



# Sudbury & District Board of Health

Thursday, April 20, 2017, 1:30 p.m.

SDHU Boardroom

1300 Paris Street

# Sudbury & District Board of Health Meeting - April 20, 2017

Sudbury & District Board of Health Meeting #03-17

## 1.0 CALL TO ORDER

## 2.0 ROLL CALL

## 3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

Agenda - April 20, 2017

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## 4.0 DELEGATION / PRESENTATION

i) Accessibility @SDHU – Moving Beyond the Legislative Requirements  
Joanne Beyers, Foundational Standard Specialist and Troy Haslehurst, Manager, Human Resources

## 5.0 CONSENT AGENDA

### i) Minutes of Previous Meeting

a. Second Meeting, February 16, 2017

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### ii) Business Arising From Minutes

None

### iii) Report of Standing Committees

a. Joint Board/Staff Performance Monitoring Working Group Meeting Notes, January 24, 2017

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b. Joint Board/Staff Performance Monitoring Working Group Unapproved Meeting Notes, April 4, 2017

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c. Board of Health Executive Committee Unapproved Minutes dated February 16, 2017

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

a. MOH/CEO Report, April 2017

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Financial Statement ending February 28, 2017

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v) Correspondence

a. Public Appointment Secretariat Reappointment

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b. Opioid Addiction and Overdose

Letter from the Windsor-Essex County to the Minister of Health and Long-Term Care dated February 3, 2017 Page 52

Letter from the Member of Parliament, Algoma-Manitoulin-Kapuskasing dated March 8, 2017 Page 53

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

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Letter from The Corporation of the Municipality of Killarney to Dr. Sutcliffe dated February 10, 2017 Page 57

Letter from the Township of Nairn and Hyman to the Minister of Health and Long-Term Care dated February 17, 2017 Page 59

d. Expert Panel on Public Health

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Letter from Leeds, Grenville & Lanark Board of Health to the Minister of Health and Long-Term Care dated March 22, 2017, and Page 62

MOHLTC Email Response dated April 3, 2017 Page 64

Letter from the aPHa Board to the Public Health Expert Panel dated March 15, 2017 Page 65

e. Boards of Health Budgets 2016

Letter from the aPHa to the Minister of Health and Long-Term Care dated January 13, 2017 Page 68

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j. Low-Income Dental Program for Adults and Seniors	
Letter from the Porcupine Unit Board of Health to the Minister of Health and Long-Term Care dated March 28, 2017	Page 79
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m. Support for Legislation under the HPPA to allow for the Inspection and Enforcement Activities of Personal Service Settings

Letter from the Wellington-Dufferin-Guelph Board of Health to the Premier of Ontario dated January 4, 2017

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Letter from the Algoma Board of Health to the Premier of Ontario dated March 29, 2017

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n. Office of the Auditor General of Ontario's Value-For-Money Audit

Email from the Assistant Deputy Minister, Population and Public Health Division, MOHLTC dated March 2, 2017

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o. HIV/AIDS Strategy to 2026

Letter from the Minister of Health to Community-Based HIV Organizations or Programs dated January 26, 2017

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b. Update: Health System Integration

April 7, 2017

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6.0 NEW BUSINESS

i) alPHa Conferences

a. Winter Symposium – February 2017

- Winter 2017 Symposium Proceedings

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- Verbal Report from Board Chair and Member R. Lapierre and M. Bailey	
b. Annual General Meeting (AGM) and Conference, June 2017	Page 140
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li) Standards for Public Health Programs and Services	
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- Diagram of MOHLTC Committee Structure for Standards Modernization	Page 147
- Standards for Public Health Programs and Services Consultation Document (Standards) released on February 17, 2017	Page 148
- Response letter from aPHa to the Ministry of Health and Long-Term Care Assistant Deputy Minister dated March 17, 2017	Page 193
- Letter from the Sudbury & District Board of Health dated April 21, 2017, and Appendix A	Page 196
- Appendix A to the letter from the Sudbury & District Board of Health dated April 21, 2017	Page 198
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v) Age Restrictions on Energy Drinks

Briefing Note from the Medical Officer of Health/Chief Executive Officer to the Sudbury & District Board of Health Chair dated April 13, 2017 Page 220

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Labour Relations or Employee Negotiations

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**AGENDA – THIRD MEETING**  
**SUDBURY & DISTRICT BOARD OF HEALTH**  
**BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT**  
**THURSDAY, APRIL 20, 2017 – 1: 30 P.M.**

**1. CALL TO ORDER**

**2. ROLL CALL**

**3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST**

**4. DELEGATION/PRESENTATION**

**i) Accessibility @SDHU – Moving Beyond the Legislative Requirements**

- Joanne Beyers, Foundational Standard Specialist
- Troy Haslehurst, Manager, Human Resources

**5. CONSENT AGENDA**

**i) Minutes of Previous Meeting**

- a. Second Meeting – February 16, 2017

**ii) Business Arising From Minutes**

- a. None

**iii) Standing Committees**

- a. Joint Board/Staff Performance Monitoring Working Group Meeting  
Notes, January 24, 2017
- b. Joint Board/Staff Performance Monitoring Working Group Unapproved  
Meeting Notes, April 4, 2017
- c. Board of Health Executive Committee Unapproved Minutes dated  
February 16, 2017

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

- a. MOH/CEO Report, April 2017

**v) Correspondence**

- a. Public Appointment Secretariat Reappointment
  - Letter from the Minister of Health and Long-Term Care dated  
February 24, 2017, Reappointing Sudbury & District Board of Health  
member, J. Bradley

b. Opioid Addiction and Overdose

**Sudbury & District Board of Health Motion #12-17**

- Letter from the Windsor Essex County to the Minister of Health and Long-Term Care dated February 3, 201
- Letter from the Member of Parliament, Algoma-Manitoulin-Kapuskasing dated March 8, 2017

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

**Sudbury & District Board of Health Motion #04-17**

- Letter from the Windsor Essex County to the Minister of Health and Long-Term Care dated February 3, 2017
- Letter from The Corporation of the Municipality of Killarney to Dr. Sutcliffe dated February 10, 2017
- Letter from the Township of Nairn and Hyman to the Minister of Health and Long-Term Care dated February 17, 2017

d. Expert Panel on Public Health

- Letter from the Peterborough Public Health to the Minister of Health and Long-Term Care dated February 27, 2017
- Letter from the Leeds, Grenville & Lanark Board of Health to the Minister of Health and Long-Term Care dated March 22, 2017, and the Ministry of Health and Long-Term Care (MOHLTC) email response dated April 3, 2017
- Letter from the alPHa Board to the Public Health Expert Panel dated March 15, 2017

e. Boards of Health Budgets 2016

- Letter from the alPHa to the Minister of Health and Long-Term Care dated January 13, 2017

f. Basic Income

- Letter from the Huron County Board of Health to the Minister of Community and Social Services dated March 9, 2017

g. Restricting the Marketing of Unhealthy Foods and Beverages to Children

**Sudbury & District Board of Health Motion #60-16**

- Letter from the Corporation of the Municipality of Killarney to Dr. Sutcliffe dated February 10, 2017
- Letter from the Township of Nairn and Hyman to the Federal Minister of Health Care dated February 17, 2017
- Letter from the Perth District Board of Health to the Federal Minister of Health dated March 15, 2017

- h. Anti-Contraband Tobacco Campaign  
**Sudbury & District Board of Health Motion #03-17**
  - Letter from the Township of Nairn and Hyman to the Minister of Finance dated February 17, 2017
- i. HPV Immunization Programs
  - Letter from the Simcoe Muskoka Board of Health to the Minister of Health and Long-Term Care dated January 18, 2017
- j. Low-Income Dental Program for Adults and Seniors
  - Letter from the Porcupine Unit Board of Health to the Minister of Health and Long-Term Care dated March 28, 2017
- k. Stop Marketing to Kids Coalition's Ottawa Principles and Further Action on Sugary Drinks
  - Letter from Middlesex-London Board of Health to the Ontario Boards of Health dated March 28, 2017
- l. Tobacco Endgame
  - Letters from the Simcoe Muskoka Board of Health to the Federal Minister of Health and Provincial Minister of Health and Long-Term Care dated March 15, 2017
- m. Support for Legislation under the HPPA to allow for the Inspection and Enforcement Activities of Personal Service Settings
  - Letter from the Wellington-Dufferin-Guelph Board of Health to the Premier of Ontario dated January 4, 2017
  - Letter from the Algoma Board of Health to the Premier of Ontario dated March 29, 2017
- n. Office of the Auditor General of Ontario's Value-For-Money Audit
  - Email from the Assistant Deputy Minister, Population and Public Health Division, MOHLTC dated March 2, 2017
- o. HIV/AIDS Strategy to 2026
  - Letter from the Minister of Health to Community-Based HIV Organizations or Programs dated January 26, 2017

**vi) Items of Information**

- |  |                   |
|--|-------------------|
| a. alPHa Information Break                       | March 6, 2017     |
| b. Update: Health System Integration             | April 7, 2017     |
| c. Water Does Wonders Pledge Gold Certificate    |                   |
| d. NE LHIN Organizational Chart                  | February 22, 2017 |
| e. Chief Medical Officer of Health Annual Report | 2015              |

**vii) Approval of Consent Agenda**

**MOTION: APPROVAL OF CONSENT AGENDA**

**THAT the Board of Health approve the consent agenda as distributed.**

**6. NEW BUSINESS**

**i) alPHa Conferences**

- a. Winter Symposium – February 2017
  - Winter 2017 Symposium Proceedings
  - Verbal Report from Board Chair and Member R. Lapierre and M. Bailey
- b. Annual General Meeting (AGM) and Conference – June 2017

**MOTION: ALPHA CONFERENCE**

**WHEREAS the Sudbury & District Health Unit (SDHU) has a modest travel budget to cover remuneration, registration, travel, meals, and accommodation as per the Board Manual Policy and Procedure I-I-10, permitting Board members to attend official Board of Health functions; and**

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

**THEREFORE, BE IT RESOLVED THAT in addition to the Medical Officer of Health, the following Board member(s) attend(s) the 2017 alPHa Annual General Meeting as voting delegates for the Sudbury & District Board of Health:**

**ii) Standards for Public Health Programs and Services**

- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board Chair dated April 13, 2017 and attachments:
  - Letter from the Minister of Health and Long-Term Care dated November 16, 2015
  - Diagram of MOHLTC Committee Structure for Standards Modernization
  - Standards for Public Health Programs and Services Consultation Document (Standards) released on February 17, 2017

- Response letter from alPHa to the MOHLTC Assistant Deputy Minister dated March 17, 2017
- Letter from the Sudbury & District Board of Health dated April 21, 2017, and Appendix A: Standards for Public Health Programs and Services, Sudbury & District Board of Health Overarching Issues and Detailed Operational Feedback

**MOTION: STANDARDS FOR PUBLIC HEALTH PROGRAMS AND SERVICES CONSULTATION DOCUMENT**

**WHEREAS the Sudbury & District Board of Health (Board) has reviewed the Standards for Public Health Programs and Services Consultation Document (Standards) released February 17, 2017; and**

**WHEREAS the Board has reviewed the March 17, 2017 feedback to the Ministry of Health and Long-Term Care (MOHLTC) from the Association of Local Public Health Agencies (alPHa) and has received a report from the Medical Officer of Health on related operational considerations and implementation requirements;**

**THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the March 17, 2017, alPHa feedback on the Standards for Public Health Programs and Services Consultation Document; and**

**AND FURTHER THAT the Board communicate its overarching and program-specific operational feedback to the Ministry of Health and Long-Term Care, sharing the same with all area municipalities, the Association of Local Public Health Authorities, all Ontario boards of health, and other relevant stakeholders.**

**iii) Performance Monitoring Plan**

- Strategic Priorities: Narratives Report, April 2017

**iv) People with Disabilities Person-Centered Language**

- Sudbury & District Board of Health People with Disabilities Person-Centered Language Position Statement – 2017

**MOTION: PEOPLE WITH DISABILITIES PERSON-CENTERED LANGUAGE POSITION STATEMENT**

**WHEREAS the Sudbury & District Board of Health, having considered that bias, stigma, and discrimination towards people with disabilities can be**



reduced through the use of respectful language, is supportive of the rationale for use of person-centered language;

**THEREFORE BE IT RESOLVED THAT** the Sudbury & District Board of Health endorse the People with Disabilities Person-Centered Language Position Statement; and recognize, apply and promote attitudes and practices that are sensitive and respectful to people with disabilities and to all priority populations; and

**FURTHER BE IT RESOLVED THAT** The Sudbury & District Board of Health share this motion and Position Statement with the Association of Local Public Health Agencies (alPHa), Ontario Boards of Health, Ontario Public Health Association (OPHA)-Advocacy Committee and People with Disabilities Task Group, and alPHa-OPHA Health Equity Working Group.

**v) Age Restrictions on Energy Drinks**

- Briefing Note from the Medical Officer of Health/Chief Executive Officer to the Sudbury & District Board of Health Chair dated April 13, 2017
- Toronto Public Health Motion Re: Caffeinated Energy Drinks: Feasibility of /Restricting Sales and Marketing to Youth in Toronto dated March 28, 2017

**MOTION: REGULATIONS TO RESTRICT THE SALE OF CAFFEINATED ENERGY DRINKS TO CHILDREN AND YOUTH**

**WHEREAS** the Sudbury & District Board of Health's concerns about caffeinated energy drinks (Motion #13-11), endorsement of Ontario's Healthy Kids Strategy (Motion #19-13), and concerns about marketing to children (Motion #60-16) are part of the public record; and

**WHEREAS** the Board has carefully reviewed health and consumption information about caffeinated energy drinks (CEDs) relevant to its local context;

**THEREFORE BE IT RESOLVED THAT** the Sudbury & District Board of Health urge the provincial and federal Ministers of Health to advance regulations prohibiting the sale of CEDs to children and youth under the age of majority, in venues where they frequent; and

**FURTHER THAT** this motion be forwarded to the federal Minister of Health, the provincial Minister of Health, Ontario boards of health, the

Ontario Public Health Association (OPHA), the Association of Local Public Health Agencies (alpha), local Boards of Education, and the Federation of Northern Ontario Municipalities (FONOM).

## **7. ADDENDUM**

### **MOTION: ADDENDUM**

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

## **8. IN CAMERA**

### **MOTION: IN CAMERA**

**That this Board of Health goes in camera. Time: \_\_\_\_\_ p.m.**

– Labour Relations or Employee Negotiations

## **9. RISE AND REPORT**

### **MOTION: RISE AND REPORT**

**That this Board of Health rises and reports. Time: \_\_\_\_\_ p.m.**

## **10. ANNOUNCEMENTS / ENQUIRIES**

## **11. ADJOURNMENT**

### **MOTION: ADJOURNMENT**

**THAT we do now adjourn. Time: \_\_\_\_\_ p.m.**

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

**BOARD MEMBERS PRESENT**

Maigan Bailey  
Robert Kirwan  
Stewart Meikleham  
Mark Signoretti

Janet Bradley  
René Lapierre  
Ken Noland  
Carolyn Thain

Jeffery Huska  
Richard Lemieux  
Rita Pilon

**BOARD MEMBERS REGRETS**

Paul Myre

**STAFF MEMBERS PRESENT**

Megan Dumais  
Jamie Lamothe  
Dr. P. Sutcliffe

Sandra Laclé  
Rachel Quesnel  
Dr. A. Zbar

Stacey Laforest  
Renée St Onge

Media

**R. LAPIERRE PRESIDING**

**1.0 CALL TO ORDER**

The meeting was called to order at 1:32 p.m.

**2.0 ROLL CALL**

**3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST**

There were no declarations of conflict of interest.

**4.0 DELEGATION / PRESENTATION**

**i) 2016 Year-In Review**

1) *2016 Highlights by the Numbers* Infographic

2) 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

Dr. Sutcliffe noted that every year, typically at the February Board meeting, senior managers present divisional statistical year-in reviews of activities that have taken place over the preceding year. The presentation showcases the scope, breadth and volume of divisional work and complements the annual statistical report included in this month's Medical Officer of Health and Chief Executive Officer report to the Board.

The program directors were introduced and each presented an overview of their divisional highlights of program activities undertaken in 2016.

Dr. Sutcliffe concluded that the Sudbury & District Health Unit's work in achieving its mission and vision would not be achievable without its skilled staff and partnerships noting that in 2016, 299 SDHU employees working 436 055 hours and worked with 287 community partnerships. The SDHU has a variety of professionals including for example, health promoters, nutritionists, epidemiologists and communications officers.

An infographic sampling select "numbers" also included in today's agenda package will be shared broadly through social media to share with our community partners and the public.

Questions were entertained and directors were thanked for their presentations.

On behalf of the Board, the Board Chair thanked the staff for compiling and sharing these impressive statistics.

## **5.0 CONSENT AGENDA**

There were no consent agenda items identified for discussion.

- 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**

- |  |                                      |
|--|--------------------------------------|
| 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<br>February 3, 2017 |
| d. SDHU Submission for Pre-Budget Consultation   | February 2017                        |
| e. 2017 alPHa Annual General Meeting and Conference  |                                      |

It was noted that, as part of the provincial government's consultation session, the province held pre-budget consultation sessions and Dr. Zbar made a presentation at the consultation session held in Sudbury on December 2. The SDHU subsequently sent a formal written submission which creates a strong case for the work of public health. The SDHU submission included in today's agenda package has also been shared with all boards of health and the Association of Local Public Health Agencies (alPHa).

**11-17 APPROVAL OF CONSENT AGENDA**

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

**CARRIED**

**6.0 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

Associate Medical Officer of Health, Dr. A. Zbar, was invited to present on behalf of the Community Drug Strategy Committee for the City of Greater Sudbury, to cover recent reports that speak to the impact of opioid use in Sudbury & District, as well as share actions that have been planned and undertaken last year to address opioid use and how these actions are applied at the local level through the work of the community drug strategy.

In sharing results of recent reports, including the Ontario Drug Policy Research Network, 2016, it was cautioned that these statistics likely underestimate the true burden of opioid use in Sudbury & District, particularly with respect to illicit use of opioids. Alarming statistics were shared, including that, in Ontario, there are seven opioid poisoning ED visits per day (2014-15), which is an increase of 22% as compared with 2010-15.

Progress with the community drug strategy was highlighted noting that the five pillars of the local community drug strategy are needed to help prevent and reduce opioid-related harms in Sudbury & District. Key community partners will be coming together in the next few months to discuss various aspects of the opioid issue. These meetings will culminate in a community forum to develop an opioid action plan to help ensure a speedy and comprehensive approach to opioid-related harms in our community.

The drug strategy is taking these steps now while the provincial strategy continues its community consultations. Opioid-related harms, however, are not only a local issue and require coordinated provincial and federal responses.

The following proposed motion addresses the need for timely development and implementation of these local strategies.

Dr. Zbar was thanked for her presentation. Questions were entertained and it was noted that further work is underway in the SDHU district offices to develop local drug strategies.

#### **12-17 OPIOID USE IN SUDBURY & DISTRICT**

***Moved by Lemieux – Meikleham: 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.***

**CARRIED**

**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

The Sudbury & District Health Unit is mandated under the Ontario Building Code Act to enforce the provisions pertaining to sewage systems. Under the authority of this 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.

Dr. Sutcliffe provided highlights from the briefing note that recommends a proposed increase in Part VIII – Ontario Building Code fees in order to administer the program on a cost-recovery basis.

As per the Building Code requirements, the SDHU held a public meeting and have notified all contractors, municipalities, lawyers, and other affected individuals of the proposed fee increases and there are no outstanding concerns. It was also noted that the current user fees have been in place since 2011.

Clarification was provided regarding the rates for 1 a and 1 b and the Board agreed to a friendly amendment correcting an error within the fee schedule under the sewage system permits.

In response to an inquiry, Dr. Sutcliffe clarified that a systematic approach be taken for fee schedule increases was not previously supported; however, this can be explored for the future taking into consideration ongoing fiscal pressures. The SDHU has tried to strike a balance between reducing expenses and setting reasonable fees for this cost-recovery program.

**13-17 AMENDMENT TO FEE SCHEDULE “A” TO BY-LAW 01-98**

***Moved by Meikleham – Thain: 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.***  
***CARRIED***

**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

C. Thain, on behalf of the Joint Board of Health/Staff Performance Monitoring Working Group, provided introductory remarks for the Annual Performance Monitoring Report for 2016. The Working Group, for which R. Pilon and J. Bradley are also members, reviewed the report to ensure it is clear and easily understood. C. Thain congratulated staff on preparing this report for the Board.

The 2016 Performance Monitoring Report provides information about the Sudbury & District Health Unit’s status in meeting various accountability measures, which are grounded within the 2013-2017 Strategy Map.

Krista Galic, Quality & Monitoring Specialist, was invited to present the detailed findings of the report.

The Sudbury & District Board of Health Strategy Map, which is an annex document to the SDHU 2013-2017 Strategic Plan, was also displayed as a poster in the Boardroom.

The Performance Monitoring Plan includes four reporting components:



1. Strategic Priorities Narrative Reports
2. SDHU Specific Performance Monitoring Indicators
3. Public Health Organizational Standards (provincially mandated reporting requirements)
4. Provincial Accountability Agreement Indicators (provincially mandated reporting requirements)

Reporting for each indicator occurs on an annual basis and provides a quick snapshot of all of our results throughout the reporting timeframe.

Specific results for the SDHU Specific Performance Monitoring Indicators for 2016 within the report were highlighted. Results have remained fairly consistent over time and the report illustrates that the SDHU is meeting its performance monitoring goals.

It was concluded that the measurement and monitoring strategies 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.

K. Galic was thanked for her presentation. R. Pilon, C. Thain and J. Bradley were also thanked for their active participation on the Joint Board/Staff Performance Monitoring Working Group

#### **14-17 SDHU 2016 PERFORMANCE MONITORING REPORT**

***Moved by Thain – Bailey: 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***

**CARRIED**

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

It is recommended that the Board Chair be added as a member of the Finance Standing Committee. It was pointed out that although the Board Chair is listed as an ex-officio at all meetings, it is important to explicitly document this expectation.

Terms of Reference from other health units in the province have been reviewed as it relates to Board Chair participation on Board finance committees and this is the common practice.

Board members concurred that it is wise to imbed the Board Chair in the Terms of Reference due to that position's responsibilities.

**15-17 BOARD OF HEALTH FINANCE STANDING COMMITTEE TERMS OF REFERENCE**

***Moved by Noland – Bradley: 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.***

**CARRIED**

**7.0 ADDENDUM**

No addendum.

**8.0 ANNOUNCEMENTS / ENQUIRIES**

M. Signoretti will share details regarding an event being held at Laurentian University to support the City of Greater Sudbury's bid to host the 2021 Canada Summer Games.

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

**9.0 ADJOURNMENT**

**16-17 ADJOURNMENT**

***Moved by Bailey – Noland: THAT we do now adjourn. Time: 2:44 p.m.***

**CARRIED**

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(Chair)

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(Secretary)

## MEETING NOTES

**JOINT BOARD OF HEALTH/STAFF PERFORMANCE MONITORING WORKING GROUP**  
**TUESDAY, JANUARY 24, 2017, 10 A.M., BOARDROOM**

PAGE 1 OF 2

**Chair:** Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer

**Recorder:** Rachel Quesnel, Executive Assistant and Board Secretary

**Members:** Janet Bradley Krista Galic David Groulx  
Rita Pilon \* Renée St Onge Carolyn Thain

\* via teleconference

#	Item	Decisions, Assignments, Required Follow-up
1.0	<b>CALL TO ORDER / WELCOME</b>	The meeting was called to order at 10 a.m.
2.0	<b>PURPOSE</b>	The main purpose of today's meeting is to review and obtain feedback the draft 2016 Performance Monitoring Report.
3.0	<b>REVIEW AND APPROVAL OF THE AGENDA</b>	The agenda was reviewed and approved as distributed.
4.0	<b>NEW BUSINESS</b>	
4.1	Meeting Notes – September 27, 2016	The Joint Board/Staff Performance Monitoring Working Group meeting notes dated September 27, 2016, were approved.
4.2	Draft 2016 Performance Monitoring Report	<p>Dr. Sutcliffe prefaced by indicating that the SDHU Performance Monitoring Report is found to be impressive by all, including by others provincially.</p> <p>The outcomes are not yet known from the current Ontario Public Health Standards review and the MOHLTC's Accountability Committee who is tasked with looking at an accountability framework for public health; however, we will consider any applicable indicator changes in future performance monitoring reports. Dr. Sutcliffe noted that our Report was reviewed by the Accountability Committee as an example of an internal performance monitoring tool.</p> <p>It was observed that possible changes might be timely as we begin a new strategic planning cycle in 2018 and we already have solid monitoring and reporting tools that are adaptable.</p> <p>R. St Onge introduced the draft 2016 performance monitoring report acknowledging the work of K. Galic and team.</p> <p>It was recapped that the performance monitoring report is made up of four monitoring components to provide the Board with information about the SDHU's status in meeting these various accountability measures:</p> <ol style="list-style-type: none"> <li>1. Strategic Priorities: Narrative Report</li> <li>2. SDHU-Specific Performance Monitoring Indicators Report</li> <li>3. Ontario Public Health Organizational Standards Report</li> <li>4. Public Health Accountability Agreement Indicators Report</li> </ol> <p>It was commented that the 2016 Strategic Priorities Narrative Topics summary is a good reminder of the topics that were presented in 2016. Hyperlinks to each narrative report will be added.</p> <p>This is the fourth year that we report on the thirteen SDHU-specific performance monitoring indicators that were developed internally and there is only one more year to report on to align with our 2013-2017 strategic plan timelines. The report provides trends overtime and highlights that we have been fairly consistent over the last four years with exception of</p>

## MEETING NOTES

**JOINT BOARD OF HEALTH/STAFF PERFORMANCE MONITORING WORKING GROUP**  
**TUESDAY, JANUARY 24, 2017, 10 A.M., BOARDROOM**

PAGE 2 OF 2

#	Item	Decisions, Assignments, Required Follow-up
		<p>website reporting due to the change in the SDHU website in 2015. An explanatory note provides the context and advises reader to not compare 2016 to data from previous years. It was suggested that, in addition to the explanatory note, a note be added in table if doable.</p> <p>Some adjustments were identified for the leadership excellence explanatory notes and the number of partnerships will be checked.</p> <p>Clarification was provided regarding the worker engagement index notes under the Organizational Excellence pillar.</p> <p>The Public Health Accountability Agreement Indicators Report was also reviewed.</p> <p>Suggestions made at today's meeting will be incorporated in the final report.</p> <p>The focus for these annual reports was for internal monitoring purposes; however, consideration for future iterations will be given to making it an external report.</p> <p>C. Thain agreed to introduce the 2016 Performance Monitoring Report at the next Board meeting and K. Galic will make a presentation highlighting salient points. J. Bradley will present the narrative at the April Board meeting.</p>
<b>5.0</b>	<b>NEXT MEETING DATE/TIME</b>	To be determined.
<b>6.0</b>	<b>ADJOURNMENT</b>	The meeting was adjourned at 10:45 a.m.

## UNAPPROVED MEETING NOTES

**JOINT BOARD OF HEALTH/STAFF PERFORMANCE MONITORING WORKING GROUP**  
**TUESDAY, APRIL 4, 2017, 10:30 A.M., TELECONFERENCE**

PAGE 1 OF 2

**Chair:** Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer

**Recorder:** Rachel Quesnel, Executive Assistant and Board Secretary

**Members:** Janet Bradley \*      David Groulx      Rita Pilon \*  
Renée St Onge      Carolyn Thain \*

**Regrets** Krista Galic

\* via teleconference

#	Item	Decisions, Assignments, Required Follow-up
1.0	<b>CALL TO ORDER / WELCOME</b>	The meeting was called to order at 10:30 a.m.
2.0	<b>PURPOSE</b>	The main purpose of today's meeting is to review and obtain feedback regarding the draft Narrative Report.
3.0	<b>REVIEW AND APPROVAL OF THE AGENDA</b>	The agenda was reviewed and approved as distributed.
4.0	<b>NEW BUSINESS</b>	
4.1	Meeting Notes – January 24, 2017	The Joint Board/Staff Performance Monitoring Working Group meeting notes dated January 24, 2017, were approved.
4.2	Strategic Priorities: Narrative Report – April, 2017	<p><i>Strategic Priority 1:</i> Champion and lead equitable opportunities for health <i>Narrative topic:</i> Advocating for a Basic Income Guarantee to Promote Optimal Health for All</p> <p>It was observed that this submission showcases that the Board and staff are championing equitable health. It highlights the SDHU's extensive role and public health's fundamental role.</p> <p><i>Strategic Priority 2:</i> Strengthen relationships <i>Narrative topic:</i> SDHU's Baby-Friendly Initiative Journey</p> <p>There are unique partnerships that vary from individual and organization level partnerships. Kudos were extended for establishing these important partnerships to move our work forward.</p> <p><i>Strategic Priority 3:</i> Ridgecrest Playground Research Student – Utilizing <i>Narrative topic:</i> Evidence to Promote Accessible Playgrounds</p> <p>The description of this narrative will be updated to be explicit on the what, why and how, including the purpose and methodology.</p> <p><i>Strategic Priority 4:</i> Support community actions promoting health equity <i>Narrative topic:</i> Youth in Crisis: Employability Partnership with the Sudbury Food Bank</p> <p>This topic relates to our work and partnership with the Sudbury Food Bank to increase individual skills and ultimately positively impact their health. This was observed to be a great initiative which has the potential to expand to increasing cooking skills.</p> <p><i>Strategic Priority 5:</i> Foster organization-wide excellence in leadership and innovation <i>Narrative topic:</i> Risk Management at SDHU</p>

## UNAPPROVED MEETING NOTES

JOINT BOARD OF HEALTH/STAFF PERFORMANCE MONITORING WORKING GROUP  
TUESDAY, APRIL 4, 2017, 10:30 A.M., TELECONFERENCE

PAGE 2 OF 2

#	Item	Decisions, Assignments, Required Follow-up
		<p>This narrative describes the SDHU's process and direction for implementation of risk management.</p> <p>The term enterprise risk management was explained and will be updated to organizational-wide risk management. An acknowledgement of our proactive work in this area, the language will be updated to <i>proactively initiated</i>.</p> <p>With these approved edits, the report will be finalized and presented to the Board at the April 20, 2017, Board meeting. J. Bradley will present the narrative report on behalf of the working group.</p>
5.0	NEXT MEETING DATE/TIME	To be determined.
6.0	ADJOURNMENT	The meeting was adjourned at 10:50 a.m.

**BOARD OF HEALTH EXECUTIVE COMMITTEE  
UNAPPROVED MEETING NOTES**

**THURSDAY, FEBRUARY 16, 2017**

**11 A.M.**

**RAMSEY ROOM, SUDBURY & DISTRICT HEALTH UNIT**

**MEMBERS:** Janet Bradley                      Jeff Huska                      René Lapierre  
Ken Noland

**REGRETS:** Paul Myre

**STAFF:** Krista Galic                      Rachel Quesnel                      Renée St Onge  
Dr. Penny Sutcliffe

**STAFF REGRETS:** France Quirion

**R. QUESNEL PRESIDING**

**1. CALL TO ORDER**

The meeting was called to order at 11:08 a.m.

**2. ROLL CALL**

**3. REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST**

The agenda was reviewed and there were no declarations of conflict of interest.

**4. ELECTION OF BOARD EXECUTIVE COMMITTEE CHAIR FOR 2017**

**01-17 ELECTION OF BOARD EXECUTIVE COMMITTEE CHAIR FOR 2017**

*Moved by Bradley – Lapierre: THAT the Board of Health Board Executive Committee appoint Jeffery Huska as the Board Executive Committee Chair for 2017.*

**CARRIED**

**J. HUSKA PRESIDING**

**5. APPROVAL OF BOARD EXECUTIVE COMMITTEE MEETING NOTES**

5.1 Board Executive Committee Meeting Notes dated June 28, 2016



## 02-17 APPROVAL OF BOARD EXECUTIVE COMMITTEE MEETING NOTES

***Moved by Lapierre – Noland: THAT the meeting notes of the Board of Health Executive Committee meeting of June 28, 2016, be approved as distributed.***

**CARRIED**

## 6. NEW BUSINESS

### 6.1 Strategic Planning Engagement

Purpose of today's meeting:

- To provide a high-level background on Strategic Planning
- To review and approve the engagement plan for the next Strategic Plan
- To conduct a SWOT analysis to inform the Strategic Plan
- To share results of our environmental scan to date
- To get insights into the Board's vision for the next iteration of the Strategic Plan (scope, duration, type of content, community and stakeholder engagement)

#### 6.1.1 Strategic Plan Engagement Plan

K. Galic and N. Frappier were acknowledged for their work in mapping out the strategic plan engagement process being proposed today.

#### 6.1.2 Strategic Planning – Engagement Plan Visual

A one-page honeycomb colored graphic visually displays the steps and timelines of the strategic planning engagement plan until its launch in January 2018. It was suggested interactive components be included for electronic-based formats of the visual.

#### 6.1.3 History of Strategic Plan

A two-page summary was distributed outlining the SDHU's strategic plan history since its 2002 – 2004 strategic plan, including its mission, vision, strengths/values, and strategic directions.

#### 6.1.4 2013-2017 SDHU Strategic Plan

The 2013 – 2017 Strategic Plan brochure was included in today's agenda package as a refresher and a print copy distributed.

#### 6.1.5 Background Reading:

- Mittenthal, R.A. (2002). *Ten Keys to Successful Strategic Planning for Nonprofit and Foundation Leaders*. TCC Group. Retrieved from: [http://www.tccgrp.com/pdfs/per\\_brief\\_tenkeys.pdf](http://www.tccgrp.com/pdfs/per_brief_tenkeys.pdf) \*

The above-noted background article was shared. It describes how the benefits and components of an effective strategic plan will focus agencies in meeting their goals for the next 3 to 5 years.

Through a presentation, Dr. Sutcliffe, R. St Onge and K. Galic facilitated the strategic plan engagement session.

A mid-level engagement is proposed that will include a number of groups but no broad town hall consultations. On February 1, 2017, a Senior Management Executive Committee (SMEC) consultation session was held using similar questions as those that will be discussed today. The purpose is to get a sense of scope and broad themes for the next strategic plan.

In addition to the SMEC and Board EC consultation sessions, additional engagement would include an online community stakeholder survey that would be promoted through our partners and the SDHU website. The survey would be available for clients to complete electronically in all SDHU offices. Follow-up sessions would be held as required.

A half-day session would be held for SDHU staff during the annual SDHU Staff Day at end of April. A full day consultation will be held with the full Board of Health member.

It suggested that meetings be held with the constituent municipalities to ensure alignment of strategic priorities, identify gaps, duplications, etc. It was also suggested that consultation include Indigenous community partners.

Timelines were reviewed and external considerations discussed such as provincial changes; pending announcement and implications of the modernization of the Ontario Public Health Standards, etc.

It is proposed that the Board Executive Committee meet mid-June and that a Board of Health workshop be held on September 21. It was suggested that the workshop be held on a different day than the regular Board meeting such as September 28. This will be further explored.

The following SWOT questions were discussed:

1. What opportunities has the SDHU had in the last five years? What opportunities exist currently?
2. What threats has the organization had to deal with? What threats exist currently?
3. What strengths does the organization have to deal with threats or opportunities?
4. What weaknesses does the organization have to deal with threats and opportunities?

Staff have conducted an environmental scan and reviewed strategic plans from 45 other agencies, including public health and other health organizations. Examples of strategic plan models and themes identified through environmental scan were shared:

- Windsor Public Health: 2017-2021
- Peel Public Health: 2009-2019
- Toronto Public Health: 2015-2019
- Ottawa Public Health: 2015-2018
- Middlesex-London: 2015-2020

- NE LHIN: 2016-2019

19 of the most frequent themes from other strategic plans were summarized. Some agencies focus on programmatic strategies while others are high level organizational priorities and others are mixed. In past, SDHU direction has focused on organizational/broader priorities given that at the program or policy level, we are mandated through legislative and provincial requirements and respond to local needs. The Board agreed with a broader strategic direction, especially given the current provincial and fiscal climate.

The Committee proceeded to these consultation questions:

1. What is your vision for the next Strategic Plan?

Feedback provided included but was not limited to:

Public health protection such as enforcement/inspections; accountability such as performance monitoring; health equity/social determinants of health; sustainability; impact on rural communities; mental health; aging population; Indigenous engagement

2. The Organizational Standards suggest the Strategic Plan cover a 3 to 5 year timeframe
  - i) Discussion on the duration of SDHU's next Strategic Plan

Discussion was held regarding the possible change in Board membership with the municipal elections occurring in 2022. The Board EC members agreed on a five year plan for the next strategic plan from 2018 to 2022. The new plan would be developed in 2022 for release in 2023.

3. What do you see as the key priorities the SDHU should establish in its next Strategic Plan?

Some program priorities that were discussed included the SDHU's health equity work, needle exchange program, children programs, promotion of healthy lifestyles/behaviours; innovation such as social media/accessibility; community drug strategies.

Relating to organizational priorities, sustainability and maintaining our current programs and services was highlighted given the current fiscal climate. Communication, self-promotion and strengthening relationships were also identified as key priorities.

4. Based on what has been identified so far, what should we ask the community as part of the engagement? Our stakeholders?

The following suggestions were entertained:

- SWOT questions
- Identify one area your organization needs to focus
- What do you think SDHU is?

- What is the community leaders expectation of us
- Do district office citizens know what the SDHU does
- What can the HU do for you and what can you do for HU?

It was pointed out that work is currently underway relating to the SDHU's visual identity and communication strategies for education/awareness relating to the SDHU and public health.

Members agreed that the current strategic plan resonated with the questions discussed today. It was noted that this was also the case for senior managers and staff. A good starting point to probe partners regarding our next plan might be to ask them what in our current plan needs to be updated.

From this, we have endorsement or consensus of the proposed process and good ideas of who and how to probe for what that will help to inform next steps.

## 7. ADJOURNMENT

### 03-17 ADJOURNMENT

***Moved by Bradley – Noland: THAT we do now adjourn. Time: 1:02 p.m.***

***CARRIED***

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(Chair)

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(Secretary)

## Medical Officer of Health/Chief Executive Officer Board of Health Report, April 2017

### Words for thought

Dear Colleagues,

I am pleased to provide you with a copy of my 2015 Annual Report, [\*Mapping Wellness: Ontario's Route to Healthier Communities\*](#).

