention, with some activities intersecting with health care such as sexual health clinics, where public health fills in a local service gap or increases access to a particular service. Importantly, we work further "upstream" in primordial prevention. This refers to preventing disease risk factors from even occurring (7). Both primordial and primary prevention involve addressing the SDOH.

Health: needs and current challenges in Ontario

Ontario's government seeks to create jobs and grow its economy. It seeks a health care system that is high-quality, cost-effective and sustainable. Current challenges to achieving these goals include:

- A slowing global economy,
- Increasingly expensive end-of-life care,
- An aging population that does not fully cover its health care costs through tax recovery,
- A “sandwich generation” of working-age adults stressed economically, physically and mentally to provide both child and parental care,
- Increasing prevalence of non-communicable diseases (NCDs), and
- A widening wealth gap (2).

The last two points are priority areas for public health. Our success in reducing communicable disease burden through initiatives such as immunization and sewage disposal have shifted more of our work to addressing NCDs. Major NCDs include cancer, cardiovascular disease, chronic respiratory disease and diabetes. These are responsible for nearly 80% of all deaths in the province (3). These NCDs, however, are largely preventable. For example, the four major behavioural drivers of these diseases include physical activity, smoking, unhealthy diet and unhealthy alcohol consumption. These behaviours accounted for more than \$89.4 billion (22%) of health care costs in Ontario between 2004 and 2013 (5). Health care acts on addressing these behaviours at the individual level. Public health acts on these behaviours at a population level and further upstream by addressing the social and environmental conditions that promote or prevent these behaviours.

The differences in preventable mortality achieved by health care and public health initiatives can be illustrated as follows:

- Heart-related medical services can prevent 2 deaths per 100,000 people per year through automated external defibrillators, 15 deaths through angioplasty and 63 deaths through implantable defibrillators.
- Public health policies and initiatives can prevent 158 deaths per 100,000 people per year by promoting eating five vegetables and fruits per day, 159 deaths through preventing tobacco use including second hand smoke exposure, and 334 deaths by encouraging 150 minutes of physical activity per week (10).

The widening wealth gap has an adverse impact on population health, where an estimated 40,000 deaths per year in Canada can be attributed to inadequate income (11). In Ontario, income inequality alone accounted for \$60.7 (15%) of Ontario's health care costs between 2004 and 2013 (2,4,5). Furthermore, NCDs are more prevalent among lower-income Ontarians who are more likely to experience poorer health outcomes and become high-cost users of the health care system. Health care works to provide access to timely and high quality health care regardless of one's geography or socioeconomic status. Public health works to ensure that there are equitable opportunities for healthy living overall, regardless of socioeconomic status or other SDOH.

Health: finding a strategic fit for public health and health care

With the many challenges facing Ontario's economy and health, how does public health contribute to a high quality, cost-effective and sustainable health care system? In the following section, we will consider two options against the status quo. These options aim to capture the basic elements of health care reform outlined in the *Patients First Act* and the experiences from other provinces and countries. These include the following:

1. "Downstream integration": public health is integrated with health care providers predominantly at the level of primary care. Public health analyzes population-based trends to inform health care planning and service provision. While non-health care functions are maintained such as food inspection, this option largely involves a clinical focus including secondary prevention (ex. diabetes screening) and clinical intervention (ex. tobacco cessation).
2. "Upstream with collaboration": public health collaborates with both health care and non-health care sectors to prevent disease and promote health. While maintaining some clinical services to protect population health (ex. immunization and outbreak management), the focus is on upstream activities including the provision of information to inform the development of equitable policies (ex. basic income) as well as planning and implementing programs that support healthy communities (ex. positive parenting programs and municipal infrastructure planning).

Analysis and Recommendations

Following the status quo, it is expected that health care will consume 80% of provincial budgets by 2030 (5). This stresses quality health care provision, and is expensive, unsustainable and detrimental to Ontario's economy. We will consider how the alternative options compare.

Options: strategic alignment and cost-benefit analysis

I. Downstream integration

This option focuses on the epidemiological capabilities of public health. It is oriented more towards individual patient care than population health. It uses population trends such as age and disease prevalence to help plan where best to provide health care services and the types of services to offer. This can contribute to quality health care by planning and providing the right kind of health care accessible to those who require those services. Knowing where to target early identification of disease (ex. diabetes screening), as well as effective preventive clinical intervention (ex. tobacco cessation) can be cost-effective if these interventions (1) can reduce the probability of more serious and costly health outcomes and (2) if additional practices are generated at lower cost (12). Some interventions can even produce a return on investment (ROI). These are shown in Table 1, next page.

Table 1: examples of cost-benefit in downstream integration, adapted from WHO (12)

Intervention focus	Quick wins (0-5 years)	Longer-term gains (>5 years)
Treatment	Treatment of depression in diabetes patients	--
Screening	[§] Screening for abdominal aortic aneurysm [§] Screening for depression in diabetes	Screening for diabetes and impaired glucose tolerance Vascular disease health checks
Vaccination	[§] For children: norovirus, pneumococcus, rotavirus, influenza	[§] Influenza, pneumococcus [§] MMR, DTP HPV, MenB, MenC

[§]Indicates ROI, cost-effective otherwise

Early identification and treatment of disease can contribute to a sustainable health care system by reducing the demand on costly acute care and potentially freeing-up resources for other health care priorities. Earlier screening and effective interventions may also contribute to a healthier and more productive workforce, ultimately contributing to Ontario's economy.

II. Upstream with collaboration

This option uses both of public health's roles of understanding and acting on population health through upstream intervention. There is less of an emphasis on quality health care provision, with a greater focus instead on the factors that promote or prevent disease. These interventions can be cost-effective and yield ROI both within and beyond the health care sector. Examples are shown in Table 2, below.

Table 2: examples of cost-benefit in upstream with collaboration, adapted from WHO (12)

Intervention focus	Quick wins (0-5 years)	Longer-term gains (>5 years)
Vaccination	(see Table 1)	
Behaviour	\$*Lifestyle diabetes prevention program \$Restricting alcohol availability Community-based youth tobacco control intervention Workplace obesity prevention	Alcohol minimum price
Resilience	\$Violence prevention legislation \$Prevention of postnatal depression \$Family support projects \$Social emotional learning \$Bullying prevention (school-based) \$Mental health in the workplace \$Psychosocial groups for older people Parenting programs Depression prevention	\$Preschool programs (early childhood development) \$Prevention of conduct disorder \$Multisystemic therapy for juvenile offenders Detection of and care for the victims of intimate partner violence
SDOH	\$Healthy employment programs \$*Insulating homes Housing ventilation for asthma Community falls prevention	
Environmental determinants	\$*Road traffic injury prevention \$*Active transport \$*Safe green spaces \$*Heat wave plan	\$Removal of lead and mercury \$Chemical regulation

\$Indicates ROI, cost-effective otherwise

**Contribute to wider aspects of sustainability including economic, social and environmental benefits*

Caveat: economic assessment underestimates benefit

Economic assessment captures only a partial picture of the full benefits of this type of integration and the effects are likely underestimated. However, by preventing disease from occurring in the first place and promoting a healthy population overall, this option is expected to have a greater impact on health care sustainability than downstream integration. In addition, efficiencies can be further increased by clustering a variety of cost-effective approaches. For example, safe urban design initiatives can involve clustering of safe green spaces, safer driving and active transportation (12). Unlike downstream intervention, this impact is not limited to those at risk for disease, but the generations to follow who are raised in healthy communities with equitable opportunities to achieve a healthy life. By extension, this option is expected to have a greater impact on Ontario's economy relative to downstream integration.

Options: risks

I. Downstream integration

Experience from other provinces and countries have brought several risks to light when this option is exercised. Integration can bring public health into the area of population health management by using population health-based analytics to predict, plan for and manage local patient needs and service requirements. This requires dedicated health authority leadership combined with strong public health leadership and capacity. The latter has been shown to be particularly at risk from integration in the form of (1) reduced public health capacity in both adequate personnel and funding, and (2) too great of a focus on clinical, downstream work (13).

One common scenario is referred to as the “tyranny of acute” where immediate and expensive acute care services pull funding from public health. This impairs the ability of public health to promote a population-based approach and limits the ability of public health to participate in health system decision making and in other sectors that influence health (13). This also risks the creation of a “false economy” where cuts to public health save money in the short term, but whose decreased capacity and function increase the bill further down the line (14). For example, cuts proposed to the UK’s public health system are expected to “save” £200m on health care in the short-term, but will cost the National Health Service £1 billion in the long-run through the loss of important public health functions.

In addition, this option focuses on clinical treatment, re-orienting public health away from health prevention and promotion and the valuable non-health care sector partnerships formed by public health. In some cases, public health has been actively discouraged from maintaining these partnerships. These relationships are also placed at risk in the case of geographical misalignment between public health and health authorities (13,15).

As summarized in one paper, when working too far downstream, public health integration in health care risks “practicing population health one patient at a time” (16).

II. Upstream with collaboration:

Risks associated with upstream work include the reliance on multiple sectors acting together to effect changes in population health. These partnerships can take time to develop and are subject to changes in partners’ capacities and funding. This includes public health’s own funding from provincial and municipal sources. Local public health in Ontario currently receives less than 2% of the provincial MOHLTC budget and the current funding formula does not assess funding needs (i.e. the size of the public health “pie”) but rather how the pie should be sliced between health units. The formula results in many public health units facing a provincial funding freeze affecting their ability to effectively address upstream determinants of health.

While there are short-term investments to be made in public health as highlighted in previous sections, those that require long-term investment require long-term political will extending beyond election cycles. These can be invested in by one government but the impacts are reaped by its successor. This can negatively impact political will in investing in public health. However, perspectives may depend on how one measures the success of an intervention. For example, a public health intervention can reduce

demand on acute care over the short term with an ROI yielded in the long-term. The short-term outcomes can be counted as “successful” by reducing emergency department wait times or freeing-up staff and health care resources for other priorities (17).

Finally, upstream work is complex and involves many moving parts, potentially leading to paralysis in action at the provincial level. Specific actions have therefore been highlighted in Table 2 to show how health promotion and prevention has been acted upon at the upstream level.

Options: summary and recommendation

The status quo is an untenable situation for our province’s health care system. Poor health outcomes harm the economy through decreased worker productivity. The opportunities for health are not the same for all Ontarians and it is particularly the socioeconomically disadvantaged who will be unable to participate and benefit from the returns of Ontario’s economy.

Downstream integration of public health with health care has the potential to result in quality health care that is cost-effective, sustainable and may contribute to Ontario’s economy. The risks seen in this kind of integration, however, have resulted in public health capacity and resource limitations in the face of growing acute care costs. Furthermore, barriers have been faced in achieving and maintaining effective partnerships outside of the health care sector. Ontarians have already experienced the costs of inadequate public health leadership and capacity. The SARS pandemic highlighted the consequences of facing a public health emergency with diminished public health infrastructure, coordination and leadership and why greater investment in public health was needed (18).

Upstream work with collaboration between public health and both health care and non-health sectors focusing less on health care quality, but yielding cost-benefits both in and outside of the health care sector. While this work relies on multi-sector collaborations and often on long-term investments, the gains from this strategy contribute to long-term sustainability and a healthy economy to be enjoyed all Ontarians regardless of age, orientation or socioeconomic stats. Recalling that health care accounts for less than a quarter of health while the SDOH account for the majority, upstream work with collaboration produces equitable health gains at a greater magnitude than can be expected with downstream integration of health care.

Overall, while there may be value in orienting public health to informing public health care planning and effective screening and treatment programs, its most valuable work lies upstream. This is our recommended investment priority.

Managing the Investment

Evidence-informed public health system elements associated with improved performance (productivity and efficiency) include:

1. Financial resources: for example, 10% increase in local public health spending significantly associated with decreased mortality of between 1.1% and 6.9%
2. Workforce: for example, increase in local public health staffing significantly associated with decreased cardiovascular mortality
3. Population size: the size of the jurisdiction served by a public health agency is the strongest predictor of performance in delivering essential public health services
4. Organizational structure: these include workforce development, leadership, organizational climate and culture, inter-organizational relationships and partnerships, and financial processes (19).

We stress evidence-informed as the experience with other provincial jurisdictions have cut public health capacity without considering these factors (19,20).

Specific to the context of the *Patients First Act*, effective upstream work with collaboration includes maintaining independent public health governance, protecting public health funding, strengthening the Ontario Public Health Standards, aligning geographical boundaries, formalizing the relationship between Local Health Integration Networks and non-health care partners, increasing the capacity for population health planning and implementing accountability measures for population health and equity (13). Equity includes not only access to health care, but to the SDOH that account for at least half of what contributes to the health of Canadians. This includes, for example, stratifying instead of controlling for socioeconomic status to help highlight and act on health inequities (21).

This concludes the pre-budget consultation on investing in public health in Ontario.

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2017 alPHa ANNUAL CONFERENCE

“Driving the Future of Public Health”

June 11 – 13

***Chatham-Kent John D. Bradley Convention Centre
565 Richmond Street, Chatham, Ontario***

This package contains the following information:

- Notice of the 2017 alPHa Annual General Meeting
- Call for 2017 alPHa Resolutions
- Call for 2017 alPHa Distinguished Service Awards
- Call for Board of Health Nominations to the alPHa Board of Directors.

N O T I C E

2017 ANNUAL GENERAL MEETING

NOTICE is hereby given that the 2017 Annual General Meeting of the **ASSOCIATION OF LOCAL PUBLIC HEALTH AGENCIES** will be held at the Chatham-Kent John D. Bradley Convention Centre, 565 Richmond St., Chatham, Ontario on **Monday, June 12, 2017 at 8:00 AM** at the *2017 Annual Conference*, for the following purposes:

1. To consider and approve the minutes of the 2016 Annual General Meeting in Toronto, 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 2016-2017;
4. To appoint an auditor for 2017-2018; and
5. To transact such other business as may properly be brought before the meeting.

DATED at Toronto, Ontario, January 30, 2017.

BY THE ORDER OF THE BOARD OF DIRECTORS.



Linda Stewart
Executive Director

Call for Resolutions

alPHA members are invited to submit resolutions for consideration at the 2017 alPHA Annual General Meeting & Resolutions Session during the Annual Conference in June.

It is important that resolutions are drafted using the "**Procedural Guidelines for alPHA Resolutions**" found by [clicking here](#).

We request that resolutions be limited to **one** operative clause per issue (other than specific directions on whom to advise) to allow for focused advocacy and monitoring.

Who may submit?

- a member board of health
- a Section Executive Committee, or general meeting of a Section
- the alPHA Board of Directors, its Executive Committee or a Standing Committee of the Association; or
- an Affiliate member organization

What is required?

- resolutions must first be endorsed by a properly constituted body, i.e. a board of health, a Section of alPHA, etc.
- a covering letter specifying your submission must accompany the resolution(s)
- proper formatting according to procedural guidelines, including clearly-worded introductory and operative clauses
- any concise background material to help prepare members voting on the issue

When is the deadline to submit?

- ***Friday, April 21, 2017, 4:30 PM for all resolutions that do not request a change in alPHA's Constitution.***
- ***For resolutions to amend the alPHA Constitution, the deadline is April 6, 2017, 4:30 PM.***
- Taking into account that a late resolution may be necessary in response to a current event, you may bring a late resolution to the 2017 Resolutions Session. These late resolutions, however, will not have the benefit of being reviewed by alPHA's Executive Committee and there will be a vote during the Resolutions Session to determine if the membership will consider late resolutions. If the vote is successful, your resolution will be brought forward and considered.

When will resolutions be debated by the alPHA membership?

- There will be a special session to consider resolutions on June 6 immediately following the 2016 Annual General Meeting.

How may I submit the resolutions?

- only electronic submissions in MS Word will be accepted; [click here](#) to download a template.
- e-mail to: Susan Lee, Manager, Administrative & Association Services, alPHA
susan@alphaweb.org

CALL FOR NOMINATIONS

alPHa Distinguished Service Award

The Distinguished Service Award (DSA) is awarded annually by the Association of Local Public Health Agencies to individuals in recognition of their outstanding contributions made to public health in Ontario.

How many awards are given yearly?

- One award per Section and Affiliate organization may be presented in any given year.
- On occasion, an award may be given to individuals outside alPHa for their contributions to public health.

Who is eligible to receive the DSA?

- Members of alPHa who fall under the following categories are eligible:
 - an elected/appointed member of a local board of health or regional health committee;
 - a medical officer of health or associate medical officer of health;
 - one of alPHa's seven affiliated organizations (i.e. AOPHBA, APHEO, ASPHIO, HPO, OAPHD, OPHNL, OSNPPH).
- An individual outside the alPHa membership who has made outstanding contributions to public health in Ontario.

Who deserves the DSA?

- Eligible recipients have:
 - demonstrated exceptional qualities of leadership in his/her own milieu;
 - achieved tangible results through lengthy service and/or distinctive acts; and
 - displayed exemplary devotion to public health at the provincial level.

What are the eligibility criteria for nominees?

- Nominees:
 - currently hold a position of significant responsibility in one of alPHa's member agencies (i.e. board of health/local public health unit/affiliated organization) and have been a member in alPHa for at least three years; and
 - have been nominated by at least three voting members from the **nominee's Section or Affiliate organization** who are in good standing of alPHa.

- Note:
1. good standing refers to members who have paid their membership dues;
 2. voting members are individuals representing a member health unit. These individuals include board of health chairs, medical and associate medical officers of health, representatives appointed to the alPHa Board of Directors by the seven alPHa Affiliate organizations.

continued on next page

Who can nominate?

- Any member of alPHA including Board of Health members, medical and associate medical officers of health, and Affiliate representatives may nominate. Please note that three Section or Affiliate members of alPHA must sign the nomination form.
- In the case of nominations of *non-members of alPHA*, nominations must come from any three active members of alPHA; only alPHA members may nominate potential candidates.
- The Award is presented on behalf of each of alPHA's various membership groups, i.e. the Boards of Health Section, Council of Ontario Medical Officers of Health (COMOH), and the seven Affiliate organizations of alPHA. **Therefore, nominations must be issued by the nominee's Section or Affiliate organization** (i.e. nominations of Board of Health members must come from the Board of Health Section; nominations of medical/associate medical officers of health must come from the Council of Ontario Medical Officers of Health; and nominations of senior public health staff must come from the nominee's respective Affiliate organization). If you want to recommend an individual for nomination by their Section or Affiliate organization, please contact the Chair or President of the respective Section or Affiliate organization.

What material must accompany the nomination form?

- Include signatures of the nominator and two other supporting voting members of alPHA.
- Include a **cover letter explaining why the nominee is deserving of this award** must be included with the form. Since the members of the Selection Committee more than likely will not know the nominee, they will base their assessment on what is conveyed to them in the cover letter. The letter should tell the Selection Committee what the nominee has achieved and why it is outstanding.
- A service record or curriculum vitae must also accompany the nomination form and could include the following:
 - personal achievements at the local level;
 - special or distinctive services on behalf of public health provincially;
 - leadership and contributions on behalf of alPHA and/or one of its Sections; an affiliated organization; or a provincial public health organization

Where should I send the nominations to?

- Nomination forms along with all relevant accompaniments should be e-mailed to Susan Lee, Manager, Administrative and Association Services, alPHA, at susan@alphaweb.org

When is the deadline to submit nominations?

- **Friday, April 7, 2017, 4:30 PM**

Who selects the DSA recipients?

- All nominations are reviewed by the Executive Committee of alPHA.
- In the event of a tie, the alPHA Board of Directors will determine the Award recipient.

How are Award recipients notified?

- Award recipients are notified in writing by alPHa approximately one month prior to the conference date.
- Award recipients are invited to attend as guests of the association at the Annual Awards Banquet, which is held in conjunction with the Annual Conference.

Who can I contact if I have further questions on the Awards?

- Susan Lee, Manager, Administrative and Association Services, alPHa
 - tel: (416) 595-0006 ext. 25
 - e-mail: susan@alphaweb.org

CALL FOR BOARD OF HEALTH NOMINATIONS 2017-2018 & 2018-2019 alPHa BOARD OF DIRECTORS



*alPHa is accepting nominations for **three** Board of Health representatives from the following regions for the following term on its Board of Directors:*

<ol style="list-style-type: none"> 1. Central West 2. South West 3. East 	2 year term <i>(i.e. June 2017 to June 2018 and June 2018 to June 2019)</i>
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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 representatives will be held at the Boards of Health Section Meeting on June 13 during the 2017 alPHa Annual Conference, Chatham-Kent John D. Bradley Convention Centre, 565 Richmond St., Chatham, Ontario.

*Nominations close **4:30 PM, Thursday, June 1, 2017.***

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 **June 1, 2017**.

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 **three** Board of Health representatives to fill positions on its 2017-2018 and 2018-2019 Board of Directors from the following regions and for the following terms:

1. Central West 2. South West 3. East	2 year term (i.e. June 2017 to June 2018 and June 2018 to June 2019)
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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 West Region

Boards of health in this region include:

Brant
(Haldimand-Norfolk)
Halton
Hamilton
Niagara
Waterloo
Wellington-Dufferin-Guelph

South West Region

Boards of health in this region include:

Chatham-Kent
Elgin St. Thomas
Grey Bruce
Huron
Lambton
Middlesex-London
Oxford
Perth
Windsor-Essex

Continued on next page

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 2017-2018 & 2018-2019

_____, 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*):

- ☐ **Central West Region (2 year term)**
- ☐ **South West Region (2 year term)**
- ☐ **East 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:

1. Nominations close **4:30 PM, June 1, 2017** and must be submitted to alPHA by this deadline.
2. 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.
3. E-mail the completed form, biography and copy of Board motion by **4:30 PM, June 1, 2017** to Susan Lee at susan@alphaweb.org

APPROVAL OF CONSENT AGENDA

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

February 2, 2017

Dr. David Williams
Chief Medical Officer of Health
Ministry of Health and Long-Term Care
393 University Avenue, 21st Floor
Toronto, ON M5G 2M2

Dear Dr. Williams:

Re: Provincial Opioid Action Plan

At its January 11, 2017 meeting, the Board of Health for Peterborough Public Health endorsed the enclosed motion from the Middlesex London Health Unit regarding “Opioid Addiction and Overdose” which identified opioid misuse as the third leading cause of accidental death in Ontario. We have written to the Registrar of the College of Physicians and Surgeons of Ontario regarding the safer prescribing of opioids by physicians. Coroner’s data and our own local police indicate that in addition to prescription opioid harms, we are also witnessing an increase in deaths from the illicit use of fentanyl. We understand that recreational drug users can often take fentanyl unknowingly as it can contaminate other street drugs in Canada.

We are writing to you, as the Province’s first Provincial Overdose Coordinator, to congratulate you for your leadership on this important issue. We are encouraged to see that Ontario is taking a comprehensive approach to deal with this serious public health threat. We were heartened by the release of a provincial strategy in October that would address prescribing of opioids, the treatment of pain and addictions, and the enhancement of harm reduction efforts. Here in Peterborough, we now have 7 pharmacies participating in the Naloxone program, as well as our own Take Home Naloxone program, that we provide through partnerships with our needle exchange and community addiction treatment agencies. Through efforts of our Municipal Drug Strategy, our hospital will be offering Naloxone to anyone presenting in the Emergency Department with an opioid-related overdose, starting very soon.