Mapping Wellness makes the case for how good local data can be used to improve wellness for whole communities and certain groups and individuals within a community. It explains that if we know where the problems are and what the problems are, programs and services can be developed to suit a specific community's needs, and can be made more cost effective.

Stakeholders across Ontario have acknowledged the need for and value of local data, which can contribute to healthier individuals and healthier communities. Building on these sentiments, my report recommends investing in local data by implementing a provincial population health survey that collects data at the community and neighborhood levels. It further recommends increasing access to public health information, and using the information to address health disparities.

I would like to take this opportunity to thank Peel, Niagara, Toronto, Halton, Durham and Sudbury health units for their contributions to this report. The stories that appear in this report are compelling examples of how local level data can make a real difference.

I am hopeful that this report will contribute to improving community health and wellness, and, with your support, achieve the stated goal of implementing a local-level population health survey in Ontario.

Thank you for your ongoing support.

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

Source: [http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh\\_15/default.aspx](http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_15/default.aspx)

Date: March 2017

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### Chair and Members of the Board,

The annual report of the Chief Medical Officer of Health (CMOH) is a timely call for investments in health data. The report calls for a provincial population health survey and improvements in public access to health information. Such a survey would be a huge undertaking, but one for which there is precedence. In 1990 and 1996/97 Ontario undertook the Ontario Health Survey which provided invaluable information at the local level on health behaviours, health problems and health care utilization. Similar data is currently collected across the country under the Canadian Community Health Survey (CCHS) but typically people are sampled in insufficient numbers to provide information at the community or neighbourhood levels. To fill this local data gap, we have been provincial leaders, helping develop and steer the Rapid Risk Factor Surveillance System (RRFSS) which gathers local data on health related knowledge, attitudes and behaviours and investing in RRFSS over sampling so that we can have information at the district office level. We were pleased to be invited to showcase these local initiatives in the recent CMOH report and we are strong advocates echoing the CMOH's call for provincial systems for population health data collection.

It has been a busy number of weeks since the February Board of Health meeting. I am pleased to share with you operational highlights per below.

## GENERAL REPORT

### 1. Board Updates

Board Chair, R. Lapierre, and Board member, M. Bailey, attended the alPHa Winter 2017 Symposium on February 23, 2017, along with Dr. Sutcliffe, Dr. Zbar and S. Laclé. The Board members participated 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 to 13 in Chatham, Ontario. Board members interested in attending are asked to pencil these dates in their calendars. A motion is included in the meeting agenda relating to Board attendance for the AGM.

As previously shared, provincial appointee, J. Bradley has had her Board of Health term extended to February 21, 2020.

The Joint Board/Staff Performance Monitoring Working Group met on April 24, 2017, to review the draft Narrative Report. Board representation on this working group includes C. Thain, R. Pilon and J. Bradley.

A reminder of upcoming events for Board members:

- *Unveiling of recently acquired Indigenous artwork* marking the Sudbury & District Board of Health's commitment to strengthening relations with area First Nations and Indigenous peoples to improve opportunities for health for all. Thursday, April 20 at 12:30 p.m., SDHU Ramsey Room.
- *Board of Health Strategic Planning workshop* followed by afternoon training opportunity in Bridges Out of Poverty. Thursday, September 28, 2017, from 9 a.m. to noon in the Ramsey Room (Bridges from 1 to 4 p.m.).

### 2. Engagement with Indigenous Peoples

Various activities are underway to further the Board's direction on Indigenous engagement. A workplan has been developed and structural supports are being established including an internal Steering Committee and an external Indigenous Advisory Committee.

We are planning for an Indigenous keynote speaker and panel at the annual Staff Day. This, in addition to the unveiling of the Indigenous artwork, are efforts aimed at continuing staff engagement and competency building, and creating a more welcoming and culturally safe environment within our work and public spaces. We have received funding from Public Health Ontario to explore principles of engagement with First Nations. This is a multi-partner Locally Driven Collaborative Project in collaboration with northeast health units and academic and community partners.

### **3. Financial Report**

The approved 2017 cost-shared budget was \$22,774,566 reflecting a decrease of 0.43% compared to 2016.

The 2017 budget request was submitted on time to the MOHLTC on February 28, 2017. The Ministry grant announcement is not expected until this summer. The Ministry continues to emphasize the government's direction regarding fiscal constraint and the need to protect service delivery.

The February statements are the first set of statements presented for 2017 and they reflect the Board of Health approved budget. Adjustments due to calendarization will be reflected in the March statements. The positive variance in the cost-shared program is \$298,455 for the period ending February 28, 2017. Gapped salaries and benefits account for \$38,103 or 12.8% with operating expenses and other revenue accounting for \$260,352 or 87.2% of the variance. The operating and revenue variance is attributable to timing and calendarization of revenues and expenses.

The 2016 audit is being conducted by KPMG. This is KPMG's first year conducting the SDHU audit. KPMG was onsite December 19 to 22, 2016, for the interim audit work and returned on March 13 to 16, 2017 to complete the in-house audit review. The audit report will be presented to the Board Finance Standing Committee on May 4 and will be included in the May 18, 2017, Board of Health agenda.

### **4. Quarterly Compliance Report**

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

The SDHU has paid all payable remittances for employee income tax deductions and Canada Pension Plan and Employment Insurance premiums, as required by law to March 24, 2017, on March 24, 2017. The Employer Health Tax has been paid as required by law, to March 31, 2017, with a cheque dated April 14, 2017. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to March 31, 2017, with a cheque dated April 28, 2017. There are no outstanding issues regarding compliance with the Occupational Health & Safety Act, Ontario Human rights Code or Employment Standards Act.

## **5. Strategic Engagement Unit / Communications**

The SDHU's 2018–beyond Strategic Plan Engagement Plan has been approved by Senior Management and the Board of Health Executive Committee. The engagement process, which includes an all staff survey, Board of Health member survey and surveys of community members and partners, is currently underway. Results will be shared and validated with staff at our annual 2017 Staff Day on April 26, 2017.

## **6. Local and Provincial Meetings**

I chaired Northern Ontario Health Equity Steering Committee meetings which took place March 21 and April 10.

On March 27, the SDHU hosted the MOHLTC north east regional consultation session on the draft Standards for Public Health Programs and Services. Medical Officers of Health and senior staff from each north east health unit participated in the session.

The COMOHE Executive has had several meetings since February to discuss provincial issues such as the draft Standards and provincial audits. COMOHE section meeting was held on February 24, 2017. I participated in the alPHA Board meeting on April 7.

The work of the provincial Public Health Work Stream to advise on the implementation of the LHIN/public health provisions of Patients First continues with recent meetings held on February 28 and April 5.

As co-leads for Sudbury's Community Drug Strategy, we worked with the Greater Sudbury Police Services to co-host a community service provider forum on opioids on April 3.

I continue to serve as a mentor for Dr. Catton, Acting MOH for Porcupine Health, under the provisions of the College of Physicians and Surgeons Change of Scope of Practice program.

## **7. The Ontario Public Health Conference (TOPHC)**

SDHU staff contributed to and participated in the annual provincial public health conference, TOPHC (The Ontario Public Health Convention), jointly hosted by Public Health Ontario, the Ontario Public Health Association (OPHA), and the Association of Local Public Health Agencies (alPHA). The theme for TOPHC 2017 was "*Global Challenges, Local Solutions*". I had the honour of moderating the closing plenary session on immigrant and refugee health. Among other contributions, SDHU collaborated with members of a provincial project team to present the poster, "*Beyond BMI: A Public Health/Primary Care Collaboration to Build a Healthy Weights Surveillance System Including Nutritional Risk and Protective Factors in Children in Ontario*". We also presented on the results of the local texting and driving study – Perceptions and Behaviour of Youth who Text and Drive. The study is a partnership between the SDHU and Laurentian University.



## 8. Expansion of Proactive Disclosure System Update

The Environmental Health and Corporate Services Divisions continue to work with Hedgerow Software Limited regarding implementation of the enhanced *Check Before You Go!* disclosure website that is being developed in response to Board of Health Motions 36-15 and 02-17 (Expansion of Proactive Disclosure System). Though SDHU staff continue to work diligently toward the successful launch of the *Check Before You Go!* disclosure website, Hedgerow Software Limited has encountered issues with completion of the project by the agreed upon deadline of February 28, 2017. Environmental Health and Corporate Services staff continue to work with the company toward successful completion of the project.

Highlights from the last two months from the program divisions follow.

### CLINICAL AND FAMILY SERVICES DIVISION

#### 1. Control of Infectious Diseases

*Influenza:* As of April 3, 2017, 134 cases of Influenza A and two cases of Influenza B have been reported within the Sudbury & District Health Unit service area this flu season.

*Respiratory Outbreaks:* Since January 2017, the CID team has managed 13 respiratory outbreaks (8 influenza A, 1 Respiratory Syncytial Virus (RSV), 1 parainfluenza, 2 Coronavirus and 1 unknown).

*Vaccine Preventable Disease:* The CID team is in the process of reviewing approximately 26,000 immunization records of all local school-aged children up to 18 years of age for compliance with the Immunization of School Pupils Act (ISPA).

*Influenza Vaccine Variance:* A variance was reported in February for the Influenza vaccine wastage accountability indicator. An inventory review of district offices was concluded and some Flumist vaccine was noted as overdue for return to the Ontario Government Pharmacy. The Clinical & Family Services Division has completed a review of inventory processes for monitoring district office site vaccines and implemented improvement measures.

*Tuberculosis:* In support of World TB Day (March 24, 2017), the CID program provided a public education campaign to raise awareness about tuberculosis prevention, testing and treatment. Over the past 10 years, the SDHU CID team has followed up with 18 pulmonary TB clients. There are currently no active TB cases in the SDHU service area.

#### 2. Family Team

*Prenatal Education:* Onsite prenatal classes reached 45 community participants since January and 20 participants enrolled in online in the same time frame. An outcome evaluation of the onsite curriculum is being prepared with the assistance of RRED staff.

*Breastfeeding:* Staff, in collaboration with a BFI provincial strategy staff member, provided a 20-hour breastfeeding education session to nine community health care providers on Manitoulin Island in March. Breastfeeding education was provided to the N'Swakamok Friendship Centre in response to a community need.

*Positive Parenting Program (Triple P):* Several sessions of Triple P have taken place since January including transitions group sessions with parents, one-on-one and group sessions for clients, Children's Aid Society case conference and tip sheet sessions at Barrydowne Campus (alternative school for Rainbow District School Board). Follow-up sessions are being organized for other public health services from Sexual Health and Healthy Babies Healthy Children at Barrydowne Campus.

*Baby Friendly Initiative (BFI):* Staff continue to lead the BFI network monthly meetings locally and help to facilitate the progress of the BFI journey for HSN and the community at large.

### **3. Oral Health**

The oral health screening program in elementary schools will be complete by the end of April. The Oral Health team will return to all elementary schools in the following month to monitor the progress of dental treatment for children identified during the screening process and to provide preventive services to participating children. Three new childcare centres are now participating in the Smile Care tooth brushing program for children. Children in these centres will participate in a daily tooth brushing program and will receive education about oral health.

The Oral Health team is promoting the need for children to receive their first dental visit by the age of one as part of the oral health month campaign. Messaging will be promoted through social media and targeted media in walk-in clinics. Outreach visits to dental offices will also occur to promote newly created patient resources, Baby's First Dental Visit and the Healthy Smiles Ontario program.

Fluoridation update: The Onaping/Levack fluoridation equipment has been offline for more than 90 days as the equipment is pending replacement. It is expected the repairs will be completed and that the system will be back online by April 21.

### **4. Sexual Health\Sexually Transmitted Infections including HIV and Blood Borne Infections**

The Sexual Health program responded to 11 community requests for presentations during the months of February and March with 1013 attendees. One display was held at Science North as part of their annual event "Love, sex and oh!!". "MyTest" (online testing) and the Sexual Health Clinic services at the Rainbow Centre were promoted. Of note, 11 individuals used the "MyTest" application during the month of February with one positive case reported.

We participated in the “Classroom closet” conference hosted by Réseau Access Network. The conference’s purpose was to help foster safer spaces for individuals, specifically students identifying within a range of diverse sexual orientations, gender identities, and gender expressions; otherwise known as the LGBTQI2-S or Queer and Two-Spirit community. SDHU provided information related to our Sexual Health program services and “My Test” at this event.

A healthy relationships campaign was promoted between February 17 to 24, 2017, airing at SilverCity during the pre-show for adult only rated movies.

## **5. Needle Exchange Program (NEP)**

During the month of February, the needle exchange program distributed 75,255 syringes to 1,147 contacts at their three NEP sites and through outreach initiatives.

## **6. Substance Misuse - Drugs and Community Drug Strategy**

Since January, the Community Drug Strategy Steering Committee organized two meetings with drug strategy partners. The first was a discussion of gaps and opportunities concerning naloxone supply and distribution, and the second was on data sources that could be used to inform surveillance and response to opioid use and opioid-related harms in the community.

# **ENVIRONMENTAL HEALTH DIVISION**

## **1. Control of Infectious Diseases**

During the months of February and March, 14 sporadic enteric cases and one infection control complaint were investigated. Seventeen enteric outbreaks were declared in institutions. The causative organism of three outbreaks were confirmed to be Norovirus.

## **2. Food Safety**

During the months of February and March, three food product recalls prompted public health inspectors to conduct checks of 279 local premises. All affected establishments had been notified, and subsequently had removed the recalled products from sale. The recalled food products included: PC Organics brand Apple, Blueberry & Green Pea Strained Baby Food due to the possible contamination with *Clostridium botulinum*, and I.M. Healthy brand SoyNut Butter and Granola products as well as SoLo GI brand Energy Bars due to the possible contamination with *E. coli* O157:H7.

Also during February and March, public health inspectors issued one closure order to a food premises due to rodent activity. The closure order has since been rescinded following corrective action, and allowed the premises to reopen.

Public health inspectors issued two charges to one food premises for infractions identified under the *Food Premises Regulation*.

Staff issued 27 Special Event Food Service Permits to various organizations for events serving approximately 9400 attendees.

Through Food Handler Training and Certification Program sessions offered in February and March, 76 individuals were certified as food handlers.

As a result of increased norovirus illness related to the consumption of British Columbia oysters, a public advisory was issued by Ontario's Acting Chief Medical Officer of Health. In response to this, public information was posted to the Health Unit's website and a letter was mailed to supermarket, fish shop and restaurant operators within the Sudbury & District Health Unit service area informing them of the ongoing national outbreak and food safety measures needed to protect customers.

### **3. Health Hazard**

In February and March, 65 health hazard complaints were received and investigated. Six of these complaints involved marginalized populations.

From March 3 to 5, 2017, public health inspectors provided an exhibit, resources and three presentations at the Sudbury Home Show. Public health inspectors were engaged by the public in 246 specific education requests on subjects of Environmental Health programs with an emphasis on radon, mould, sewage, lead, pest control and drinking water.

### **4. Ontario Building Code**

During the months of February and March, six sewage system permits, 18 renovation applications and two consent applications were received.

### **5. Rabies Prevention and Control**

Forty-eight rabies-related investigations were carried out in the months of February and March. Two specimens were submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis, and were subsequently reported as negative.

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

### **6. Safe Water**

During February and March, 39 residents were contacted regarding adverse private drinking water samples. Public health inspectors investigated four regulated adverse water sample results.

Two boil water orders and one drinking water order were issued. Furthermore, two boil water orders and one drinking water order were rescinded.

During the month of March, one public pool was issued a closure order and remains closed.

## **7. Tobacco Enforcement**

In February and March, tobacco enforcement officers charged one person for smoking in a workplace and six people for smoking in an enclosed workplace vehicle. Two individuals were charged with smoking on school property, 24 charges were laid for smoking on hospital property, and one retail employee was charged for selling tobacco to a person who is less than 19 years of age.

# **HEALTH PROMOTION DIVISION**

## **1. Healthy Eating**

Health Promotion staff supported the Greater Sudbury Food Policy Council in the planning and hosting of another successful Four Minute Foodies event. Once again, the event took place at Tom Davies Square and highlighted seven food initiatives happening in Greater Sudbury from locally owned restaurants to a wild food bank. Information was also provided on the development of the Greater Sudbury Food Strategy. The event was well attended and received media coverage.

In January, Health Unit staff representing the Healthy Kids Community Challenge partnered with Noojmowin Teg Health Centre to launch healthy options at the Northeastern Manitoulin and the Islands (NEMI) recreation centre canteen. Over 300 participants attended the event.

## **2. Healthy Weights**

In late February, a Health Promotion staff member presented to approximately 40 parents and staff at St. Benedict Catholic School regarding the importance of healthy sleep.

Water Does Wonders is the second theme of the Health Kids Community Challenge provincial initiative. The SDHU has taken the Gold Level pledge by demonstrating our commitment to promoting water and by not selling, providing or promoting sugary drinks. By taking this pledge, we are affirming our commitment to help children sip less sugar. The Water Does Wonders website was created by the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) in partnership with 11 Healthy Kids Community Challenge communities. The SDHU has posted a number of tweets and Facebook posts encouraging people and community organizations to take the pledge.

## **3. Injury Prevention**

Road Safety: On January 30, a public health nurse who is a Certified Child Passenger Safety Technician Trainer trained 6 new technicians (2 from Greater Sudbury Police Services, 1 public health nurse, 1 from Centre Pivot du Triangle Magic daycare, and 1 from Our Children Our Future).

On March 9, a public health nurse delivered a full day in-service about Child Passenger Safety at the N'Swakamok Indigenous Friendship Centre to staff and parents. Information, handouts and poster were well received.

Falls Prevention: Health Unit staff continue to work with community partners on falls prevention programming for older adults. The Stay on Your Feet Sudbury/Manitoulin Falls Prevention coalition developed a work plan for year three with the North East Local Health Integration Network (NE LHIN). A draft of the work plan was shared with the LHIN representative and the other north east health units at the end of March.

Throughout the first quarter of 2017, public health nurses delivered several Stay On Your Feet presentations. Approximately 70 older adults from the Rockview Towers apartment building and Amberwood Suites (retirement residences) in Sudbury, as well as a seniors group in Chapleau, attended the presentations and received resource packages.

Staff from the Sudbury East office worked with the Municipality of St.-Charles to draft the Municipality of St.-Charles Age Friendly Action Plan which was approved in March of 2017.

#### **4. Physical Activity**

In February, staff from the Espanola office, in partnership with the Espanola & Area Family Health Team, hosted a Skate Exchange event at the Espanola Winter Carnival where 36 skates were handed out. Similarly, a new partnership with the M'Chigeeng Health Centre resulted in a request for skates for families.

Staff from the Sudbury East office worked in collaboration with the Municipality of Markstay-Warren and the Warren area to successfully secure a Canadian Tire Jumpstart Partner grant that will fund 20 pairs of hockey skates, 20 full-face helmets and five early skate learning aids.

#### **5. Prevention of Substance Misuse**

The SDHU promoted the Rethink your Drinking video, which was developed in collaboration with the Northeast Low-Risk Alcohol Drinking Guidelines Working Group as part of the provincial Rethink your Drinking campaign. This video was shown at Imagine Cinemas in downtown Sudbury for 3 months, SilverCity Sudbury Cinemas from March 10 to 16, and was boosted on the SDHU: Alcohol, Let's Get Real Facebook page from March 1 to 19.

#### **6. Tobacco Control**

The SDHU participated in a CTV media interview regarding smoking cessation resources and quit strategies. The Tobacco team also delivered several community-based presentations on comprehensive smoking cessation strategies. Staff were well received at a Healthy Babies Healthy Children Early Years Centre session on the Atikameksheng Anishnawbek First Nation Reserve, where they facilitated a discussion on the use and differences of traditional tobacco (Sema) and commercial tobacco products (including cessation strategies and tips on making homes a smoke-free environment for infants and youth).

The SDHU and the Centre for Addiction and Mental Health (CAMH) held a Smoking Treatment for Ontario Patients (STOP) on the Road smoking cessation workshop at our Paris Street location. There were 24 participants in total, of whom 21 were eligible to receive free nicotine patches from CAMH.

SDHU staff continued to provide services to the community through the Quit Smoking Clinic and Telephone Information Line. The SDHU received 134 calls and 65 visits to the clinic in January and February. A grant application requesting additional funding to expand our current tobacco cessation services was completed. The grant will support the dispensing of Nicotine Replacement Therapy (NRT) vouchers to our priority client population.

## **RESOURCES, RESEARCH, EVALUATION AND DEVELOPMENT (RRED) DIVISION**

### **1. Health Equity**

An open letter to the editor on homelessness and cold weather vulnerability was issued to media outlets across CGS in February by Dr. Sutcliffe. The advocacy letter was picked up by CTV and a television interview was arranged to discuss homelessness in our community, including upstream determinants and opportunities to address this issue. In February, an advocacy letter was sent by Dr. Sutcliffe to our local MPP, the Honourable Glenn Thibeault, requesting support on passing Bill 6 (Ministry of Community and Social Services Amendment Act of 2016) to study the cost of living in different Ontario communities and recommend realistic rates for social assistance.

In March, the Poverty Reduction Strategy Office publicly released the 30 successful grantees across the province from the 2016 Local Poverty Reduction Fund competition. This included an SDHU led three-year grant totaling \$217,000 to implement the three linked programs of Bridges out of Poverty, Getting Ahead, and Circles in the City of Greater Sudbury (CGS). This project is being undertaken in collaboration with six other agencies: CGS - Social Services, Rainbow District School Board, Our Children Our Future, Centre de Santé Communautaire du Grand Sudbury, Sudbury Social Planning Council, and Canadian Mental Health Association - Sudbury Manitoulin. As part of this collaborative project, the two SDHU trained Bridges out of Poverty facilitators delivered their inaugural workshop in the community (in March), and will continue to deliver workshops throughout the community as the project progresses.

A member from the Health Equity team attended the annual Social Determinants of Health Public Health Nurse network meeting in Toronto and participated in the workshop on the impact of power and privilege in health equity practice.

### **2. Population Health Assessment and Surveillance**

The Population Health Assessment and Surveillance team produced one new internal report with eight indicators on *Menu Labelling* from the 2014 Rapid Risk Factor Surveillance System (RRFSS).

The Population Health Assessment and Surveillance team and the Clinical and Family Services Division compiled the Quarterly Reportable Diseases Report for October to December 2016 (including a 2016 annual summary). The report was circulated to the SDHU Outbreak Team, specialists, program managers, and the Executive Committee. Data from the integrated Public Health Information System (iPHIS) include reported and confirmed cases diagnosed in the SDHU area.

### **3. Research and Evaluation**

The Health Unit participated in Laurentian University's Health Research Day on March 2, 2017, which was held within the context of the University's Research Week. Other partners on this day included the Northern School of Medicine and Health Sciences North. This was a full day event and activities spanned all four event partner locations. The SDHU showcased a sample of public health collaborative research projects and announced the 2017 recipients of the Louise Picard Public Health Research Grant.

The SDHU has received funding (\$108,000) from Public Health Ontario for a Locally Driven collaborative Project (LDCP) entitled "Relationship building with First Nations and public health: Exploring principles and practices for engagement to improved community health". The Health Unit is the lead agency for this year-long research project, which includes a multi-partner team from five other health units from across northeastern Ontario, Laurentian University and Indigenous community partners. This shared learning process aims to enhance relationships between First Nations and health units and identify promising principles and practices for engagement that can be utilized as a foundation for all Ontario public health units.

The SDHU is also a partner on a Locally Driven Collaborative Project (LDCP) which will explore what the key elements are for successful public health unit and Local Health Integration Network (PHU-LHIN) collaboration as required by the Patients First Act. The project is being led by Ottawa Public Health and the team is made up of staff from four other health units (including SDHU), two universities, and one Local Health Integration Network (LHIN).

Two research projects are being funded by the 2017 Louise Picard Public Health Research Grant, which is a joint SDHU and Laurentian University research grant. The first project will assess SDHU Psychological Health and Wellness, and is being co-led by the Manager of Human Resources and a faculty member from the School of Nursing at Laurentian University. The second project is an evaluation of the effectiveness of the Program for the Evaluation and Enrichment or Relation Skills (PEERS) among non-ASD adolescent participants in the Sudbury & Districts. It is being co-led by staff from the Clinical and Family Services Division and a faculty member from the School of Human Kinetics at Laurentian University.



#### **4. Staff Development**

In February the SDHU launched a pilot of the OnCore program. This is a new educational program developed with financial support by the Public Health Agency of Canada. The program consists of online learning modules and online small group facilitated case studies. The program reflects two of the Public Health Core Competency categories - Public Health Sciences and Assessment and Analysis. Users will learn to apply a population health approach, use data to understand public health problems, and bring research evidence to the decision making table. To date, seven staff are participating in the pilot program with a completion date set for November.

#### **5. Student Placement Program**

The SDHU is participating in an elective program delivered through the Laurentian University School of Nursing. This course focusses on offering students rural public health experiences. The SDHU will host two students during the program, to be located in the Espanola and Manitoulin District Offices. Efforts such as these provide the students with an understanding and appreciation of the northern and rural health issues and a greater understanding of the unique cultural aspects of these areas. Additionally these experiences are provided to support future public health recruitment efforts to these areas.

Beginning May 2017, the SDHU will be hosting three Masters of Public Health Students from Lakehead University, Queen's University and Western University. These students will be contributing to projects throughout the agency including those focused on health equity, Indigenous engagement, strategic planning and population health assessment.

Respectfully submitted,

*Original signed by*

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

**Sudbury & District Health Unit**  
**STATEMENT OF REVENUE & EXPENDITURES**  
**For The 2 Periods Ending February 28, 2017**

**Cost Shared Programs**

	<b>Annual Budget</b>	<b>Budget YTD</b>	<b>Current Expenditures YTD</b>	<b>Variance YTD (over)/under</b>	<b>Balance Available</b>
<b>Revenue:</b>					
MOHLTC - General Program	14,687,000	2,447,833	2,447,833	0	12,239,167
MOHLTC - Unorganized Territory	819,400	136,567	136,567	(0)	682,833
MOHLTC - VBD Education & Surveillance	65,000	10,833	10,833	0	54,167
MOHLTC - SDWS	106,000	17,667	17,667	(0)	88,333
Municipal Levies	6,943,298	1,157,215	1,157,215	0	5,786,083
Municipal Levies - Small Drinking Water Syste	47,222	7,870	7,870	0	39,352
Municipal Levies - VBD Education & Surveilla	21,646	3,608	3,608	(0)	18,038
Interest Earned	85,000	11,887	11,887	0	73,113
<b>Total Revenues:</b>	<b>\$22,774,566</b>	<b>\$3,793,480</b>	<b>\$3,793,480</b>	<b>\$1</b>	<b>\$18,981,086</b>
<b>Expenditures:</b>					
<b>Corporate Services:</b>					
Corporate Services	4,359,446	813,816	767,089	46,727	3,592,357
Print Shop	152,774	25,329	7,904	17,425	144,870
Espanola	120,973	19,430	17,572	1,858	103,401
Manitoulin	124,624	19,966	18,245	1,720	106,379
Chapleau	99,667	15,822	14,837	985	84,829
Sudbury East	16,486	2,748	2,789	(41)	13,697
Intake	318,239	49,478	48,714	764	269,525
Volunteer Services	5,711	952	9	943	5,702
<b>Total Corporate Services:</b>	<b>\$5,197,920</b>	<b>\$947,541</b>	<b>\$877,160</b>	<b>\$70,381</b>	<b>\$4,320,760</b>
<b>Clinical and Family Services:</b>					
General	920,614	147,262	133,121	14,141	787,493
Clinical Services	1,368,043	220,803	208,407	12,396	1,159,635
Branches	379,602	58,501	39,563	18,938	340,040
Family	663,316	102,077	99,350	2,727	563,966
Risk Reduction	124,408	5,243	(4,505)	9,748	128,913
Clinical Preventative Services - Outreach	141,610	22,713	21,623	1,090	119,987
Sexual Health	958,320	153,738	145,819	7,920	812,501
Influenza	0	0	606	(606)	(606)
Dental - Clinic	512,984	78,609	64,886	13,723	448,097
Family - Repro/Child Health	1,185,292	183,053	152,423	30,630	1,032,869
Substance Misuse Prevention	162,563	25,208	22,575	2,633	139,988
Indigenous Engagement Initiative	0	0	11,118	(11,118)	(11,118)
<b>Total Clinical Services:</b>	<b>\$6,416,751</b>	<b>\$997,207</b>	<b>\$894,986</b>	<b>\$102,221</b>	<b>\$5,521,766</b>
<b>Environmental Health:</b>					
General	787,124	113,536	101,240	12,295	685,884
Enviromental	2,609,493	433,517	409,053	24,464	2,200,440
Vector Borne Disease (VBD)	86,667	3,751	7,629	(3,878)	79,038
Small Drinking Water System	174,185	26,808	25,704	1,104	148,480
<b>Total Environmental Health:</b>	<b>\$3,657,468</b>	<b>\$577,611</b>	<b>\$543,626</b>	<b>\$33,985</b>	<b>\$3,113,842</b>
<b>Health Promotion:</b>					
General	1,080,885	160,791	171,974	(11,183)	908,911
School	1,386,960	213,672	182,180	31,493	1,204,780
Healthy Communities & Workplaces	181,274	27,010	25,135	1,875	156,138
Branches - Espanola / Manitoulin	262,717	40,876	39,838	1,038	222,878
Nutrition & Physical Activity	1,293,387	200,082	167,072	33,010	1,126,315
Branches - Chapleau / Sudbury East	278,641	42,946	52,207	(9,262)	226,434
Injury Prevention	475,504	73,305	62,568	10,736	412,936
Tobacco By-Law	366,735	55,339	38,071	17,269	328,665
Alcohol Misuse	110,805	17,253	26,091	(8,838)	84,714
<b>Total Health Promotion:</b>	<b>\$5,436,907</b>	<b>\$831,274</b>	<b>\$765,136</b>	<b>\$66,138</b>	<b>\$4,671,772</b>
<b>RRED:</b>					
General	1,431,631	245,757	239,631	6,126	1,192,000
Workplace Capacity Development	22,007	200	199	1	21,808
Health Equity Office	14,440	1,883	618	1,265	13,822
Strategic Engagement	597,441	92,515	74,177	18,338	523,263
<b>Total RRED:</b>	<b>\$2,065,519</b>	<b>\$340,356</b>	<b>\$314,626</b>	<b>\$25,730</b>	<b>\$1,750,893</b>
<b>Total Expenditures:</b>	<b>\$22,774,566</b>	<b>\$3,693,988</b>	<b>\$3,395,533</b>	<b>\$298,455</b>	<b>\$19,379,033</b>
<b>Net Surplus/(Deficit)</b>	<b>\$0</b>	<b>\$99,492</b>	<b>\$397,947</b>	<b>\$298,455</b>	

## Sudbury & District Health Unit 2015 - current

### Cost Shared Programs

#### STATEMENT OF REVENUE & EXPENDITURES

Summary By Expenditure Category

For The 2 Periods Ending February 28, 2017

	BOH Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
<b>Revenues &amp; Expenditure Recoveries:</b>					
Funding	22,845,666	3,805,330	3,850,974	(45,643)	18,994,692
Other Revenue/Transfers	758,926	68,240	165,550	(97,310)	593,376
<b>Total Revenues &amp; Expenditure Recoveries:</b>	23,604,592	3,873,570	4,016,524	(142,954)	19,588,068
<b>Expenditures:</b>					
Salaries	15,691,413	2,412,013	2,339,422	72,591	13,351,991
Benefits	4,283,947	660,366	694,854	(34,488)	3,589,093
Travel	260,819	28,346	19,791	8,555	241,028
Program Expenses	991,106	173,290	116,513	56,777	874,593
Office Supplies	69,004	11,105	7,463	3,641	61,541
Postage & Courier Services	72,730	12,215	6,442	5,773	66,288
Photocopy Expenses	33,487	5,145	4,180	965	29,307
Telephone Expenses	58,466	9,744	9,177	567	49,289
Building Maintenance	358,814	88,577	86,034	2,543	272,780
Utilities	205,097	35,183	34,591	592	170,506
Rent	242,464	40,411	39,894	517	202,570
Insurance	103,774	93,017	92,172	845	11,602
Employee Assistance Program ( EAP)	34,969	5,828	7,891	(2,063)	27,078
Memberships	29,527	5,486	3,464	2,021	26,063
Staff Development	106,031	17,439	14,719	2,720	91,312
Books & Subscriptions	11,875	1,910	666	1,244	11,209
Media & Advertising	104,788	15,738	5,896	9,842	98,892
Professional Fees	187,351	31,743	15,648	16,095	171,703
Translation	43,600	7,038	3,027	4,011	40,573
Furniture & Equipment	14,270	2,954	2,719	236	11,551
Information Technology	701,060	116,531	114,015	2,515	587,045
<b>Total Expenditures</b>	23,604,591	3,774,078	3,618,577	155,501	19,986,015
<b>Net Surplus ( Deficit )</b>	0	99,492	397,947	298,455	

**Sudbury & District Health Unit**  
**SUMMARY OF REVENUE & EXPENDITURES**  
For the Period Ended February 28, 2017

**100% Funded Programs**

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
Pre/Postnatal Nurse Practitioner	704	139,000	20,756	118,244	14.9%	Dec 31	16.7%
OTF - Getting Ahead and Circles	706	-	821	(821)	0.0%	Mar 31/17	91.7%
SFO -TCAN - E-Cigarettes - 1-time	721	30,000	-	30,000	0.0%	Mar 31/17	91.7%
SFO - Electronic Cigarette Act - New Nov./15 - Base Fndg	722	36,700	2,753	33,947	7.5%	Dec 31	16.7%
SFO -TCAN - Prevention	724	97,200	1,417	95,783	1.5%	Dec 31	16.7%
SFO - Tobacco Control Area Network - TCAN	725	285,800	34,128	251,672	11.9%	Dec 31	16.7%
SFO - Local Capacity Building: Prevention & Protection	726	259,800	25,558	234,242	9.8%	Dec 31	16.7%
SFO - Tobacco Control Coordination	730	104,442	16,067	88,375	15.4%	Dec 31	16.7%
SFO - Youth Engagement	732	80,000	11,908	68,092	14.9%	Dec 31	16.7%
Infectious Disease Control	735	479,100	73,197	405,903	15.3%	Dec 31	16.7%
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	82,118	17,882	82.1%	Mar 31/17	91.7%
MOHLTC - Special Nursing Initiative	738	180,500	27,770	152,730	15.4%	Dec 31	16.7%
MOHLTC - Northern Fruit and Vegetable Funding	743	71,700	56,967	14,733	79.5%	Aug./17	91.7%
Beyond BMI - LDCP	747	110,000	44,026	65,974	40.0%	"May/16 to June/17	91.7%
Food Safety - Haines Funding	750	36,500	85	36,415	0.2%	Dec 31	16.7%
Triple P Co-Ordination	766	13,672	13,672	-	100.0%	Dec 31	16.7%
Healthy Babies Healthy Children	778	1,476,897	197,347	1,279,550	13.4%	Dec 31	16.7%
Healthy Smiles Ontario (HSO)	787	612,153	71,151	541,002	11.6%	Dec 31	16.7%
Anonymous Testing	788	59,393	45,701	13,692	76.9%	Mar 31/17	91.7%
HQO - Northern Health Equity	791	100,000	34,659	65,341	34.7%	Mar 31/17	91.7%
MHPS- Diabetes Prevention Program	792	175,000	10,366	164,634	5.9%	Dec 31	16.7%
<b>Total</b>		<b>4,447,857</b>	<b>770,467</b>	<b>3,677,390</b>			

**Ministry of Health  
and Long-Term Care**

Office of the Minister

10<sup>th</sup> Floor, Hepburn Block  
80 Grosvenor Street  
Toronto ON M7A 2C4  
Tel. 416 327-4300  
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**Ministère de la Santé  
et des Soins de longue durée**

Bureau du ministre

Édifice Hepburn, 10<sup>e</sup> étage  
80, rue Grosvenor  
Toronto ON M7A 2C4  
Tél. 416 327-4300  
Téléc. 416 326-1571  
www.ontario.ca/sante



**FEB 24 2017**

Ms. Janet Bradley  
85 Maki Avenue  
Sudbury ON P3E 2P3

Dear Ms. Bradley:

Congratulations on your reappointment to the Board of Health for the Sudbury and District Health Unit. I am looking forward to your continued service beginning February 22, 2017 until February 21, 2020.

I am very pleased that you have again taken on this important responsibility to serve the people of Ontario. We expect that you will continue to be committed to the principles and values of public service and that you will perform your duty with integrity.

I have enclosed a copy of the Order in Council which was approved on February 15, 2017.

Again, please accept my congratulations.

Yours sincerely,

A handwritten signature in black ink, appearing to read "Eric Hoskins".

Dr. Eric Hoskins  
Minister

Enclosure

c: Medical Officer of Health  
The Honourable Glenn Thibeault, MPP



Ontario

Order in Council  
Décret

On the recommendation of the undersigned,  
the Lieutenant Governor of Ontario, by and  
with the advice and concurrence of the  
Executive Council of Ontario, orders that:

Sur la recommandation de la personne  
soussignée, la lieutenant-gouverneure de  
l'Ontario, sur l'avis et avec le consentement du  
Conseil exécutif de l'Ontario, décrète ce qui  
suit :

PURSUANT TO subsections 49(3) and 51(1) of the *Health Protection and Promotion Act*,

**Janet Bradley of Sudbury**

be reappointed as a part-time member of the Board of Health for the Sudbury and District Health Unit  
for a period of three years, effective February 22, 2017 to and including February 21, 2020.

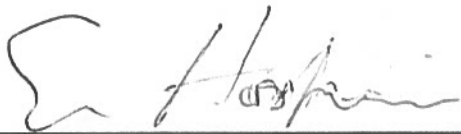
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EN VERTU DES paragraphes 49 (3) et 51 (1) de la *Loi sur la protection et la promotion de la santé*,

**Janet Bradley de Sudbury**

Page 50 of 232

est reconduite au poste de membre à temps partiel du Conseil de santé de la circonscription sanitaire de Sudbury et du district pour une durée fixe de trois ans à compter du 22 février 2017 jusqu'au 21 février 2020 inclusivement.