The risk of overdose is high and climbing, and there is much work to be done at every level, whether it is local, provincial, national or international. We were pleased to see the specific commitments made by Ontario in the Joint Statement of Action to Address the Opioid Crisis. We would appreciate having access to an updated provincial action plan, with targets, deliverables and timelines, that is supported by regular communication to stakeholders and partners like our board of health. One cannot underestimate the role and power of communications if we hope to turn this opioid crisis around and prevent the suffering and harm being experienced in jurisdictions like British Columbia and elsewhere.

We thank you for your attention to opioids as a public health risk that can and must be prevented, wherever possible. We hope that our request for more transparent and routine communications is something which can be accommodated and addressed. We look forward to all and any updates from our provincial colleagues, partners and leaders.

Yours in health,

Original signed by

Mayor Mary Smith
Chair, Board of Health

/ag
Encl.

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

GREATER SUDBURY

2016 Progress Report

Substance misuse is changing lives and impacting our community. News reports and headlines have focused on new and emerging substances, opioid addiction and overdose, and upcoming plans to legalize marijuana. These are just some of the many challenges facing our community.

Since its endorsement in October 2015, the Community Drug Strategy for the City of Greater Sudbury has been making a difference in our community. The following inaugural milestones were achieved in its first full year:

- + Launching the **www.takeactionsudbury.ca** / **www.agissonsudbury.ca** website and the Call to Action video.
- + Developing an evaluation and monitoring plan to better understand the process, outcomes, and impact of the work of the Drug Strategy.
- + Receiving a Civil Remedies grant through the Ministry of the Attorney General, which supported community initiatives, educational activities, and the development of the website and video for the Drug Strategy.
- + Responding to local and national media inquiries on substance related issues such as the evolving opioid crisis, needle kiosks, and other drug concerns.
- + Undertaking advocacy efforts with local, provincial, and federal decision makers around addressing substance use.
- + Issuing Drug Information and Drug Alert bulletins on the website and to community partners.



The 2016 Progress Report highlights the concerted efforts of community stakeholders, including, but not limited to, enforcement partners, public health, health care workers, physicians, pharmacists, addictions counsellors, social workers, and community advocates. The Progress Report also demonstrates how activities have reached thousands of people in Greater Sudbury.



A strategy built on strong foundations

The Community Drug Strategy is built on **five foundations**. Below are highlights of the work and activities accomplished within each foundation in 2016.



Health Promotion and Prevention of Drug Misuse

Throughout the year, presentations to professionals, community members, interest groups, and students brought messaging about substance misuse prevention and substance use issues to over 1 000 people in the Sudbury area.

- + Singer, Stephen Page, presented his own struggles with depression as guest speaker for the Dr. Dan Andreae Distinguished Presidential Lecture Series, and supported mental health awareness events encouraging others to share their stories and seek help.
- + Dr. Wayne Hammond spoke to 150 professionals in Sudbury about using a strengths-based approach when working with youth.
- + Chris Cull, who is in recovery from an opioid addiction, shared his inspirational story of recovery and advocacy at two events held in conjunction with the Sudbury Alcohol and Drug Concerns Coalition—one for 25 health care professionals and another for 60 members of the public.
- + Dr. Jeff Turnbull from Ottawa Inner City Health and Health Quality Ontario spoke with health

care professionals about harm reduction programming and ways to promote equitable access to harm reduction and treatment services.

With Greater Sudbury Police Service taking the lead, the Prescription Drug Drop-off Day was an outstanding success.

Approximately **270 lbs. of unused medication** from **141 people** was collected through **35 pharmacies**.



This greatly reduced the amount of unused drugs from potentially being misused or improperly disposed.



Enforcement and Justice

- + Discussions continue toward developing a special court for offences related to substance misuse.
- + 310 drug offenses were laid (2016).

Greater Sudbury Police Service drug seizures

= \$1.5 million (2016)





Treatment

Greater Sudbury Paramedic Services responded to



343

calls for drug overdoses



592

calls related to alcohol intoxication (Greater Sudbury Paramedic Services, 2016)

- + Monarch Recovery Services (MRS) now offers a new intensive men's day treatment program. Wait times for women's residential treatment programs at MRS was 83 days. (MRS, 2016)
- + Wait times to initiate outpatient addictions treatment at Health Sciences North (HSN) was 12 days for adults and 11 days for youth in 2016. (HSN, 2017)
- + The Rapid Access Addictions Management (RAAM) Clinic offered by HSN provided services to

72 individuals through a total of 221 visits, providing early, assertive treatment to help manage cravings and withdrawal symptoms from alcohol and opioid addiction. (HSN, 2016)

- + Emergency Medical Services and HSN implemented a new protocol that successfully diverted 170 people directly to Withdrawal Management Service bypassing the emergency department to promote access to timely and appropriate care.
- + The North East Local Health Integration Network released the NE LHIN Addictions Services Review which was read and will be considered for future planning.
- + Through HSN, over 100 health care professionals received training on the use of evidence-based protocols and strategies to treat and manage withdrawal symptoms from opiates and alcohol.



Harm Reduction

- + In 2016, just over **800 000 sterile needles** were distributed for use by people who inject drugs.
 - + The Sudbury & District Health Unit (SDHU) added two new needle exchange program sites (in the Rainbow Mall and at 1300 Paris Street), and the Sudbury Action Centre for Youth continued to be a program site. Réseau ACCESS Network, and the Ontario Aboriginal HIV/AIDS Strategy continued to provide supplies.
- + Free standing needle kiosks provide a safe and anonymous way for people to dispose of used syringes. Three were installed in Sudbury at the following sites:
 - Junction Creek trail near Hnatyshyn Park
 - two at the SDHU's Paris Street site
 More kiosks have been purchased and will be installed at various locations.

- + Naloxone is a medication that can be safely administered to reverse a potentially lethal opioid overdose.
 - + Réseau ACCESS Network **trained 123 individuals** in the community on overdose prevention and response, and **distributed 56 naloxone kits**.
- + Through the Ontario Naloxone Pharmacy Program, pharmacists can now provide naloxone kits without a prescription and at no cost to eligible Ontarians.
- + Under the leadership of the Canadian Mental Health Association (CMHA), Sudbury's Harm Reduction Home day program is running at capacity serving the needs of chronic substance users.
- + CMHA opened the Off the Street Emergency Shelter.



Sustaining Relationships

Building the community's capacity to work on substance misuse issues included:

- + Liaising and offering support to local school boards and post-secondary institutions.

- + Supporting local community groups to bring educational events to Sudbury.
- + Liaising with local Alcoholics Anonymous and Narcotics Anonymous groups.
- + Liaising with local agencies to raise awareness of the Community Drug Strategy.

A look ahead

In 2017, the Strategy will continue to do work within its five foundations, while monitoring the development of government legislation and policies. The Strategy will continue to advocate for enhanced addiction services for people in need at a local, provincial, and federal level, and will emphasize the prevention of drug use.

Substance misuse affects everyone. We encourage your organization or group to be aware of substance misuse and become involved in Drug Strategy programming.

Make 2017 your time to:

- + Learn about drugs that are commonly misused.
- + Talk to your family and neighbours about what you have learned.
- + Dispose of any old or unused medications.
- + Get involved. Your ideas can help find solutions to prevent the initiation of and the harms associated with drug use.
- + Let people know that you care, if you are concerned about their use of substances.
- + Seek professional help for substance misuse for yourself or someone you love.

People who live the experience of substance use are a great resource for this Strategy as we strive to improve support and services. The Strategy is grateful to these individuals who have offered their insights to enhance the Community Drug Strategy.

Together, we will continue to make a difference.



Visit **www.takeactionsudbury.ca** for more information and a list of steering committee partner agencies who have led this work in 2016.

OPIOID USE IN SUDBURY & DISTRICT

MOTION: WHEREAS the Sudbury & District Board of Health is alarmed by the rise in opioid-related harms as evidenced by a tripling of the number of opioid prescriptions in Canada over the past decade and the growing number of opioid-related poisonings presenting to Ontario emergency departments; and

WHEREAS within Greater Sudbury indicators of harmful opioid use exceed those for the province, including the rates of opioid users, opioid maintenance therapy use, high strength opioid use, opioid-related emergency department visits, hospital visits and hospital deaths; and

WHEREAS federal and provincial governments have signed a Joint Statement of Action committed to addressing the burden of opioid-related harms in Canada and, recently, Ontario announced a provincial opioid strategy that includes modernizing opioid prescribing and monitoring, improving the treatment of pain and enhancing addiction supports and harm reduction; and

WHEREAS the Community Drug Strategy for the City of Greater Sudbury, of which the Sudbury & District Health Unit is a leading member, supports Ontario's opioid strategy and is committed to implementing the strategy within the local context;

THEREFORE BE IT RESOLVED the Sudbury & District Board of Health congratulate the Ontario Minister of Health and Long-Term Care and the Chief Medical Officer of Health, as the province's first Provincial Overdose Coordinator, and request that the new provincial plan be further developed with targets, deliverables and timelines that are supported by regular communication to stakeholders and partners such as boards of health; and

FURTHER THAT the Sudbury & District Board of Health urge the federal Minister of Health to similarly communicate and promptly implement the federal opioid strategy.

Briefing Note

To: René Lapierre, Chair, Sudbury & District Board of Health
From: Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer
Date: February 9, 2017
Re: Part VIII - Ontario Building Code Fee Increases

☐ For Information

☐ For Discussion

☒ For a Decision

Issue:

In order to administer the Part VIII (Sewage System) Ontario Building Code program on a cost-recovery basis, it is necessary for the Sudbury & District Health Unit to increase program user fees.

Recommendation:

That the Board of Health approve the proposed increase in Part VIII – Ontario Building Code fees as outlined within Schedule “A” to Board of Health By-Law 01-98.

Background:

The Sudbury & District Health Unit is mandated under the Ontario Building Code (O. Reg. 332/12), under the Building Code Act to enforce the provisions of the Act and the Building Code pertaining to sewage systems.

Under the authority of the Ontario Building Code, the Health Unit collects fees for Part VIII permits and services in order to recover costs associated with administration and enforcement of the Act.

The current user fees have been in place since 2011. The proposed fee increases are necessary in order to address increasing program operation and delivery costs. The proposed fee increases are in line with those of other Northern Ontario health units.

In accordance with Building Code requirements, staff have held a public meeting and have notified all contractors, municipalities, lawyers, and other affected individuals of the proposed fee increases.

The proposed fee increases represent the first of a proposed two-phase plan to increase Part VIII user fees. The second phase of proposed fee increases will be of the same amount as those included within the first phase. The need for implementation of this second phase in 2018 will be determined through the 2018 budgeting process.

¹ Strategic Priorities:

1. Champion equitable opportunities for health in our communities.
2. Strengthen relationships with priority neighbourhoods and communities and strategic partners.
3. Strengthen the generation and use of evidence-informed public health practices.
4. Support community voices to speak about issues that impact health equity.
5. Maintain excellence in leadership and agency-wide resource management as key elements of an innovative learning organization.

Financial Implications:

Increase revenue from Part VIII fees will enable the Health Unit to administer the program on a cost-recovery basis.

Contact:

Stacey Laforest, Director, Environmental Health Division

¹ Strategic Priorities:

1. Champion equitable opportunities for health in our communities.
2. Strengthen relationships with priority neighbourhoods and communities and strategic partners.
3. Strengthen the generation and use of evidence-informed public health practices.
4. Support community voices to speak about issues that impact health equity.
5. Maintain excellence in leadership and agency-wide resource management as key elements of an innovative learning organization.

O: October 19, 2001
R: February 2010

Sudbury & District Health Unit Board of Health Manual

Information

Category: Board of Health By-Laws
Section By-laws
Subject: By-law 01-98
Number: G-I-50
Approved By: Board of Health
Original Date March 26, 1998
Revised Date: ~~February 16, 2017~~ June 18, 2015

Information

Being a By-law of the Board of Health of the Sudbury & District Health Unit Respecting Construction, Demolition, Change of Use Permits, Inspections and Fees Related to Sewage Systems

WHEREAS the Board of Health of the Sudbury & District Health Unit is responsible for the enforcement of the provisions of the *Building Code Act* and Regulations related to sewage systems;

AND WHEREAS the Board of Health is empowered pursuant to Section 7 of the *Building Code Act* to make by-laws respecting sewage systems;

NOW THEREFORE the Board of Health of the Sudbury & District Health Unit hereby enacts as follows:

Short Title

This by-law may be cited as “the Sewage System By-law”.

Definitions

In this By-law,

- a) “Act” means the *Building Code Act, 1992*, and attendant O. Reg. 332/12 including amendments thereto.

- b) **“applicant”** means the owner of a building or property who applies for a permit or land use planning report or any person authorized in writing by the owner to apply on the owner’s behalf, or any person or corporation empowered by statute to cause the demolition of a building or buildings and anyone acting under the authority of such person or corporation.
- c) **“as constructed plans”** means as constructed plans as defined in the Building Code.
- d) **“Board of Health”** means the Board of Health of the Sudbury & District Health Unit.
- e) **“building(s)”** means a building as defined in Section 1(1) of the Building Code.
- f) **“Building Code”** means the regulations made under Section 34 of the Act.
- g) **“Notice of Substantial Completion”** relates to the day on which a sewage system has been completed and is ready for a final inspection before backfilling.
- h) **“sewage system inspector”** means an inspector appointed by the Board of Health under Section 3(2) of the Act.
- i) **“permit”** means written permission or written authorization from the Chief Building Officer to perform work regulated by the Act, this By-law, and the Building Code.
- j) **“permit holder”** means the person to whom the permit has been issued and who assumes the primary responsibility for complying with the Act, the Building Code and this By-law.
- k) **“plumbing”** means plumbing as defined in Section 1(1) of the Act.
- l) **“renovation”** means the extension, alteration or repair of an existing building or sewage system or the change in use or part of the use of an existing building or sewage system.
- m) **“repair requiring permit”** means the replacement of a treatment unit or the replacement or alteration of materials in a leaching bed or any component contained therein.
- n) **“sewage system”** means sewage system as defined in Section 1(1) of the Act.
- o) **“sewage system permit”** means a building permit as defined in Section 8(1) of the Act for the purposes of this By-law.

Terms not defined in this By-law shall have the meaning ascribed to them in the Act or the Building Code.

Classes of Permits

Classes of permits required for the construction, demolition or change of use of a sewage system or for the renovation of an existing building or sewage system are set forth in Schedule "A" attached hereto and forming part of this By-law.

Permit Applications

To obtain a permit, an applicant shall file an application in writing by completing the form(s) prescribed and available from the Chief Building Inspector and satisfy the following:

- 1) Where application is made for a sewage system permit under subsection 8(1) of the Act, the application shall:
 - a) identify and describe in detail the work, use and occupancy to be covered by the permit for which application is made;
 - b) identify and describe in detail the existing use(s) and the proposed use(s) for which the premises are intended;
 - c) include complete plans and specifications as described in this By-law for the work to be covered by the permit and show the occupancy of all parts of the building;
 - d) include the legal description, municipal address and where appropriate the unit number of the land on which the work is to be done;
 - e) be accompanied by the required fees as calculated with Schedule "A";
 - f) state the name, address and telephone number of the owner, and if the owner is not the applicant, the applicant's name, address and telephone number and the signed statement of the owner consenting to the application;
 - g) where applicable, state the name, address and telephone number of the architect, engineer or other designer, and the constructor or person hired to carry out the construction or demolition;
 - h) where any person named in clause (g) requires a license under the Act or Building Code, include the number and date of issuance of the license and the name of the qualified person supervising the work to be covered by the permit;
 - i) when Section 2.3 of the Building Code applies, be accompanied by a signed acknowledgement of the owner that an architect or professional engineer, or both, have been retained to carry out the general review of the construction or demolition of the sewage system;
 - j) when Section 2.3 of the Building Code applies, be accompanied by a signed statement of the architect or professional engineer, or both, undertaking to provide a general review of the construction or demolition of the sewage system;

- k) include the applicant's registration number where the applicant is a builder or vendor as defined in the Ontario New Home Warranties Plan Act;
 - l) include, as the Chief Building Inspector deems necessary, proof of the zoning and permitted uses applicable to the land on which the work is to be done; and
 - m) be signed by the applicant who shall certify as to the truth of the contents of the application.
- 2) Where application is made for the demolition of a sewage system under subsection 8(1) of the Act, the application shall:
- a) contain the information and other requirements provided in subsection 4(1), and;
 - b) be accompanied by satisfactory proof that arrangements have been made with the proper authorities for the termination and capping of the appropriate utilities and for the removal and disposal of the sewage system components.
- 3) Where application is made for a renovation to an existing building under the Act and Building Code, the application shall:
- a) contain the information and other requirements provided in subsection 4(1), and;
 - b) include plans and specifications which show the current and proposed occupancy of all parts of the building, and which contain sufficient information to establish compliance with the requirements of the Building Code, including floor plans, and detailed information respecting the existing sewage disposal system and prior permits.
- 4) Inspections will be carried out on properties that are identified under the mandatory maintenance inspection program according to section 1.10.2 of Division C, Part 1 of the Ontario Building Code and a fee will be charged as noted in Schedule "A".
- 5) Where compliance with all the requirements for a permit application is unnecessary or unreasonable, the Chief Building Inspector may, in cases where he or she deems appropriate, authorize deletion of one or more of the requirements provided the intent and purpose of this By-law is maintained.
- 6) Where an application for a permit remains incomplete or inactive for six (6) months after it is made, the application may be deemed by the Chief Building Inspector to have been abandoned and notice thereof shall be given to the applicant.

Plans, Specifications, Documents and Information

- 1) Every applicant shall furnish sufficient plans, specifications, documents and other information to enable the Chief Building Inspector to determine whether the proposed construction, demolition, change of use or occupancy conforms to the Act, the Building Code and any other applicable law including, without limiting the generality of the foregoing:

- a) zoning approval from the applicable Planning Authority;
- b) plans that are legible and drawn to scale on paper, cloth or other suitable and durable material;
- c) documents submitted that are legible;
- d) if applicable, Conservation Authority or Ministry of Natural Resources approval.

Site plans submitted should be referenced to a current survey certified by a registered Ontario Land Surveyor and a copy of the survey shall be filed with the Chief Building Inspector, if deemed necessary.

Site Plans shall show:

- a) lot size and dimensions of the property;
- b) setbacks from existing and proposed buildings to the property boundaries and to each other;
- c) setbacks from existing and proposed wells, including wells on adjacent properties;
- d) setbacks from property boundaries, lakes, rivers, streams, reservoirs, ponds and water drainage courses;
- e) the location of any unsuitable, disturbed or compacted areas;
- f) proposed access routes for system maintenance and proposed parking areas;
- g) culverts, drainage patterns and swales;
- h) existing and proposed utility corridors, whether above or below grade;
- i) existing right-of-ways, easements and crown reserves;
- j) the legal description of the property, and if available, the municipal address.

Specifications submitted shall be based on a site specific evaluation of the property and soils and shall include:

- a) depth of existing soils to bedrock;
- b) depth of soils to groundwater table;
- c) soil properties including soil percolation test results and/or soil permeability as determined by a grain size analysis utilizing the Unified Soil Classification System;
- d) soil conditions, including the potential for flooding;

- e) soil profiles as determined by test pits excavated in the area of the proposed leaching bed;
- f) where the applicant is proposing a raised or partially raised leaching bed, specifications on the amount of fill required, the dimensions of the area to be filled and the soil properties as noted in subsection 3(c);
- g) detailed specifications on the type of sewage system proposed, the size of the sewage system proposed and detailed design drawings;
- h) where deemed necessary by the Chief Building Inspector, a site plan shall include contour mapping, existing and finished ground elevations;
- i) an application for a Class 5 system shall be accompanied by evidence that confirms that the proposal is in compliance with the Building Code.

Equivalents

- 1) Where an application for a permit or for authorization to make a material change to a plan, specifications, document or other information on the basis of which a permit was issued, contains an equivalent material, system or system design for which authorization under Section 9 of the Act is requested, the following information shall be provided:
 - a) a description of the proposed material, system or system design for which authorization is requested;
 - b) any applicable provisions of the Building Code, and;
 - c) evidence that the proposed material, system or system design will provide the level of performance required by the Building Code.
 - d) the Chief Building Inspector reserves the right to have any application requiring authorization under Section 9 of the Act referred to the Building Materials Evaluation Commission for review.

Revisions to Permit

- 1) After the issuance of a permit under the Act, notice of any material change to a plan, specification, document or other information on the basis of which the permit was issued, must be given in writing to the Chief Building Inspector together with the details of such change which is not to be made without his or her written authorization;
- 2) The fees for revising a permit, reviewing new plans and repeating inspections shall be set out in Schedule "A" of this By-law.

Notice Requirements

- 1) Notices required by Section 10.2 (1) of the Building Code shall be given by the permit holder to the Director at least 5 business days in advance of the stages of construction specified therein.
- 2) A notice pursuant to clause (1) of this By-law is not effective until written or oral notice is actually received by the Chief Building Inspector, the sewage system inspector or designate.
- 3) Notice required upon completion of the sewage system Section 11 (4)a of the Building Code shall be in writing in a form designated by the Chief Building Inspector. The completion form shall be given to the Chief Building Inspector at least 10 days in advance of the intended use of the sewage system.
- 4) Where the applicant files a completion form with the Chief Building Inspector, the form shall:
 - a) indicate that the sewage system was backfilled, graded and seeded or sodded in accordance with the Building Code;
 - b) indicate the date on which the work was completed;
 - c) where the applicant has retained an architect or professional engineer, or both, to carry out the general review of the construction of the sewage system, contain the written opinion of the architect or engineer that the completed work conforms to the Building Code;
 - d) be signed by the applicant who shall certify the truth of the contents of the information contained within the completion form;
 - e) where information is received by the Chief Building Inspector as required by this section, the Chief Building Inspector may, upon the signed recommendations of a sewage system inspector, deem that the requirements of the Building Code have been satisfied, without having an inspection conducted to verify the information;
 - f) the Chief Building Inspector may require that a set of as constructed plans of the sewage system or any part of the sewage system be submitted by the applicant.

Transfer of Permits

- 1) If the registered owner of the land to which the permit applies changes, the permit is transferable only upon the new owner completing a permit application, to the requirements of Section 4 of this By-law. The new owner shall then be the permit holder for the purposes of the Act and the Building Code and assume all responsibilities for compliance with the permit documents.
- 2) The fee for transferring a permit shall be set out in Schedule "A".

Refunds

- 1) No refund of fees shall be made once a site inspection for a permit or a land use evaluation has been carried out.
- 2) All requests for withdrawal of an application shall be in writing by the applicant.

Revocation

- 1) The Chief Building Inspector may revoke a permit subject to Section 8(10) of the Act or for an "N.S.F. Cheque" that was issued as payment of fees and notice thereof shall be given to the applicant.

Fees

- 1) The payment of fees for a permit or maintenance inspection shall be set out in Schedule "A" and are due and payable upon submission of an application or completion of inspection.
- 2) No permit shall be issued until the fees therefore have been paid in full.

Forms

The Chief Building Inspector shall be responsible for the development and maintenance of forms required for the sewage system program. Classifications of forms shall be set out in Schedule "B" of this By-law.