**Recommended: Minister of Health and Long-Term Care**

**Recommandé par : le ministre de la Santé et des Soins de longue durée**



**Concurred: Chair of Cabinet**

**Appuyé par : le président/la présidente du Conseil des ministres**

**Approved and Ordered:  
Approuvé et décrété le :**

**FEB 15 2017**



**Administrator of the Government**

**L'administratrice du gouvernement**

February 3, 2017

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

Dear Minister Hoskins:

### **Opioid Addiction and Overdose**

On January 19, 2017, at a regular meeting of the Board of the Windsor-Essex County Health Unit, Administration brought forward a letter supported by the Middlesex-London Health Unit regarding improved opioid prescription practices and access to life-saving naloxone.

The Windsor-Essex County Board of Health supported the recommendation from the Middlesex-London Health Unit to better inform Canadians about the risks of opioids, improve prescribing practices, reduce easy access to unnecessary opioids, support better treatment options, and improve the national evidence base. Through collaboration with CPSO, a comprehensive set of guidelines related to counselling, prescribing practices, and naloxone administration would ensure that physicians have the tools needed to address the unnecessary overdose and death associated with the abuse and misuse of these medications.

The Windsor-Essex County Board of Health further commends the Ontario Government on their decision to develop a comprehensive strategy to address opioid misuse and addictions. With increasing rates of opioid prescription and overdose in Ontario, there exists an urgent need to create a comprehensive multi-sectoral approach to prevent the unnecessary deaths caused by the abuse and misuse of opioids. The Windsor-Essex County Board of Health agrees with the stance from Middlesex-London that engagement of physicians through CPSO represents a reasonable starting point to address the issue from the prescription and overdose prevention perspectives. This approach, coupled with improved access to naloxone, will ensure that all opioid users have access to the education and lifesaving medication they need to prevent unnecessary death.

Sincerely,



Gary McNamara  
Chair, Windsor-Essex County Board of Health



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

c: Chief Medical Officer of Health of Ontario  
Ontario Public Health Association  
Brian Masse, MP Windsor-West  
Dave Van Kesteren, MP Chatham-Kent — Leamington  
Lisa Gretzky, MPP Windsor-West  
Municipal Councils in Windsor-Essex – (County Clerks)  
Windsor-Essex County Board of Health

Association of Local Public Health Agency  
Cheryl Hardcastle, MP Windsor-Tecumseh  
Tracey Ramsey, MP Essex  
Percy Hatfield, MPP Windsor-Tecumseh  
Taras Natyshak, MPP Essex  
Ontario Boards of Health



**House of Commons**  
Room 960, The Valour Building  
Ottawa, Ontario K1A 0A6  
Tel.: 613-996-5376  
Fax.: 613-995-6661

**Elliot Lake**  
255 Hwy 108 North  
Elliot Lake, Ontario P5A 2T1  
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1-855-297-4200  
Tel/Tél.: (705) 848-8080  
Fax./Télé.: (705) 848-1818



HOUSE OF COMMONS  
CHAMBRE DES COMMUNES  
CANADA

**Carol Hughes**  
Member of Parliament / Députée  
Algoma—Manitoulin—Kapusksing

**Chambre des communes**  
Pièce 960, Édifice de la Bravoure  
Ottawa (Ontario) K1A 0A6  
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**Kapusksing**  
12-B, rue Byng Rd.  
Kapusksing (Ontario) P5N 1W3  
Toll Free/San Frais:  
1-800-920-2057  
Tel/Tél.: (705) 335-5533  
Fax/Télé.: (705) 337-6869

March 8, 2017

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

SUDBURY & DISTRICT HEALTH UNIT Medical Officer of Health and CEO			
MAR 16 2017			
Environ Health	_____	RRED	_____
CFS	_____	SEU	_____
Corporate Services	_____	Board	_____
Health Promotion	_____	Committee	_____
( ) Circulate ( ) Return ( ) F.Y.I ( )			

Dear Dr. Sutcliffe,

Thank you for including me in your recent correspondence regarding the passing of a resolution concerning opioid use.

You are correct that the opioid crisis is an ongoing and growing concern that requires leadership and action at the federal level. The NDP has been raising the alarm on this issue and managed to secure a key study of the opioid crisis in Canada. We have also pushed for the fast passage of Bill C-37 and will continue to impress upon the government that we must do more on this front. I have forwarded a copy of this resolution on to the federal Minister of Health; attached is a copy of my letter.

Thank you again for your letter. I appreciate the time you took to update me on the happenings of the Sudbury & District Board of Health and your advocacy on this issue.

Sincerely,

Carol Hughes, MP  
Algoma-Manitoulin-Kapusksing

Encl. (1)



carol.hughes@parl.gc.ca  
<http://carolhughes.ndp.ca>

House of Commons  
Room 960, The Valour Building  
Ottawa, Ontario K1A 0A6  
Tel.: 613-996-5376  
Fax.: 613-995-6661

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1-855-297-4200  
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Fax./Téléc: (705) 848-1818



HOUSE OF COMMONS  
CHAMBRE DES COMMUNES  
CANADA

*Carol Hughes*  
Member of Parliament / Députée  
Algoma—Manitoulin—Kapuskaing

Chambre des communes  
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1-800-920-2057  
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March 8, 2017

Honourable Jane Philpott  
Minister of Health  
162 Confederation Building  
House of Commons  
Ottawa, ON K1A 0A6

Dear Minister Philpott,

Please find enclosed a resolution passed by the Sudbury & District Board of Health concerning opioid use. They are calling on the federal government to communicate and implement a federal opioid strategy.

Thank you in advance for taking the time to review their resolution and I trust you will respond accordingly.

Sincerely,

Carol Hughes, MP  
Algoma-Manitoulin-Kapuskaing

Encl. (1)

Cc: Sudbury & District Board of Health



carol.hughes@parl.gc.ca  
<http://carolhughes.ndp.ca>

February 3, 2017

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

Dear Minister Hoskins:

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

On January 19, 2017, at a regular meeting of the Board of the Windsor-Essex County Health Unit, Administration brought forward a letter supported by the Simcoe Muskoka District Health Unit regarding the inclusion of Marijuana as a prescribed product or substance under Bill 178, Smoke-Free Ontario Amendment Act, 2016.

The Windsor-Essex County Board of Health supports the position of Simcoe Muskoka District Health Unit recommending the enactment of the Smoke-free Ontario Amendment Act which received Royal Assent on June 9, 2016, as well as their suggestion to include medicinal and recreational marijuana as a prescribed substance within the regulations. By utilizing the strong framework set forth in the Smoke-free Ontario Strategy, the provincial government will take advantage of an established and effective means to address the risks associated with the use of these products using the three pillar approach of prevention, protection, and cessation.

As a result, the risks associated with increased uptake of marijuana will be mitigated through appropriate and consistent regulation, and exposure to smoking behaviour in public spaces will be minimized. Increased access to marijuana poses a significant public health concern with the most notable negative outcomes tied to impaired driving, exacerbation of mental illness and addictions, and potential harms to the children of pregnant or lactating women. First and second-hand marijuana smoke also contains known carcinogens and exposure to either can lead to respiratory or cardiovascular disease.

The Windsor-Essex County Board of Health applauds the efforts of the Ontario Government in the development of the Smoke-free Ontario Amendment Act, and the inclusion of marijuana as a prescribed substance is a practical and feasible means through which to lessen the potentially negative public health impacts of legalization. Should this approach be taken, and the enforcement behaviours fall within the scope of Ontario public health units, it is further recommended that sustainable funding and tailored enforcement training be provided.

Lastly, it is recommended that the above-mentioned protections are expanded into the Electronic Cigarettes Act, where the prohibitions related to use in public spaces have yet to be enacted. The vaping of medicinal and recreational marijuana, in any form, also represents a concern related to exposure to smoking behaviour and the unintended inhalation of second-hand smoke.

Sincerely,



Gary McNamara  
Chair, Windsor-Essex County Board of Health



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

c: Chief Medical Officer of Health of Ontario  
Association of Local Public Health Agency  
Ontario Public Health Association  
Cheryl Hardcastle, MP Windsor-Tecumseh  
Brian Masse, MP Windsor-West  
Tracey Ramsey, MP Essex  
Dave Van Kesteren, MP Chatham-Kent — Leamington  
Percy Hatfield, MPP Windsor-Tecumseh  
Lisa Gretzky, MPP Windsor-West  
Taras Natyshak, MPP Essex  
Municipal Councils in Windsor-Essex – (County Clerks)  
Ontario Boards of Health  
Windsor-Essex County Board of Health

---

References: [Simcoe-Muskoka - Letter to Minister Hoskins - Marijuana and Bill 178](#)





# Municipality of Killarney

**Main Office:**  
32 Commissioner Street  
Killarney, Ontario  
P0M 2A0

Tel: 705-287-2424  
Fax: 705-287-2660

E-mail:  
[inquiries@municipalityofkillarney.ca](mailto:inquiries@municipalityofkillarney.ca)

**Public Works Department:**  
1096 Hwy 637  
Killarney, Ontario  
P0M 2A0

Tel: 705-287-1040  
Fax: 705-287-1141

website:  
[www.municipalityofkillarney.ca](http://www.municipalityofkillarney.ca)

February 10, 2017

Sudbury & District Health Unit  
c/o Penny Sutcliffe, MD,  
1300 Rue Paris Street  
Sudbury, Ontario  
P3E 3A3

SUDBURY & DISTRICT HEALTH UNIT Medical Officer of Health and CEO	
FEB 14 2017	
Environ Health	RRD
CFRISC, FRCPC	SEU
Corporate Services	Board
Health Promotion	Committee
File ( ) Circulate ( ) Return ( ) F.Y.I ( )	

Dear Penny:

Attached hereto are Resolutions #17-042 and #17-043 that were passed at the Regular Meeting of Council held February 8, 2017 which are self-explanatory.

Should you have any questions, please contact the municipal office.

Sincerely,  
**THE MUNICIPALITY OF KILLARNEY**

(Mrs.) Angie Nuziale,  
Administrative Assistant

Attachment

Word: Letters-GeneralLetters-SDHU-food/substance-10-02-2017



*The Corporation of the Municipality of Killarney*  
32 Commissioner Street  
Killarney, Ontario  
P0M 2A0

MOVED BY: Pierre Paquette

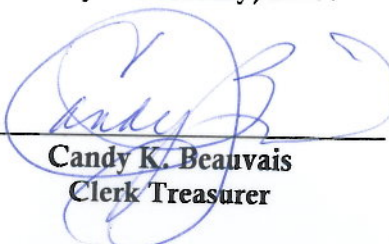
SECONDED BY: Nancy Wirtz

**RESOLUTION NO. 17-043**

**BE IT RESOLVED THAT** the Municipality of Killarney support resolution #04-17 passed by the Sudbury & District Health Unit on January 19, 2017 calling for the inclusion of marijuana (medicinal and recreational) as a prescribed product or substance under the Smoke Free Ontario Act.

**CARRIED**

I, Candy K. Beauvais, Clerk Treasurer of the Municipality of Killarney do certify the foregoing to be a true copy of Resolution #17-043 passed in a Regular Council Meeting of The Corporation of the Municipality of Killarney on the 8<sup>th</sup> day of February, 2017.

  
Candy K. Beauvais  
Clerk Treasurer



64 McIntyre Street • Nairn Centre, Ontario • P0M 2L0 ☎ 705-869-4232 📠 705-869-5248  
Established: March 7, 1896 Office of the Clerk Treasurer, CAO E-mail: [nairncentre@personainternet.com](mailto:nairncentre@personainternet.com)

---

February 17, 2017

The Honourable Eric Hoskins  
Ministry of Health and Long-Term Care  
10<sup>th</sup> Floor, Hepburn Block  
80 Grosvenor Street  
Toronto, Ontario M7A 2C4

RE: Cannabis Regulation and Control

Dear Honourable Minister:

Please be advised that our Council adopted the following motion at their meeting of February 14, 2017:

**CANNIBAS REGULATION AND CONTROL**

**RESOLUTION #2017-2-34**

MOVED BY: Brigita Gingras

SECONDED BY: Charlene Y. Martel

**RESOLVED:** that Council supports the resolution adopted by the Sudbury and District Health Unit, resolution #04-17 requesting the inclusion of marijuana (medicinal and recreation) as a prescribed product or substance under the Smoke Free Ontario Act.

**CARRIED**

Sincerely Yours,

Robert Deschene,  
CAO-Clerk-Treasurer  
LF/lc

cc: The Right Honourable Justin Trudeau, Prime Minister of Canada  
The Honourable Kathleen Wynne, Premier of Ontario  
The Honourable Jody Wilson-Raybould, Minister of Justice & Attorney General of Canada  
The Honourable Yasir Naqvi, Attorney General of Ontario  
The Honourable Jane Philpott, Minister of Health  
Carol Hughes, MP, Algoma-Manitoulin-Kapuskasing  
Michael Mantha, MPP, Algoma-Manitoulin  
Sudbury & District Health Unit

February 27, 2017

Honourable Dr. Eric Hoskins  
Ministry of Health and Long-Term Care  
10<sup>th</sup> Floor, Hepburn Block  
80 Grosvenor Street  
Toronto, ON M7A 2C4  
[ehoskins.mpp@liberal.ola.org](mailto:ehoskins.mpp@liberal.ola.org)

Dear Minister Hoskins:

Thank you for your recent communications regarding the striking of your Expert Panel on Public Health, chaired by Ontario's Chief Medical Officer of Health, Dr. David Williams. We are delighted to learn that this panel, referred to frequently during the consultations related to your "Patients First" transformation agenda, has now become a reality.

As one of your 36 board of health responsible for the delivery of a broad range of public health programs and services in our respective communities, we are very concerned, however, about the terms of reference of this esteemed panel.

First of all, we would like to understand your rationale for limiting the panel to making only confidential recommendations to you, without any public consultation, validation or scrutiny. This is the third panel to be commissioned by you as part of your transformation agenda. The first, the Expert Group on Home and Community Care, chaired by Dr. Gail Donner, reported publicly with their document "Bringing CARE HOME" in March 2015. The second, the Primary Health Care Expert Advisory Committee, released its report, "Patient Care Groups: A new model of population based primary health care for Ontario" in May of 2015, triggering numerous consultations and public debate. Please help us understand why there has been a decision to remove the transparency and public accountability from the mandate of this third panel which will be looking more closely at public health? With the deepest of respect, we ask why this expert panel's work is so very different from the 2006 Capacity Review of boards of health that was undertaken and delivered within a context of board engagement and consultation?

Our board was further surprised to see that recommendations on funding and funding models is "out of scope" for the panel. This concerns us as well. As you know, the funding formula that has been applied to boards of health with the goal of establishing a more equitable share of provincial funding is new and un-tested. We have requested that the Province undertake an evaluation of this funding formula, to understand whether it is meeting its intended goals, uncover any unintentional consequences and assess underlying validity of its assumptions. We were also under the impression that your decision to maintain the current funding relationship with "obligated municipalities" as described under the Health Protection and Promotion Act, and



which in Peterborough includes municipal and First Nation governments, was only temporary until the expert panel could undertake a more fulsome study of this issue. While we wholeheartedly support your decision not to flow funding to boards of health through LHINs, and are grateful that our direct link to local and provincial governments has been retained, we wish to understand more fully how and when issues of funding will be addressed, if in fact they are outside the scope of the panel.

We thank the Minister for your dedication and commitment to ensuring that all Ontarians are able to expect a healthier future. We look forward to your response with the hope that our concerns can be addressed.

Yours in health,

***Original signed by***

Mayor Mary Smith  
Chair, Board of Health

/ag

cc: Jeff Leal, MPP, Peterborough  
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock  
Dr. David Williams, Chief Medical Officer of Health, MOHLTC  
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division  
City of Peterborough  
County of Peterborough  
Curve Lake First Nation  
Hiawatha First Nation  
Association of Local Public Health Agencies  
Ontario Boards of Health

March 22, 2017

*VIA EMAIL*

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

Dear Minister Hoskins:

The Leeds, Grenville and Lanark Board of Health is very concerned about two recent initiatives of the Ministry of Health and Long-Term Care – the Expert Panel on Public Health and the Healthy Menu Choices Act.

With respect to the Expert Panel on Public Health, you stated in your letter of January 18, 2017:

“The work of the 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.”

We have learned that the work of the Expert Panel will be done in confidence and will not include consultation with local public health units. This is in contrast to the Liberal government's commitment to transparency in its work. The Expert Panel will be making recommendations that could have a profound impact on how we do business, and yet we won't have any opportunity to provide input into the discussion or the options being considered. To rectify this concern, the Board requests that all recommendations from the Expert Panel be made public, and that a formal consultation process be undertaken with all Ontario public health units before any decisions are made about the integration of public health into the broader health system.

The Honourable Eric Hoskins  
Page 2  
March 22, 2017

The implementation of the Healthy Menu Choices Act requires a significant investment of resources at the local level and among the food premise industry. Concerns have been raised by other organizations about the effectiveness of this measure. Has the Ministry of Health and Long-Term Care identified indicators of success that will assess if this investment is justified; and are these indicators being tracked? The Liberal government has publicly stated a commitment to accountability. The Board of Health requests that the Minister respect this commitment and notify all parties how the impact of the Healthy Menu Choices Act will be assessed.

Sincerely,



Anne Warren, Chair  
Board of Directors  
Leeds, Grenville and Lanark District Health Unit

AW/hb

cc: Steve Clark, MPP Leeds-Grenville  
Randy Hillier, MPP Lanark-Frontenac-Lennox and Addington  
Jack MacLaren, MPP Carleton-Mississippi Mills  
Ontario Boards of Health

**From:** Correspondence Services (MOHLTC) [<mailto:CSU.MOH@ontario.ca>]  
**Sent:** April-03-17 2:19 PM  
**To:** Bruce, Heather  
**Subject:** email to Ministry of Health and Long-Term Care/ks/HLTC2966MC-2017-2696

Thank you for your letter to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, regarding the Expert Panel on Public Health and the Healthy Menu Choices Act.

The expert panel members have a mandate to provide advice on structural, organizational, and governance changes for public health within a transformed health system. The panel will review various operational models for the integration of public health into the broader health system and develop options and considerations for implementation.

This Panel was chosen pursuant to section 9 of the Ministry of Health and Long-Term Care Act, appointed by the Lieutenant Governor in Council and each member was selected to provide their unique and expert advice as a professional in their area of vocation and education

The deliberations are confidential, however; please be assured that no recommendations will be considered without consultation.

With respect to the Healthy Menu Choices Act, the menu labelling legislation is a key component of Ontario's Healthy Kids Strategy and responds to the recommendations of the Healthy Kids Panel, an expert committee established to advise government on evidence-informed interventions to help children achieve healthy weights. In conducting its work, the Healthy Kids Panel undertook an extensive evidence review, as well as a comprehensive public and stakeholder engagement approach.

Calories displayed on menus at regulated food premises provide consumers with information they need to make more informed, healthier choices about what to feed themselves and their families.

The ministry will measure the impact of the legislation, including compliance with the requirements, impact on consumer choices and impact on choices offered by regulated food service premises. The ministry is also developing a co-ordinated approach to public reporting on compliance with the requirements, and is currently determining ways to make this information broadly available.

We hope this information is helpful.

Sincerely,

K. Szmon

alPHA's members are  
 the public health units  
 in Ontario.

**alPHA Sections:**

Boards of Health  
 Section

Council of Ontario  
 Medical Officers of  
 Health (COMOH)

**Affiliate**

**Organizations:**

Association of Ontario  
 Public Health Business  
 Administrators

Association of  
 Public Health  
 Epidemiologists  
 in Ontario

Association of  
 Supervisors of Public  
 Health Inspectors of  
 Ontario

Health Promotion  
 Ontario

Ontario Association of  
 Public Health Dentistry

Ontario Association of  
 Public Health Nursing  
 Leaders

Ontario Society of  
 Nutrition Professionals  
 in Public Health

March 15, 2017

Public Health Expert Panel Members

c/o

Dr. David Williams, Chair

Roselle Martino, Executive Sponsor

Dear Panel Members,

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHA), I am writing to share alPHA's perspectives on key issues currently under the Expert Panel's consideration. As the provincial association that provides leadership to Ontario's boards of health and public health units<sup>1</sup>, we have long been engaged in the matters within the mandate of the Expert Panel. We hope that the distillation of our years of experience is helpful to you as you pursue this important work.

As you will know, Ontario's local public health system is grounded in a population health approach – focused on upstream efforts to improve health and health equity. Our system is enviable across Canada in that it benefits from: i) a structure that promotes strong municipal and other non-health sector relationships so important to health, and ii) a comprehensive legal and programmatic framework. These assets mean that Ontarians are effectively served by a local public health system that works in partnership to respond to local needs while at the same time ensuring compliance with provincial standards<sup>2</sup>.

Such strengths in Ontario's local public health system notwithstanding, there have been a number of occasions to scrutinize and recommend improvements. Many improvements have been made as our system has evolved and recommendations from numerous reports have been implemented over the years.

As the Panel will be aware, since the May 2000 *E. coli* outbreak and tragic deaths in Walkerton there have been numerous opportunities to review the structure, organization, governance, functions and capacity of Ontario's local public health system.

Page 1 of 3

<sup>1</sup> For clarity, please note that each local public health unit in Ontario is governed by a local board of health. For simplicity, the term *local public health* will be used to refer to these entities as a whole in this document.

<sup>2</sup> Local public health works through multiple channels and on multiple issues in order to have an impact on the health of the population. The work is diverse, including individual clinical service delivery, education, inspection, surveillance, and policy development among other activities. What unifies local public health action is its focus on prevention, upstream interventions and societal factors that influence health.

These reviews have afforded alPHA's members with many opportunities to carefully consider how the local public health system could best support the health of Ontarians. Through much participation in the many reviews over many years, a number of consistent messages have been put forward by alPHA that we would like to share with the Expert Panel for your consideration in the current review. These are described in our comments that follow, noting that we would be pleased to discuss any of these items in more detail.

1. PROVINCIAL RELATIONSHIP

Local public health should remain independent of health care structures such as local health integration networks (LHINs). While alPHA views Ontario's LHINs as important partners in community health, and we welcome our new role in supporting population level planning for the health system, it is important for local public health to remain organizationally separate from these structures. Provincial public health funding and accountability agreements must continue to be directly negotiated between local boards of health and the MOHLTC. This direct relationship mitigates against the threat of financial and functional resource allocation to the acute care system as has been evidenced in the experience of the many other regions in Canada and around the world with integrated health systems. Despite the best of intentions in many jurisdictions, over time, the resources available to local public health have been eroded and public health functions have become dispersed and focused more on downstream secondary prevention and treatment.

2. MUNICIPAL RELATIONSHIP

Board of health members should be drawn from the communities the board serves, and should include a balance of municipally elected officials, as well as committed citizens chosen by the Board or appointed by the province. Municipal representation on boards of health ensures valuable connections with decision makers and staff in non-health sectors where there is scope of authority over key determinants of health (e.g., by-laws, built environment, social services, child care, land use planning, long-term care, safe drinking water, recreational facilities, first responders, etc.). Board members should be selected based on their interest in public health issues and the fulfillment of specified competencies through recruitment processes where possible and complemented with training where specific competencies require further development.

3. NUMBERS OF BOARDS OF HEALTH

Changes to health unit boundaries should be considered only in the context of optimizing human and financial resources, and ensuring equitable availability of public health expertise and technical requirements for full local delivery of public health services in all parts of the province. Any such consideration must be undertaken in full consultation with local public health.

4. ALIGNING LOCALLY TO PROMOTE HEALTH

Local public health is responsible to plan for the overall health of the population each board serves. The LHIN boundaries have been established based on referral patterns for patients of acute care institutions. This markedly contrasts with the health promoting approach of local public health that is much broader, reaching people where they live, go to school, work and socialize. alPHA has recommended that when re-thinking LHIN boundaries consideration should be given to the current alignments between local public health, education, municipal and social service boundaries because of the support these sectors provide to local public health, population health and local health systems.

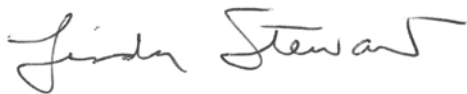
5. LOCAL PUBLIC HEALTH CAPACITY CONSIDERATIONS

There is an important distinction between providing population health information and translating this information into planning, funding and delivery decisions for acute care and other downstream services. It should not be assumed that the latter is a public health competency. It must be recognized that the work for public health as described in the Patients First discussion paper is additional to public health's core functions and mandate and the related resources must be identified to accommodate this work to ensure that public health capacity to promote and protect health and improve health equity is not eroded.

Local public health in Ontario is uniquely mandated and positioned to promote and protect the health of the population. We play a role that is often not well understood and we appreciate the opportunity to provide input based on our many years of experience and wealth of grounded knowledge. We would be pleased to discuss these and related issues further with you and ask that you not hesitate to follow up with us.

On behalf of alPHA, I wish you all the best in your deliberations on these important matters and I look forward to your recommendations.

Yours sincerely,

A handwritten signature in cursive script that reads "Linda Stewart". The ink is dark and the signature is fluid, with a long horizontal stroke at the end of the name.

Linda Stewart  
Executive Director

alPHA's members are  
the public health units  
in Ontario.

**alPHA Sections:**

Boards of Health  
Section

Council of Ontario  
Medical Officers of  
Health (COMOH)

**Affiliate  
Organizations:**

Association of Ontario  
Public Health Business  
Administrators

Association of  
Public Health  
Epidemiologists  
in Ontario

Association of  
Supervisors of Public  
Health Inspectors of  
Ontario

Health Promotion  
Ontario

Ontario Association of  
Public Health Dentistry

Ontario Association of  
Public Health Nursing  
Leaders

Ontario Society of  
Nutrition Professionals  
in Public Health

Hon. Eric Hoskins  
Minister of Health and Long-Term Care  
10th Flr, 80 Grosvenor St,  
Toronto, ON M7A 2C4

January 13 2017

Dear Minister Hoskins,

**Re: Boards of Health Budgets 2016**

---

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHA), I am writing to express our concerns about the diminishing capacity of Ontario's public health system to effectively carry out its existing mandate and how that will affect our ability to make important contributions to the sustainability of the health care system as a whole.

In particular, we are concerned that the ever-increasing resources required to meet patient needs are draining the capacity of the very sectors needed to support health and reduce patient needs.

Public health bridges these competing pressures by leveraging the health-enhancement potential of decision making in other sectors and working directly with individuals and communities to protect and promote health. As recognized in the Patients First Act, 2016, public health also works to understand patterns of health and its determinants so that we can monitor progress, identify issues, strategize solutions and plan interventions effectively.

A solid provincial public health system that has the capacity to meet its mandate of keeping Ontarians healthy is critical to a sustainable future for our health care system. The fact is that ongoing austerity measures have imposed budgets within which we are increasingly unable to meet our existing mandates, and these difficulties will be compounded by the increasing expectations placed on boards of health for service delivery including recent vaccine program expansions and new roles legislated by the Patients First Act.

We enthusiastically support those parts of The Patients First Act that facilitate stronger engagement between medical officers of health and the LHINs on issues relating to local health system planning, funding and service delivery and in developing LHIN integrated health service plans. However, this cannot be done effectively with current resources.

We are acutely aware of Ontario's current and projected fiscal challenges and those faced by the publicly-funded health care system, but without a serious Government commitment to supporting a robust, appropriately resourced local public health system, it will become destabilized and unable to meet Ontarians' expectations.



Ontario's 36 local public health units collectively receive less than 2% of the provincial health budget, the distribution of which is now determined by a funding formula that has left the vast majority of them with 0% base budgetary increases for two years. Taking inflation and collective agreement requirements into account, no growth is a de facto budget cut. This has already resulted in contraction of services and reduction of staff in some areas, and municipal subsidies to cover the provincial portion in others.

In context of the new Patients First Act requirement for LHINs to promote health equity and equitable health outcomes and to reduce or eliminate health disparities, it is especially noteworthy that many of the public health units with frozen budgets are also the ones with the greatest overall health equity challenges and the greatest percentage of francophone and indigenous populations.

We are very concerned that our capacity to do our work is already limited and is being further eroded. New resources and funding will certainly be required for public health to effectively engage in the work required by Patients First, but this cannot be viewed in isolation, as our existing work also makes such important contributions to the desired outcomes of the initiative.

We would appreciate the opportunity to meet with you to discuss these issues and identify a sustainable path forward to optimally support the health of Ontarians and the sustainability of the health care system.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jaeger', with a stylized, cursive script.

Dr. Valerie Jaeger,  
President

**Copy:** Hon. Kathleen Wynne, Premier of Ontario  
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care  
Dr. David Williams, Chief Medical Officer of Health  
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division  
Sharon Lee Smith, Associate Deputy Minister - Policy and Transformation



March 9, 2017

The Hon. Dr. Helena Jaczek  
Minister of Community and Social Services

The Hon. Chris Ballard  
Minister Responsible for the Poverty Reduction Strategy

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

Dear Ministers;

We are writing to convey our support for Basic Income in Ontario and the recommendations made in the Honourable Hugh Segal's discussion paper, "Finding a Better Way: A Basic Income Pilot Project for Ontario".

The Huron County Board of Health feels strongly that ensuring everyone has an income sufficient to meet basic needs and live with dignity is one of the most important initiatives the provincial government could pursue to promote health, well-being and equity amongst Ontarians. Our support for basic income is informed by overwhelming evidence of the powerful link between income and health. People living with a lower income are at far greater risk of preventable medical conditions across the lifespan, including cancer, diabetes, heart disease, mental illness, and their associated health care costs, compared with those living with higher income. Children are particularly vulnerable to the impacts of growing up with low income, due to its deleterious effect on early childhood development.

This letter also serves to support our views on the important principles and elements of Basic Income:

- the pursuit of both health and social equity,
- income security for all, across the lifespan and regardless of employment status,
- universality – that no one is left behind,
- non-conditionality, other than based on income level and family composition,
- ensuring dignity by creating a process for receiving basic income that is comparable to other well accepted income security programs in Canada, such as child and seniors' benefits,
- ensuring the autonomy of basic income recipients so that they have the ability to spend money as they see fit to support the wellbeing of themselves and their family,

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**Huron County Health Unit**

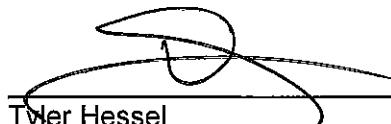
77722B London Road, RR 5, Clinton, ON N0M 1L0 CANADA  
Tel: 519.482.3416 Confidential Fax: 519.482.9014

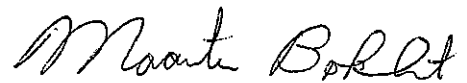
[www.huronhealthunit.ca](http://www.huronhealthunit.ca)

- replacing Ontario Works (OW) and Ontario Disability Support Program (ODSP) with basic income at rates that reflect the cost of living,
- the stipulation that no one is worse off than before the basic income program.

As has been conveyed by The Ontario Public Health Association and other Boards of Health in Ontario, we would emphasize that while basic income is an important form of income security for those on OW and ODSP, it is also crucial for those who are employed yet still living in poverty, including the precariously employed. While we see a great deal of promise in Basic Income, we also believe that basic income can only have a strong impact on the health-damaging conditions of poverty and precarious employment if it is part of, and not a replacement for, a comprehensive approach that includes progress on other key policies and programs. This includes affordable high quality child care, affordable housing, expanded health benefits, and labour law reform, among others.

Yours Sincerely,

  
 Tyler Hessel  
 Chair, Huron County Board of Health

  
 Maarten Bokhout  
 Acting Medical Officer of Health

cc:

Ontario Public Health Association – Mary Wales, Communications Coordinator  
 Association of Local Public Health Agencies  
 All Health Units

### **Huron County Health Unit**

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# Municipality of Killarney

February 10, 2017

Sudbury & District Health Unit  
c/o Penny Sutcliffe, MD,  
1300 Rue Paris Street  
Sudbury, Ontario  
P3E 3A3

SUDBURY & DISTRICT HEALTH UNIT Medical Officer of Health and CEO			
FEB 14 2017			
Environ Health	_____	ARED	_____
Off Sc, FRCPC	_____	SEU	_____
Corporate Services	_____	Board	_____
Health Promotion	_____	Committee	_____
File ( ) Circulate ( ) Return ( ) F.Y.I ( )			

**Main Office:**  
32 Commissioner Street  
Killarney, Ontario  
P0M 2A0

Tel: 705-287-2424  
Fax: 705-287-2660

E-mail:  
[inquiries@municipalityofkillarney.ca](mailto:inquiries@municipalityofkillarney.ca)

**Public Works Department:**  
1096 Hwy 637  
Killarney, Ontario  
P0M 2A0

Tel: 705-287-1040  
Fax: 705-287-1141

website:  
[www.municipalityofkillarney.ca](http://www.municipalityofkillarney.ca)

Dear Penny:

Attached hereto are Resolutions #17-042 and #17-043 that were passed at the Regular Meeting of Council held February 8, 2017 which are self-explanatory.

Should you have any questions, please contact the municipal office.

Sincerely,  
**THE MUNICIPALITY OF KILLARNEY**

(Mrs.) Angie Nuziale,  
Administrative Assistant

Attachment

Word: Letters-GeneralLetters-SDHU-food/substance-10-02-2017



*The Corporation of the Municipality of Killarney  
32 Commissioner Street  
Killarney, Ontario  
P0M 2A0*

MOVED BY: Pierre Paquette

SECONDED BY: Nancy Wirtz

**RESOLUTION NO. 17-042**

**BE IT RESOLVED THAT** the Municipality of Killarney support resolution #60-16 passed by the Sudbury & District Health Unit on November 24, 2016 regarding restricting the marketing of unhealthy foods and beverages to children.

**CARRIED**

I, Candy K. Beauvais, Clerk Treasurer of the Municipality of Killarney do certify the foregoing to be a true copy of Resolution #17-042 passed in a Regular Council Meeting of The Corporation of the Municipality of Killarney on the 8<sup>th</sup> day of February, 2017.

  
Candy K. Beauvais  
Clerk Treasurer



64 McIntyre Street • Nairn Centre, Ontario • P0M 2L0 ☎ 705-869-4232 📠 705-869-5248  
Established: March 7, 1896 Office of the Clerk Treasurer, CAO E-mail: [nairncentre@personainternet.com](mailto:nairncentre@personainternet.com)

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February 17, 2017

The Honourable Jane Philpott  
Confederation Building, Suite 162  
House of Commons  
Ottawa, Ontario  
K1A 0A6

RE: Restricting of Marketing of Unhealthy Foods and Beverages to Children

Dear Honourable Minister:

Please be advised that our Council adopted the following motion at their meeting of February 14, 2017:

**RESTRICTING THE MARKETING OF UNHEALTHY FOODS AND BEVERAGES TO CHILDREN**  
**RESOLUTION #2017-2-33**

MOVED BY: Brigita Gingras

SECONDED BY: Charlene Y. Martel

**RESOLVED:** that Council supports the resolution adopted by the Sudbury and District Health Unit, resolution # 60-16, restricting the marketing of unhealthy foods and beverages to children.

**CARRIED**

Sincerely Yours,

Robert Deschene,  
CAO-Clerk-Treasurer

LF/lc

cc: The Honourable Kathleen Wynne, Premier of Ontario  
Sudbury & District Health Unit  
The Honourable Eric Hoskins, Minister of Health & Long Term Care  
Ms. Roselle Martino, Assistant Deputy Minister, Population and Public Health Division  
Carol Hughes, MP, Algoma-Manitoulin-Kapuskasing  
Michael Mantha, MPP, Algoma-Manitoulin





## Perth District Health Unit

653 West Gore Street  
Stratford, Ontario N5A 1L4  
519-271-7600 Fax 519-271-2195  
www.pdhu.on.ca

March 15, 2017

The Honourable Dr. Jane Philpott  
Health Canada  
70 Colombyne Driveway  
Tunney's Pasture  
Ottawa, ON I1A 0K9

[Jane.Philpott@parl.gc.ca](mailto:Jane.Philpott@parl.gc.ca)

Dear Minister Philpott:

**Re: Children's Marketing Restrictions, Federal Healthy Eating Strategy & Support for Bill S-228 & Bill C-313**

The Perth District Health Unit Board of Health received correspondence from Huron County regarding children's marketing restrictions, the federal Healthy Eating Strategy and support for Bill S-228 and Bill C-313 (attached). Our Board of Health passed a resolution endorsing Huron County's position and is writing this letter to indicate support for the federal government's Healthy Eating Strategy and, in particular, the strategy initiatives that would protect children through restricting the commercial marketing of foods and beverages. In addition, the Board of Health also supports two current private members bills seeking to address this issue: Senator's Green-Raine's Private Member's Bill S-228, which if passed, would prohibit advertisement of food and beverages to children under the age of 13 years; and Peter Julian's Private Members Bill C-313 which focuses on developing a national strategy on advertising to children and amending the *Broadcasting Act*.

The time for action on this issue is now. Food and beverage advertising influences food choices. The majority of food and beverages marketed to children and youth are high in sugar, fat, and sodium. Children are exposed to this marketing repeatedly each day through television, websites, video games, apps and social media. In Canada, the average child watches about two hours of television each day and sees 4-5 food and beverage ads per hour. In Perth County, NutriSTEP surveillance data shows that 40% of children 3-5 years old watch TV while eating and about 65% of children have two or more hours of screen time each day.

Given the screen time of children and youth, their exposure to food and beverage advertising is higher than it has ever been. They are especially vulnerable to advertising because they lack an understanding of the persuasive intent of marketing. The research is clear that the marketing of food and beverages high in sugar, fat and salt to children contributes to the unhealthy eating habits of Canadian youth and the rising risk of nutrition related diseases presenting in this generation. Legislation that restricts food and beverage marketing to this susceptible population is a crucial and proven strategy for improving the eating habits and overall health of children and youth.

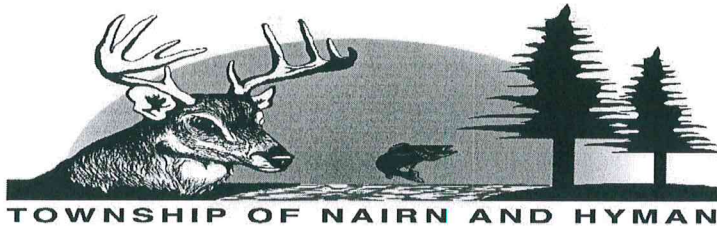
The Perth District Health Unit is committed to protecting the health and well-being of our residents. We strongly believe that the implementation of federal marketing restrictions along with the other initiatives outlined in the recently announced Healthy Eating Strategy will help to do this.