Offence/Penalty

- 1) Every person who contravenes any provision of this By-law is guilty of an offence.
- 2) Every person who is convicted of an offence is liable to a fine as provided for in the Provincial Offences Act, R.S.O. 1990, cP.33.

Policies and Procedures

- 1) The Board of Health of the Sudbury & District Health Unit shall from time to time establish policies and procedures related to sewage program activities as are appropriate.

Validity

Should any section, subsection, clause or provision of this By-law be declared by a Court of competent jurisdiction to be invalid, the same shall not affect the validity of this By-law as a whole or any part thereof, other than the part so declared to be invalid.

That this By-law shall come into force and take effect on the 6th day of April 1998.
Read and passed in open meeting this 26th of March 1998

Revised and passed by the Board of Health, Sudbury & District Health Unit this 27th day of May 1999.

Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 25th day of May 2000.

Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of February 2001.

Revised and passed by the Board of Health, Sudbury & District Health Unit this 19th day of February 2004.

Revised and passed by the Board of Health, Sudbury & District Health Unit this 17th day of June 2004.

Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of November 2007.

Revised and passed by the Board of Health, Sudbury & District Health Unit this 14th day of May 2009.

Revised and passed by the Board of Health, Sudbury & District Health Unit this 20th day of January 2011.

Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of February 2012.

Revised and passed by the Board of Health, Sudbury & District Health Unit this 20th day of February 2014.

Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of February 2017

SCHEDULE "A" TO BY-LAW 01-98

Cost Per Permit and Record

1) Sewage System Permits:

a) Class 2 Sewage System (Leaching Pit)	\$350.00 300.00
b) Class 2 Sewage System (more than 4 sites) (plus \$50 for each lot over 4)	\$1400.00 1200.00 \$100.00
c) Class 3 Sewage System (Cesspool)	\$350.00 300.00
d) Class 4 Sewage System (Septic Tank and Leaching Bed)	\$825.00 750.00
e) Class 4 Sewage System (Leaching Bed Only)	\$500.00 450.00
f) Class 4 Sewage System (Tank Only)	\$325.00 300.00
g) Class 5 Sewage System (Holding Tank)	\$825.00 750.00

2) Renovation Permit **\$300.00**

3) Demolition Permit ~~\$250.00~~**200.00**

4) Revisions to Permit (Inspection Required) ~~\$350.00~~**300.00**

5) Transfer of Permit to New Owner **\$100.00**

6) Extraordinary Travel Costs by Air, Water, etc. **Full Cost Recovery**

7) Sewage System Permits Re-Inspection ~~\$ 200.00~~**150.00**

Other Fees

Mandatory Maintenance Inspection	\$175.00
File Search	\$225.00 150.00
Consent Applications	\$225.00 200.00/lot
Minor Variance Applications	\$225.00 200.00
Copy of Record.....	\$65.00 50.00
Other Government Agencies	\$225.00 200.00

SCHEDULE "B" TO BY-LAW 01-98

Forms for Sewage Systems

1) Sewage System Permits:

- a) Application Form for a Sewage System Permit
- b) Inspection Reports

- c) Form Letters and Orders
 - d) Completion Notice Re: Readiness for Use of a Sewage System
- 2) Mandatory Maintenance Inspections
- a) Inspection Reports

AMMENDMENT TO FEE SCHEDULE “A” TO BY-LAW 01-98

MOTION: WHEREAS the Board of Health is mandated under the Ontario Building Code (O. Reg. 332/12), under the Building Code Act to enforce the provisions of this Act and the Building Code related to sewage systems; and

WHEREAS program related costs are funded through user fees on a cost-recovery basis; and

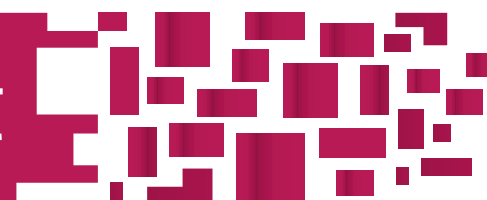
WHEREAS the fees charged by the Board of Health have not been increased since 2011; and

WHEREAS the proposed fees are necessary to address increased program associated operational and delivery costs;

THEREFORE BE IT RESOLVED THAT the Board of Health approve the amended fees within Schedule “A” and that the appendix of Board of Health By-law 01-98 be correspondingly updated; and

FURTHERMORE THAT this fee schedule shall come into effect immediately

2016 Performance Monitoring Report



Performance
Monitoring Plan

2013
2017

February 2017



Sudbury & District

Health Unit

Service de
santé publique

The 2016 Performance Monitoring Report has been compiled to provide the Board of Health with information about the Sudbury & District Health Unit's status in meeting various accountability measures, which are grounded within the 2013–2017 Strategy Map (see Strategy Map). This report provides evidence of our commitment to excellence and accountability, detailing performance in the following key areas:

Strategic Priorities: Narrative Report



The 2013–2017 Strategic Plan includes five Strategic Priorities that represent areas of focus that steer the planning and delivery of public health services, learning activities, and partnerships. Ongoing monitoring of the integration of the Strategic Priorities within SDHU programs or services provides an opportunity to gauge progress on these key areas.

SDHU-Specific Performance Monitoring Indicators Report



SDHU-Specific Performance Monitoring Indicators are meant to provide the Board of Health with information about the “current state” of key focus areas and to allow for monitoring of their progress year after year. Both individually and as a whole, the indicators demonstrate the SDHU's commitment toward performance excellence and its Vision of “Healthier communities for all”.

Ontario Public Health Organizational Standards Report



The Ontario Public Health Organizational Standards outline the expectations for the effective governance of boards of health and effective management of public health units. There are 44 requirements grouped within 6 standard categories. When implemented, they are essential to establishing consistent organizational processes, which in turn, facilitate desired program outcomes.

Public Health Accountability Agreement Indicators Report



The Ministry of Health and Long-Term Care (MOHLTC) has set out performance expectations for boards of health that includes a set of performance indicators. These are measured and monitored by the MOHLTC throughout accountability agreement periods and represent outcomes relating to the delivery of public health programs and services.

Reporting Timelines



* Includes Strategic Priorities Narratives “roll-up”, Ontario Public Health Organizational Standards Report, Public Health Accountability Agreement Indicators Report, and SDHU-Specific Performance Monitoring Indicators Report

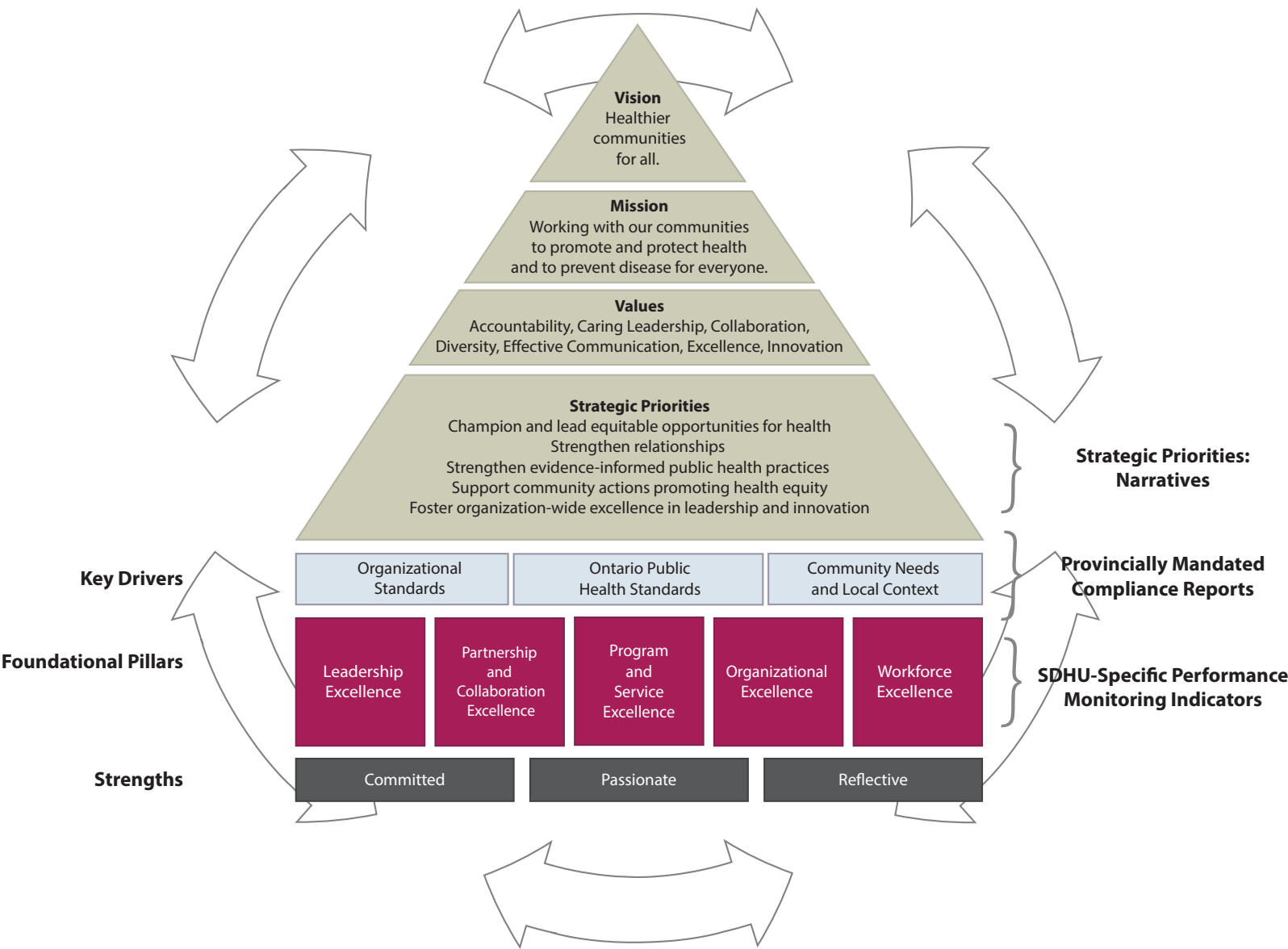
Executive Summary

Overall, the results of the report illustrate that the SDHU is meeting its performance monitoring goals. The measurement and monitoring strategies that are in place, and which are highlighted in the report, provide evidence for decision making and continuous quality improvement. Progress is continually monitored and adjustments to practice are made to ensure desired outcomes are achieved.

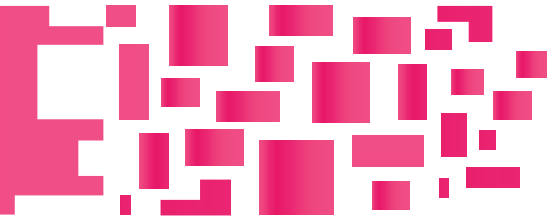
Key Findings

- 15 Strategic Priorities Narratives that highlight descriptive stories of SDHU programs and/or services that demonstrate the 5 Strategic Priorities “in action”
- On track with meeting the 13 SDHU-Specific Performance Monitoring Indicators
- Compliance with all 44 Ontario Public Health Organizational Standards
- Compliance with 11 of the 14 Performance Indicators as outlined by the Public Health Accountability Agreement with the Ministry of Health and Long-Term Care

Figure 1: Sudbury & District Board of Health Strategy Map 2013–2017

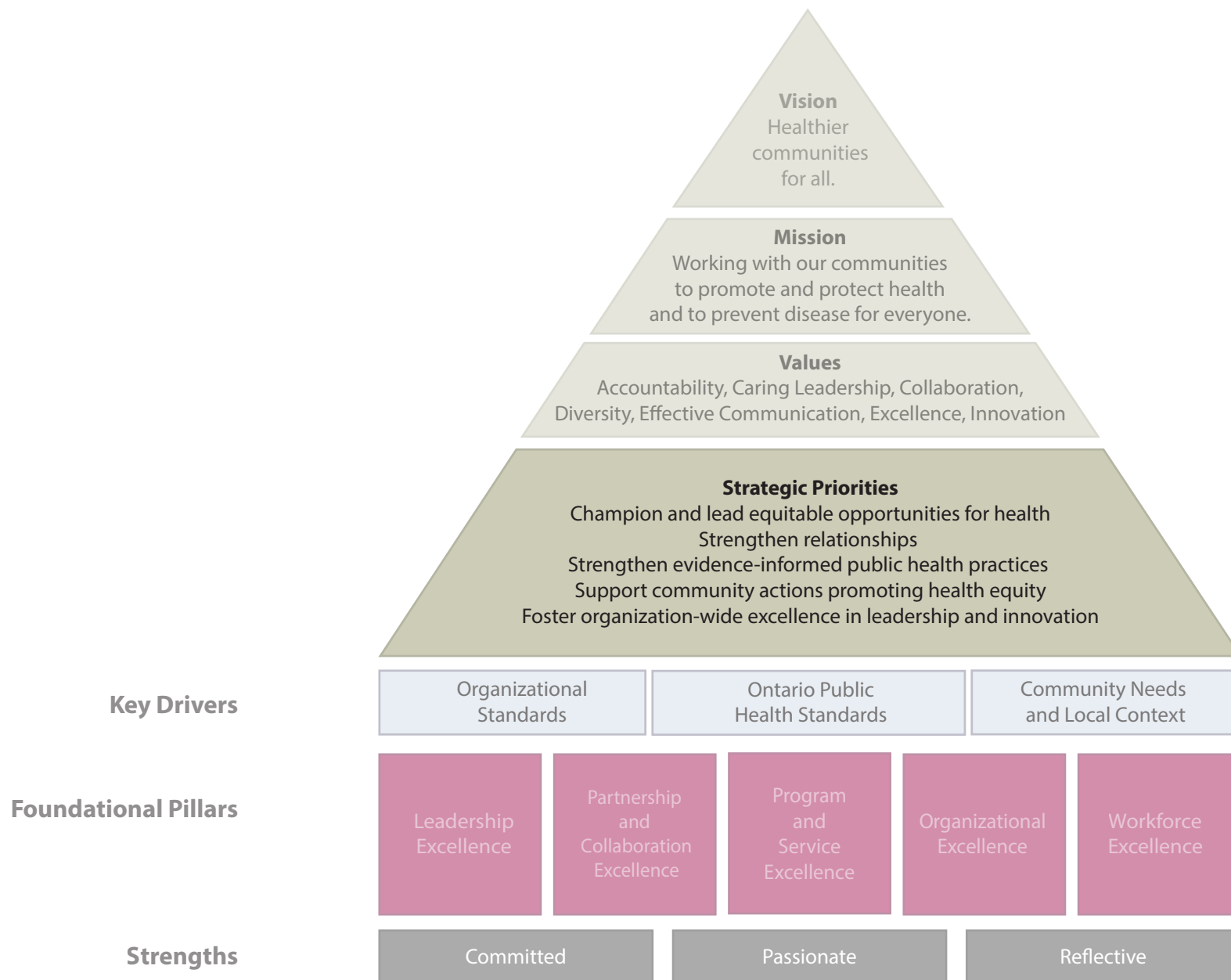


Strategic Priorities: Narrative Report



The 2013–2017 Strategic Plan includes five Strategic Priorities that represent areas of focus that steer the planning and delivery of public health services, learning activities, and partnerships. Ongoing monitoring of the integration of the Strategic Priorities within SDHU programs or services provides an opportunity to gauge progress on these key areas.

Figure 2: Sudbury & District Board of Health Strategy Map 2013–2017, Strategic Priorities



2016 Strategic Priorities Narrative Topics

The following presents a summary of the Strategic Priorities Narrative topics that were presented in 2016.

Click on the narrative title below for more information.

1

Strategic Priority: Champion and lead equitable opportunities for health

A Bike Giveaway to Children in an Identified Neighbourhood

Opening New Doors to Harm Reduction Services

Six-week Community Kitchen Program

2

Strategic Priority: Strengthen relationships

Ramsey Lake Main Beach Receives International Blue Flag Award

Workplace Safety and Prevention Services: Knowledge Exchange Session

Online Triple P: Investing in Innovative Partnerships With the Education Sector

3

Strategic Priority: Strengthen evidence-informed public health practice

Implementation of New Processes Leads to Improvements for Parents and Schools

Blue-green Algae Forum

Working With Indigenous Communities to Promote Health

4

Strategic Priority: Support community actions promoting health equity

Supporting the LaCloche Area Community With an Early Years Screening Day for Families

Education and Skill-building With Alternative Schools

Intersectoral Dialogue on Health Equity

5

Strategic Priority: Foster organization-wide excellence in leadership and innovation

Staff Develop Meaning to the Strategic Plan Values

Mentorship Matters

A Psychologically Healthy and Safe Workplace Is Essential for Everyone

SDHU-Specific Performance Monitoring Indicators Report



SDHU-Specific Performance Monitoring Indicators are meant to provide the Board of Health with information about the “current state” of key focus areas and to allow for monitoring of their progress year after year. Both individually and as a whole, the indicators demonstrate the SDHU’s commitment toward performance excellence and its Vision of “Healthier communities for all”.

Figure 3: Sudbury & District Board of Health Strategy Map 2013–2017, Foundational Pillars

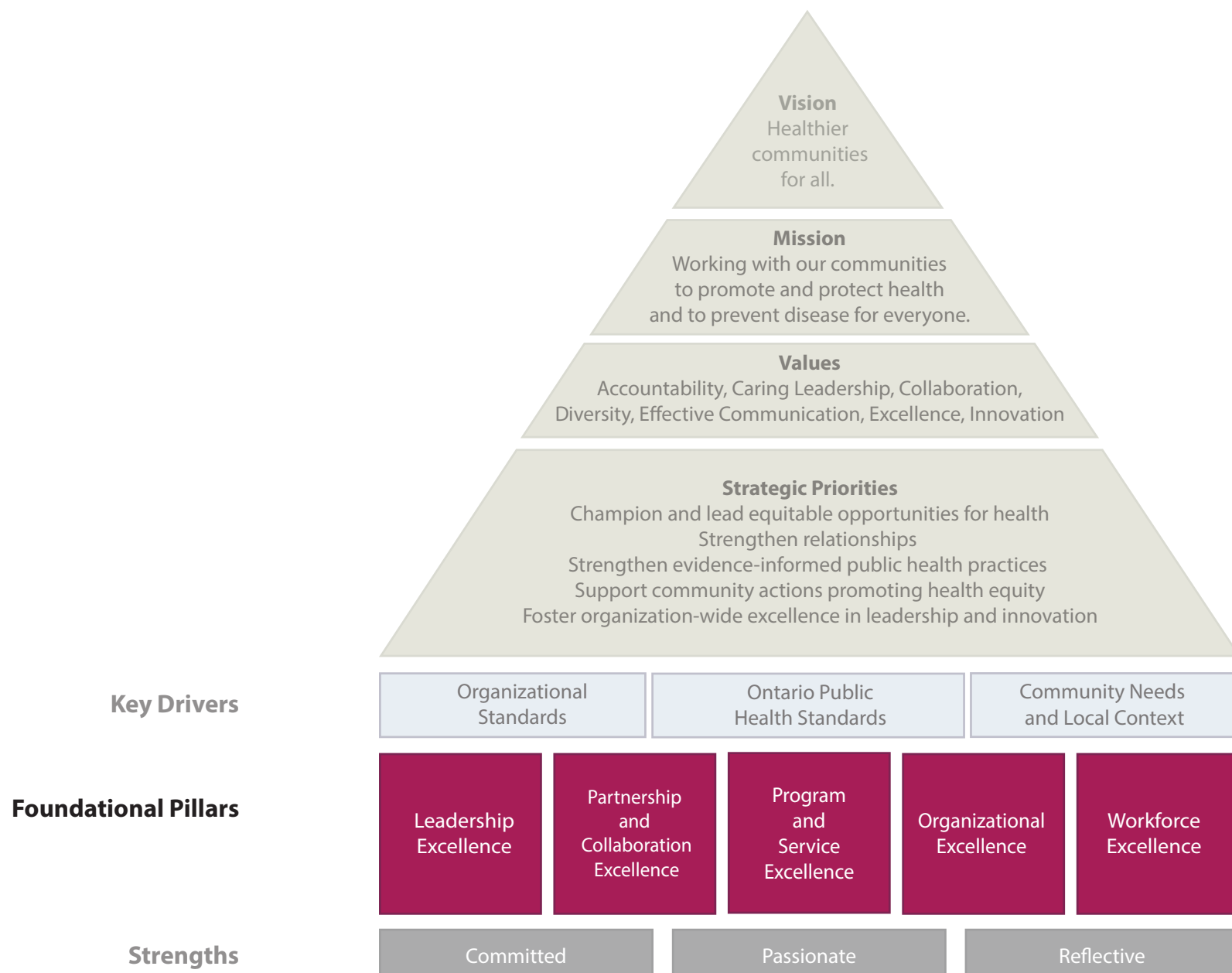


Table 1: SDHU-Specific Performance Monitoring Indicator Trends 2013–2017

FOUNDATIONAL PILLAR	INDICATOR	2013	2014	2015	2016	2017
Leadership Excellence	Board of Health Commitment Index	95	89	85	86	—
	Number of Program-related Board of Health Motions Passed	9	8	9	12	—
	Board of Health Member's Satisfaction Index	96	100	95	96	—
Partnership and Collaboration Excellence	Percent of Partnerships That Are Intersectoral	61%	63%	66%	66%	—
	Number of External Partnership Effectiveness Reviews Goal: 5	Under Development	5	5	5	—
	Website Usage Status					
	Average web visits per day Average web page views per day	1 773 16 555	1 736 13 415	See Notes	373 1134	— —
Program and Service Excellence	Number of New Advanced Knowledge Products	106	97	152	180	—
	Number of Academic Research Projects	18	17	19	18	—
	Organization-wide Program or Service Evaluations Used by Senior Management Goal: 1	2	3	1	1	—
	Emergency Preparedness Index	99	99	100	98	—
Organizational Excellence	Worker Engagement Index	88	See Notes	90	92	—
	SharePoint Deployment Status	P1, P2, P3 In Progress	P1, P3–P5 In Progress; P2 Complete	P1, P3, P4, P5 In Progress; P2 Complete	P1, P3, P4, P5 In Progress; P2 Complete	—
Workforce Excellence	Workforce Development Status	P1, P2 In Progress	P1, P2 In Progress	P1, P2 In Progress P3 Complete	P2, P4 In Progress; P1, P3 Complete	—

Explanatory Notes

The SDHU-Specific Performance Monitoring Indicators measure the SDHU's performance as an organization and further demonstrate its commitment to excellence and accountability.

LEADERSHIP EXCELLENCE

Board of Health (BoH) Commitment Index

- A score of 86% indicates that those BoH members who completed the survey reported strongly agreeing or agreeing with the statements regarding satisfaction with their individual performance, with the Board's processes, and with the overall performance of the Board.

Number of Program-related Board of Health (BoH) Motions Passed

- Board's activities in providing leadership for public health in our communities and in the province. Compared to 2015, there are 3 additional BoH motions passed in 2016. Some year-to-year fluctuation can be expected depending on the current public health context and the issues brought forward to the BoH.

PARTNERSHIP AND COLLABORATION EXCELLENCE

Percent of Partnerships That Are Intersectoral

- Intersectoral means at least one member represents a sector other than public health or health care (examples of sectors: childcare, school board, university).
- Out of 287 partnerships, 188 were intersectoral.
- The % of partnerships that are intersectoral remained similar to that of 2015. Some year-to-year fluctuation can be expected given the dynamic nature of partnerships.