Sincerely,

Teresa Barresi  
Board Chair

Page 75 of 232

c. alPha  
John Nater, MP  
Randy Pettapiece, MPP  
Huron County Health Unit



TOWNSHIP OF NAIRN AND HYMAN

64 McIntyre Street • Nairn Centre, Ontario • P0M 2L0 ☎ 705-869-4232 📠 705-869-5248  
Established: March 7, 1896 Office of the Clerk Treasurer, CAO E-mail: [nairncentre@personainternet.com](mailto:nairncentre@personainternet.com)

---

February 17, 2017

The Honourable Charles Sousa  
Minister of Finance  
7th Floor, Frost Building South  
7 Queen's Park Crescent  
Toronto, Ontario M7A 1Y7

RE: Anti-Contraband Tobacco Campaign

Dear Honourable Minister:

Please be advised that our Council adopted the following motion at their meeting of February 14, 2017:

**ANTI-CONTRABAND TOBACCO CAMPAIGN**

**RESOLUTION #2017-2-32**

MOVED BY: Charlene Y. Martel

SECONDED BY: Brigita Gingras

**RESOLVED:** that Council supports the resolution adopted by the Sudbury and District Health Unit, resolution #03-17, requesting 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.

**CARRIED**

Sincerely Yours,

Robert Deschene,  
CAO-Clerk-Treasurer

LF/lc

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



January 18, 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:

At the January 18, 2017 meeting of the Board of Health for the Simcoe Muskoka District Health Unit, a motion was passed to endorse the resolution shared by Algoma Public Health regarding "Changes to the HPV Immunization Programs". As this resolution clearly articulates, while expansion of public health delivery of expanded immunizations is a positive move for public health, the funding models for these expanded programs is inadequate. We therefore join the Board of Algoma Public Health in urging the Ministry of Health and Long-Term Care (MOHLTC) to increase the annual funding for the Vaccine Preventable Disease Program to levels necessary to meet their growing mandate.

In recent years public health vaccination programming in Ontario has experienced continual, positive changes in an effort to not only expand the vaccines that are provided to the public, but also to improve systems of record keeping, communication, and immunization compliance. In the past two years alone we have seen the implementation of broader legislation, a new innovative database for vaccine inventory management, the arrival of two new publicly funded vaccines, and the enhancement of the HPV vaccine for boys in Grade 7 and high risk men between the ages of 9-26, the subject of the Algoma resolution.

These changes are commendable. However, unfortunately, the funding we receive at \$8.50 per dose for HPV vaccination does not reflect the real costs of program delivery. In 2010 the cost per vaccination has been estimated to be between \$21.54 and \$28.68, depending on the location and number of students attending the school clinic. Therefore the Board of Health requests an enhancement in the funding provided for public health vaccination programming to adequately support this very important and effective disease prevention strategy.

... 2

**Barrie:**  
15 Sperling Drive  
Barrie, ON  
L4M 6K9  
705-721-7520  
FAX: 705-721-1495

**Collingwood:**  
280 Pretty River Pkwy.  
Collingwood, ON  
L9Y 4J5  
705-445-0804  
FAX: 705-445-6498

**Cookstown:**  
2-25 King Street S.  
Cookstown, ON  
L0L 1L0  
705-458-1103  
FAX: 705-458-0105

**Gravenhurst:**  
2-5 Pineridge Gate  
Gravenhurst, ON  
P1P 1Z3  
705-684-9090  
FAX: 705-684-9887

**Huntsville:**  
34 Chaffey St.  
Huntsville, ON  
P1H 1K1  
705-789-8813  
FAX: 705-789-7245

**Midland:**  
B-865 Hugel Ave.  
Midland, ON  
L4R 1X8  
705-526-9324  
FAX: 705-526-1513

**Orillia:**  
120-169 Front St. S.  
Orillia, ON  
L3V 4S8  
705-325-9565  
FAX: 705-325-2091

The Board of Health commends you for your commitment to effective immunization programs and your recognition for the role of local public health in delivering these programs across the province.

Sincerely,

**ORIGINAL SIGNED BY**

Scott Warnock  
Chair, Board of Health

SW:CG:mk

- c. Dr. David Williams, Chief Medical Officer of Health  
Linda Stewart, Association of Local Public Health Agencies  
Ontario Boards of Health  
Ann Hoggarth, MPP  
Norm Miller, MPP  
Patrick Brown, MPP  
Jim Wilson, MPP  
Julia Munro, MPP  
NSM LHIN  
Central LHIN

March 28, 2017

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

Dear Minister Hoskins,

**RE: LOW-INCOME DENTAL PROGRAM FOR ADULTS AND SENIORS**

On March 17, 2017, the Porcupine Health Unit Board of Health passed the following resolution:

WHEREAS, the Board of Health for the Porcupine Health Unit recognizes the importance of dental health in the overall health and well-being in our population; and

WHEREAS, the Porcupine Health Unit has identified that oral health concerns lead to greater emergency department and day surgery visit rates in our area, than the Provincial average; and

WHEREAS, a 2015 Porcupine Health Unit Study demonstrated that more than a third of emergency department visits for dental concerns are repeat visits, and the highest proportion of repeat visits are in the 19-44 year age group; and

WHEREAS, there is a great cost to both acute health care services and the individual patient from a lack of dental care. Pain, low self-esteem, complications from antibiotic treatment, and infections which may be serious and progress rapidly are all common complications of a lack of dental services; and

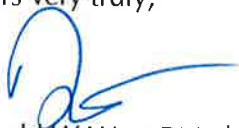
WHEREAS, the majority of these acute dental complications are avoidable with proper dental treatment, and the lack of treatment is largely due to an inability to pay for dental services;

NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for the Porcupine Health Unit appreciates the Ministry of Health and Long-Term Care's plan to address this important public health issue, but encourages consideration for more urgent implementation of expanded public dental programs for those living on low incomes; and

FURTHERMORE BE IT RESOLVED THAT, a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. David Williams, Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Boards of Health, and Gilles Bisson, MPP, Timmins - James Bay.

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

Yours very truly,



Donald W West BMath, CPA, CA  
Chief Administrative Officer

DW:mc



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169 Pine Street South  
Postal Bag 2012  
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email: [info4you@porcupinehu.on.ca](mailto:info4you@porcupinehu.on.ca)  
Website: [www.porcupinehu.on.ca](http://www.porcupinehu.on.ca)

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

Tuesday March 28, 2017

**RE: Support for Stop Marketing to Kids Coalition's Ottawa Principles and Further Action on Sugary Drinks**

Dear Ontario Boards of Health,

Sugar consumption has progressively become a major public health concern. Excessive intake of sugar has been linked to obesity, type 2 diabetes, cardiovascular disease, dental caries, metabolic syndrome and a lower intake of nutrient-dense beverages. Two priority areas for reducing sugar consumption and supporting healthy eating behaviours among children, youth and families, include restricting food and beverage marketing to children and improving the food environment in municipal and family-focused centres.

At its February 16<sup>th</sup>, 2017 meeting, the Middlesex-London Board of Health received [Report No. 006-17](#), "*City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks*", where it was recommended that the Board of Health:

- Direct staff to complete the online endorsement of the Stop Marketing to Kids Coalition's (Stop M2K) [Ottawa Principles](#) to communicate its support to restrict food and beverage marketing to children and youth 16 years of age and younger; and,
- Communicate support for STOP M2K's Ottawa Principles by sending Report No. 006-17 re: City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks, and its appendices to other Boards of Health in Ontario.

There is greater understanding today about how commercial food and beverage marketing negatively impacts the development of healthy habits, particularly for children and youth. According to the World Health Organization 2016 report, [Report of the Commission to End Childhood Obesity](#), "the evidence base shows that unhealthy food marketing is an important and independent causal factor in the childhood obesity epidemic". Children and youth are targeted by companies and highly exposed to the marketing of less healthy food and beverage through many channels including online, on television and through social media. Stop M2K's Ottawa Principles outline definitions, scope and principles to guide policy-making in Canada to help protect children and youth from the influence of commercial food and beverage marketing.

Restricting marketing to children and youth is one part of a comprehensive strategy to improve children's nutrition and long-term health outcomes. Changes to the food environment are also needed. Public health units are in a unique position to work with their local municipalities to implement healthy changes within the local food environment, as well as to communicate support for restricting food and beverage marketing to children at a federal level by [endorsing Stop M2K's Ottawa Principles](#).

Sincerely,



Jesse Helmer, Chair  
Middlesex-London Board of Health

Sent by Email at: [Jane.Philpott@parl.gc.ca](mailto:Jane.Philpott@parl.gc.ca)

March 15, 2017

Dr. Jane Philpott  
Minister of Health  
Government of Canada  
House of Commons  
Ottawa, Ontario  
K1A 0A6

Dear Minister Philpott,

On March 15th the Board of Health for the Simcoe Muskoka District Health Unit passed the following motion:

THAT the Board of Health write to the federal Minister of Health supporting the federal government's proposal to commit to a target of less than 5% tobacco use by 2035;

AND FURTHER THAT the Board of Health recommend that the federal government's approaches include those identified at the 2016 summit, A Tobacco Endgame for Canada;

AND FURTHER THAT the Board of Health write to the Ontario Minister of Health to recommend that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada.

This motion is in recognition of the fact that despite a substantial reduction of tobacco use in the Canadian population in recent decades, smoking remains the most important cause of death. It is also in recognition that without fundamentally new approaches to tobacco control there will be an inadequate continued reduction in use, and an increase in tobacco-related mortality in the decades to come. Background on this motion, including a definition of the endgame concept can be found in the attached briefing note.

The federal government is to be commended for its stated commitment to the renewal of its Federal Tobacco Control Strategy, and to this end for its consultation paper, Seizing the Opportunity: the Future of Tobacco Control in Canada proposing a target of less than 5% tobacco use by 2035. This is a commendable goal, in keeping with a tobacco endgame approach. The federal consultation paper also proposes six key elements that would help to

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FAX: 705-458-0105

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address population health inequities and to support tobacco control in priority populations, such as indigenous populations, tobacco users and youth. It also speaks to the importance of capacity building in the pursuit of enhanced tobacco control.

This is commendable content, however the Board of Health supports a further strengthening of the Federal Tobacco Control Strategy with the inclusion of the approaches within the 2016 summit paper, A Tobacco Endgame for Canada (attached).

The tobacco endgame approach proposed in this document includes some of the concepts within the federal consultation paper; however its content goes beyond this, and includes a number of recommendations that are either very well supported by research or are promising new possibilities for action. These include the strong endorsement for increased tobacco taxation (and other price-enhancing strategies) as the most important means of smoking reduction, very well supported by research, with data provided in the endgame report on both the anticipated impact on tobacco use and on government revenues. Others include increasing restrictions on marketing, including instituting plain packaging (which the federal government has already proposed) and implementing a 18A classification (adult accompaniment) for movies that depict smoking.

Both the federal consultation paper and the endgame document speak to the importance of enhancing smoking cessation. The endgame document provides a range of actions that are consistent with this goal and would augment those provided within the federal consultation paper. It also proposes strategies to reduce the production, supply and distribution of tobacco, including possible new structures to these ends.

Both documents speak of holding the tobacco industry accountable for its impact on health. The endgame strategies include the importance of litigation and the resulting substantial financial impact on the industry. In addition it should be noted that the release of internal industry documentation would serve to enhance surveillance on tobacco industry strategies and actions.

The endgame paper also cites the importance of new funding streams for tobacco control, and also proposes the creation of an endgame steering committee or “cabinet”. These recommendations would serve as important enhancements to building capacity, in keeping with one of the key elements in the federal consultation paper. In order to develop and maintain a sustained and successful tobacco endgame strategy over time, a clear model of leadership and accountability will be required.

In order to achieve a tobacco endgame, the tobacco control strategies of the provinces would need to align with the Federal Tobacco Control Strategy. To this end the Federal Tobacco Control Strategy should specifically site such provincial alignment, and the policy instruments to achieve this. Consistent with this, attached you will find my letter on behalf of the Board of

Health to Ontario Minister of Health Dr. Eric Hoskins recommending that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada.

The federal government is to be commended for considering a bold but very necessary goal of less than 5% tobacco use by 2035. The Board of Health is entirely in support of this goal, and recommends the inclusion of the endgame strategies that will be necessary to achieve it for the health of Canadians.

Sincerely,

**ORIGINAL SIGNED BY**

Scott Warnock,  
Chair, Board of Health

Att. (3) Briefing Note and attachments  
A Tobacco Endgame for Canada 2016 Summit Paper  
Letter to Minister Dr. Eric Hoskins

- c. Ontario Minister of Health  
Chief Public Health Officer of Canada  
Chief Medical Officer of Health of Ontario  
Association of Local Public Health Agencies  
Ontario Public Health Association  
Ontario Boards of Health  
Simcoe Muskoka local Members of Parliament  
Local Members of Provincial Parliament  
North Simcoe and Centre Health Integration Networks  
Association of Municipalities of Ontario  
Simcoe Muskoka Municipalities



Sent by Email at: [ehoskins.mpp@liberal.ola.org](mailto:ehoskins.mpp@liberal.ola.org)

March 15, 2017

Dr. Eric Hoskins  
Minister of Health  
Government of Ontario  
Hepburn Block, 10th Flr.  
80 Grosvenor St.  
Toronto ON M7A 2C4

Dear Minister Hoskins:

On March 15<sup>th</sup> the Board of Health for the Simcoe Muskoka District Health Unit passed the following motion:

THAT the Board of Health write to the federal Minister of Health supporting the federal government's proposal to commit to a target of less than 5% tobacco use by 2035;

AND FURTHER THAT the Board of Health recommend that the federal government's approaches include those identified at the 2016 summit, A Tobacco Endgame for Canada;

AND FURTHER THAT the Board of Health write to the Ontario Minister of Health to recommend that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada.

This motion is in part in recognition of the fact that despite a substantial reduction of tobacco use in the Ontario population with the successes of the Smoke Free Ontario Strategy, smoking remains the most important cause of death. It is also in recognition that without fundamentally new approaches to tobacco control there will be an inadequate continued reduction in use, and an increase in tobacco-related mortality in the decades to come. Background on this motion, including a definition of the endgame concept can be found in the attached briefing note.

In the attached letter to federal Minister of Health Dr. Jane Philpott, I have communicated the Board of Health's commendation of the federal government for its stated commitment to the renewal of its Federal Tobacco Control Strategy, and to this end for its consultation paper, Seizing the Opportunity: the Future of Tobacco Control in Canada (attached) proposing a target of less than 5% tobacco use by 2035. This is a commendable goal, in keeping with a tobacco

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705-721-7520  
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280 Pretty River Pkwy.  
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L9Y 4J5  
705-445-0804  
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❑ **Cookstown:**  
2-25 King Street S.  
Cookstown, ON  
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705-458-1103  
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❑ **Gravenhurst:**  
2-5 Pineridge Gate  
Gravenhurst, ON  
P1P 1Z3  
705-684-9090  
FAX: 705-684-9887

❑ **Huntsville:**  
34 Chaffey St.  
Huntsville, ON  
P1H 1K1  
705-789-8813  
FAX: 705-789-7245

❑ **Midland:**  
B-865 Hugel Ave.  
Midland, ON  
L4R 1X8  
705-526-9324  
FAX: 705-526-1513

❑ **Orillia:**  
120-169 Front St. S.  
Orillia, ON  
L3V 4S8  
705-325-9565  
FAX: 705-325-2091



endgame approach. My letter to Minister Philpott also cites the Board of Health's support for a further strengthening of the Federal Tobacco Control Strategy with the inclusion of the approaches within the 2016 summit paper, A Tobacco Endgame for Canada (attached), and provides examples of the benefits of this.

The tobacco endgame approach proposed in this document includes some of the concepts within the federal consultation paper; however its content goes beyond this, and includes a number of recommendations that are either very well supported by research or are promising new possibilities for action.

Building capacity is one of the key elements in the federal consultation paper. Continued financial support for tobacco resource centres such as the Ontario Tobacco Research Unit and the Smoking and Health Action Foundation is crucial as their work has been essential over the decades, and will be needed to help inform and guide in a tobacco control endgame in Ontario.

In order to achieve a tobacco endgame, the tobacco control strategies of the provinces would need to align with the Federal Tobacco Control Strategy. Given that the Smoke Free Ontario Strategy is presently under review, its alignment with a tobacco endgame approach presently emerging within the Federal Tobacco Control Strategy would be very timely. Such an approach would be consistent with the provincial government's stated commitment to achieve the lowest smoking rate in the country.

The federal government is to be commended for considering a bold but very necessary goal of less than 5% tobacco use by 2035. The Board of Health is entirely in support of this goal, and recommends the inclusion of the endgame strategies necessary to achieve it. Consistent with this, the Board of Health also recommends that the Smoke Free Ontario Strategy be aligned with the proposed tobacco endgame to achieve better health for Ontarians.

Sincerely,

**ORIGINAL SIGNED BY**

Scott Warnock,  
Chair, Board of Health

**Att. (4) Briefing Note and attachments**

Seizing the Opportunity: the Future of Tobacco Control in Canada Paper  
A Tobacco Endgame for Canada 2016 Summit Paper  
Letter to Minister Dr. Jane Philpott

- c. Minister of Health of Canada  
Chief Public Health Officer of Canada  
Chief Medical Officer of Health of Ontario

Association of Local Public Health Agencies  
Ontario Public Health Association  
Ontario Boards of Health  
Simcoe Muskoka local Members of Parliament  
Local Members of Provincial Parliament  
North Simcoe and Centre Health Integration Networks  
Association of Municipalities of Ontario  
Simcoe Muskoka Municipalities



January 4, 2017

**DELIVERED VIA E-MAIL & REGULAR MAIL**

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

Dear Premier,

**Re: Requesting Support for Enactment of Legislation under the HPPA to Allow for the Inspection and Enforcement Activities of Personal Service Settings**

On behalf of the Board of Health of Wellington-Dufferin-Guelph Public Health (WDGPH), I am writing to request your support of the enactment of legislation under the *Health Promotion and Protection Act (HPPA)* to allow for the inspection and enforcement activities of personal service settings.

Six provinces and territories currently have specific legislation for the regulation of personal service settings which increases the enforcement abilities of public health staff and provides an incentive for operators to comply with infection protection and control best practices. Ontario has no provincial legislation that requires operators to comply with these best practices.

In those provinces and territories where regulations exist, non-compliance with the regulations by personal service setting staff or operators can result in a conviction and/or strict monetary fines, without requiring public health staff to prove the existence of a health hazard in order to proceed with enforcement actions.

The creation of legislation under the *HPPA*, specific to personal service settings, would contribute to the standardization of minimum infection control best practices in personal service settings. Based on an assessment of complaints received by WDGPH, most complaints in personal service settings are associated with potentially invasive services such as manicure, pedicure and aesthetics services. The enactment of legislation for all premises offering personal services could help mitigate infection control risks to staff working in these premises and members of the public receiving these services.

.../2  
Page 87 of 232

The most recent complaint to WDGPH was in December 2016 and pertained to the cleanliness of reusable tools and equipment and the reuse of single-use items such as nail files and buffer blocks. If legislation was in place that allowed for inspection and enforcement procedures similar to those in food premises, a ticket could have been issued on the spot with a set fine for non-compliance with infection prevention and control best practices. This would have helped lower infection risks for current staff and clients as well as been an incentive for ongoing infection control for this specific owner and a general incentive for the wider community of personal service setting operators.

Recently, WDGPH has observed an expansion in the range of services offered within personal service settings to include more invasive services such as micro-needling, botox injections and microdermabrasion. The invasive nature of these services is accompanied by an increased risk of subsequent infection if appropriate infection prevention and control practices are not followed during the provision of these services. In many cases, these services are being offered by non-Regulated Health Professionals, meaning that inspection of these services and enforcement of minimum infection control best practices falls to public health.

It is therefore our hope that you will consider enacting legislation for infection protection and control requirements for all personal service settings under the *HPPA*, supported by short-form wording under the *Provincial Offences Act*.

Thank you for giving this correspondence your every consideration.

Sincerely,



Nancy Sullivan

Chair, Wellington-Dufferin-Guelph Board of Health

Encl. (Legislation to enforce infection prevention and control practices within personal service settings, Board of Health Report, December, 2016)

cc (via e-mail):

Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care  
MPP Liz Sandals, Guelph  
MPP Sylvia Jones, Dufferin-Caledon  
MPP Ted Arnott, Wellington-Halton Hills  
Dr. David Williams, Chief Medical Officer of Health  
Association of Local Public Health Agencies  
Ontario Boards of Health



March 29, 2017

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

Dear Premier Wynne,

**Re: Requesting Support for Enactment of Legislation under the HPPA to Allow for the Inspection and Enforcement Activities of Personal Service Settings.**

At its meeting on March 22, 2017, the Board of Health for the District of Algoma Health Unit considered the correspondence forwarded by Wellington-Dufferin-Guelph Public Health in regards to support for enactment of legislation under the HPPA to allow for the inspection and enforcement activities of personal service settings.

The Board of Health for the District of Algoma Health Unit passed the following resolution in support of Wellington-Dufferin-Guelph Public Health's request for support:

***Resolution 2017-***

*WHEREAS the Hepatitis C rate in Algoma between 2012-2016 has increased by 7.2% compared with a decrease in the province of 4%; and*

*WHEREAS some services provided by Personal Service Settings (PSS) potentially expose individuals to bloodborne infections; and*

*WHEREAS due to the lack of legislation for PSS, APH instituted an optional program where operators are provided with a "Registered for Inspection" certificate that they post at their premise to showcase to the patrons that they have voluntarily been inspected; and*

*WHEREAS education and training are the first steps to ensure Infection Prevention and Control Practices (IPAC) best practices are adhered to, there are occasions when enforcement maybe needed; and*

*WHEREAS due to the lack of legislation, associated regulations, and set fee schedules to allow for issuing of certificates of offence (tickets) for enforcement purposes, APH has had to utilize more cumbersome and inefficient Section 13 orders to ensure compliance; and*

Page 89 of 232

**Blind River**  
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Blind River, ON P0R 1B0  
Tel: 705-356-2551  
TF: 1 (888) 356-2551  
Fax: 705-356-2494

**Elliot Lake**  
ELNOS Building  
302-31 Nova Scotia Walk  
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Tel: 705-848-2314  
TF: 1 (877) 748-2314  
Fax: 705-848-1911

**Sault Ste. Marie**  
294 Willow Avenue  
Sault Ste. Marie, ON P6B 0A9  
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TF: 1 (866) 892-0172  
Fax: 705-759-1534

**Wawa**  
18 Ganley Street  
Wawa, ON P0S 1K0  
Tel: 705-856-7208  
TF: 1 (888) 211-8074  
Fax: 705-856-1752

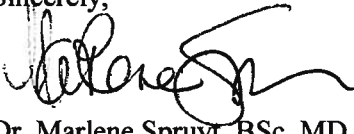
*WHEREAS some PSS providers are conducting the procedures in uninspected environments such as private homes in the Algoma district, and*

*WHEREAS creation of provincial legislation governing PSSs would support a consistent, progressive enforcement model amongst Ontario's public health units.*

*THEREFORE BE IT RESOLVED THAT the Algoma Public Health Board support the Wellington-Dufferin-Guelph Public Health in recommending that the Government of Ontario enact legislation under the HPPA to support inspection and enforcement activities within PSSs; and*

*FURTHER THAT this resolution is shared with the Minister of Health and Long Term Care, Members of Provincial Parliament, Chief Medical Officer of Health, Association of Local Public Health Agencies and all Ontario Boards of Health.*

Sincerely,



Dr. Marlene Spruyt BSc, MD, CCFP, FCFP, MSc-PH  
Medical Officer of Health/CEO  
On behalf of Algoma Public Health Board of Health

Encl. Wellington-Dufferin-Guelph Public Health correspondence

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care  
Dr. David Williams, Chief Medical Officer of Health  
Michael Mantha, MPP Algoma-Manitoulin  
Association of Local Public Health Agencies  
Ontario Public Health Units



**From:** Hope, Amy (MOHLTC) [<mailto:Amy.J.Hope@ontario.ca>] **On Behalf Of** Martino, Roselle (MOHLTC)  
**Sent:** March 02, 2017 6:11 PM  
**To:** MOH  
**Cc:** Walker, Elizabeth S. (MOHLTC); Feeney, Brent (MOHLTC)  
**Subject:** Office of the Auditor General - follow up with PHUs

Dear Colleagues,

In December 2016, we received notification from the Office of the Auditor General of Ontario (OAG) that the Public Health Program had been identified as a candidate for a value-for-money audit. Since that time, OAGO has been conducting research work to establish the scope of the audit and timing for such work.

It is expected that the scope of the audit will be finalized in the next few weeks. The OAGO does not publically announce these audits and so we were not in a position to advise you prior to this point.

The OAGO has notified us that they are interested in selecting a few public health units to do some audit work at and will be contacting some of you very shortly to get the process started (most likely very early next week). The OAGO has asked that we provide a heads up to all of you that they will be conducting on-site audit work. We are aware that some of you may have been contacted by them already, however we are not aware which public health units will be contacted at this stage.

In addition, OAGO is also planning on conducting a survey of some of the individuals at all public health units and have requested contact information for your board of health members (we only have the contact information for board of health chairpersons) and some of your senior employees (e.g., Director or lead person responsible for Chronic Disease Prevention programs and services). Upon receipt of this email, please provide Brent Feeney ([Brent.Feeney@ontario.ca](mailto:Brent.Feeney@ontario.ca)) with this contact information and we will forward it to the OAGO.

We appreciate your cooperation and support throughout this process. If you have any questions, please contact Elizabeth Walker, Director, Accountability and Liaison Branch at 416-212-6359 or via email at [Elizabeth.Walker@ontario.ca](mailto:Elizabeth.Walker@ontario.ca).

Thank you,

Roselle Martino  
Assistant Deputy Minister  
Population and Public Health Division

**Ministry of Health  
and Long-Term Care**

Office of the Minister

Hepburn Block, 10<sup>th</sup> Floor  
80 Grosvenor Street  
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Fax 416 326-1571  
www.ontario.ca/health

**Ministère de la Santé  
et des Soins de longue durée**

Bureau du ministre

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Toronto ON M7A 1R3  
Tél. 416 327-4300  
Téléc. 416 326-1571  
www.ontario.ca/sante



HLTC3968IT-2016-1297

January 26, 2017

Dear Community-based HIV Organization or Program:

It is with great enthusiasm that I write to you about the *HIV/AIDS Strategy to 2026: Focusing Our Efforts - Changing the Course of the HIV Prevention, Engagement and Care Cascade in Ontario*. The strategy represents the combined wisdom of those of you working in HIV community, public and clinical health services, those of you living with HIV or living with the risk of acquiring the virus. It integrates significant scientific advances from HIV research, including knowledge developed by HIV researchers here in Ontario. And it reflects your ongoing collaboration with the Ministry of Health and Long-Term Care; collaboration that I am confident will continue to be successful as you work together to move these recommendations forward. I thank you and my Ontario Advisory Committee on HIV/AIDS for the tremendous efforts made in the development and preparation of this strategy

This is an optimistic time in the fight to stop HIV/AIDS. And reflecting this, this strategy assumes a bold vision - a time when HIV infections are rare in Ontario and all people with HIV have the opportunity at a long healthy life, free from stigma and discrimination. This vision is possible partly because in Ontario we are already well on our way, but also because there now exists the scientific knowledge to support it.

Ontario has a strong, committed and well networked community of HIV researchers, health care providers, community and harm reduction workers, and knowledge exchange and capacity-building supports. As well, there is an active commitment to ensure the voice of people living with and at-risk of HIV informs all aspects of the response. This history of collaboration provides a solid foundation for the vision outlined in this strategy, a vision of a well networked community of services through which those most challenged to manage the risks of HIV in their lives are able to access the knowledge, tools and supports they need to respond effectively to HIV and improve their overall health and well-being.

Within this strategy you can see evidence for the responsiveness of this collaborative system when you look at the first reports of progress on the UNAIDS 90-90-90 targets. and the HIV cascade of care. I know that these indicators are going to be followed over time and will provide important information to assess the progress being made towards the strategy vision. What these data demonstrate is that you have already covered considerable distance towards stopping HIV in Ontario. The data also show there remains work to be done.

.../2



## HIV/AIDS Strategy to 2026

We now know there are several effective tools to prevent the transmission of HIV, including condoms and the use of HIV treatments. And we now know it's vital that all people who acquire HIV be diagnosed soon after infection and actively linked to HIV care and treatment quickly. By doing so, both of this strategy's visions are advanced, knowing early treatment produces the best health outcomes for people with HIV and an undetectable viral load is highly effective at preventing HIV transmission.

The challenges to effectively controlling HIV are the ones that have shaped the HIV epidemic from the beginning. HIV continues primarily within communities who experience stigma, discrimination and added personal and social challenges to maintaining health. The recommendations in the strategy indicate the importance of continuing to develop services that are accessible to these 'HIV priority populations'. Through stronger collaboration and integration across service networks and through a continued commitment to capacity-building and knowledge exchange, services and service networks can better engage with those in their communities most at-risk with the information, and testing, care support and/or treatment services they need.

This is really the heart of the HIV strategy. And this is also at the core of transforming the health care system through the Action Plan for Health. Not all people are at equal risk of HIV. Not all people who have HIV are at the same risk of poor health. By focusing our efforts towards better serving the people in our communities most at-risk, we can achieve our goals. Of course, there are activities in this strategy that will improve policies, create service standards, strengthen oversight of resources, and otherwise impact the larger systems in place to support the response. But ultimately, success will be found in the day-to-day ways that those of you choose to work together and to develop the response on the ground.

Thank you, once again, for your work to build this strategy and for your work every day in the service of your communities and in the service of social progress and health system transformation. Together, we are going to improve the health of those we serve and stop HIV once and for all.

Yours sincerely,



Dr. Eric Hoskins  
Minister

Ontario's HIV/AIDS Strategy to 2026

OCMS No.: HLTC3968IT-2016-1297

bc: Dr. Bob Bell, Deputy Minister, MOHLTC

Ms. Lynn Guerriero, Assistant Deputy Minister, Negotiations and Accountability  
Management Division, MOHLTC

Ms. Debbie Korzeniowski, Director, Provincial Programs Branch, Negotiations and  
Accountability Management Division, MOHLTC



## Information Break

March 6, 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.*

### **alPHA Winter 2017 Symposium - Feb. 23**

alPHA has wrapped up another successful Symposium last week in Toronto which focused on the updated Ontario Public Health Standards. Sincere thanks to the guest presenters, Dr. Brent Moloughney and attendees who contributed to the productive, engaging discussion on the new Standards. alPHA is currently preparing a summary of the event proceedings and will share these with the membership in the coming weeks. In the meantime, slide presentations from the Symposium may be viewed on alPHA's website (see below; username and password required).

[Download Winter 2017 Symposium PowerPoints here](#)

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### **Patients First Update**

Health system integration bulletins from the Province are available online to keep the public abreast of work supported by the *Patients First Act, 2016*.

[Read the latest \(Feb. 24\) Health System Integration bulletin](#)  
[Go to Health System Integration updates](#)

*Updated Public Health Standards* – On February 17, the Ministry of Health and Long-Term released its Standards for Public Health Programs and Standards Consultation Document. Ministry officials are in the process of organizing regional consultations which will allow boards of health to seek clarification and context on the standards and to provide input on anticipated operational considerations, implementation requirements and supports. Written submissions to the ministry on the draft standards are due April 3.

[Download the OPHS Consultation Document](#)

At the February 23rd Winter Symposium, assistant deputy minister Roselle Martino gave an overview of the updated Standards, and Dr. Brent Moloughney followed up with a preliminary assessment of the changes. Immediately at the end of the event, alPHa emailed their slide presentations to the membership and outlined the association's next steps.

alPHa has requested that the province extend the April 3rd deadline, but encourages all boards of health to submit their input by this date in the event an extension is not granted. On behalf of the Association, Dr. Moloughney has prepared a report on Symposium participants' comments on the standards provided during the group discussion on February 23rd (click link below; login required). In the next several weeks, alPHa will share its position statement(s) on the new standards with boards of health so that they can endorse and/or include them in their own board's response to the ministry.

[Read alPHa's request to extend the OPHS consultation deadline](#)

[View Dr. Moloughney's report on initial analysis & summary of alPHa members' input on new Standards](#)

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### **Boards of Health Section Meeting Wrap-Up**

On February 24, board of health representatives from across the province attended the alPHa BOH Section meeting during the Winter Symposium. Guest presenters included Ontario's Chief Medical Officer of Health, Dr. David Williams, in his inaugural address to Section members. He spoke to the updated Standards for Public Health Programs and Services, as well as the Province's strategy on opioid addiction and overdose. Public health nurse Elena Hasheminejad (York Region) and health promoter Allison Imrie (Peel Region) from the Ontario Public Health Unit Collaboration on Cannabis (OPHUCC) gave an overview of the federal framework on cannabis legalization and regulation, including Task Force recommendations. Michael Perley, Director of the Ontario Campaign for Action on Tobacco, concluded the meeting with his update on Smoke-Free Ontario and the current landscape of tobacco and vaping.

[Download the Feb. 24 BOH slide presentations](#) (scroll down list)

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### **TOPHC 2017: Global challenges. Local solutions.**

More than 700 public health professionals from across the province are expected to gather in Toronto from March 29 to 31 to attend TOPHC 2017. The Ontario Public Health Convention this year, located at the Beanfield Centre (formerly Allstream Centre), will explore global public health challenges and showcase local solutions while examining opportunities to collaborate locally, provincially and nationally on challenges. Keynote speakers will share insights on climate change and public health emergencies, urban renewal, and immigrant and refugee health. Attendees can choose from a variety educational pathways in chronic disease and injury prevention, environmental health, family health, infectious diseases and control, among others.

[View TOPHC 2017 program](#)

[Register here for TOPHC 2017](#)

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### **Upcoming Events - Mark your calendars!**

**March 29-31, 2017 - [TOPHC 2017](#):** Global challenges. Local Solutions. The Beanfield Centre (formerly Allstream Centre), Toronto. [Register now!](#)

**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](mailto:quesnelr@sdhu.com) from the Association of Local Public Health Agencies ([info@alphaweb.org](mailto:info@alphaweb.org)).

To stop receiving email from us, please UNSUBSCRIBE by visiting: <http://www.alphaweb.org/members/EmailOptPreferences.aspx?d=15240857&e=quesnelr@sdhu.com&h=968b2892a6f19d007b8126f595db0e78d85cbef0>

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



April 7, 2017

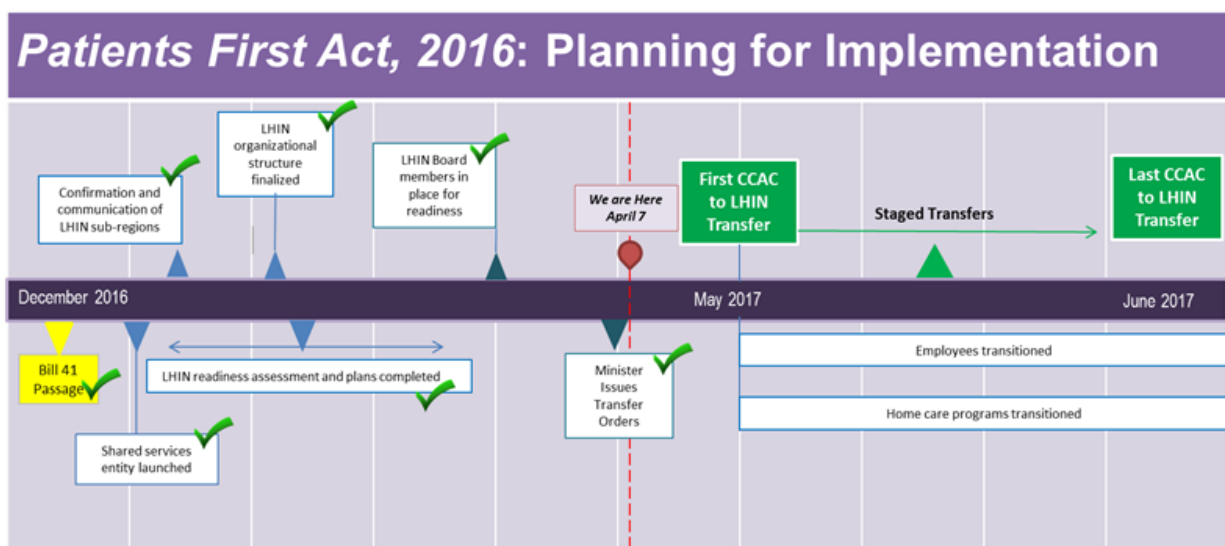


We are pleased to share this update on the work supported by the *Patients First Act, 2016*.

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.

### Implementation Updates

Four weeks to the First Planned CCAC to LHIN Transfer



### **Recent Accomplishments:**

- The Minister of Health and Long-Term Care has signed transfer orders to initiate the transition process. Each transfer order indicates the date CCAC services and staff will transfer into the local LHIN. Please see spotlight below for more details.
- The Transition Package to support LHINs through transition was distributed, which included information and communications tools and messaging to support CCACs and LHINs at various points during this process.

### **Coming Up Next:**

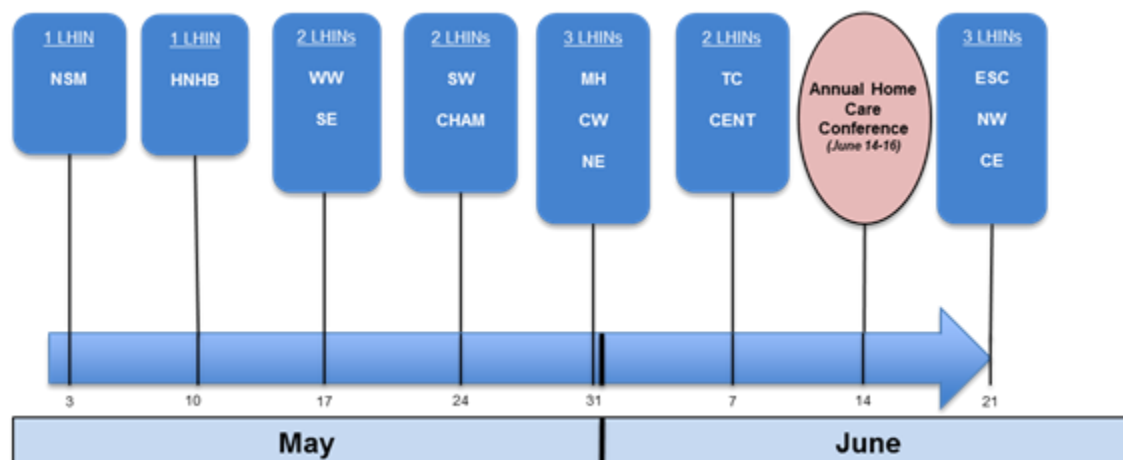
- Preparations are ongoing in support of CCAC to LHIN transfers, with a special emphasis on readiness for the earlier transfers.