Number of External Partnership Effectiveness Reviews (Goal: 5)

- Highlights the SDHU's commitment to ensure that our contributions to external community partnerships meet our strategic and operational priorities.
- Each division (5) conducted one review.

Website Usage Status

- The SDHU launched a new website in June 2015, and 2016 marks the first year of reporting usage data on the new website. The new website uses different website analytic software to monitor website traffic, therefore, data from 2016 should not be compared to data from previous years.
- The website usage status data represents average daily visits and page views to the Health Unit's website from users who have their locations set as "Canada", and excludes SDHU staff activity.
- In 2016, there were a total of 136 529 sessions (visits) to the site, which generated 414 019 page views. On average, each visitor viewed 3 pages and stayed on the site for roughly 2 minutes. And, nearly 40% of the traffic to the Health Unit's website comes from Facebook, which is used by the Health Unit to share and advertise content.

PROGRAM AND SERVICE EXCELLENCE**Number of New Advanced Knowledge Products**

- Captures the number of new internally developed or significantly altered products that require knowledgeable interpretation by an informed audience (reports, manuals, presentations).
- Compared to 2015, there were 28 additional advanced knowledge products produced. Some year-to-year fluctuation can be expected.

Number of Academic Research Projects

- Captures new and ongoing research projects conducted in collaboration with academic and research institutions, such as projects funded by the Louise Picard Public Health Research Grant, a joint SDHU/Laurentian University research grant.
- Out of the 18 academic research projects, 4 are new in 2016: 3 were completed and 11 are ongoing.
- Examples of completed projects include research on topics such as: rural wildlife preparedness, reducing health inequities, and examining viewpoints of the impacts of physical, social and psychological health of residents in the Ridgcrest playground area.

Organization-wide Program or Service Evaluations Used by Senior Management

- Evaluations that are undertaken that inform organization-wide decisions.
- Our target goal of one was met: the transfer of SDHU's Intake Services to the Corporate Services Division from the Clinical and Family Services Division.

ORGANIZATIONAL EXCELLENCE

Worker Engagement Index

- Data for 2013 and 2016 were collected using the 5 worker engagement focused questions from the Guarding Minds @ Work (GM@W) survey. Data for 2015 were collected using a different measuring tool, that measured similar physical, cognitive, and emotional engagement concepts. Direct comparisons between results reported in 2013 and those reported in 2016 can be made; however, comparison of results from 2015 to other years should be made with caution.
- A total of 194 staff members completed the 2016 survey; which represents a 75% response rate.
- Based on the results, the Worker Engagement index score is 92/100.
- The SDHU has received permission to use questions from the Guarding Minds @ Work survey for monitoring purposes and will continue to use the questions related to worker engagement from this survey to measure and report on this concept on an ongoing basis.

SharePoint Deployment Status

- SharePoint is an internal collaboration tool that allows for content to be shared and helps users find the right people and the right information to be able to make more informed decisions.
- One out of five SharePoint phases is complete; all other phases are being worked on simultaneously. SharePoint is currently implemented in all divisions.
- The project team is developing workflows, which include automated approval processes.
- Maintenance continues and plans are underway for a formalized audit.

WORKFORCE EXCELLENCE

Workforce Development Status

- The Workforce Development Framework will outline a structure to guide the SDHU in ensuring that its workforce has the knowledge, skills, and abilities needed to respond to and be aligned with current and future public health service demands.
- Phase 1 and 3 are completed, while Phase 2 and 4 continue to be worked on simultaneously.
- Key 2016 project milestones include implementing the recommendations from a LEAN Review, continuing to implement the Mentorship Program, and developing and approving of behavioural statements for all five of the Leadership Core Competencies.

Ontario Public Health Organizational Standards Report



The Ontario Public Health Organizational Standards outline the expectations for the effective governance of boards of health and effective management of public health units. There are 44 requirements grouped within 6 standard categories. When implemented, they are essential to establishing consistent organizational processes, which in turn, facilitate desired program outcomes.

Figure 4: Sudbury & District Board of Health Strategy Map 2013–2017, Organizational Standards

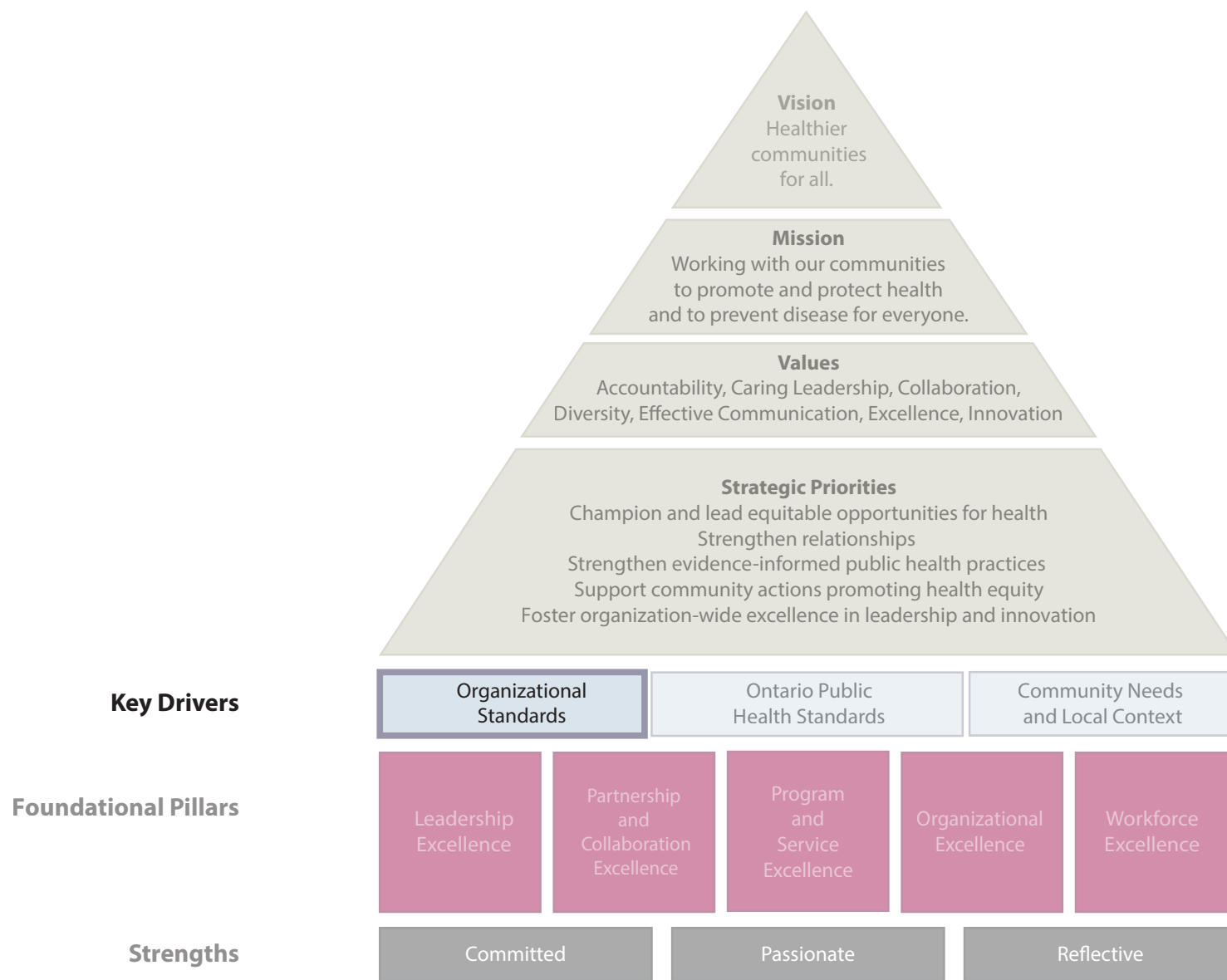


Table 2: Ontario Public Health Organizational Standards Compliance, 2013–2017

STANDARD	REQUIREMENT	2013	2014	2015	2016
1. Board Structure	1.1 Definition of a board of health	-			
	1.2 Number of members on a board of health	-			
	1.3 Right to make provincial appointments	-			
	1.4 Board of health may provide public health services on reserve	-			
	1.5 Employees may not be board of health members	-			
	1.6 Corporations without share capital	-			
	1.7 Election of the board of health chair	-			
	1.8 Municipal membership	-			
2. Board Operations	2.1 Remuneration of board of health members	-			
	2.2 Informing municipalities of financial obligations	-			
	2.3 Quorum	-			
	2.4 Content of by-laws	-			
	2.5 Minutes, by-laws and policies and procedures	-			
	2.6 Appointment of a full-time Medical Officer of Health	-			
	2.7 Appointment of an acting Medical Officer of Health	-			
	2.8 Dismissal of a Medical Officer of Health	-			
	2.9 Reporting relationship of the Medical Officer of Health to the board of health	-			
	2.10 Board of health policies	-			

 Met or exceeded standard  Non-compliant with standard

Table 2 continued: Ontario Public Health Organizational Standards Compliance, 2013–2017

STANDARD	REQUIREMENT	2013	2014	2015	2016
3. Leadership	3.1 Board of health stewardship responsibilities	-			
	3.2 Strategic plan	-			
4. Trusteeship	4.1 Transparency and accountability	-			
	4.2 Board of health member orientation and training	-			
	4.3 Board of health self-evaluation	-			
5. Community Engagement and Responsiveness	5.1 Community engagement	-			
	5.2 Stakeholder engagement	-			
	5.3 Contribute to policy development	-			
	5.4 Public reporting	-			
	5.5 Client service standards	-			
6. Management Operations	6.1 Operational plan	-			
	6.2 Risk management	-			
	6.3 Medical Officer of Health provides direction to staff	-			
	6.4 Eligibility for appointment as a Medical Officer of Health	-			
	6.5 Educational requirements for public health professionals	-			
	6.6 Financial records	-			
	6.7 Financial policies and procedures	-			
	6.8 Procurement	-			



Met or exceeded standard



Non-compliant with standard

Table 2 continued: Ontario Public Health Organizational Standards Compliance, 2013–2017

STANDARD	REQUIREMENT	2013	2014	2015	2016
6. Management Operations	6.9 Capital funding plan	-			
	6.10 Service level agreements (The SDHU has an autonomous Board not integrated with the municipality.)	-	N/A	N/A	N/A
	6.11 Communications strategy	-			
	6.12 Information management	-			
	6.13 Research ethics	-			
	6.14 Human resources strategy	-			
	6.15 Staff development	-			
	6.16 Professional practice support	-			



Met or exceeded standard



Non-compliant with standard

Explanatory Notes—Program Highlights

1.0 BOARD STRUCTURE

1.2 Number of members on a board of health

- There is currently one vacancy (one provincial appointee); however, the numbers remain in accordance with the standard.

2.0 BOARD OPERATIONS

2.10 Board of health policies

- More consideration of the recruitment and selection of board of health members based on skills, knowledge, competencies and representativeness of the community.

3.0 LEADERSHIP

3.1 Board of health stewardship responsibilities

- The Board of Health completed training on Indigenous engagement, risk management and governance.

3.2 Strategic plan

- The 2013–2017 Performance Monitoring Plan Report, which includes the Strategic Priorities: Narrative Report, SDHU-Specific Performance Monitoring Indicators Report, the Ontario Public Health Organizational Standards, and the Public Health Accountability Agreement Indicators, illustrates our direction for performance management and quality improvement.
- The development of an Engagement Plan to inform the development of the next iteration of the Strategic Plan.

4.0 TRUSTEESHIP

4.1 Transparency and accountability

- The SDHU posts Board of Health agenda packages and proceedings on its website.