- Operational supports continue to be strengthened in collaboration with CCACs, LHINs, and Health Shared Services Ontario.

### **Spotlight On: Transition**

The last eblast described the in-depth process and tools used by the CCACs, LHINs and the ministry to assess each LHIN area's (i.e., LHIN and CCAC pair) organizational readiness to form a combined organization. These broad ranging and intensive reviews and consultations, in addition to other key factors such as the volume of CCAC IT users transitioning on a given day, informed the ministry's recommendations to the Minister regarding transfer sequencing. All LHINs will be ready on their transfer day to take on the home and community care responsibilities.

The Minister has now approved transfer orders for all CCAC to LHIN transitions, which include the dates for the transfers to occur. The transfer orders are all posted [here](#) and the following diagram sets out the sequencing.



Consistent with our commitment to ensure that patient care is not disrupted and that the transition is as smooth as possible for employees and health service providers, transfers have been staged over the course of eight weeks. By starting with one LHIN in each of the first two weeks, it will be possible to identify and apply leading practices from the first waves of transition to the LHINs that will follow over the subsequent weeks. We look forward to learning from the North Simcoe Muskoka LHIN transition which will occur on May 3<sup>rd</sup>.

The ministry and Deloitte will continue to actively support the LHIN areas as they implement the plan to support the transfers.

The Minister's signing of the Transfer Orders is an important milestone for all of us. The level of commitment and dedication demonstrated by CCACs and LHINs has been exceptional and is a key ingredient for a successful transition across the province. We look forward to completing the final implementation steps of the transition phase and our continued partnership with our health sector partners.

**Stay in Touch**

Your support, partnership and patience during this time of transition is appreciated.

We value your feedback and want to provide you with the information you need. If you have questions or comments or would like to join our email list, please send an email to [patientsfirst@ontario.ca](mailto:patientsfirst@ontario.ca).

You can find this update archived [here](#) and some Frequently Asked Questions [here](#).



# Water does Wonders Pledge



## Gold Certificate

Congratulations for taking the **#WaterDoesWonders** Pledge!

This certificate is to commend **Sudbury & District Health Unit** located in **Sudbury, Ontario** for their commitment to promoting water and not selling, providing or promoting sugary drinks.

Supporting this initiative makes them a leader in their community.

Thanks for helping kids sip less sugar!



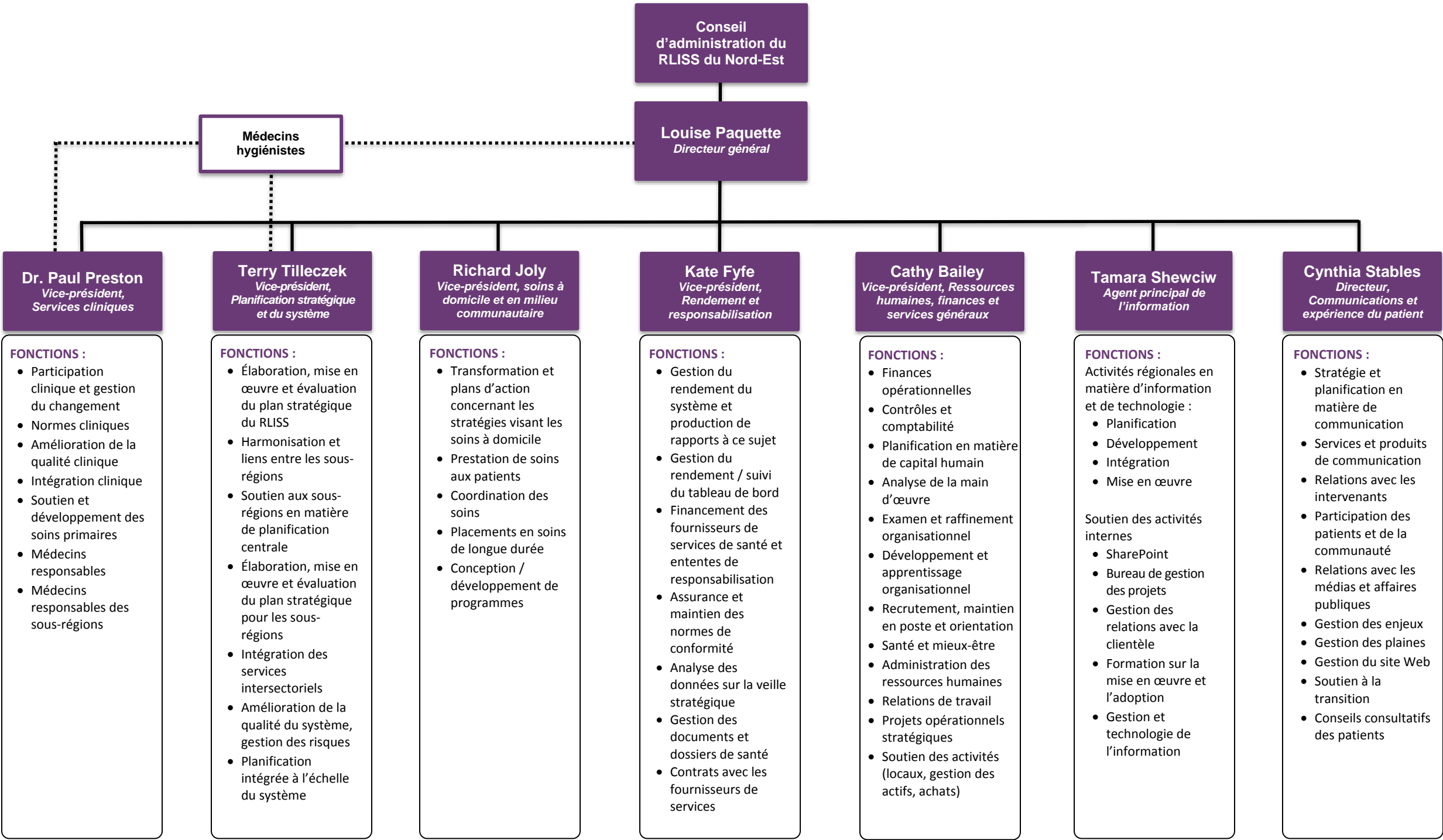
We're committed to promoting water and not selling, providing or promoting sugary drinks.

- Provide drinking water when food or beverages are served
- Ensure children and adults can always access safe drinking water
- Post water prompt signs near water sources in your building
- Promote water as the preferred drink for hydration and health
- Ensure staff encourage kids to drink water when thirsty—especially during physical activity
- Allow kids to bring refillable water bottles or provide cups so they can use the water fountain or hydration station to fill up and have water at snacks or meals
- Use Sip Smart!™ Ontario materials to raise awareness about the harms of sugary drinks (for example, posters, newsletters)
- Do not offer or sell sugary drinks
- Avoid marketing sugary drinks (for example, displaying corporate branding of sugary drinks)

# Mise en œuvre de Priorité aux patients par le RLISS du Nord-Est

Sous condition d'arrêté de transfert

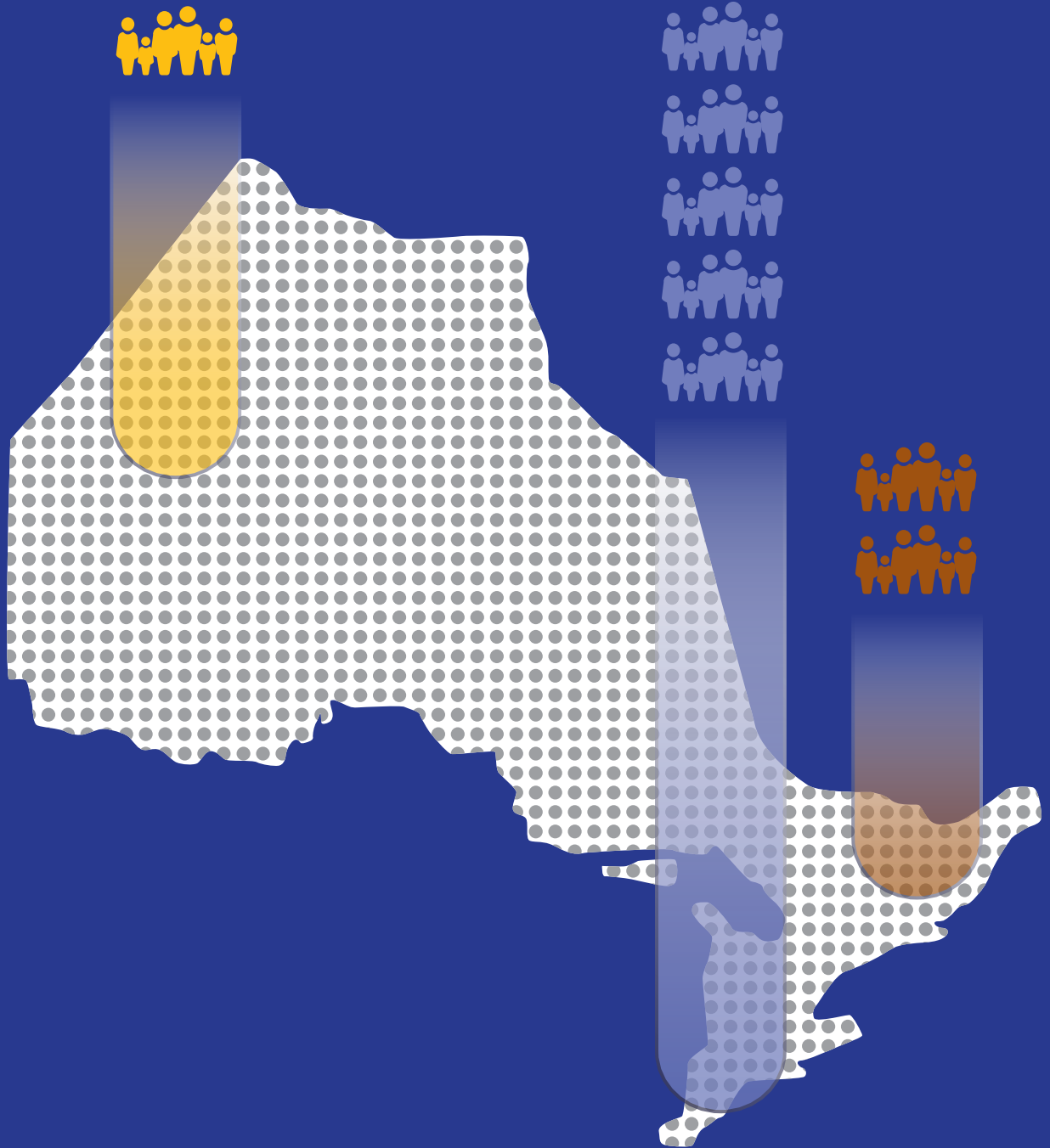
Le 22 février 2017



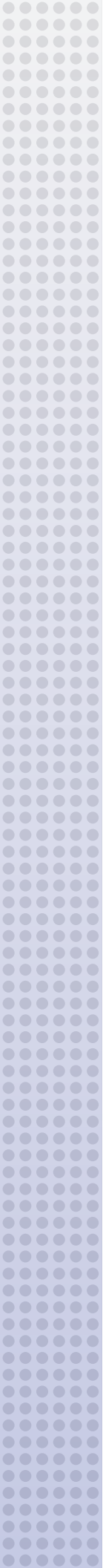


## 2015 ANNUAL REPORT

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



# MAPPING WELLNESS: ONTARIO'S ROUTE TO HEALTHIER COMMUNITIES



Ministry of Health and Long-Term Care  
Chief Medical Officer of Health  
21st Floor, 393 University Avenue  
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Telephone: (416) 212-3831  
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée  
Médecin hygiéniste en chef  
393 avenue University, 21e étage  
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## A Message from Ontario's Chief Medical Officer of Health

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

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

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

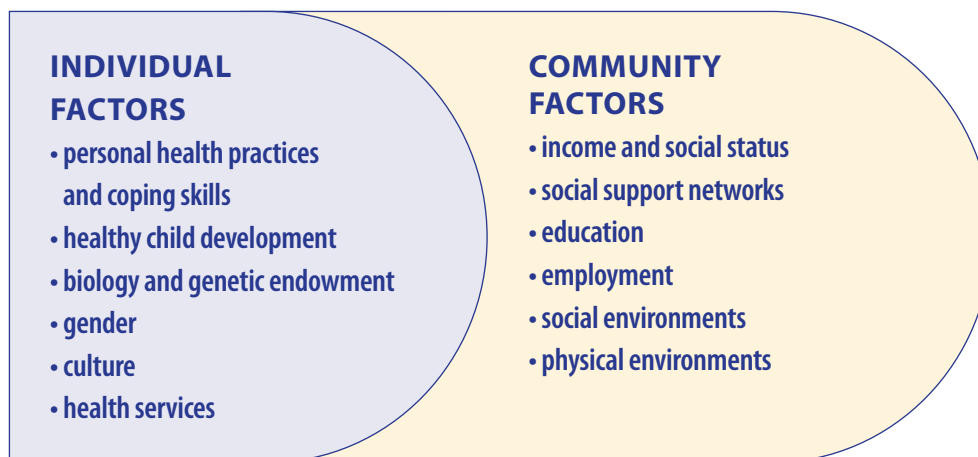
***Building our communities for health will keep Ontarians healthier and make them less likely to become patients or need costly health care services.***

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

A handwritten signature in dark ink, reading "D Williams".

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

## Individual and community health factors that contribute to health:



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

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

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

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# I. THE CASE FOR MAPPING WELLNESS

## Mapping Personal Health

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

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

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



## Mapping Community Health

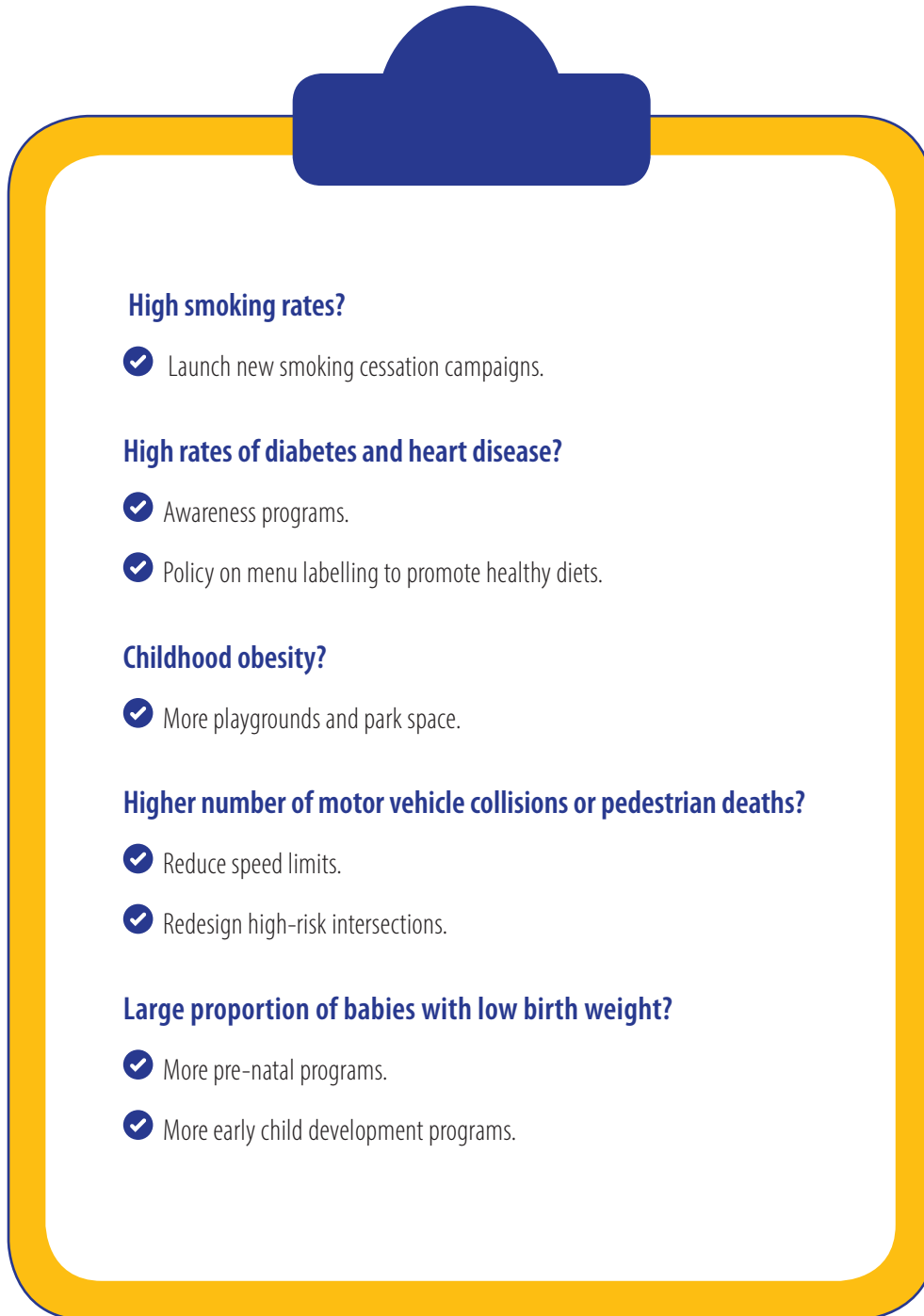
Public health professionals take a similar approach to mapping community health. They gather information to create a map of the wellness of their communities and of the neighbourhoods and populations within their communities.

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

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

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

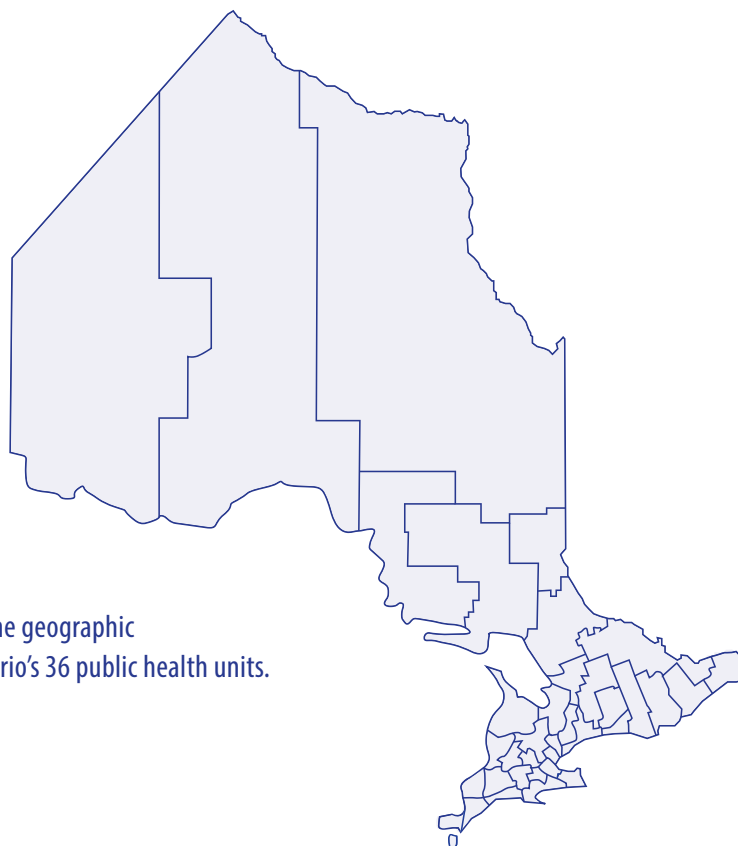
For example:



# Who is Responsible for Mapping Community Wellness?

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

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



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

## II. THE CASE FOR STRONG LOCAL DATA

### Using Local Data to Map Community Wellness

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

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

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

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

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

# Using Local Data to Target Health Problems

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

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

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

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

### TARGETING NEIGHBOURHOODS WITH HIGH RATES OF DIABETES

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

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

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



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

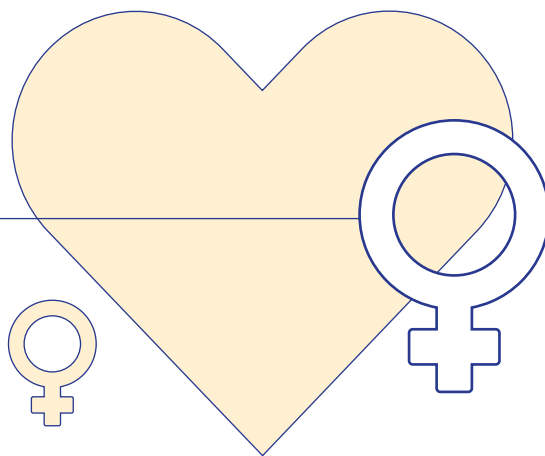
Using local data to map community wellness, health units can identify the most important health problems — both in terms of the number of people affected and their impact. Health problems that threaten a large number of people, cause significant harm or lead to preventable deaths become community priorities.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

### ENHANCING HEALTH BY REDUCING INTIMATE PARTNER VIOLENCE

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

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

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



### 3 Respond quickly to health threats

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

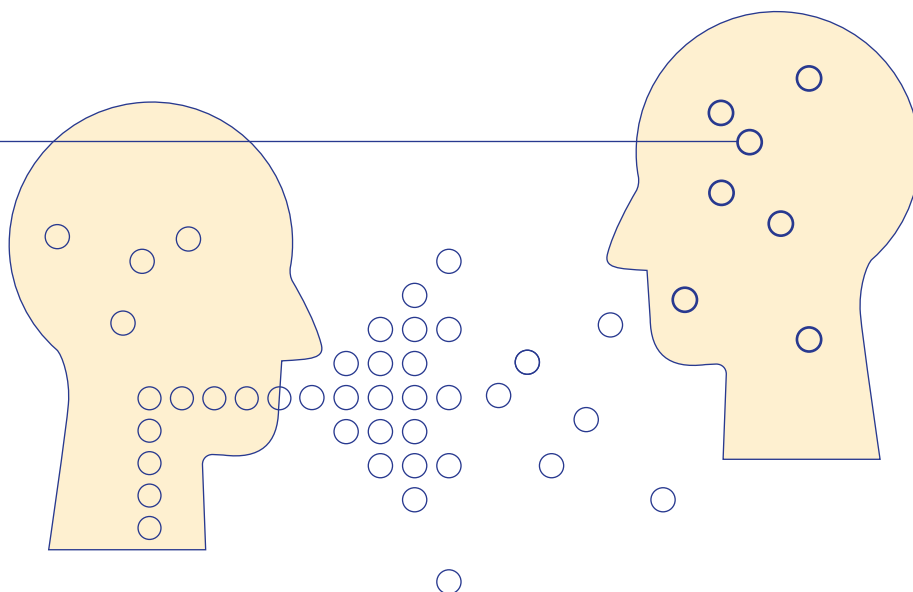
When health units have good local data, they can identify new health threats early and take steps to protect everyone. For example, if one doctor sees a patient with an E. coli infection, it may be an isolated problem. However, when doctors across a region are reporting people with similar symptoms,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

#### RESPONDING TO A MEASLES OUTBREAK

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

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

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



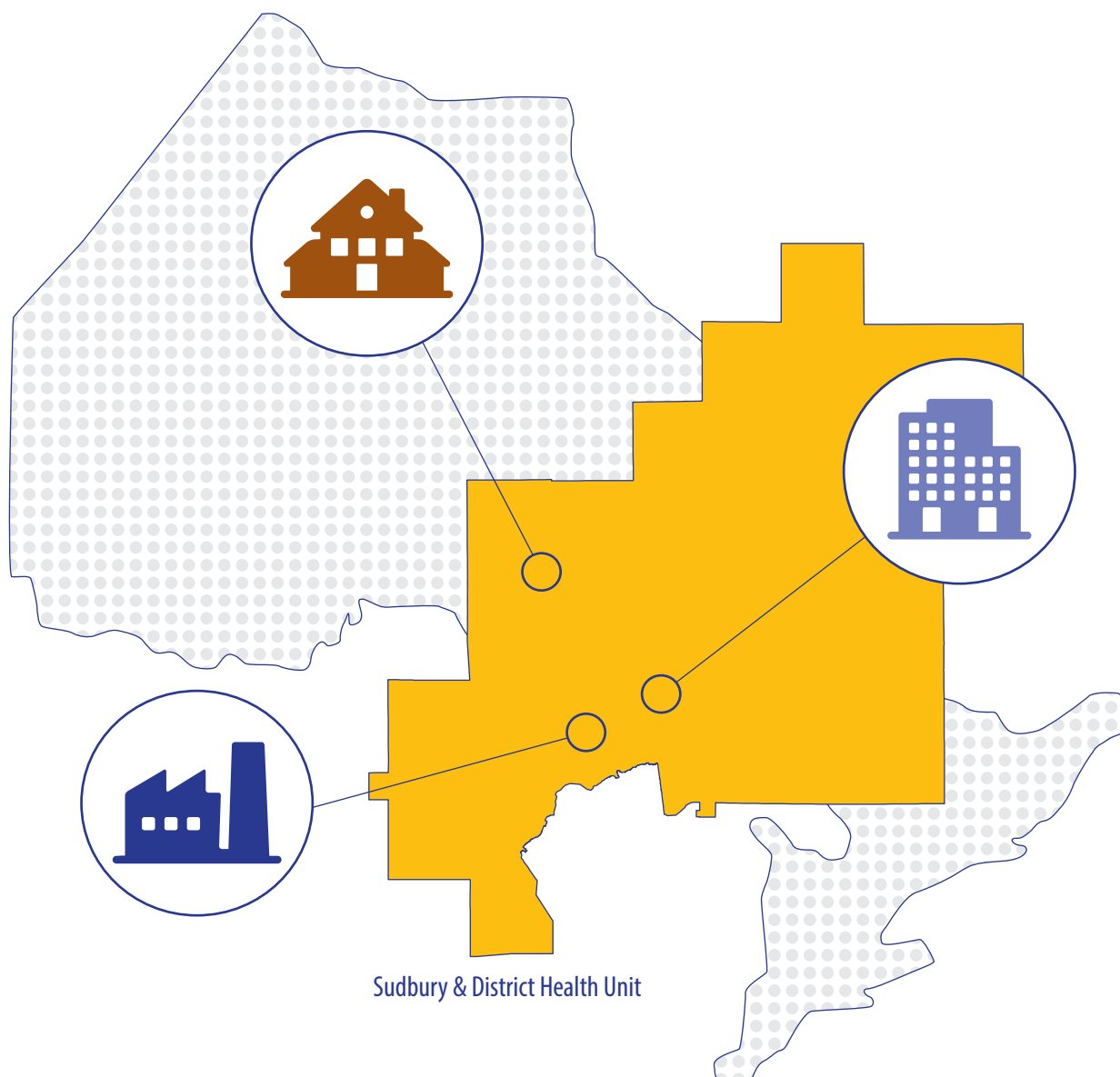
# Using Local Data to Engage Communities in Wellness

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

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

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




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












## The findings?

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

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

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

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

## The impact?

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

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

## DURHAM REGION: Using Data to Target Neighbourhood Health Issues

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

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

— Councillor Dan Carter

### The findings?

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



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



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

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

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

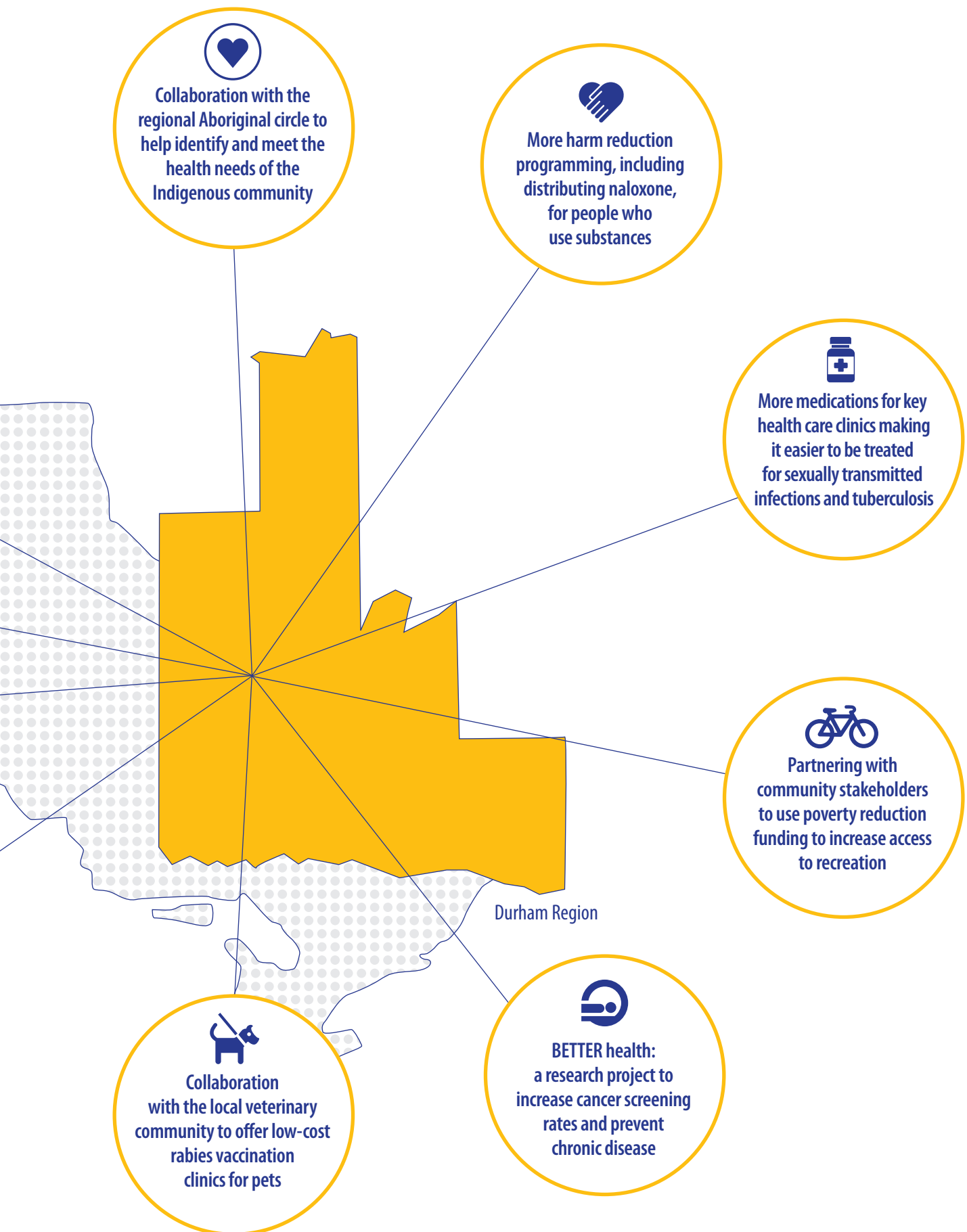
Each of these priority neighbourhoods is unique and has strengths as well as challenges, so portraying them as similar would be misleading. For example, breastfeeding rates are low in some priority neighbourhoods but high in others. Kindergarten children in one of the priority neighbourhoods are more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

## The impact?

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

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





### III. CHALLENGES IN GETTING GOOD LOCAL DATA

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

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

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

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

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

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

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

#### GOOD DATA FOR THE PURPOSES OF MAPPING COMMUNITY WELLNESS IS:

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

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

## STRATEGIES TO CLOSE DATA GAPS

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

**Table 1: Examples of Current Data Sources and Their Limitations**

NAME	DESCRIPTION	LIMITATIONS
Canada Census	A national household survey conducted every five years that collects demographic and statistical information (e.g., age, ethnicity, education, income, employment, housing, disabilities)	<ul style="list-style-type: none"> <li>Long-form not used in 2011 so some data not available</li> </ul>
Vital Statistics Canada	A national database on births, marriages and deaths, including cause of death	<ul style="list-style-type: none"> <li>Data not always complete</li> <li>Time lag of <math>\pm</math> five years to obtain data</li> </ul>
Canadian Community Health Survey	An annual telephone survey of about 108,000 households across Canada that gathers data on a number of health indicators and is able to link them with demographic and socio-economic data	<ul style="list-style-type: none"> <li>Relies on self-reported data</li> <li>Doesn't reach enough households in some health unit areas to provide relevant, granular data at the neighbourhood level</li> <li>Doesn't provide data on children</li> <li>Doesn't include many indicators of interest to Ontario communities</li> </ul>
Ontario Health Survey	Conducted in 1990 and 1996/97 to provide consistent information about community health across the province	<ul style="list-style-type: none"> <li>Information now more than 20 years old</li> <li>Survey no longer done</li> </ul>
Rapid Risk Factor Surveillance System (RRFSS)	An annual telephone survey of about 18,000 Ontario households conducted through York University that collects information on risk behaviours, chronic health conditions and use of health services	<ul style="list-style-type: none"> <li>Covers a limited number of topics</li> <li>Self-reported data and reaches only some Ontarians (particularly those who have land lines — although it is starting to use cell phone numbers as well)</li> <li>Health units have to pay to participate</li> </ul>
Better Outcomes Registry and Network (BORN)	Ontario database on births from hospitals, labs, midwifery practices and clinical programs	<ul style="list-style-type: none"> <li>Reporting varies by public health unit and may lag by six to 15 months</li> <li>Does not capture the small number of births each year in hospitals with no obstetrical services</li> <li>Indigenous births are under-represented</li> </ul>
Early Development Instrument (EDI)	An Ontario assessment of school readiness completed by teachers on all five-year-olds in kindergarten	<ul style="list-style-type: none"> <li>Does not provide data on developmental progress of children under age five</li> </ul>
Panorama	Ontario's immunization registry/information system	<ul style="list-style-type: none"> <li>Currently contains only immunizations for school-aged children</li> </ul>

## IV. RECOMMENDATIONS: ONTARIO'S ROUTE TO HEALTHIER COMMUNITIES

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

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



### UNDERSTAND OUR COMMUNITIES:

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

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

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

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



### SHARE WITH OUR COMMUNITIES

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

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

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

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

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



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

3

## **INVEST IN OUR COMMUNITIES**

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

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

4

## **STRENGTHEN OUR COMMUNITIES**

### **Use the data to reduce health disparities and reinforce health equity**

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

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



## V. CONCLUSION

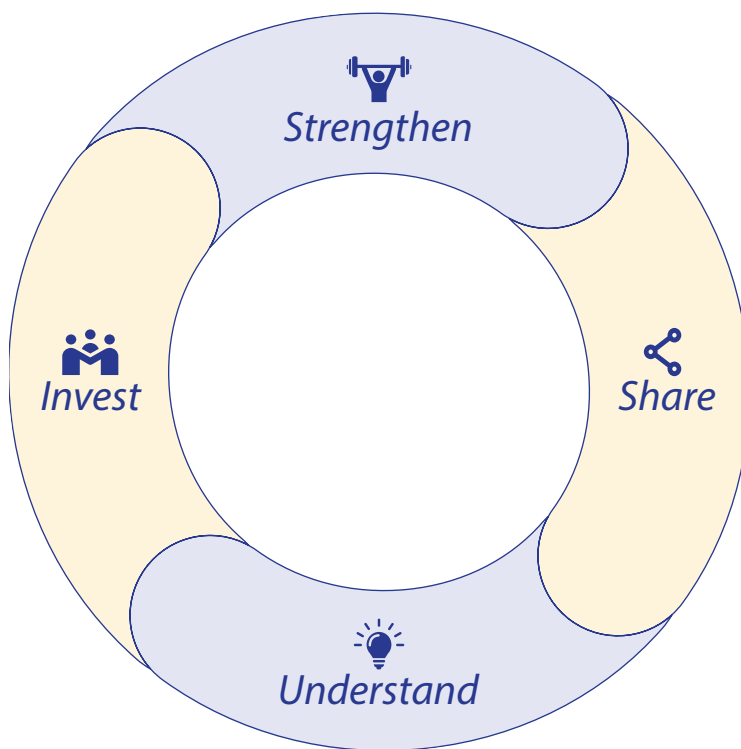
When we focus on community wellness, we improve the health of everyone who lives there.

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

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

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

### STRENGTHEN OUR COMMUNITIES:



# VI. ACKNOWLEDGEMENTS

## **Advisory Committee:**

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

## **Advising Staff:**

Fiona Kouyoumdjian, David McKeown

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## **Publishing:**

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## **Contributing Public Health Units:**

Peel Regional Health Unit, Niagara Regional Area Health Unit, City of Toronto Health Unit, Halton Regional Health Unit, Durham Regional Health Unit, Sudbury & District Health Unit

## **Other:**

Sarah Cox, Meghan Walker

## VII. APPENDIX

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

Filed by acting MOHs as of February 3, 2017

District of Algoma Health Unit\*\*

Haldimand-Norfolk Health Unit

Hastings & Prince Edward Counties Health Unit

Huron County Health Unit

Oxford County Health Unit

Porcupine Health Unit

Renfrew County & District Health Unit

Timiskaming Health Unit

City of Toronto Health Unit

**Total = 9 Health Units with MOH Vacancies**

*\*Under 62.(1)(a) of the Health Protection and Promotion Act, every board of health shall appoint a full-time medical officer of health.*

*\*\*Vacancies may include positions filled by qualified physicians awaiting appointment by boards of health and ministerial approval.*

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

As of February 3, 2017

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

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

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

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**APPROVAL OF CONSENT AGENDA**

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





## PROCEEDINGS

**DAY 1: THURSDAY FEBRUARY 23 2017**

*A full-day session to examine and discuss the Consultation Document for the updated Ontario Public Health Standards*

[CLICK HERE TO DOWNLOAD THE COLLECTED SLIDE DECKS\\*](#)

### Panel – Local Public Health in a Transformed Health System

**Moderator:** Valerie Jaeger, alPHa President

**Panelists:** Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation; Tim Hadwen, Assistant Deputy Minister, Health System Accountability and Performance Division; Michael Barrett, LHIN CEO, Co-Chair Public Health Work Stream; David Williams, Ontario Chief Medical Officer of Health & Chair, Public Health Expert Panel;

\*Please note that Sharon Lee Smith's slide deck was not made available for posting.



alPHa President Dr. Valerie Jaeger welcomed delegates to the 2017 alPHa Winter Symposium, noting that we are in interesting, challenging and changing times. While we may differ on how to get there, we agree on where we want to go. Even if public health practitioners may rightly believe that their voice may be the most important one on matters related to the practice of public health, the reality and that many agents have a hand in system transformation.

To illustrate this, she read the final stanza from the Robbie Burns poem, *To a Louse* (translated from the original Scots):

*And would some Power give us the gift  
To see ourselves as others see us!  
It would from many a blunder free us,  
And foolish notion:  
What airs in dress and gait would leave us,  
And even devotion!*

With this understanding, alPHa has attempted to assemble a panel that reflects different facets of the system transformation that we are dealing with at this time.

**Sharon Lee Smith** opened the discussion by thanking alPHa for its work and contributions to facilitating the partnerships and providing the crucial public health perspectives that look deeper into what “health” means and all of the things that make it possible.

She used this to introduce some new areas of focus within the Ministry, including [mental health and addictions](#), related investments in housing, a new funding model for community services, and bringing the health promotion and prevention to the forefront in health system planning. She also mentioned the [Ontario Opioid Addiction and Overdose Strategy](#) as an example of a multi-faceted approach to what has been acknowledged as a public health problem.



A core capacity planning framework is also under development that will provide LHINS and decision makers with a more consistent, integrated approach to health system planning, along with a tool that estimates current and future population health needs. It will allow for predicting demographic, clinical, and socio-economic profiles for each person in Ontario and

stratify the population by levels of need (e.g. low, medium, high, and very high) to determine priority interventions. Engagement with the public health community will be a key mechanism.

Finally, she turned to the Province's [efforts to improve Indigenous health](#), having recognized that First Nations communities as well as off-reserve populations are at the lowest rung of the health ladder. She acknowledged the upstream work already being done by public health units and welcomed input to this and the other priorities to assist the Ministry in its work.

**Tim Hadwen** then emphasized the locally-focused approach to health system transformation, and summarized recent achievements of the Ontario Health System, recognizing that continued improvement is always needed. He then summarized the goals of Patients First (effective integration, access to primary care, seamless links among the different facets to streamline the patient's navigation of the system, consistent home and community care throughout the province, and stronger links to public health and other health services).

He then dealt specifically with the legislative objects related to stronger linkages with MOHs and LHINs, namely improving health outcomes, recognizing the value of the social determinants as a basis for health equity and bringing the health promotion lens to planning activities.



He finished with an acknowledgement that we are in a transitional stage at the moment, where expansion of LHIN boards, transformation of management structures, redefinition of corporate services, and sub-regional disparities need to be settled before strategies to identify local needs and health priorities can begin.

#### [Slide Deck](#)

**Michael Barrett** turned the focused to the work of the Public Health Work Stream (PHWS) that is part of the LHIN Renewal. He summarized the path of the Patients First initiative so far and referred to the five goals of health system transformation, characterizing them as “relentless incrementalism”, wherein the Patients First Act is a direction rather than a destination. He then pointed out the various existing examples of collaboration between LHINs and Boards of Health and summarized the PHWS scope and objectives. He then clarified that the Expert Panel on Public Health is separate and distinct from this.



PHWS conversations about integrated planning and population health assessment will begin next week after a couple of meetings that were mainly about getting acquainted. The shared goal is of course to improve health and wellbeing of individuals within our communities, and the discussion is sure to include finding ways to ensure that the misalignment of LHIN and PHU boundaries is not an obstacle.

#### [Slide Deck](#)

**Dr. David Williams** concluded the panel presentations by giving an overview of the progress that public health has enjoyed since the turn of the millennium, much of which can be attributed to transformative events. He argued that the Walkerton and SARS outbreaks brought public health out of a dark corner, which resulted in the positive changes brought about by Operation Health Protection. All the while, there has been an ongoing tension between the public health mandate as overseen by public health units and the health care goals and objectives as overseen by the LHINs. While public health has been emphatic in its desire to remain separate for this reason, there has still been recognition that reciprocal contributions can and should be made. We have an opportunity to contribute to a paradigm shift from a health care system to a health system. He also noted that Ontario is the only jurisdiction that has the municipal factor, and the intent is to use this to ensure the successful achievement of the aims of health system transformation.

#### **Q&A**

Much of the ensuing discussion was focused on the possible impacts of the integration and shift of public health resources and expertise to health system planning. In general, participants were in favour of bringing the public health lens to the health care side of the equation, but remain concerned about the potential of a more centralized approach coming at the expense of local needs. Different areas face different challenges (an HIV crisis that appears to be unique to the Middlesex-London area was raised as an example) that may require resources that fall outside of the way that money is allocated.



The critical role of municipalities was reiterated, with a comment that they, along with their boards of health, have made significant contributions through policy, by-laws and advocacy to the health of their communities. Decisions around the built environment and tobacco restrictions are just two examples of local action by locally-elected representatives that has a deep impact. Mr. Barrett agreed that municipal officials are indeed a crucial link between the people and the policies that affect them, and Sharon Lee Smith expressed her support for the current model while acknowledging that senior levels of government would be well served by considering local perspectives on things like housing, seniors, and oral health.

Concerns were also raised about the recently announced Expert Panel on Public Health, which has been tasked with providing advice on structural and organizational factors that will improve the integration of population and public health into the health system. Unlike similar recent “expert panels”, it is not open to public discussion and debate, and addressing funding is not within the scope of its mandate, which will complicate the in-scope discussions of system capacity.

Sharon Lee Smith acknowledged that ongoing evaluation of funding and funding formulas will indeed be important and admitted that there is some work to do at the Ministry level on this. On the transparency issue, Roselle Martino responded that the members of the Expert Panel need a “safe space” to have full and frank discussions. Panel members were appointed according to skill and need to be allowed to say their piece. While deliberations will be confidential, whatever report is submitted to the minister will be made available. She added that funding issues will continue to be addressed separately through accountability processes and eventual OPHS capacity reviews.

Other participants rose to emphasize the importance of a strong commitment to following through on the plans to improve health in First Nations communities as well as ensuring that the health needs of off-reserve, non-status and Métis are addressed. Sharon Lee Smith agreed that the primary focus of the First Nations Health Action Plan is indeed on-reserve, but she expects that there will be ripple effects throughout the indigenous populations through areas such as home-care, diabetes prevention and management, primary care etc. and that those voices will be invited to the various tables that influence decisions. Dr. Williams added that the community needs and issues are as disparate as the communities themselves.

The importance of social services to our efforts in improving health was also raised as an example of an area that appears to have been sidelined in the current conversations about system integration. Housing and mental health for example are critical in this area, and those with unaddressed needs are consuming a significant proportion of health care costs. In the absence of significant new investments in these areas, it will be more difficult for government to improve the system as a whole. Sharon Lee Smith reiterated that these are indeed current priorities at the provincial level and added that the relationship between housing and mental health is part of the conversation. Tim Hadwen continued with the observation that this is part of the rationale for bringing the service delivery functions of CCAC into the LHINs, in an effort to be more efficient with the money we have.



Responding to a question about the transformation of LHINs into service providers through the absorption of the functions of CCACs, Tim Hadwen responded that the first principle of the transitional stage is consistency and continuity – existing patterns need to be maintained while the new relationships and duties are established. He characterized this as an opportunity to embed home and community care into the policy development and funding aspects of the LHIN role, which

may in turn help to better identify areas requiring emphasis.

To conclude the discussion, Valerie Jaeger invited panelists to summarize what they would see as evidence of success in three words or less. The responses were a shared journey, integration and outcomes, Triple Aim and growing healthy together.



### Role of Public Health Ontario

*PHO's contribution to supporting the new role of local public health in a transformed health system*

**Speakers:** Peter Donnelly, President & CEO, PHO; George Pasut, Vice President, Science & Public Health, PHO

### Slide Deck

Drs. Peter Donnelly and George Pasut joined delegates to provide insights into Public Health Ontario's contributions to local public health within a transformed health system. Dr. Donnelly began with a recitation of the penultimate stanza of Robbie Burns' "To a Mouse", suggesting that it is an observation that a good management consultant might make:



*But little Mouse, you are not alone,  
In proving foresight may be vain:  
The best laid schemes of mice and men  
Go often askew,  
And leave us nothing but grief and pain,  
For promised joy!*

He interpreted this to mean that a great idea is not enough, and avoiding grief requires thinking very carefully about the actions and partnerships needed to realize it. With that, he assured that Public Health Ontario is very enthusiastic about supporting this process.

He continued with an overview of some of the different structures within which he has worked in the past – not to assess quality of one system or another, but rather to illustrate the constellation of options. He also reminded members of his own writing about the Three Domains: health protection (safety), health promotion (supports for health), and health service quality (informed by epidemiology).

He acknowledged that there are advantages and disadvantages in using epidemiological capacity to plan health care, but argued that if one proximates the application of such expertise to all three domains, the outcomes are summative. Recognizing that there are only so many hours in a day, we will need to have a real conversation about what the right balance is. The Patients First Act lays the groundwork for this by building in the two-way relationship, and it will be up to all parties to ensure that it remains balanced.

He then moved on to the alignment of PHOs role and mandate with the intent of the Patients First initiative. He gave a brief overview of why PHO was created and cautioned that its scientific activities were intended to inform policy, but not dictate it. Government, public health and health care are the primary audiences for accessible scientific information and the idea is to build capacity throughout the system through evidence.

Dr. Pasut reported that, since the Patients First discussion started in 2015, PHO has been asked about how it can help the



envisioned system get to where it needs to be. The response has been offered in the form of a question: “where do we want to go?” He took the earlier jumbo jet metaphor further, pointing out that a successful flight does not just depend on the crew, but also the designers and engineers, controllers, chefs, and even passengers that are all part of that system.

PHO has been trying to anticipate where we may be going through its strategic directions. Priorities will always be to help the public health sector to achieve its own goals, and it looks like the main thing at the moment is going to be the implementation of the revised Ontario Public Health Standards while so much emphasis is being put on our abilities to contribute data and information to other parts of the system.

PHO will be prioritizing supports for communicating health information, recognizing that public health has important contributions to make to ensuring that considerations beyond provision of care to an individual are part of the conversation about health.



The explicit emphasis on health equity will be an important opportunity for this given that this is one of our strengths. Boards of Health will have important opportunities to use their duties in this area to influence health impacts in policy areas that have been overlooked. Following the identification of priority issues, PHO can help with the synthesis of information and analysis into research and knowledge products that support the effective implementation actions to address them. At the provincial level, it is anticipated that this will also inform the development of the protocols and guidance documents that will bring policy directions in the new Standards to granular level.

He then observed that system change requires answering questions about what staff needs to know in order to apply new things. Professional development and capacity building are therefore critical, and consideration will need to be given to how we use knowledge exchange mechanisms to enable the change processes that are related to system transformation. He suggested for example that it may be helpful to have a webinar series on public health system transformation targeted at front line staff and workshops on population health assessment for both LHIN and PHUs. These are the kinds of opportunities that should be explored over the next 12 – 18 months.

The Locally Driven Collaborative Projects that are supported by PHO were also identified as an important mechanism for linking the systemic policy directions with their on-the-ground impacts. Some of the current ones were based on anticipation of the systemic changes we are discussing today and are designed to address three questions: what are the key elements for collaboration; what is an optimal method to select, analyze, interpret, and distribute key data that will enable community partners to better advance health equity for the populations that they serve; and what principles and practices of engagement between First Nation communities and public health units can be identified, as an important step in working toward improved opportunities for health for all? Each is described in more detail in the final three slides.

He then clarified that while LDCPs may appear to be led by a single health unit, they are designed to get the PHUs to work together. In an ideal world, all 36 would participate in every project, but the reality is that the nature and breadth of a project will depend on the lead and the priority. And at the end of the day, the idea is to exchange knowledge so that everyone can benefit even if there was no direct participation.

PHO will continue to provide guidance but also to receive guidance from local level on how its own role might evolve.

## Q&A

During the discussion that followed, questions were raised about systematically connecting the work of the LCDPs with parallel and complementary processes, and about system-level absorption of and guidance on the new demands in the areas of health equity and population health assessment.

Acknowledging the need to maximize and leverage collaborative capacity without overburdening, Dr. Donnelly indicated that PHO remains receptive to hearing whatever is most important to the field and exploring how it can help. Ongoing dialogue will be important to informing the way in which planning and delivery of services can have a significant impact on health equity along the entire continuum, all the way through to the patient experience. George Pasut added that this will

also depend on having a clear perspective on the local interpretation and application of the outcomes of that dialogue.

As for the capacity considerations related to the implementation of the revised Standards for Public Health (including health equity, population health assessment and aboriginal health), they both indicated that much remains undefined, and there will as a result likely be opportunities to identify areas that require greater degrees of specificity (e.g. via protocols and guidance documents) that ensure consistency and others that would benefit from flexibility in methods and tools.

Their hope is that the proposed advisory committee of local colleagues (see slide 29) will help guide PHO in its new role in sorting through the issues identified above and identifying the means through which PHO can provide maximum value.

## **Presentation of the Updated Ontario Public Health Standards**

## **[SLIDE DECK](#)**

*Speaker: Roselle Martino, Assistant Deputy Minister, Population and Public Health Division*

*With assistance from: David Williams (CMOH), Paulina Salamo (Manager, Standards and Performance Unit, MOHLTC) and Jackie Wood (Director, Planning and Performance Branch, MOHLTC)*

Roselle Martino returned to the podium and referred to her linked slide deck as she gave delegates an overview of the updated Public Health Standards for Ontario.

She confirmed that the revision of the Standards is linked to the broader health system transformation agenda, and needs to be understood in the context of Patients First. The LHIN – Public Health Work Stream and the Expert Panel on Public Health are expected to provide further context for their implementation.

She clarified that the policy intent of the bringing population health assessment to the forefront of health system planning was to emphasize that such activities are not “owned” by a single sector, and the Minister wanted to ensure that when health services are planned at the local level, population health assessment can be expanded beyond a simple accounting of health status to planning the continuum of health services (from prevention to treatment) at the local level.

She summarized and explained the most significant changes, pointing out that many requirements have been consolidated and some have been migrated to different program areas. The direction from the Minister was to bring some more standardization where possible, while understanding that this isn’t possible in all cases, in order to establish clearer benchmarks for measurement. She also confirmed that the revised standards are intended to relate more closely to Ministry priorities, which is why there is more language related to these than there has been in past iterations.

The Effective Public Health Practice standard is a new element related to this, in that it will require the development of an annual service plan (to be submitted along with budget to give more context for it). This will be tied into the new Accountability Framework that is being developed by the Accountability Committee.

She also acknowledged that the School Health standard area is a new approach to the delivery some existing programs (e.g. oral health, immunizations) and new ones (e.g. vision screening). This is reflective of Government priorities on health in schools, but is not meant to exclude other settings for the programs and services themselves.

She also reiterated that many of the operational details have yet to be determined, and that these will emerge through the development of the guidance documents and protocols that will take place in the months leading up to next year’s implementation. She also expects that a regular schedule of updating the Standards will be established, as the revised Standards are envisioned as more of a living document.

## **Q&A:**

alpha members provided positive feedback about the explicit inclusion of Health Equity requirements, and enhanced focus on mental health and indigenous health. There were however many questions were raised about implementation and capacity.

With the obligations related to school health and health system planning activities for instance, there were questions about reciprocity with the Ministry of Education in the former case and with LHINs in the latter. The Council of Ontario Directors of Education (CODE) partnership with COMOH and the PH-LHIN Work Stream were identified as the bodies that are sorting some of this out. Jurisdictional issues related to indigenous health were also raised, and the hope is that the new obligations can become part of the discussion at the tables that are already addressing the topic.

The stagnation of base funding for public health was reiterated as an ongoing issue, which is likely to be magnified by the new requirements and rearrangement of service delivery models. Roselle Martino stated that the revision of the Standards was undertaken with cost-neutrality in mind, but there may be differences of opinion on the resource implications. She expects that this will be a central discussion item during the upcoming consultations. She also suggested that with the new arrangement with the LHINs, there may be additional capacity for some of the related activities brought from the LHIN side.

The fact that the majority of the determinants of health are influenced in areas that have nothing to do with the health care system also came up, with the fear that the newly explicit requirements to interact with LHINs and language about integrating public health into the health care system might start to erode public health's alignments with far more important partners at the local level. The removal of specific language around the development of healthy public policy in partnership with local municipalities was given as an example.

The one significant concern that was raised about the standards themselves was the new requirement for vision screening, which has been shown in the past to yield a very low return on investment (which was the reason that it was abandoned years ago). Roselle Martino responded that this was included as it was, in the Minister's opinion, the right thing to do.

The response to these and other concerns was largely that they would be fair game during the upcoming consultations and that they will have a bearing on the development of the more detailed protocols and guidance documents.

## Updated Public Health Standards

## [SLIDE DECK](#)

*Facilitated Discussion with Brent Moloughney, Public Health Consultant*



Brent Moloughney greeted delegates and gave an overview of the purpose of the afternoon, which was to provide his own initial analysis of the updated standards, followed by a facilitated discussion of initial impressions, the identification of burning issues and the formulation of next steps for alpha on behalf of its members.

Before turning to the analysis presented in the linked slide deck, he gave an overview of his own experience as a consultant on public health standards at various times and in various places, and then emphasized that this is one person's analysis under tight timelines. As such, this is meant to be a starting point that will benefit from further

discussions.

A full account of the afternoon's proceedings is contained in the attached special report prepared by Dr. Moloughney in the days following the conclusion of the meeting.

## Draft Program-at-a-Glance\*

NOTE: All events will be held at the Chatham-Kent Convention Centre unless otherwise indicated

<b>SUNDAY, JUNE 11, 2017</b>		
4:00 – 7:00 PM	<b>Final Meeting of 2016-17 alPHa Board of Directors</b>	Meeting Room 1A
5:00 – 8:00 PM	<b>Registration Desk Open</b>	Pre-Function
7:30 – 9:00 PM	<b>Opening Reception</b>	TBA
<b>MONDAY, JUNE 12, 2017</b>		
7:00 – 8:00 AM	<b>Breakfast &amp; Registration &amp; Exhibits</b>	Registration: Pre-Function Breakfast: Ballroom B&C <b>Exhibits: Pre-Function</b>
8:00 – 10:00	<b>Combined Annual Business Meeting &amp; Resolutions Session</b> Chair, Dr. Valerie Jaeger, alPHa President	Ballroom A
10:00 – 10:30	<b>Fitness Break &amp; Exhibits</b>	<b>Exhibits &amp; Break: Pre-Function</b>
10:30 – 10:35	<b>Opening Remarks</b>	Ballroom A <b>Dr. Valerie Jaeger</b> , alPHa Past-President
10:35 – 11:30	<b>Plenary Session – Public Health Updates</b> <ul style="list-style-type: none"> <li>Patients First, OPHS Modernization, Public Health Work Stream, Public Health Expert Panel, etc.</li> </ul> <p><i>Objectives: After active participation in this session, participants will be able to identify policy and structural changes to the Ontario public health system in the context of health system transformation and Patients First; summarize current government activities and initiatives in public health that support health transformation; and discuss impacts of public health and health system changes on the delivery of local public health programs and services.</i></p>	Ballroom A <i>Speakers to be confirmed</i>
11:30 – 12:30	<b>Plenary Session – Influencing and Coping with Change</b> <p><i>Objective: After active participation in this session, participants will be able to describe the role and best practices of change management.</i></p>	Ballroom A <i>Speaker to be confirmed</i>
12:30 – 1:30 PM	<b>Lunch &amp; Exhibits</b>	Lunch: Ballroom B&C <b>Exhibits: Pre-Function</b>



1:30 – 3:00 PM	<p><b>Concurrent Breakout Sessions:</b></p> <p>A. Assessing the Impact of the Updated Ontario Public Health Standards</p> <p><i>Objective: After active participation in this session, participants will be able to identify and describe strategies to influence government decision-makers.</i></p> <p>B. Flourishing Under the 2018 Budget: Understanding Your Core Business</p> <p><i>Objective: After active participation in this session, participants will be able to identify and explain strategies to cope with budget constraints at the health unit level.</i></p> <p>C. Age Friendly Framework – Fostering the Health and Well-being of People as They Age</p> <p><i>Objective: After active participation in this session, participants will be able to apply the experiences of others in creating a supportive environment that facilitates healthy aging.</i></p>	<p>A. Meeting Room 1A <i>Speaker to be confirmed</i></p> <p>B. Meeting Room 1B <i>Speaker to be confirmed</i></p> <p>C. Meeting Room 3A&amp;B <b>Greg Shaw</b>, Director, International &amp; Corporate Relations, International Federation on Ageing (official agency of World Health Organization)  <i>Local PHU Speaker TBA</i></p>
3:00 – 3:30	<b>Break &amp; Exhibits</b>	<b>Exhibits &amp; Break: Pre-Function</b>
3:30 – 4:30	<p><b>Plenary Session and Wrap Up – Key Learnings Panel</b></p> <p><i>Objectives: After active participation in this session, participants will be able to summarize anticipated changes to the public health system and their impact on local public health units; identify and apply strategies to manage these anticipated changes; and identify areas for potential advocacy.</i></p>	<p>Ballroom A</p> <p><i>Panelists to be confirmed</i></p>
6:00 – 6:30 PM	<b>President's Reception</b>	TBA
6:30 – 9:00 PM	<p><b>alPHA Distinguished Service Awards Dinner Banquet</b></p> <p><i>Presentation of annual awards in recognition of outstanding public health service in 2017</i></p>	TBA

CONTINUED ON NEXT PAGE

<b>TUESDAY, JUNE 13, 2017</b>		
7:30 – 8:30 AM	<b>Breakfast* &amp; Registration &amp; Exhibits</b>	Registration: Pre-Function Breakfast: Ballroom B&C <b>Exhibits: Pre-Function</b>
8:30 – 12:00	<b>Concurrent Business Meetings for alPHa Sections (Closed Meetings for COMO H &amp; BOH members)</b>	<b>COMO H:</b> Meeting Room 1A <b>BOH:</b> Meeting Room 1B
10:00 – 10:30	<b>Break &amp; Exhibits</b>	<b>Exhibits &amp; Break: Pre-Function</b>
12:00 – 1:00 PM	<b>Lunch</b>	Ballroom B&C
12:30 – 1:00 PM	<b>Inaugural Meeting of 2017-18 alPHa Board of Directors</b>	Meeting Room 5
1:00 PM	<b>Conference Ends</b>	

*Edited 2017/04/06*

*\* Subject to change*

## **MOTION: ALPHA CONFERENCE**

**WHEREAS the Sudbury & District Health Unit (SDHU) has a modest travel budget to cover remuneration, registration, travel, meals, and accommodation as per the Board Manual Policy and Procedure I-I-10, permitting Board members to attend official Board of Health functions; and**

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

**THEREFORE, BE IT RESOLVED THAT in addition to the Medical Officer of Health, the following Board member(s) attend(s) the 2017 alPHa Annual General Meeting as voting delegates for the Sudbury & District Board of Health:**

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# Briefing Note

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

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

**Date:** April 13, 2017

**Re:** Standards for Public Health Programs and Services Consultation Document, February 17, 2017  
– Sudbury & District Board of Health Response

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☐ For Information

☐ For Discussion

☒ For a Decision

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**Issue:**

The Board of Health has an opportunity until April 21, 2017, to provide comment on the modernized Ontario Public Health Standards (OPHS).

**Recommended Action:**

That the Sudbury & District Board of Health, having reviewed the contents of this briefing note, endorse the March 17, 2017, feedback to the Ministry of Health and Long-Term Care (MOHLTC) from the Association of Local Public Health Agencies (alPHA) and communicate its overarching and program-specific operational feedback to the MOHLTC by the April 21, 2017, deadline.

**Background:**

- The Minister of Health and Long-Term Care formally announced the review and modernization of the Ontario Public Health Standards on November 16, 2015. (Letter dated November 16, 2015, is attached)
- The Ministry established a comprehensive committee structure to undertake this review, including the Practice and Evidence Program Standards Advisory Committee (PEPSAC) and the Executive Steering Committee (ESC), on which Dr. Sutcliffe (PEPSAC) and Sandra Laclé (ESC) participated. (Diagram of MOHLTC committee structure for Standards Modernization is attached)
- The Standards for Public Health Programs and Services Consultation Document (Standards) was released on February 17, 2017. (Standards document is attached)
- The Standards were presented by the Ministry and discussed by the membership at the February 23 provincial alPHA Symposium.
- alPHA requested an extension to the original April 3, 2017, deadline for comments and the deadline was extended to April 21, 2017.

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2013–2017 Strategic Priorities:

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

O: October 19, 2001  
R: October 2013

- Regional consultations were led by the MOHLTC throughout March, including a northeast session hosted by the SDHU on March 27. The SDHU senior management team and other SDHU personnel joined their northeastern counterparts at this session. The focus of the consultations was on operational considerations and implementation supports; needs for clarity or context were also discussed although substantive feedback was not sought.
- Following careful review by the alPHa Board, on which Dr. Sutcliffe and Sandra Laclé are members, the Council of Ontario Medical Officers of Health and the Board of Health Section, alPHa submitted on March 17, 2017, its initial feedback on the Standards. (Letter is attached)
- SDHU senior management and staff have engaged in an inclusive internal consultation process to identify overarching issues and program-specific operational and implementation considerations for feedback. (Letter and appendices are attached)
- Additional context includes the concurrent provincial health system transformation agenda and the passage of the Bill 41, *Patients First Act*, requiring a formal relationship between Local Health Integration Network (LHIN) CEOs and medical officers of health.

**Financial Implications:**

The modernization of the OPHS was communicated by the Ministry to be a revenue neutral process.

A thorough assessment of the resource implications of the Standards for Public Health Programs and Services is not possible at this time as there are significant program and administrative details yet to be developed and communicated.

The public health sector has been operating under significant fiscal constraint with the implementation of the Public Health Funding Model in 2015, resulting in a funding freeze for (currently) 28 of 36 boards of health.

**Contact:**

Dr. P. Sutcliffe, MOH/CEO

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HLTC2976MC-2015-231

November 16, 2015

Dear Board of Health Chairs and Medical Officers of Health:

When I released the *Patients First: Action Plan for Health Care*, I committed to transforming our health care system to make it more transparent, accountable, and sustainable.

Our government continues to work toward this commitment, and I am pleased to formally announce a review and modernization of the Ontario Public Health Standards (OPHS).

The OPHS modernization will result in a renewed set of program standards that are responsive to emerging evidence and priority issues in public health and are aligned with the government's strategic vision and priorities for public health within a transformed health system.

An Executive Committee is currently being established to provide strategic leadership to oversee the modernization. An Advisory Committee will be convened to provide expert advice and make recommendations on a set of evidence-based standards, reflective of current accepted practice, that will support system accountability, transparency, and demonstrate value for money.

Work on the OPHS modernization will begin shortly and will conclude December 2016.

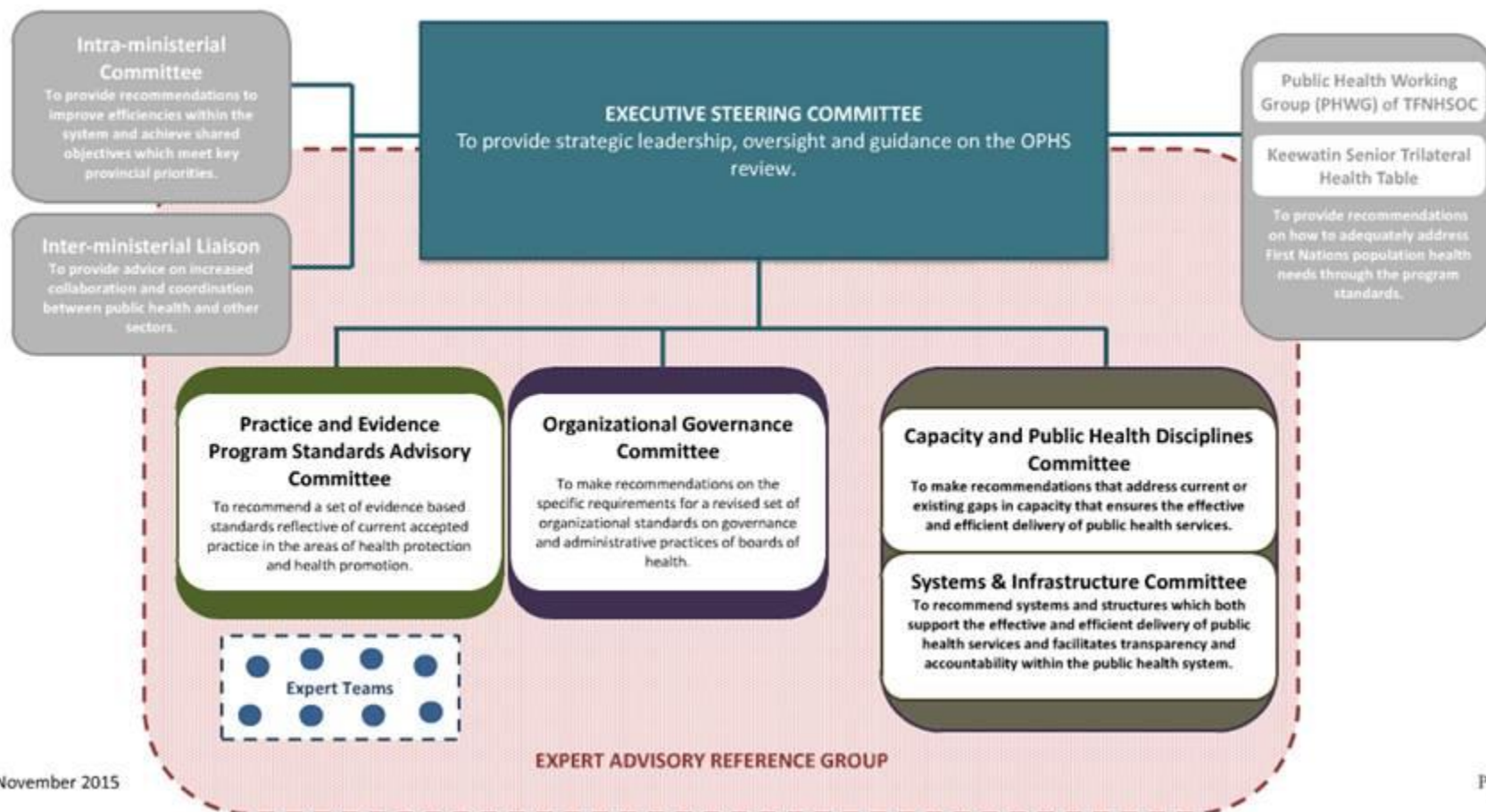
Throughout the modernization exercise, there will be extensive consultation and engagement with the public health community and others. I look forward to continuing to work with you to deliver on our shared goal of ensuring the good health of all Ontarians.

Yours sincerely,

Dr. Eric Hoskins  
Minister

c: Dr. Robert Bell, Deputy Minister  
Dr. David C. Williams, Acting Chief Medical Officer of Health  
Roselle Martino, Executive Director, Public Health Division  
Jackie Wood, Acting Assistant Deputy Minister, Health Promotion Division

## Draft Governance Structure for Standards Modernization



November 2015

Page

# Standards for Public Health Programs and Services

## Consultation Document

Planning and Performance Branch  
Population and Public Health Division

February 17, 2017

Ministry of Health and Long-Term Care

**THIS DOCUMENT IS FOR CONSULTATION PURPOSES ONLY AND IS  
SUBJECT TO CHANGE. THE FINAL STANDARDS FOR PUBLIC  
HEALTH PROGRAMS AND SERVICES MUST BE APPROVED BY THE  
MINISTER OF HEALTH AND LONG-TERM CARE.**



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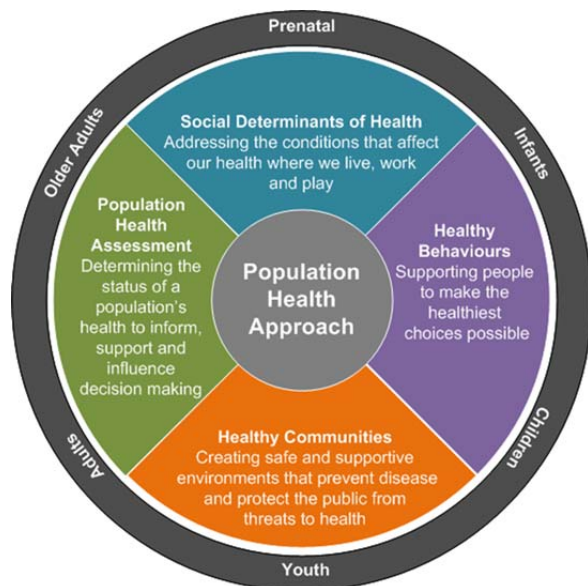
# What is Public Health?

The focus of public health is on the whole population. Its work is embedded in the daily lives of the people of Ontario. Public health interventions have made the cars we drive and the food we eat safer, they have protected us from infectious diseases and environmental threats to health, and they have created healthier environments to support and inform choices about risks including those related to tobacco and alcohol. Public health also impacts communities by developing healthier built environments, responding to public health emergencies, and promoting social conditions that improve health.

Public health works through multiple channels and on multiple issues in order to have an impact on the health of the population. The work is diverse, including individual clinical service delivery, education, inspection, surveillance, and policy development among other activities. What unifies public health action is its focus on prevention, upstream interventions and societal factors that influence health.

Our public health system reflects the diversity of the Ontario population. Boards of health serve populations large and small, in urban and rural settings. Each has responsibility for delivering local public health programs and services within their geographic borders. Public health does this in partnership with many other entities including governmental, non-governmental and community organizations. Public health also builds partnerships with Indigenous communities to work together to address their public health needs.

Figure 1: What is Public Health?



Public health work is grounded in a population health approach – focused on upstream efforts to promote health and prevent diseases to improve the health of populations and the differences in health among and between groups. Health risks and priorities change as people grow and age and public health works to address health across the life course.

# Defining Our Work: Policy Framework for Public Health Programs and Services

The work of public health is diverse, multi-faceted and expansive. The **Policy Framework for Public Health Programs and Services** (Figure 2) brings focus to core functions of public health and highlights the unique approach to our work. It articulates our shared goal and objectives as the sector transforms, and outlines the contribution of our work in reaching population health outcomes related to health and health equity.

Our goal is realized through the achievement of program outcomes and contributions to population health outcomes - by reducing preventable disease, injury and death and taking action on health inequities for the people of Ontario. The public health sector works in partnership with health and social sectors to contribute to these population health outcomes.

Consistent with the Ministry of Health and Long-Term Care (ministry) policy direction, public health programs and services are focused primarily in four domains:

- Social Determinants of Health
- Healthy Behaviours
- Healthy Communities
- Population Health Assessment

The population health approach assesses more than health status and the biological determinants of health but includes the social factors that influence health, including income, education, and employment. It moves beyond traditional health perspectives that focus on disease and disability, taking into account mental and social well-being and quality of life.

The work of public health is supported and shaped by a series of enabling factors. These include legislation (including the *Health Protection and Promotion Act*), funding, evidence and research, agencies such as Public Health Ontario, public health associations, municipal and federal governments, and organizations with whom we partner both provincially and locally. These enablers help us to achieve our objectives.

The public health sector achieves its objectives and ultimately improves population health outcomes through the delivery of public health programs and services. Our programs and services reach all Ontarians, with a special focus on those at greater risk of poor health outcomes. Delivering public health programs and services also requires partnering with multiple sectors both within and outside of the health system.

Figure 2: Policy Framework for Public Health Programs and Services

GOAL	To improve and protect the health and well-being of the population of Ontario and reduce health inequities						
POPULATION HEALTH OUTCOMES	<ul style="list-style-type: none"><li>Improved health and quality of life</li><li>Reduced morbidity and mortality</li><li>Reduced health inequity among population groups</li></ul>						
DOMAINS	Social Determinants of Health		Healthy Behaviours		Healthy Communities		Population Health Assessment
OBJECTIVES	To reduce the negative impact of social determinants that contribute to health inequities		To increase knowledge and opportunities that lead to healthy behaviours		To increase policies and practices that create safe, supportive and healthy environments		To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system
ENABLERS	Legislation	Funding	Evidence	Agencies & Associations	Municipal & Federal Governments		Partner Organizations
PROGRAMS AND SERVICES	GOALS						
	<ul style="list-style-type: none"><li>To increase the use of public health knowledge and expertise in the planning and delivery of programs and services within an integrated health system</li><li>To reduce health inequities with equity focused public health practice</li><li>To increase the use of current and emerging evidence to support effective public health practice</li><li>To improve behaviours, communities and policies that promote health and well-being</li><li>To improve growth and development for infants, children and adolescents</li><li>To reduce disease and death related to infectious and communicable diseases of public health importance</li><li>To reduce disease and death related to vaccine preventable diseases</li><li>To reduce disease and death related to food, water and other environmental hazards</li><li>To reduce the impact of emergencies on health</li></ul>						
PARTNERS	Health Care (including Primary, Community, Acute and Long-Term Care), Education, Housing, Children and Youth Services, Community and Social Services, Labour, Environment, Agriculture and Food, Transportation, Municipalities, Non-Governmental Agencies, Public and Private Sectors, Academia, and Indigenous communities and organizations						

# Public Health Transformation

Transformation is happening within the public health sector, including its role in the broader health system. These changes aim to maximize public health's contributions to improve the health of the population and leverage our strengths to inform and reorient the health care system. They will strengthen the public health sector, making it more transparent, accountable, and sustainable. Alongside changes in health care, public health transformation will lead to a more integrated health system that can meet the needs of all Ontarians.

Public Health Transformation is triggered by a series of drivers.