5.0 COMMUNITY ENGAGEMENT AND RESPONSIVENESS

5.1 Community engagement

- In order to identify best practices for implementing, sustaining, and measuring the effectiveness and impact of community engagement activities, the SDHU's Strategic Engagement Unit (SEU) is leading the implementation of the SDHU Community Engagement Primer.

5.2 Stakeholder engagement

- The SEU is developing a Stakeholder Engagement Strategy to engage and enhance collaborative partnerships with health and non-health sector partners with whom the SDHU seeks work in addressing health issues.
- Future activities include the development and implementation of the Stakeholder Engagement Plan.

5.4 Public reporting

- The 2016 Annual Report incorporated a multimedia component.

5.5 Client service standard

- The development of clear procedures and communication materials for parents/guardians reporting immunizations for their children.
- The development of an accessible, mobile friendly immunizations reporting interface significantly increased reporting ease for parents/guardians.

6.0 MANAGEMENT OPERATIONS

6.2 Risk management

- The Board of Health engaged with Senior Management in working through a risk management process. Through this process, a Board of Health policy, Risk Management Framework, and Risk Management Plan was developed and approved.

6.11 Communications strategy

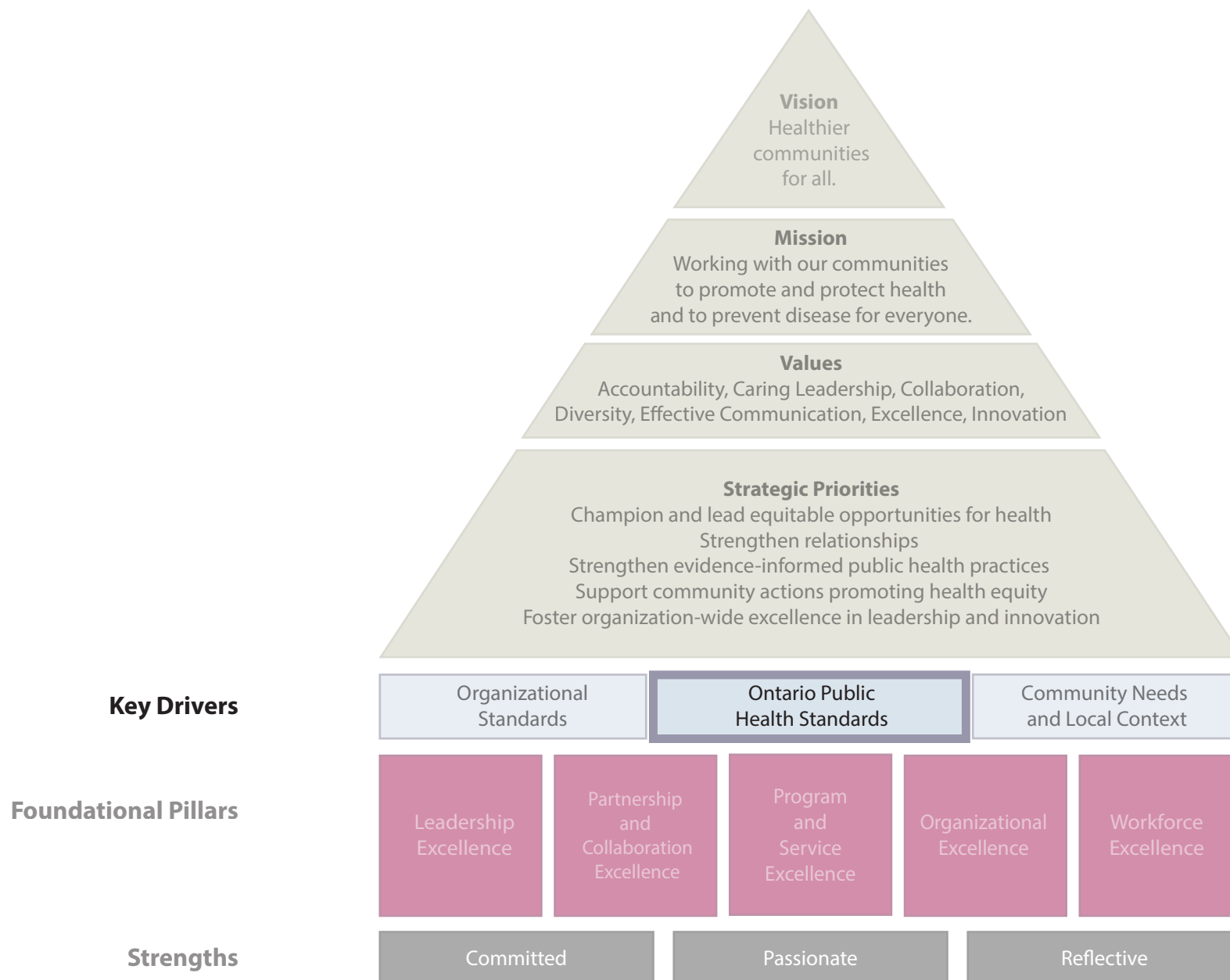
- The *Return on Investment* of Public Health video was developed and promoted through multiple channels including social media to increase the reach of the message.

Public Health Accountability Agreement Indicators Report



The Ministry of Health and Long-Term Care (MOHLTC) has set out performance expectations for boards of health that includes a set of performance indicators. These are measured and monitored by the MOHLTC throughout accountability agreement periods and represent outcomes relating to the delivery of public health programs and services. Presented in the report are both performance indicators and monitoring indicators.

Figure 5: Sudbury & District Board of Health Strategy Map 2013–2017, Accountability Agreement Indicators



Public Health Accountability Agreement Indicators: Includes both Performance (3a) and Monitoring Indicators (3b)*Table 3a: Accountability Agreement Performance Indicators 2013–2017*


Performance indicators have set targets and are utilized to monitor performance improvements.

DIVISION	PERFORMANCE INDICATOR	2013	2014	2015	2016
Clinical and Family Services	% of 7 or 8 year old students in compliance with Immunization of Schools Pupils Act (ISPA) *NEW*				
	% of 16 or 17 year old students in compliance with ISPA *NEW*				
	Oral health assessment and surveillance: % of JK, SK and Grade 2 students screened in publicly funded schools				
	Implementation status of NutriSTEP®				
	Baby-Friendly Initiative (BFI) status				
	% of influenza vaccine wasted that is stored/administered by the public health unit				
	% of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection				

 Baseline
  Met or exceeded target
  Variance*

Table 3a continued: Accountability Agreement Performance Indicators 2013–2017

DIVISION	PERFORMANCE INDICATOR	2013	2014	2015	2016
Environmental Health	% of tobacco vendors in compliance with youth access legislation at the time of last inspection				
	% of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act (SFOA)				
	% of tobacco retailers inspected for compliance with section 3 of the SFOA				
	% of tobacco retailers inspected once per year for compliance with display, handling and promotion sections of the SFOA				
	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection				
	% of suspected rabies exposures reported with investigations initiated within one day of public health unit (PHU) notification				
	% of salmonellosis cases where one or more risk factor(s) other than “Unknown” was entered into integrated Public Health Information System (iPHIS)				

 Baseline
  Met or exceeded target
  Variance*

Explanatory Notes

As articulated by the Ministry, the purpose of the Accountability Agreement Indicators is to ensure the board of health's ability to comply with the Ontario Public Health Standards; address Health Unit specific performance issues; demonstrate effective use of public funds and value for money; and demonstrate clear movement on government priorities.

As of December 31, 2016, the Sudbury & District Health Unit (SDHU) has demonstrated compliance with 11 of the 14 Ministry of Health and Long-Term Care Accountability Agreement Performance Indicator targets.

CLINICAL AND FAMILY SERVICES

- The wastage of 4.2% is not representative of actual wastage per se. With the transition of vaccine inventory systems, there were 200 doses that were distributed to providers in the community, but were not recorded in the inventory and were, therefore, counted as our wastage. There is no way to retrospectively adjust for these doses in the Panorama system.
- A team member is now assigned to be the inventory super-user to oversee the database, and the entire CID team continues to be reminded of our responsibility for precise inventory.
- The Ministry did not require a variance report for last year's variance.

ENVIRONMENTAL HEALTH

- Investigations of two suspected rabies exposures (one each in April and October) were not initiated within one day of the Health Unit being notified. Measures have been implemented within the Environmental Health division to address the issues that lead to these delays.
- Five salmonellosis investigations (three in September and two in December) did not identify potential risk factors for exposure. The Ministry of Health and Long-Term Care recognizes that some cases may be lost to follow-up or may have recall bias, which would account for behavioural risk factors not being identified. Environmental Health Division staff will continue to ensure thorough investigation of all reported cases.

Table 3b: Accountability Agreement Monitoring Indicators 2013–2017

Monitoring indicators do not have set targets and are used to ensure that high levels of achievement are sustained, to allow time for baseline levels of achievement to be confirmed, and to monitor risks related to program delivery.

DIVISION	MONITORING INDICATOR
Clinical and Family Services	% of confirmed gonorrhea cases where initiation of follow up occurred within two business days •
	% of laboratory confirmed N. gonorrhea cases treated according to guidelines •
	% of confirmed Invasive group A streptococcal disease (iGAS) cases where initiation of follow up occurred on the same day as receipt of lab confirmation of a positive case •
	% of the human papillomavirus (HPV) vaccine wasted that is stored/administered by the public health unit •
	% of school-aged children who have completed immunizations for Hepatitis B †
	% of school-aged children who have completed immunizations for HPV †
	% of school-aged children who have completed immunizations for meningococcus ‡
	% of MMR vaccine wasted *NEW*

Monitoring Indicator: used to monitor progress

Previous Performance indicator; became a Monitoring Indicator in:

† 2012

‡ 2013

¶ 2014

• 2016

Table 3b continued: Accountability Agreement Monitoring Indicators 2013–2017

DIVISION	MONITORING INDICATOR
Environmental Health	% of high-risk food premises inspected once every 4 months while in operation •
	% of moderate-risk food premises inspected once every 6 months while in operation •
	% of restaurants with a Certified Food Handler on site at time of routine inspection *NEW*
	% of Class A pools inspected while in operation •
	% of public spas inspected while in operation •
	% of personal services settings inspected annually •
Health Promotion	Fall-related emergency visits in older adults aged 65+ •
	% of youth (ages 12–18) who have never smoked a whole cigarette •
	% of population (19+) that exceeds the Low-risk Drinking Guidelines ¶

Monitoring Indicator: used to monitor progress

Previous Performance Indicator; became a Monitoring Indicator in:

† 2012 ‡ 2013 ¶ 2014 • 2016



Sudbury & District

Health Unit

Service de
santé publique

SDHU 2016 PERFORMANCE MONITORING REPORT

MOTION: **WHEREAS the Sudbury & District Board of Health is working toward achieving its vision of Healthier Communities for All; and**

WHEREAS the 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 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 2016 Performance Monitoring Report.

Sudbury & District Health Unit Board of Health Manual

Information

Category: Board of Health Structure & Function
Section: Board of Health Committees
Subject: Board of Health Finance Standing Committee Terms of Reference
Number: C-II-11
Approved By: Board of Health
Original Date: June 18, 2015
Revised Date: ~~June 16, 2016~~ February 16, 2017

Information

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)
- Board of Health Chair
- 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

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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.

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. Teleconferencing for meetings will be in accordance with a Board of Health procedural policy on 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.

Agendas are made available to the public via the SDHU website.

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 closed meeting of the Board Finance Standing Committee.

BOARD OF HEALTH FINANCE STANDING COMMITTEE TERMS OF REFERENCE

MOTION: THAT the Board of Health, having reviewed the revised Information C-II-11, approve the contents therein for inclusion in the Board of Health Manual.

ADDENDUM

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

All Board members are encouraged to complete the Board of Health Meeting Evaluation following each regular Board meeting.

ADJOURNMENT

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