- There are opportunities to improve the quality and delivery of public health programs and services. The evidence base for public health is growing; we know more about effective practice across the core public health functions. The work of public health needs to be responsive to this emerging evidence and Ontario's priority issues.
- There is recognition that public health is disconnected from the broader health care system. Public health's programs and services are not seamlessly integrated with those of other health sectors and public health knowledge and expertise is not a consistent part of health system planning.
- There is a call for greater efficiency across all health sectors, including public health, and a need to strengthen accountability and transparency to demonstrate the contribution and value of public health.

The Standards for Public Health Programs and Services will fulfill three main purposes:

- Incorporate emerging evidence and current accepted best practices in public health.
- Align public health programs and services with broader public health and health system changes.
- Facilitate optimal delivery of public health functions and coordinate delivery of public health programs and services across the full continuum of health.

The Standards for Public Health Programs and Services support tangible improvements in the health of all Ontarians through the delivery of public health programs and services based on the needs and contexts of local communities.

# Standards for Public Health Programs and Services

## Purpose

The standards define the roles of public health in a transformed system and are informed by the core public health functions which include:

- Assessment and Surveillance
- Health Promotion and Policy Development
- Health Protection
- Disease Prevention
- Emergency Preparedness

Boards of health are responsible for activities in all core function areas.

**NOTE:** In order to respect the board of health as the body that is accountable to the ministry while also respecting the delegation of authority for the day to day management and administrative tasks to the Medical Officer of Health (and CEO or other executive officers, where applicable), the requirements for the Standards for Public Health Programs and Services have been written as “The board of health shall...”

## Scope

Boards of health are responsible for the assessment, planning, delivery, management, and evaluation of a range of public health programs and services that address multiple health needs and respond to the contexts in which these needs occur. The following standards articulate only those programs and services that all boards of health shall provide and are not intended to encompass the total potential scope of public health programming in Ontario.

The scope of these standards includes a broad range of population-based activities designed to promote and protect the health of the population as a whole and reduce health inequities. The role of boards of health is to support and protect the physical and mental well-being, resiliency and social connectedness of the local health unit population with a focus on promoting the protective factors and addressing the risk factors.

The Standards for Public Health Programs and Services identify requirements that should result in specified program outcomes and contribute to population based

outcomes and goals.<sup>1</sup> Boards of health shall tailor programs and services to meet local needs and work towards the achievement of specified outcomes and goals.

Many of the standards are supported by protocols that further specify how to operationalize specific requirements. Boards of health are accountable for implementing requirements articulated in these standards and protocols. Other documents referenced in the standards support planning and implementation. If the phrase ‘in accordance with’ precedes the document title within the text of the standards or protocols, then compliance with the document is expected.

The achievement of overall goals builds on achievements by boards of health along with those of many other organizations, governmental bodies, and community partners. Population based outcomes and goals help to qualify the collective contribution towards broader health and societal aspirations. Measurement at these levels will meet provincial reporting requirements while assisting boards of health in planning and organizing programs and services in relation to other community partners.

## Statutory Basis

Section 5 of the *Health Protection and Promotion Act* (HPPA) specifies that boards of health must superintend, provide or ensure the provision of a minimum level of public health programs and services in specified areas as follows:

- Community sanitation and the prevention or elimination of health hazards;
- Provision of safe drinking water by small drinking water systems;
- Control of infectious and reportable diseases, including providing immunization services to children and adults;
- Health promotion, health protection, and disease and injury prevention;
- Family health;
- Collection and analysis of epidemiological data; and
- Such additional health programs and services as prescribed by regulations.

Section 7 of the HPPA grants authority to the Minister of Health and Long-Term Care to “publish guidelines for the provision of mandatory health programs and services, and every board of health shall comply with the published guidelines” (s.7(1)), thereby establishing the legal authority for the Standards for Public Health Programs and Services.

Where there is a reference to the HPPA within the Standards for Public Health Programs and Services, the reference is deemed to include the HPPA and its regulations.

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<sup>1</sup> Refer to Figure 3 for a definition of program outcomes and goals.

Boards of health may deliver additional programs and services in response to local needs identified within their communities, as acknowledged in Section 9 of the HPPA.

Furthermore, boards of health should bear in mind that in keeping with the *French Language Services Act*, services in French should be made available to French-speaking Ontarians located in designated areas.

Boards of health need to be knowledgeable about their duties and responsibilities as specified in other applicable Ontario laws, including but not limited to: the *Building Code Act, 1992*; the *Child Care and Early Years Act, 2014*; the *Employment Standards Act, 2000*; the *Immunization of School Pupils Act*; the *Healthy Menu Choices Act*; the *Smoke Free Ontario Act*; the *Electronic Cigarettes Act*; the *Skin Cancer Prevention Act*; the *Occupational Health and Safety Act*; and the *Personal Health Information Protection Act, 2004*.

## Format

The four principles of Need, Impact, Capacity, Partnership, Collaboration and Engagement underpin the Foundational and Program Standards. Boards of health shall use the principles to guide the assessment, planning, delivery, management, and evaluation of public health programs and services.

The Standards for Public Health Programs and Services are organized as follows:

- Four Foundational Standards:
  - Population Health Assessment
  - Health Equity
  - Effective Public Health Practice includes three sections:
    - Program Planning, Evaluation, and Evidence-Informed Decision-Making;
    - Research, Knowledge Exchange, and Communication; and
    - Quality and Transparency.
  - Emergency Preparedness, Response, and Recovery

The Foundational Standards articulate specific requirements that underlie and support all Program Standards. Population health assessment and surveillance requirements are also included in each Program Standard.

- Eight Program Standards include requirements grouped thematically to address Chronic Diseases and Injury Prevention, Wellness and Substance Misuse; Food Safety; Healthy Environments; Healthy Growth and Development; Immunization; Infectious and Communicable Diseases Prevention and Control; Safe Water; and School Health.

Both the Foundational Standards and the Program Standards articulate broad population based goals, program outcomes, and requirements.



Although requirements are listed thematically, boards of health shall assess, plan, deliver, manage, and evaluate programs and services cohesively across thematic areas, impacting multiple settings and meeting needs across the lifespan.

A description of the Principles, the Foundational Standards, Program Standards, and related goals, program outcomes, and requirements is depicted in Figure 3.

**Figure 3: Standards for Public Health Programs and Services: Description of the Principles, the Foundational Standards and the Program Standards**

Principles							
Need	Boards of health shall continuously tailor their programs and services to address needs of the health unit population. Need is established by assessing the distribution of social determinants of health, health status, and incidence of disease and injury.						
Impact	Boards of health shall assess, plan, deliver, and manage their programs and services by considering evidence, effectiveness of the intervention, barriers to achieving maximum health potential, relevant performance measures, and unintended consequences.						
Capacity	Understanding local public health capacity required to achieve outcomes is essential to ensure the effective and efficient delivery of public health programs and services. Boards of health shall strive to make the best use of available resources to achieve the capacity required to meet the standards.						
Partnership, Collaboration and Engagement	<p>Boards of health shall engage and establish meaningful relationships with a variety of sectors, partners, communities, priority populations, and citizens, which are essential to the work of public health and support health system efficiency.</p> <p>Establishing meaningful relationships with priority populations includes building and further developing the relationship with Indigenous communities. These relationships may take many forms and need to be undertaken in a way that is meaningful to the community and/or organization.</p>						
Foundational Standards							
Population Health Assessment		Health Equity		Effective Public Health Practice		Emergency Preparedness, Response, and Recovery	
Program Standards							
Chronic Diseases and Injury Prevention, Wellness and Substance Misuse	Food Safety	Healthy Environments	Healthy Growth and Development	Immunization	Infectious and Communicable Diseases Prevention and Control	Safe Water	School Health

Components of Each Standard		
Goal	Program Outcomes	Requirements
The goal is a statement that reflects the broadest level of results to be achieved in a specific standard. The work of boards of health, along with other parts of the health system, community partners, non-governmental organizations, governmental bodies, and community members, contribute to achieving the goal.	Program outcomes are the results of programs and services implemented by boards of health. Outcomes often focus on changes in awareness, knowledge, attitudes, skills, practices, environments, and policies. Each board of health shall establish internal processes for managing day-to-day operations of programs and services to achieve desired program outcomes.	Requirements are the specific statements of action. Requirements articulate the activities that boards of health are expected to undertake. Some requirements are core to public health practice and are expected to be adhered to consistently across the province while others are to be carried out in accordance with the local context through the use of detailed population based analysis and situational assessment. All programs and services are tailored to reflect the local context and are responsive to the needs of priority populations. <sup>2</sup> Protocols are named in many requirements to provide further direction on how boards of health must operationalize specific requirement(s).

## Standardization and Variability

The modernized Standards for Public Health Programs and Services balance the need for **standardization** across the province with the need for **variability** to respond to local needs, priorities and contexts.

Specificity remains for those programs and services where standardization is required to protect the health of the public.

A flexible approach accommodates greater variability where there is an opportunity to plan programs to decrease health inequities and address the needs of priority populations.

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<sup>2</sup> Priority populations as defined in the Foundational Standards.

# Standards

## Foundational Standards

Public health programs and services that are informed by evidence are the foundation for effective public health practice. Evidence-informed practice is responsive to the needs and emerging issues of the health unit and uses the best available evidence to address them.

- Population health assessment is integral to public health practice.
- A focus on health equity is important to the delivery of all public health programs and services in order to support people to reach their full health potential.
- Effective public health practice requires boards of health to apply skills in evidence-informed decision-making, research, knowledge exchange, program planning and evaluation, communication, with a continued focus on quality and transparency.
- Emergency preparedness, response and recovery are critical roles that boards of health play in ensuring that they have the capacity to respond to new and emerging events and cope with a range of disruptions.

## Population Health Assessment

Population health assessment includes measuring, monitoring, and reporting on the status of a population's health, including determinants of health and health inequities. Population health assessment provides the information necessary to understand the health of populations through the collaborative development and ongoing maintenance of population health profiles, identification of challenges and opportunities, and monitoring of the health impacts of public health practice.

Population health assessment also includes a monitoring role, described as epidemiological surveillance. This is the systematic and ongoing collection, collation, and analysis of health-related information that is communicated in a timely manner to all who need to know, so that action can be taken. It contributes to effective public health program planning, delivery, and management. Dissemination of analyses may take the form of reports, advisories, healthy public policy recommendations, alerts, or warnings.

## Goal

**Public health practice responds effectively to current and evolving conditions, and contributes to the public's health and well-being with programs and services that are informed by the population's health status, including determinants of health and health inequities.**

## Program Outcomes

- Local public health programs and services align with the needs of the local population, as demonstrated through surveillance and assessment.
- Public health programs and services are planned and implemented to address local population health needs.
- The public, community partners, and health care providers are aware of relevant and current population health information.
- Resources are allocated to reflect public health priorities and reallocated, as feasible, to reflect emergent public health priorities.
- Planning and delivery of programs and services is tailored to meet the identified needs of priority populations.
- Local Health Integration Networks (LHIN(s)) and other relevant community partners have and use available population health information, including information on health inequities, that is necessary for planning, delivering, and monitoring health services responsive to population health needs.

## Requirements

1. The board of health shall conduct surveillance, including the ongoing collection, collation, analysis, and periodic reporting of population health information, as required by the *Health Protection and Promotion Act* and in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall interpret and use surveillance data to communicate information on risks to relevant audiences in accordance with the *Healthy Environments Protocol, 2017* (to be drafted); the *Infectious Diseases Protocol, 2016* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
3. The board of health shall assess current health status, health behaviours, preventive health practices, health care utilization relevant to public health, and demographic indicators, including the assessment of trends and changes, in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
4. The board of health shall use population health, determinants of health and health inequities information to assess the needs of the local population, including the identification of populations at risk, to determine those groups that would benefit most from public health programs and services (i.e., priority populations).<sup>3</sup>

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<sup>3</sup> Priority populations are identified by surveillance, epidemiological, or other research studies. They are those populations that are at risk and for which public health interventions may be reasonably considered to have a substantial impact at the population level.

5. The board of health shall tailor public health programs and services to meet local population health needs, including those of priority populations, to the extent possible based on available resources.
6. The board of health shall provide population health information, including determinants of health and health inequities, to the public, LHIN(s), community partners, and health care providers, in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
7. *Requirement pending:*  
*\*Work is currently underway to define the parameters of population health assessment and expectations for the relationship between LHIN(s), boards of health, as well as LHIN CEOs and Medical Officers of Health or their designates.*

# Health Equity

Health is influenced by a broad range of factors - genetics, individual lifestyles and behaviours, and the physical, social, and economic environments in which we live. These factors contribute to health experienced by individuals and to the overall level of health in a community or population. Factors beyond an individual's biology and behaviours - those that form the conditions in which people are born, grow up, live, and work - are known as the social determinants of health. Any differences or variations in health status between groups are known as health inequalities. When health inequalities have the potential to be changed or decreased by social action, they are labelled as health inequities.

Health inequities are health differences that are:

- Systematic, meaning that health differences are patterned, where health generally improves as socio-economic status improves;
- Socially produced, and therefore could be avoided by ensuring that all people have the social and economic conditions that are needed for good health and well-being; and
- Unfair and unjust because opportunities for health and well-being are limited.

Health equity means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance. Boards of health shall assess the impact of the social determinants of health on population health outcomes as they consider the need for programs and services.

## Indigenous Communities and Organizations

The Indigenous population in Ontario is comprised of First Nations, Métis, and Inuit people. There are many different First Nation and urban Indigenous communities across the province, each with their own histories, cultures, governance and organizational approaches.

Relationships between boards of health and Indigenous communities and organizations need to come from a place of trust, mutual respect, understanding, and reciprocity. It is important to acknowledge that as part of this relationship building, First Nations in Ontario believe that Canada, as a Treaty partner, also has an obligation to continue to contribute to the improvement of health care and health outcomes for their communities.

One important first step for boards of health in beginning to build and/or further develop their relationships with Indigenous communities is to ensure it is done in a culturally safe way. A series of tools will be made available to boards of health and will be further outlined in a Guidance Document, including opportunities for cultural safety training approaches.<sup>4</sup>

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<sup>4</sup> An accompanying Guidance Document will provide further guidance to boards of health on how Indigenous communities view these relationships and will provide some potential approaches and best practices that may be considered. It will also include a better understanding of the different Indigenous communities that may be within the geographic boundaries of the health unit.

## Goal

**Public health practice aims to decrease health inequities such that everyone has equal opportunities for health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances.**

## Program Outcomes

- Multi-sectoral collaboration informs development of local strategies to decrease health inequities.
- Community partners and the public are aware of local health inequities and their causes.
- There is an increased awareness on the part of the LHIN(s) and other community partners of the impact of social determinants of health on health outcomes and increased support for actions to decrease health inequities.
- Priority populations are meaningfully engaged in the planning of public health interventions.
- Indigenous communities are engaged in a way that is meaningful for them.

## Requirements

1. The board of health shall assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies to decrease health inequities.
2. The board of health shall modify and orient public health interventions to decrease health inequities by:
  - a) Engaging priority populations in considering their unique needs, histories, cultures, and capacities; and
  - b) Aiming to improve the health of the entire population while leveling up the health of priority populations.
3. The board of health shall engage in community and multi-sectoral collaboration with LHIN(s) and other relevant stakeholders in decreasing health inequities. Engagement with Indigenous organizations and communities shall include, but not be limited to, fostering the creation of meaningful relationships with them, starting with engagement through to collaborative partnership.
4. The board of health shall lead, support, and participate with other stakeholders in policy development, health equity analysis, and promoting decreases in health inequities.

# Effective Public Health Practice

## Goal

**Public health practice is transparent, responsive to current and emerging evidence and emphasizes continuous quality improvement.**

## Program Outcomes

- Public health programs and services are reflective of local population health issues, the best available evidence, new public health knowledge, and adapted to the local context.
- Public health programs are modified to address issues related to program effectiveness.
- Public health practitioners, policy-makers, community partners, health care providers, and the public are aware of the factors that determine the health of the population.
- Public health research and knowledge exchange activities are reflective of effective partnerships with community researchers, academic partners, and other appropriate organizations.
- The public and community partners are aware of ongoing public health program improvements.
- Public health communication strategies reflect a variety of communication modalities and local needs.
- Ongoing program improvements enhance client and community partner experience and address issues identified through various means.

## Program Planning, Evaluation, and Evidence-Informed Decision-Making

Program planning and evaluation are part of an ongoing and iterative cycle of program development and improvement.

A program is a plan of action intended to achieve specific outcomes. Program planning is an ongoing, iterative process that organizations use to develop and modify a program throughout its lifespan.

Program evaluation is the systematic gathering, analysis, and reporting of data about a program to assist in decision-making. It includes quantitative, qualitative, and mixed-method approaches. Program evaluation produces the information needed to support the establishment of new programs and services (needs assessment); assess whether evidence-informed programs and services are carried out with the necessary reach,



intensity, and duration (process evaluation); or document the effectiveness and efficiency of programs and services (outcome evaluation).

Evidence-informed decision-making is the process of analyzing and using the best available evidence from research, context, and experience to inform decisions on development and delivery of public health programs and services.

Evidence to inform the decision-making process may come from a variety sources including: key facts, findings, trends, and recommendations from published scientific research; data and analyses obtained from population health assessment and surveillance; legal and political environments; stakeholder perspectives; public engagement; and recommendations based on past experiences including program evaluation information.

A number of tools and resources are available to support decision-makers in making evidence-informed decisions.

## Requirements

1. The board of health shall develop, implement, and make available to the public a Board of Health Annual Service Plan and Budget Submission<sup>5</sup> which:
  - a) Demonstrates the use of a systematic process to plan public health programs and services to address the needs of the community by integrating the best available research and evaluation evidence with contextual factors such as local population health issues, priority populations, community assets and needs, political climate, public engagement, and available resources; and
  - b) Describes the public health programs and services planned for implementation and the information which informed it.
2. The board of health shall routinely monitor program activities and outcomes to assess and improve the implementation and effectiveness of programs and services, including collection, analysis, and periodic reporting of indicators related to inputs, resources, implementation processes, reach, outputs, and outcomes.
3. The board of health shall consider the need for program evaluation (e.g., when new interventions are developed or implemented, or when there is evidence of unexpected operational issues or program results, to understand the linkages between inputs, activities, outputs, and outcomes) and conduct program evaluation where required.
4. The board of health shall use a range of methods to facilitate public health practitioners' and policy-makers' awareness of the factors that contribute to program effectiveness.
5. The board of health shall ensure all programs and services are informed by evidence.

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<sup>5</sup> The Board of Health Annual Service Plan and Budget Submission will be further delineated in the Ministry-Board of Health Accountability Agreement.

## Research, Knowledge Exchange, and Communication

Exploring an issue or investigating a question is accomplished through research - the organized and purposeful collection, analysis, and interpretation of data.

Research may involve the primary collection of new data or the analysis or synthesis of existing data and findings.

Knowledge exchange is collaborative problem-solving among public health practitioners, researchers, and decision-makers. It results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision-making.

Promoting and protecting the public's health require effective communication. Various communication strategies may be needed to ensure the greatest impact, depending on the population, local context, available resources, and local and provincial priorities.

### Requirements

6. The board of health shall engage in knowledge exchange activities with public health practitioners, policy-makers, community partners, health care providers, and the public regarding factors that determine the health of the population as informed by population health assessment, surveillance, research, and program evaluation.
7. The board of health shall foster relationships with community researchers, academic partners, and other appropriate organizations including Public Health Ontario, to support public health research and knowledge exchange.
8. The board of health shall engage in public health research activities,<sup>6</sup> which may include those conducted by the board of health alone or in partnership or collaboration with other organizations.
9. The board of health shall use a variety of communication modalities, including social media, taking advantage of existing resources where possible, and complementing national/provincial health communications.

## Quality and Transparency

A public health system with a culture of quality and transparency is safe, effective, client and community/population centered, efficient, responsive, and timely.

### Requirements

10. The board of health shall ensure a culture of quality and continuous organizational self-improvement that underpins programs and services and public health practice and demonstrates transparency and accountability to clients, the public, and other stakeholders. This includes, but is not limited to:

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<sup>6</sup> Research activities that involve personal health information must comply with the *Personal Health Information Protection Act, 2004* and specifically with Section 44 of that Act.

- a) Identification and use of tools, structures, processes and priorities to measure and improve the quality of programs and services. This may include the establishment of a Quality/Practice Committee and/or the development and monitoring of a Quality Improvement Plan;
  - b) Measurement of client, community, and stakeholder/partner experience to inform transparency and accountability;
  - c) Regular review of outcome data that includes variances from performance expectations and implementation of remediation plans; and
  - d) Use of external peer reviews.
11. The board of health shall publicly disclose results of all inspections or information in accordance with the *Drinking Water Protocol, 2014* (or as current); the *Food Safety Protocol, 2016* (or as current); the *Electronic Cigarettes Compliance Protocol, 2016* (or as current); the *Infection Prevention and Control in Child Care Centres Protocol, 2016* (or as current); the *Infection Prevention and Control in Personal Services Settings Protocol, 2016* (or as current); the *Infection Prevention and Control Practices Complaint Protocol, 2015* (or as current); the *Recreational Water Protocol, 2016* (or as current); the *Tanning Beds Compliance Protocol, 2014* (or as current); the *Tobacco Compliance Protocol, 2016* (or as current); and the *Vaccine Storage and Handling Protocol, 2016* (or as current).

# Emergency Preparedness, Response, and Recovery

Emergencies can occur anywhere and at any time. Boards of health in Ontario regularly experience new and emerging events ranging from infectious diseases such as SARS, the H1N1 influenza pandemic, and Ebola virus disease to extreme weather events and environmental hazards such as flooding and forest fires.

Effective emergency preparedness, response, and recovery ensures that boards of health are ready to cope with and recover from threats to public health or disruptions to public health programs and services. This is done through a range of activities carried out in coordination with other partners.

This planning, and its associated activities, is a critical role in strengthening the overall resilience of boards of health and the broader health system. Ministry policy and expectations to support a ready and resilient health system will be outlined separately.

## Goal

**To enable consistent and effective preparedness for, response to, and recovery from emergency situations.**

## Program Outcome

- The ongoing readiness of the board of health to respond to and recover from new and emerging events and/or emergencies with public health impacts.

## Requirement

1. The board of health shall effectively prepare for emergencies to ensure timely, integrated, safe, and effective response to, and recovery from emergencies with public health impacts, in accordance with ministry policy and guidance documents.<sup>7</sup>

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<sup>7</sup> The forthcoming ministry policy for a ready and resilient health system will set expectations across the broader health system. This will include direction for public health units in the establishment of an integrated program that incorporates emergency management practices.

# Program Standards

## Chronic Diseases and Injury Prevention, Wellness and Substance Misuse

### Goal

**To reduce the burden of chronic diseases of public health importance, preventable injuries, and substance misuse.<sup>8</sup>**

### Program Outcomes

- There is a reduction in population health inequities related to chronic diseases, injuries, and substance misuse.
- Population health inequities and priority populations have been identified and relevant data have been communicated to community partners.
- Public health chronic diseases, injury prevention, and substance misuse programs and services are implemented taking into account all relevant programs and services available in the health unit.
- Community partners, including policy-makers, and the public are meaningfully engaged in the planning, implementation, development and evaluation of chronic diseases, injury prevention, and substance misuse programs and services of relevance to the community.
- There is increased public awareness of the risk factors and healthy behaviours associated with chronic diseases, substance misuse, and injuries.
- There is an increased adoption of healthy living behaviours among populations targeted through chronic diseases, injury prevention, and substance misuse program interventions.
- Youth have reduced access to tobacco products, e-cigarettes and tanning beds.
- Tobacco vendors are in compliance with the *Smoke-Free Ontario Act*.

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<sup>8</sup> Chronic diseases of public health importance include, but are not limited to, cardiovascular diseases, respiratory disease, cancer, diabetes, and mental illness (including problematic use of alcohol and other substances, suicide, suicide attempts, and suicide ideation). Injury, both intentional and unintentional, prevention includes, but is not limited to, falls across the lifespan, road and off-road safety, and other injuries of public health importance.

- Tanning bed operators are in compliance with the *Skin Cancer Prevention Act (Tanning Beds), 2013*.
- E-cigarette vendors are in compliance with the *Electronic Cigarettes Act, 2015*.
- Community partners have knowledge of, and increased capacity to act on, the factors associated with healthy living behaviours, skills and practices, healthy policies, and supportive environments.
- Food premises are in compliance with the *Healthy Menu Choices Act, 2015*.

## Requirements

1. The board of health shall collect and analyze relevant data to monitor trends over time and population inequities in outcomes, and communicate the population results in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall implement a program of public health interventions that addresses chronic diseases and substance misuse risk factors to reduce the burden of illness from chronic diseases and substance misuse in the health unit population, informed by:
  - a) An assessment of the risk and protective factors for, and distribution of, chronic diseases and substance misuse;
  - b) Evidence of the effectiveness of the interventions employed;
  - c) Consultation and collaboration with local stakeholders in the health, education, municipal, non-governmental and other relevant sectors including LHIN(s); and
  - d) Consideration of the following topics based on an assessment of local needs:
    - Alcohol and other substance misuse (e.g., illicit drugs, including harm reduction strategies);
    - Built environment;
    - Comprehensive tobacco control (including addressing e-cigarettes and emerging products);
    - Healthy eating;
    - Healthy sexuality;
    - Mental health promotion;
    - Oral health;
    - Physical activity and sedentary behaviour;
    - Sleep;

- Suicide risk and prevention; and
  - UV exposure.
3. The board of health shall implement a program of public health interventions to reduce the burden of illness from injuries in the health unit population, informed by:
    - a) An assessment of the risk factors for, and distribution of, injuries;
    - b) Evidence of the effectiveness of the interventions employed;
    - c) Consultation and collaboration with local stakeholders in the health, education, municipal, non-governmental and other relevant sectors including LHIN(s); and
    - d) Consideration of the following topics based on an assessment of local needs:
      - Concussions;
      - Falls;
      - Off-road safety;
      - Road safety; and
      - Violence.
  4. The board of health shall include a description, as part of its Board of Health Annual Service Plan and Budget Submission, of its programs of public health interventions that:
    - a) Address chronic diseases and substance misuse risk factors to reduce the burden of illness from chronic diseases in the health unit population; and
    - b) Prevent and reduce the burden of illness from injuries in the health unit population.
  5. The board of health shall implement and enforce the *Smoke-Free Ontario Act* in accordance with the *Tobacco Compliance Protocol, 2016* (or as current).
  6. The board of health shall implement and enforce the *Skin Cancer Prevention Act (Tanning Beds), 2013* in accordance with the *Tanning Beds Compliance Protocol, 2014* (or as current).
  7. The board of health shall implement and enforce the *Electronic Cigarettes Act, 2015*, in accordance with the *Electronic Cigarettes Compliance Protocol, 2016* (or as current).
  8. The board of health shall implement and enforce the *Healthy Menu Choices Act, 2015*, in accordance with the *Menu Labelling Compliance Protocol, 2017* (or as current).

# Food Safety

## Goal

**To prevent or reduce the burden of food-borne illnesses.**

## Program Outcomes

- Timely and effective detection, identification, and response to food-borne illnesses, their associated risk factors, emerging trends, and unsafe food offered for public consumption.
- Food-borne illness risks are mitigated.
- Food handlers handle and manage food for public consumption in a safe and sanitary manner.
- The public and community partners are aware of safe food-handling practices and food safety issues.
- There is reduced incidence of food-borne illnesses.

## Requirements

1. The board of health shall:
  - a) Conduct surveillance of suspected and confirmed food-borne illnesses, food premises, and food for public consumption;
  - b) Conduct epidemiological analysis of surveillance data including monitoring of trends over time, emerging trends, and priority populations; and
  - c) Respond by adapting programs and services in accordance with the *Food Safety Protocol, 2016* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall report Food Safety Program data elements in accordance with the *Food Safety Protocol, 2016* (or as current).
3. The board of health shall ensure food handlers in food premises have access to training in safe food-handling practices and principles in accordance with the *Food Safety Protocol, 2016* (or as current).
4. The board of health shall increase public awareness of food-borne illnesses and safe food-handling practices and principles in accordance with the *Food Safety Protocol, 2016* (or as current) by:



- a) Adapting and/or supplementing national/provincial food safety communications strategies where local assessment has identified a need; and/or
  - b) Developing and implementing regional/local communications strategies where local assessment has identified a need.
5. The board of health shall inspect food premises and foods offered for public consumption and provide all the components of the Food Safety Program defined by the *Health Protection and Promotion Act* and in accordance with the Food Premises Regulation (O. Reg. 562); the *Food Safety Protocol, 2016* (or as current); and all other applicable Acts.
6. The board of health shall ensure 24/7 availability to receive reports of and respond to:
- a) Suspected and confirmed food-borne illnesses or outbreaks;
  - b) Unsafe food-handling practices, food recalls, adulteration, and consumer complaints; and
  - c) Food-related issues arising from floods, fires, power outages, or other situations that may affect food safety in accordance with the *Health Protection and Promotion Act*; the *Food Safety Protocol, 2016* (or as current); and the *Infectious Diseases Protocol, 2016* (or as current).

# Healthy Environments

## Goal

**To reduce exposure to health hazards<sup>9</sup> and promote the development of healthy natural and built environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate.**

## Program Outcomes

- Timely and effective detection, identification, and response to health hazards and associated public health risks, trends, and illnesses.
- The public is aware of health protection and prevention activities related to health hazards and conditions that create healthy natural and built environments.
- Community partners have the information necessary to create healthy public policies related to reducing exposure to health hazards and creating healthy natural and built environments.
- The public and community partners are aware of health hazard incidents and risks in a timely manner.
- There is reduced public exposure to health hazards.

## Requirements

1. The board of health shall:
  - a) Conduct surveillance of the environmental health status of the community;
  - b) Conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations; and
  - c) Use information obtained to inform Healthy Environments programs and services

in accordance with the *Health Hazard Response Protocol, 2017* (to be drafted); the *Healthy Environments Protocol, 2017* (to be drafted); the *Infectious Diseases Protocol, 2016* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall identify risk factors and priority health needs in the local physical and natural environments related to building a healthy environment.

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<sup>9</sup> Health hazard, as defined in s.1(1) of the *Health Protection and Promotion Act*, means “(a) a condition of a premises, (b) a substance, thing, plant or animal other than man, or (c) a solid, liquid, gas or combination of any of them, that is likely to have an adverse effect on the health of any person.”

3. The board of health shall develop effective strategies in collaboration with community partners to reduce exposure to health hazards and promote healthy natural and built environments in accordance with the *Health Hazard Response Protocol, 2017* (to be drafted) and the *Healthy Environments Protocol, 2017* (to be drafted).
4. The board of health shall, as part of its strategy to reduce exposure to health hazards and promote healthy natural and built environments, effectively communicate with the public by:
  - a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need;
  - b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and
  - c) Addressing the following topics based on an assessment of local needs:
    - Built environment;
    - Climate change;
    - Exposure to chemical contamination;
    - Exposure to hazardous environmental contaminants and biological agents;
    - Exposure to radiation;
    - Extreme weather;
    - Indoor air pollutants;
    - Outdoor air pollutants; and
    - Other measures as emerging health issues arise.
5. The board of health shall assess and inspect facilities where there is an elevated risk of illness associated with exposures that are known or suspected to be associated with health hazards in accordance with the *Health Hazard Response Protocol, 2017* (to be drafted).
6. The board of health shall investigate potential health hazards and respond by preventing or reducing exposure to health hazards in accordance with the *Health Hazard Response Protocol, 2017* (to be drafted).
7. The board of health shall ensure 24/7 availability to receive reports of and respond to health hazards in accordance with the *Health Protection and Promotion Act* and the *Healthy Environments Protocol, 2017* (to be drafted).

# Healthy Growth and Development

## Goal

**To achieve optimal maternal, newborn, child, youth, and family health.**

## Program Outcomes

- There is a reduction in health inequities related to healthy growth and development.
- Increased community partner knowledge about the factors associated with, and effective programs for, the promotion of healthy growth and development and managing the stages of the family life cycle.
- Increased collaboration among community partners, children, youth, emerging adults, and parents in the planning, development, implementing, and evaluation of programs, services, and policies which positively impact healthy families and communities.
- Individuals and families have increased knowledge, skills and access to local resources related to healthy growth and development to effectively manage the different life stages and their transitions (e.g., maternal, newborn, child, and youth).
- Increased public knowledge about the importance of creating safe and supportive environments that promote healthy growth and development.
- Increased awareness among youth and emerging adults about contraception and healthy pregnancies.
- Families are aware of community resources and tools available to assess children's health and development.

## Requirements

1. The board of health shall collect, obtain, and analyze relevant data to monitor trends over time in outcomes, in healthy growth and development and population inequities, and communicate the population results in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall implement a program of public health interventions to support healthy growth and development in the health unit population, informed by:
  - a) An assessment of risk and protective factors that influence healthy growth and development;

- b) Evidence of the effectiveness of the interventions employed;
  - c) Consultation and collaboration with local stakeholders in the health, education, municipal, non-governmental, social, and other relevant sectors with specific attention to:
    - School boards, principals, educators, parent groups, student leaders, and students;
    - Child care providers and organizations that provide child care services, such as Community Hubs and Family Centres;
    - Health care providers and LHIN(s);
    - Social service providers; and
    - Municipalities.
  - d) Consideration of the following topics based on an assessment of local needs:
    - Breastfeeding;
    - Growth and development;
    - Healthy pregnancies;
    - Healthy sexuality;
    - Mental health promotion;
    - Preconception health;
    - Preparation for parenting; and
    - Positive parenting.
3. The board of health shall include a description, as part of its Board of Health Annual Service Plan and Budget Submission, of its programs of public health interventions to support healthy growth and development.
  4. The board of health shall provide all components of the Healthy Babies Healthy Children Program in accordance with the *Healthy Babies Healthy Children Protocol, 2012* (or as current) (Ministry of Children and Youth Services).

# Immunization

## Goal

**To reduce or eliminate the burden of vaccine preventable diseases through immunization.**

## Program Outcomes

- There is reduced incidence of vaccine preventable diseases.
- Timely and effective detection and identification of children susceptible to vaccine preventable diseases, their associated risk factors, and emerging trends.
- Timely and effective detection and identification of priority populations facing barriers to immunization, their associated risk factors, and emerging trends.
- Health care providers are knowledgeable of and adhere to improved practices related to proper vaccine management, including storage and handling and inventory management.
- There is reduced vaccine wastage.
- Target coverage rates for provincially funded immunizations are achieved.
- Effective outbreak management related to vaccine preventable disease outbreaks is achieved.
- The public and community partners are aware of the importance of immunization.
- Health care providers report adverse events following immunization to the board of health.
- Children have up-to-date immunizations according to the current Publicly Funded Immunization Schedules for Ontario, and in accordance with the *Immunization of School Pupils Act*, and the *Child Care and Early Years Act, 2014*.

## Requirements

1. The board of health shall assess, maintain records, and report on:
  - a) The immunization status of children enrolled in child care centres as defined in the *Child Care and Early Years Act, 2014*; and
  - b) Immunizations administered at board of health-based clinics as required in accordance with the *Immunization Management Protocol, 2016* (or as current) and the *Infectious Diseases Protocol, 2016* (or as current).

2. The board of health shall conduct epidemiological analysis of surveillance data for vaccine preventable diseases, vaccine coverage, and adverse events following immunization, including monitoring of trends over time, emerging trends, and priority populations<sup>10</sup> in accordance with the *Infectious Diseases Protocol, 2016* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
3. The board of health shall work with community partners to improve public knowledge and confidence in immunization programs and services by:
  - a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need;
  - b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and
  - c) Addressing the following topics based on an assessment of local needs:
    - The importance of immunization;
    - Diseases that vaccines prevent;
    - Recommended immunization schedules for children and adults and the importance of adhering to the schedules;
    - Introduction of new provincially funded vaccines;
    - Promotion of childhood and adult immunization, including high-risk programs and services;
    - The importance of maintaining a personal immunization record for all family members;
    - Immunization for travelers;
    - The importance of reporting adverse events following immunization;
    - Reporting immunization information to the board of health as required;
    - Vaccine safety; and
    - Legislation related to immunizations.
4. The board of health shall provide consultation to community partners on immunization and immunization practices based on local needs and as requested.
5. The board of health shall promote and provide provincially funded immunization programs and services to eligible persons in the health unit, including underserviced and priority populations.

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<sup>10</sup> Priority populations as defined in the Foundational Standards.

6. The board of health shall have a contingency plan to deploy board of health staff capable of providing vaccine preventable diseases outbreak management and control, such as mass immunization, in the event of a community outbreak.
7. The board of health shall provide a comprehensive information and education strategy to promote optimal vaccine management, including storage and handling practices, among health care providers in accordance with the *Vaccine Storage and Handling Protocol, 2016* (or as current). This shall include:
  - a) Training at the time of cold chain inspection;
  - b) Distributing information to new health care providers who handle vaccines; and
  - c) Providing ongoing support to existing health care providers who handle vaccines.
8. The board of health shall ensure that the storage and distribution of provincially funded vaccines, including to health care providers practicing within the health unit, is in accordance with the *Vaccine Storage and Handling Protocol, 2016* (or as current).
9. The board of health shall promote vaccine inventory management in all premises where provincially funded vaccines are stored in accordance with the *Vaccine Storage and Handling Protocol, 2016* (or as current).
10. The board of health shall:
  - a) Promote reporting of adverse events following immunization by health care providers to the local board of health in accordance with the *Health Protection and Promotion Act*, and
  - b) Monitor, investigate, and document all suspected cases of adverse events following immunization that meet the provincial reporting criteria<sup>11</sup> and promptly report all cases.

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<sup>11</sup> The provincial reporting criteria are under development at the Federal/Provincial/Territorial level.



# Infectious and Communicable Diseases

## Prevention and Control

### Goal

**To reduce the burden of communicable diseases and other infectious diseases of public health importance.**<sup>12,13</sup>

### Program Outcomes

- Timely and effective detection, identification, and management of exposures and local cases/outbreaks of infectious and communicable diseases of public health importance, including reportable diseases, their associated risk factors, and emerging trends.
- The public, health care providers, and other relevant partners, including emergency service workers are aware of the epidemiology, associated risk and protective factors, and practices related to the prevention and control of infectious and communicable diseases of public health importance.
- Effective partnerships support actions to prevent and control the spread of infectious and communicable diseases of public health importance.
- Effective case management results in limited secondary cases.
- Priority populations have access to harm reduction services and supports necessary to adopt healthy behaviours and practices that prevent exposure to and the transmission of sexually transmitted infections and blood-borne infections.
- There is reduced transmission of infections and communicable diseases including reduced progression of tuberculosis (TB).

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<sup>12</sup> Infectious diseases of public health importance include, but are not limited to, those specified reportable diseases as set out by Regulation 559/91 (as amended) under the *Health Protection and Promotion Act* and include zoonotic and vector-borne diseases. Emerging infectious diseases may be considered of public health importance based on a variety of criteria, including their designation as an emerging disease by international, Federal, and/or Provincial/Territorial health authorities, their potential for preventability or public health action, and the seriousness of their impact on the health of the population and potential spread.

<sup>13</sup> Communicable diseases are a subset of infectious diseases and defined in the legislation as set out by Regulation 558/91 (as amended) under the *Health Protection and Promotion Act*.

- The public, community partners, and health care providers report all suspected rabies exposures.
- Public health risks associated with infection prevention and control lapses are managed and mitigated effectively and efficiently.
- Settings that are required to be inspected are aware of and use infection prevention and control practices.

## Requirements

1. The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants. These efforts shall include:
  - a) Reporting data elements in accordance with the *Health Protection and Promotion Act*; the *Infectious Diseases Protocol, 2016* (or as current); the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2013* (or as current); the *Rabies Prevention and Control Protocol, 2013* (or as current); and the *Tuberculosis Prevention and Control Protocol, 2008* (or as current);
  - b) Conducting surveillance and epidemiological analysis, including the monitoring of trends over time, emerging trends, and priority populations<sup>14</sup> in accordance with the *Infectious Diseases Protocol, 2016* (or as current); the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2013* (or as current); the *Rabies Prevention and Control Protocol, 2013* (or as current); the *Tuberculosis Prevention and Control Protocol, 2008* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current);
  - c) Responding to international, Federal, Provincial/Territorial and local changes in diseases epidemiology by adapting programs and services; and
  - d) Using the information obtained through assessment and surveillance to inform program development regarding communicable diseases and other infectious diseases of public health importance.
2. The board of health shall provide public education to increase awareness related to infection prevention and control measures, including respiratory etiquette, and hand hygiene. These efforts shall include:
  - a) Adapting and/or supplementing national/provincial health education/communications strategies where local assessment has identified a need; and/or

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<sup>14</sup> Priority populations as defined in the Foundational Standards.

- b) Developing and implementing regional/local communications strategies where local assessment has identified a need.
- 3. The board of health shall work with community partners and service providers to determine and address the need for knowledge translation resources and supports in the area of infection prevention and control. These efforts shall include:
  - a) Adapting and/or supplementing national/provincial health education/communications strategies where local assessment has identified a need; and/or
  - b) Developing and implementing regional/local communications strategies where local assessment has identified a need.
- 4. The board of health shall use health promotion approaches to increase adoption of healthy behaviours among the population regarding sexual practices and injection drug use to prevent and reduce exposures to sexually transmitted and blood-borne infections by collaborating with and engaging health care providers, community and other relevant partners, and priority populations.
- 5. The board of health shall collaborate with health care providers and community partners, including school boards, to create supportive environments to promote healthy sexual practices<sup>15</sup> and access to sexual health services and harm reduction programs and services for priority populations.
- 6. The board of health shall participate on committees, advisory bodies, or networks that address infection prevention and control practices<sup>16</sup> and policies of, but not limited to, hospitals and long-term care homes in accordance with the *Institutional/Facility Outbreak Prevention and Control Protocol, 2016* (or as current).
- 7. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care, and other service providers, of:
  - a) The local epidemiology of communicable diseases and other infectious diseases of public health importance;
  - b) Infection prevention and control practices; and
  - c) Reporting requirements for reportable diseases, as specified in the *Health Protection and Promotion Act*.

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<sup>15</sup> Healthy sexual practices include, but are not limited to, contraception, pregnancy counselling, and the prevention and/or management of sexually transmitted infections and blood-borne infections.

<sup>16</sup> Infection prevention and control practices that may be addressed could include having current evidence-informed infection prevention and control policies and conducting regular staff education sessions to communicate and enhance awareness about the content of the policies.

8. The board of health shall provide public health management of cases, contacts and outbreaks to minimize the public health risk in accordance with the *Infectious Diseases Protocol, 2016* (or as current); the *Institutional/Facility Outbreak Prevention and Control Protocol, 2016* (or as current); the *Tuberculosis Prevention and Control Protocol, 2008* (or as current); the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2013* (or as current); and the *Rabies Prevention and Control Protocol, 2013* (or as current).
9. The board of health shall receive reports of complaints regarding infection prevention and control practices and respond to and/or refer to appropriate regulatory bodies, including regulatory colleges<sup>17</sup>, in accordance with applicable provincial legislation and in accordance with the *Infection Prevention and Control Practices Complaint Protocol, 2015* (or as current).
10. The board of health shall receive and evaluate reports of complaints regarding infection prevention and control practices in settings for which no regulatory bodies or regulatory colleges exist, particularly personal services settings. This shall be done in accordance with the *Infection Prevention and Control in Personal Services Settings Protocol, 2016* (or as current) and the *Infection Prevention and Control Practices Complaint Protocol, 2015* (or as current).
11. The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging infectious diseases issues.
12. The board of health shall, based on local epidemiology, supplement provincial efforts in managing risk communications to appropriate stakeholders on identified risks associated with infectious diseases and emerging diseases of public health importance.
13. The board of health shall collaborate with health care providers and other relevant partners to ensure access to, or provide, based on local assessment, clinical services for priority populations to promote and support healthy sexual practices, contraception, pregnancy counselling, and the prevention and/or management of sexually transmitted infections and blood-borne infections.
14. The board of health shall collaborate with health care providers and other relevant community partners to achieve a comprehensive and consistent approach, based on local assessment and risk surveillance, to address and manage sexually transmitted infections and blood-borne infections in accordance with the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2013* (or as current).

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<sup>17</sup> For the purposes of requirements 9 and 10, a “regulatory college” means the college of a health profession or group of health professions established or continued under a health professions Act named in Schedule 1 to the *Regulated Health Professions Act, 1991*.

15. The board of health shall receive and respond to all reported cases of suspected rabies exposures received from the public, community partners and health care providers in accordance with the *Health Protection and Promotion Act* and the *Rabies Prevention and Control Protocol, 2013* (or as current).
16. The board of health shall address the prevention and control of rabies threats as per a local Rabies Contingency Plan and in consultation with other relevant agencies<sup>18</sup> and orders of government, in accordance with the *Rabies Prevention and Control Protocol, 2013* (or as current).
17. The board of health shall develop a local vector-borne management strategy based on surveillance data and emerging trends in accordance with the *Infectious Diseases Protocol, 2016* (or as current).
18. The board of health shall inspect settings associated with risk of infectious diseases of public health importance in accordance with the *Infection Prevention and Control in Child Care Centres Protocol, 2016* (or as current); the *Infection Prevention and Control in Personal Services Settings Protocol, 2016* (or as current); and the *Healthy Environments Protocol, 2017* (to be drafted).
19. The board of health shall ensure 24/7 availability to receive reports of and respond to:
  - a) Infectious diseases of public health importance in accordance with the *Health Protection and Promotion Act*, the *Mandatory Blood Testing Act, 2006*, the *Infectious Diseases Protocol, 2016* (or as current); and the *Institutional/Facility Outbreak Prevention and Control Protocol, 2016* (or as current); and
  - b) Suspected rabies exposures in accordance with the *Health Protection and Promotion Act* and the *Rabies Prevention and Control Protocol, 2013* (or as current).

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<sup>18</sup> Currently these agencies include the Ministry of Natural Resources and Forestry (MNRF), the Canadian Food Inspection Agency (CFIA) and the Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA).

# Safe Water

## Goals

- **To prevent or reduce the burden of water-borne illnesses related to drinking water.**
- **To prevent or reduce the burden of water-borne illnesses and injuries related to recreational water use.**

## Program Outcomes

- Timely and effective detection, identification, and response to water contaminants and illnesses, their associated risk factors, and emerging trends, including levels of fluoride outside the recommended range.
- Water-borne illness risks are mitigated.
- Members of the public who use private wells, cisterns, and rain or lake water are aware of how to safely manage their own drinking-water systems.
- The public is aware of drinking water safety.
- Owners/operators of recreational water facilities and owners/operators of small drinking-water systems operate in a safe and sanitary manner.
- The public is aware of potential risk of illnesses and injuries related to public beach use.
- Public exposure to recreational water-related illnesses and hazards is reduced.

## Requirements

1. The board of health shall report Safe Water Program data elements in accordance with the *Drinking Water Protocol, 2014* (or as current) and the *Recreational Water Protocol, 2016* (or as current).
2. The board of health shall:
  - a) Conduct surveillance of:
    - Drinking water sources and systems and of drinking water illnesses of public health importance, their associated risk factors, and emerging trends;
    - Public beaches and public beach water-borne illnesses of public health importance, their associated risk factors, and emerging trends; and
    - Recreational water facilities;

- b) Conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations; and
  - c) Use the information obtained to inform Safe Water programs and services in accordance with the *Drinking Water Protocol, 2014* (or as current); the *Infectious Diseases Protocol, 2016* (or as current); the *Recreational Water Protocol, 2016* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
- 3. The board of health shall provide information to private citizens who operate their own wells, cisterns, and rain or lake water systems to promote awareness of how to safely manage their own drinking-water systems.
- 4. The board of health shall ensure the provision of education and training for owners/operators of drinking-water systems in accordance with the *Drinking Water Protocol, 2014* (or as current).
- 5. The board of health shall increase public awareness of water-borne illnesses and safe drinking water by working with community partners and by:
  - a) Adapting and/or supplementing national/provincial safe drinking water communications strategies where local assessment has identified a need; and/or
  - b) Developing and implementing regional/local communications strategies where local assessment has identified a need.
- 6. The board of health shall ensure the provision of education and training for owner/operators of recreational water facilities in accordance with the *Recreational Water Protocol, 2016* (or as current).
- 7. The board of health shall provide all the components of the Safe Water Program in accordance with all applicable statutes and regulations, and the *Drinking Water Protocol, 2014* (or as current) to protect the public from exposure to unsafe drinking water.
- 8. The board of health shall inform the public about unsafe drinking water conditions and provide the necessary information to respond appropriately in accordance with the *Drinking Water Protocol, 2014* (or as current).
- 9. The board of health shall reduce risks of public beach and recreational water facilities use in accordance with the *Recreational Water Protocol, 2016* (or as current).
- 10. The board of health shall review drinking water quality reports for its municipal drinking water supply(ies) where fluoride is added. These reports shall be reviewed at least monthly and, where necessary, action shall be taken in accordance with the *Protocol for the Monitoring of Community Water Fluoride Levels, 2014* (or as current).

11. The board of health shall ensure 24/7 availability to receive reports of and respond to:
- a) Adverse events related to safe water, such as reports of adverse drinking water of drinking water systems, governed under the *Health Protection and Promotion Act* or the *Safe Drinking Water Act, 2002*;
  - b) Reports of water-borne illnesses or outbreaks;
  - c) Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and
  - d) Safe water issues relating to recreational water use including public beaches in accordance with the *Health Protection and Promotion Act*, the *Drinking Water Protocol, 2014* (or as current); the *Infectious Diseases Protocol, 2016* (or as current); and the *Recreational Water Protocol, 2016* (or as current).



# School Health

## Goal

**To achieve optimal health of children and youth in schools through partnership and collaboration with school boards and schools.**

## Program Outcomes

- School boards and schools are aware of relevant and current population health needs impacting students in their schools.
- School boards and schools are meaningfully engaged in the planning, development, implementation, and evaluation of public health programs and services relevant to children and youth.
- School-based initiatives relevant to healthy living behaviours are informed by effective partnerships between boards of health, school boards, and schools.
- There is an increased adoption of healthy living behaviours among children and youth.
- Children, youth, and emerging adults have increased knowledge about, and skills for healthy growth and development.
- There is an increased awareness among youth and emerging adults about contraception and healthy pregnancies.
- Oral health of children and youth from low-income families is improved by enabling access to oral health care.
- There is an increase in the number of children screened for visual health concerns.
- Children have up-to-date immunizations according to the current Publicly Funded Immunization Schedules for Ontario and in accordance with the *Immunization of School Pupils Act*.

## Requirements

1. The board of health shall collect, obtain and analyze relevant data to monitor trends over time in outcomes, in the health of children and youth in schools and population inequities, and communicate the population results in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall provide population health information, including determinants of health and health inequities, relevant to the school population to school boards and schools to identify public health needs in schools.

3. The board of health shall develop and implement a program of public health interventions to improve the health of children and youth in schools, informed by:
  - a) An assessment of the local population, including the identification of priority populations in schools as well as school communities at risk for increased health inequities and negative health outcomes;
  - b) Evidence of the effectiveness of the interventions employed;
  - c) Consultation and collaboration with school boards, principals, educators, parent groups, student leaders, and students; and
  - d) A review of other relevant programs and services delivered by the board of health.
4. The board of health shall include a description, as part of its Board of Health Annual Service Plan and Budget Submission, of its programs of public health interventions to improve the health of children and youth in school.
5. The board of health shall offer support to school boards and schools to assist with the implementation of health-related curricula and health needs in schools, based on need and considering, but not limited to:
  - a) Alcohol and other substance misuse (e.g., illicit drugs, including harm reduction strategies);
  - b) Comprehensive tobacco control (including addressing e-cigarettes and emerging products);
  - c) Concussions and injury prevention;
  - d) Healthy eating and food safety;
  - e) Healthy sexuality;
  - f) Mental health promotion;
  - g) Oral health;
  - h) Physical activity and sedentary behaviour;
  - i) Road and off-road safety;
  - j) Suicide risk and prevention;
  - k) UV exposure; and
  - l) Violence and bullying.

## Oral Health

6. The board of health shall conduct surveillance of children in schools and report in accordance with the *Oral Health Assessment and Surveillance Protocol, 2016* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
7. The board of health shall conduct oral screening in accordance with the *Oral Health Assessment and Surveillance Protocol, 2016* (or as current).
8. The board of health shall provide the Healthy Smiles Ontario (HSO) Program in accordance with the *Healthy Smiles Ontario (HSO) Program Protocol, 2016* (or as current).

## Vision

9. The board of health shall provide, in collaboration with community partners, visual health supports and vision screening services in accordance with the *Child Visual Health and Vision Screening Protocol, 2017* (to be drafted).

## Immunization

10. The board of health shall enforce the *Immunization of School Pupils Act* and assess the immunization status of children in accordance with the *Immunization Management Protocol, 2016* (or as current).
11. The board of health shall work with school boards and schools to identify opportunities to improve public knowledge and confidence in immunization for school-aged children by:
  - a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need;
  - b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and
  - c) Addressing the following topics based on an assessment of local needs:
    - The importance of immunization;
    - Diseases that vaccines prevent;
    - Recommended immunization schedules for children and the importance of adhering to the schedules;
    - Introduction of new provincially funded vaccines;
    - Promotion of childhood immunization, including high-risk programs and services;
    - The importance of maintaining a personal immunization record for all family members;

- The importance of reporting adverse events following immunization;
- Reporting immunization information to the board of health as required;
- Vaccine safety; and
- Legislation related to immunizations.

12. The board of health shall promote and provide provincially funded immunization programs to eligible students in the health unit through school-based clinics.

alPHA's members are  
 the public health units  
 in Ontario.

March 17, 2017

UPDATED

**alPHA Sections:**

Boards of Health  
 Section

Council of Ontario  
 Medical Officers of  
 Health (COMOH)

**Affiliate  
 Organizations:**

Association of Ontario  
 Public Health Business  
 Administrators

Association of  
 Public Health  
 Epidemiologists  
 in Ontario

Association of  
 Supervisors of Public  
 Health Inspectors of  
 Ontario

Health Promotion  
 Ontario

Ontario Association of  
 Public Health Dentistry

Ontario Association of  
 Public Health Nursing  
 Leaders

Ontario Society of  
 Nutrition Professionals  
 in Public Health

Roselle Martino  
 Assistant Deputy Minister  
 Population and Public Health Division  
 Ministry of Health and Long-Term Care  
 10th Floor, 80 Grosvenor Street,  
 Toronto, Ontario M7A 2C4

Dear Roselle,

**Re: Public Health Programs and Services Consultation**

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On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHA), I am writing today to provide our initial feedback on the *Standards for Public Health Programs and Services Consultation Document* that was released for comment on February 17.

We recognize that a great deal of work went into this review, and appreciate the fact that many of our members were directly involved in the development of the revised Standards for Public Health. We are also pleased with the decision to hold regional consultations and hope that the feedback that you receive from our members as part of these will be carefully considered, as our members will be more likely to provide more detailed operational feedback not covered here. Finally, we are most appreciative of the extension to the original April 3 deadline to accommodate a more thorough consideration of the document.

Our response as an Association is based primarily on what we heard at the 2017 alPHA Winter Symposium and follow-up discussions during meetings of our Council of Ontario Medical Officers of Health (COMOH) and Boards of Health Sections as well as the alPHA Executive Committee and Board of Directors since that time.

We understand that the intent of the present consultation is to gather feedback on operational considerations and implementation requirements and supports. We expect that the most useful feedback on these will be heard as part of the regional consultations that will take place later this month, as staff and managers who are most familiar with the various programs and services are in the best position to provide the required analysis and advice.

Page 1 of 3

Indeed, a recurring theme that we have heard from our members during and following our February symposium is that it will be difficult to fully assess the operational implications of the revised standards before more clarity on the more specific expectations are available. We are given to understand that these will emerge with the development of protocols, guidance documents and annual service plan template, and we would appreciate assurances that the field will be fully involved in this process so that we can answer the operational and implementation questions as they arise.

Similarly, the importance of examining the existing and potential capacity, resource and funding issues cannot be overstated. These have been at the forefront of our discussions of the revised standards so far, and the expectations will need to be more clearly understood before an assessment of the capacity to meet them can be properly carried out.

The above uncertainties notwithstanding, we already have significant concerns about capacity in light of our escalating struggles to meet our existing mandate and respond to local needs with constrained budgets. These struggles will only intensify with the new program and process obligations that are laid out in the revised standards and the continued implementation of the public health funding formula.

We have, for example, communicated on several occasions as part of our feedback on the Patients First initiative that increasing engagement with the health care sector carries with it significant resource implications. Assisting with the planning of health care delivery services is a new application of public health's expertise in population health assessment, which requires different analytical approaches and is in addition to the applications that we will be expected to continue.

Even if this and the various other added requirements are offset by the subtraction or consolidation of others, there will be resource implications related to adapting our service delivery processes to the shifts in expectations, including retraining staff for new obligations, re-allocating resources and developing outreach and negotiation strategies for programs that we are no longer expected to provide directly but are still expected to ensure are available. New administrative requirements such as developing annual public health service plans and individualized programs of public health interventions will also entail significant additional consideration.


We also have some concerns about the much less prescriptive approach to the health promotion standards. Although we are very receptive to the greater latitude to tailor health promotion / chronic disease prevention programs via local public health "intervention plans", we see a potential risk to their effectiveness and sustainability in the current fiscal climate. If available resources remain static (as they have now for two years in most cases), meeting the more explicit health protection requirements on an ongoing basis will almost certainly erode the resources left over for the delivery of effective tailored health promotion programs and services over time. We recommend that there be mechanisms developed to mitigate this risk and protect our critical work in the more flexible areas of the standards.

As we observed above, there is still much that has not yet been defined within the new standards, and there are additional uncertainties about the outcomes of the correlated health system transformation processes. We do see this as an important opportunity to answer questions and address concerns, and it will be exceedingly important that these processes (including but not limited to the Expert Panel on Public Health, the Public Health-Local Health Integration Network Work Stream, the new Accountability Framework) are appropriately bridged to ensure that we have the information we need to guide us through the transformation process. We would appreciate assurances that we will be full participants in ensuring that these processes and their products serve the best interests for effective health protection and promotion throughout the province.

It is important to note that the above points are reflective of the collective discussions that our members have had in the short time since the release of the consultation document. The emergence of other questions and concerns as the revised Standards are more closely examined are a near-certainty, and we hope that you will remain open to discussing them – including feedback on content - in the months leading to the January 2018 implementation.

In closing, we recognize that having such explicit and comprehensive public health standards is unusual in Canada and we are grateful to have a strong foundation for the practice of public health in Ontario. We thank you for the opportunity to assist in further strengthening Ontario's public health system to most effectively protect and promote the health of all Ontarians.

Yours sincerely,

A handwritten signature in cursive script that reads "Carmen McGregor". The ink is grey and the signature is fluid and legible.

Carmen McGregor  
alPHa Vice-President

**COPY:** Dr. David Williams, Chief Medical Officer of Health  
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation, Ministry of Health and Long-Term Care  
Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Ministry of Health and Long-Term Care



Sudbury & District

## Health Unit

Service de  
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## ***DRAFT Governance Letter***

April 21, 2017

Ms. Roselle Martino  
Assistant Deputy Minister  
Population and Public Health Division  
Ministry of Health and Long-Term Care  
10<sup>th</sup> Floor, 80 Grosvenor Street  
Toronto, ON M7A 2C4

Dear Ms. Martino:

### **Re: Public Health Programs and Services Consultation**

The Sudbury & District Board of Health (Board) appreciates the opportunity to provide feedback on the *Standards for Public Health Programs and Services* (Standards) document, released for comment on February 17. This letter conveys our feedback, including comments from both overarching and program-specific operational levels.

We also take this opportunity to recognize the Ministry's initiative to transform and streamline the broader health system while maximizing public health's unique contributions to the health of the population. We are confident in the ability of local public health to support health and health equity for the residents and communities we serve.

We note our appreciation of revisions to language in the Standards that we believe are supportive of and consistent with the aims of a comprehensive population and public health system, specifically:

- A holistic definition of health which considers wellbeing and mental health in addition to physical health;
- The importance of upstream efforts to promote health and prevent disease of the population, including the addition of health equity as a foundational standard for public health services; and
- Commitment and flexibility to meet local needs, based on evidence and local assessment.

Please note that our comments are necessarily constrained by the context of yet-to-be-developed protocols, guidelines, annual service plans and other requirements referenced in the Standards and in anticipation of a new public health accountability framework. We understand and are grateful that the intention is to involve local public health as much as possible in the processes that will unfold to develop these materials.



At its meeting of April 20, 2017, the Board of Health formally endorsed alPHa's initial feedback on the Standards, as described in correspondence to you, dated March 15, 2017: (insert or append motion)

In addition to supporting the points raised by alPHa, we bring to your attention the overarching issues and detailed operationally-focused feedback attached as Appendix A to this letter. These considerations are informed by our review of the Standards and the northeast region consultation led by your Division on March 27.

We appreciate having the opportunity to provide, through multiple channels, the perspective of the Sudbury & District Board of Health. We acknowledge the inclusive process undertaken to develop the Standards and appreciate the opportunity that our own Medical Officer of Health and staff have had to engage in the Standards' development. Finally, while aware of the fiscal environment, the Board is also very aware of the need to invest in upstream health in our communities. We are hopeful that the new Standards for Public Health Programs and Services strike an appropriate balance between support to the health care system and engagement with other sectors to optimally create opportunities for health for all Ontarians.

On behalf of the Sudbury & District Board of Health, I thank you again for this opportunity and do not hesitate to follow-up with us if you would like to discuss our submission further.

Sincerely,

René Lapierre  
Chair, Sudbury & District Board of Health

cc: Dr. Dave Williams, Chief Medical Officer of Health  
Linda Stewart, Executive Director, alPHa

Encl.: Appendix A

## Appendix A

### *Standards for Public Health Programs and Services*

### *Sudbury & District Board of Health Overarching Issues and Detailed Operational Feedback\**

\*Note that these comments are in addition to the Sudbury & District Board of Health's endorsement of alPHa initial feedback dated March 17, 2017.

#### **Overarching Issues:**

Issue	Details	Considerations
1. Unique challenges for northern public health	Northern health units face unique challenges that require specific consideration in implementing the Standards for Public Health Programs and Services (SPHPH). The vast geography combined with uneven population distribution translate into increased costs in program delivery. The urban/rural and remote mix create challenges related to distances and economies of scale. Further, the northeast's distinct Francophone and Indigenous communities require specific focus, program strategies and adaptations to meet unique needs. Additional features include limited or no public transportation for clients and service providers, challenges with recruitment and retention of trained and experienced personnel, and limited access to specialized services. Northern Ontario residents have worse health outcomes than those of southern Ontario, influenced by factors such as food insecurity, precarious housing and employment and service gaps. With fewer services offered in the north, northern health	<ul style="list-style-type: none"><li>• Northern-specific dialogue should occur on implementation challenges for northern health units. Support for a community of practice-type approach may be helpful. Opportunities for ongoing dialogue would assist in determining and sharing solutions and potential collective action.</li><li>• Transitional funding and time should be given for northern health units to appropriately plan for unique context and challenges.</li></ul>

Issue	Details	Considerations
	units may be required to implement services that in the south are offered by other service providers.	
2. Transitioning, change management and resource reductions	There are significant programmatic and operational changes that will need to be undertaken for successful implementation of the SPHPS. Change management takes time and is critical to success and sustainability. Further, the implementation of the SPHPH is occurring in the context of significant budget reductions for the SDHU (and many others) and the resulting FTE reductions will need to be factored in from a resource perspective but also from organizational culture and productivity perspectives. Key direction and documents/templates are still under development.	<ul style="list-style-type: none"> <li>• Health units would benefit from change management training and support.</li> <li>• The field should be involved on an ongoing basis in the development and refinement of key implementation and accountability documents and tools.</li> <li>• The implementation of the SPHPS by necessity will be an incremental process and <i>progress</i> toward full implementation should be tracked as part of the annual service plans and accountability framework.</li> <li>• There is a need to re-evaluate the funding envelope to public health, in addition to the funding model, in the context of government's stated policy objectives including those of health care system sustainability, population health/health promotion and health equity priorities and poverty reduction.</li> </ul>
3. Reciprocal cross-ministerial expectations	Much of the work of public health is done in collaboration with other non-health sectors. There is a need for provincial coordination of mandates so that the scope of decision making in different sectors can be best leveraged to support population health.	<ul style="list-style-type: none"> <li>• The MOHLTC should re-invigorate efforts to facilitate reciprocal cross-ministerial mandates with a shared accountability model to optimally support the health and health equity of all Ontarians.</li> <li>• Health units should be consulted to learn from successes in partnerships at the local level so that these can be examined for potential translation into provincial cross ministerial policy direction (e.g. in the areas of education, recreation, transportation, social and environmental).</li> </ul>
4. Upstream health promotion and health equity programming	A comprehensive public health approach to primary prevention includes upstream objectives such as the development of healthy public policies, capacity building, and supportive social and built environments. An	<ul style="list-style-type: none"> <li>• The "programs of public health interventions" should incorporate clear requirements for upstream, including healthy public policy, work for identified local public health priorities.</li> <li>• Clarity is required concerning <i>protocols</i> versus <i>guidelines</i> versus <i>program of public health interventions</i>. There is concern that</li> </ul>

Issue	Details	Considerations
	upstream approach is proactive compared to secondary and tertiary prevention efforts (i.e., management of chronic diseases) which are intended to mitigate the burden of illness or chronic disease, and have the greatest return on investment. The SPHPH include relatively more requirements for health units to work downstream with a strong focus on changing individual behaviours.	prescribed protocols in health protection standards may overwhelm resource capacity, resulting in reduced investment in less prescribed health promotion standards. The above noted documents combined with the annual service plan process may mitigate this potential risk/concern.
5. Provincial support services and materials	The SPHPH anticipates the development of a number of guidelines, protocols, templates and support materials. These are very much welcomed.	<ul style="list-style-type: none"> <li>• The development of all resources should include active field engagement, adopting an iterative process such that continuous learning can be incorporated.</li> <li>• Communities of practice should be strategically and systematically developed and supported in order to foster mutual learning and resource development.</li> <li>• Training needs must be identified across the system, particularly focusing on relatively new areas of practice (e.g. Indigenous engagement, mental health, climate change, built environment, violence).</li> <li>• There should be provincial level coordination of training, communities of practice and repositories for tools and information</li> </ul>

#### Detailed Operational Feedback:

Standard	Clarification	Implementation protocols, guidelines, training, tools	Operational Supports
<b>General Comments</b>	<ul style="list-style-type: none"> <li>• Require clarity and coordination regarding mental health programs and services across the entire health system.</li> </ul>	<ul style="list-style-type: none"> <li>• Need for a glossary of terms to ensure consistent interpretation (ex: suicide risk, violence, mental health, prevention of intentional injuries,</li> </ul>	<ul style="list-style-type: none"> <li>• Communication strategies and materials for consistent messaging</li> </ul>

Standard	Clarification	Implementation protocols, guidelines, training, tools	Operational Supports
	<ul style="list-style-type: none"> <li>Need for mutual cross-referencing of standards: <ul style="list-style-type: none"> <li>Health equity to be included in each program outcome including Immunization and Healthy environments.</li> <li>Ensure topics for consideration are consistently stated within CDIPWSM, School Health and HGD Standards (i.e., healthy eating and physical activity).</li> </ul> </li> </ul>	<p>problematic use of alcohol and other substances, sleep, climate change, well-being and wellness, etc.). Definitions hyperlinked directly in the document would also be very useful.</p>	<p>would be helpful in areas such as the positioning of public health within the health system and awareness and branding of public health.</p> <ul style="list-style-type: none"> <li>The sector would benefit from centrally developed communication and campaign materials that can be adapted to local need.</li> </ul>
<b>Foundational</b>			
1.1 PHA	<ul style="list-style-type: none"> <li>Clarity on how PHUs will collaborate with LHINs on population health assessment (PHA), including data sharing.</li> </ul>	<ul style="list-style-type: none"> <li>Need for consistent measures for assessing food insecurity across the province (e.g., Nutritious Food Basket Protocol (2014)).</li> <li>Need for better and more comprehensive local data to support population health assessment expectations; this includes systematic data collection across the province and key indicators (e.g., RRFSS) – See Chief Medical Officer of Health report (2015).</li> </ul>	<ul style="list-style-type: none"> <li>Supports to facilitate appropriate data sharing across the system</li> </ul>
1.2 HE	<ul style="list-style-type: none"> <li>Include dis/ability in the list of social determinants of health on p. 15.</li> </ul>	<ul style="list-style-type: none"> <li>Need for health equity indicators and target setting.</li> </ul>	<ul style="list-style-type: none"> <li>Successful reduction of health inequities requires all sectors</li> </ul>

Standard	Clarification	Implementation protocols, guidelines, training, tools	Operational Supports
		<ul style="list-style-type: none"> <li>Need for training and guidelines on Indigenous engagement and priority population engagement. Involve PHUs and Indigenous people in the development of an Indigenous Engagement guideline document. Key content should include concepts of Indigenous determinants of health and OCAP principles<sup>1</sup>.</li> </ul>	have a consistent understanding of health equity, common measures and a common goal.
1.3 EPHP	<ul style="list-style-type: none"> <li>Clarity on expectation of an external peer review at outlined in requirement 10d.</li> </ul>	<ul style="list-style-type: none"> <li>Additional resources, supports and training are needed to implement Quality and Transparency requirements.</li> <li>Clear guideline or protocol to outline Ministry expectation of PHUs regarding public disclosure. Involve PHUs in the development of the document.</li> </ul>	
1.4 EPRR		<ul style="list-style-type: none"> <li>Assessing implementation challenges is difficult in the absence of the forthcoming Ministry protocols and guidelines in all areas of this standard.</li> </ul>	
CDIPWSM	<ul style="list-style-type: none"> <li>Clarity regarding mental health promotion is required, including a framework to guide appropriate public health actions.</li> </ul>	<ul style="list-style-type: none"> <li>Guidelines for mental health promotion and suicide risk and prevention.</li> </ul>	

<sup>1</sup> Note: SDHU is leading a PHO-funded locally driven collaborative project, in partnership with five other health units from across northeastern Ontario, Laurentian University, and Indigenous community partners. This shared learning process aims to enhance relationships between First Nations and health units and identify promising principles and practices for engagement that can be utilized as a foundation for all Ontario public health units. The project is entitled: "Relationship building with First Nations and public health: Exploring principles and practices for engagement to improved community health".

Standard	Clarification	Implementation protocols, guidelines, training, tools	Operational Supports
	<ul style="list-style-type: none"> <li>Clarity regarding Ministry expectation for PHUs to implement the Skin Cancer Prevention Act and Healthy Menu Choices Act in light of current protocol direction that PHUs are not to inspect these facilities on an ongoing routine basis but rather on a complaint basis.</li> </ul>	<ul style="list-style-type: none"> <li>Template or guideline for “program of public health intervention” to ensure consistent approach across the province.</li> </ul>	
Food Safety	<ul style="list-style-type: none"> <li>Clarity of terms and expectations related to surveillance of food premises and food for public consumption.</li> <li>Clarity of the terms <i>detection</i> and <i>identification</i> (does detection mean pre risk assessment and identification post risk assessment?).</li> <li>Clarity regarding what “and all other applicable Acts” encompasses (e.g., only public health legislation or all other applicable legislation).</li> </ul>		
Healthy Environments	<ul style="list-style-type: none"> <li>Clarity of expectations regarding surveillance of environmental health status.</li> <li>Clarity on what an environmental contaminant is, beyond those already listed.</li> </ul>	<ul style="list-style-type: none"> <li>It is difficult to assess implementation challenges in the absence of the forthcoming Ministry policy and guidance documents.</li> <li>Need guidelines on surveillance of environmental health status.</li> <li>Need for training and support in Healthy Environments particularly, Built Environment and Climate Change.</li> </ul>	
HGD	<ul style="list-style-type: none"> <li>Focus in HGD standard is building knowledge and awareness whereas the CDIPWSM is aimed at increasing adoption of healthy behaviours.</li> <li>Include sleep within HGD standard.</li> </ul>	<ul style="list-style-type: none"> <li>Need for a protocol outlining key healthy eating initiatives across the life course and across standards, including the implementation of the NutriSTEP® screening tool as well as the SCREEN® screening tool for older adults.</li> </ul>	<ul style="list-style-type: none"> <li>Need for evidenced-based approaches and the use of consistent measures in order to have comparable data across the province. Examples of these are</li> </ul>

Standard	Clarification	Implementation protocols, guidelines, training, tools	Operational Supports
			NutriStep® and SCREEN®.
Immunization			
ICDPC	<ul style="list-style-type: none"> <li>Need for a program goal ensuring the availability of low cost contraception. Contraception and pregnancy counselling should be listed in HGD rather than in ICDPC.</li> <li>Need for a program goal ensuring confidential and private access to testing for STIs.</li> </ul>		
Safe Water	<ul style="list-style-type: none"> <li>Clarity and Ministry expectation on the term “surveillance” of drinking water sources and systems. Does the term surveillance include only those sources and systems directly under public health’s mandate or more broadly (e.g., MOECC regulated systems)?</li> </ul>	<ul style="list-style-type: none"> <li>Need for standardized safe water education and training resources created by the Ministry for implementation by PHUs similar to the food handler training and certification program kit.</li> </ul>	
School Health	<ul style="list-style-type: none"> <li>A targeted approach for priority populations within schools may unintentionally result in stigmatization. Need for language around a comprehensive approach not only focusing on behaviours but also on creating supportive environments and healthy policies.</li> <li>We interpret “school communities” to be inclusive of adult influencers in the broader community, as opposed to only within the school. Is this accurate?</li> <li>Needs to be greater clarity and coordination of mental health resources and systems for public health. How can we leverage from each other? (e.g., CCAC mental health and addictions nurses).</li> </ul>	<ul style="list-style-type: none"> <li>Need for accommodation in the Annual Service Plan for consideration of the school academic year.</li> <li>Need for training, tools, and equipment for implementation of vision screening. Ensure that best practices and evidence are provided, and consider incorporating an evaluation component.</li> </ul>	



**MOTION: STANDARDS FOR PUBLIC HEALTH PROGRAMS AND SERVICES CONSULTATION DOCUMENT**

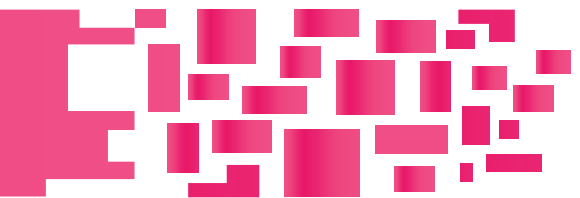
**WHEREAS the Sudbury & District Board of Health (Board) has reviewed the Standards for Public Health Programs and Services Consultation Document (Standards) released February 17, 2017; and**

**WHEREAS the Board has reviewed the March 17, 2017 feedback to the Ministry of Health and Long-Term Care (MOHLTC) from the Association of Local Public Health Agencies (ALPHA) and has received a report from the Medical Officer of Health on related operational considerations and implementation requirements;**

**THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the March 17, 2017, ALPHA feedback on the Standards for Public Health Programs and Services Consultation Document; and**

**AND FURTHER THAT the Board communicate its overarching and program-specific operational feedback to the Ministry of Health and Long-Term Care, sharing the same with all area municipalities, the Association of Local Public Health Authorities, all Ontario boards of health, and other relevant stakeholders.**

# Strategic Priorities: Narrative Report



Performance  
Monitoring Plan

2013  
2017

April 2017



Sudbury & District

Health Unit

Service de  
santé publique

## Introduction

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

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

## Advocating for a Basic Income Guarantee to Promote Optimal Health for All

People with low income are at far greater risk of preventable chronic conditions such as cancer, diabetes, heart disease, and mental illness. A livable income through initiatives such as the Basic Income Guarantee can improve economic security to support all citizens in achieving their optimal health.

In October 2015, the Board of Health approved a motion recognizing that a Basic Income Guarantee has the potential to help eliminate poverty. In October 2016, the Board commended the provincial government for announcing steps to undertake a Basic Income Guarantee pilot. The Health Unit also contributed to provincial consultations on implementing the Basic Income Guarantee by:

- Participating in a local public consultation session in December 2016.
- Encouraging staff and SDHU teams to complete consultation surveys.
- Working with a provincial Health Equity Working Group and Public Health Ontario.

Together, Board of Health members and staff continue to advocate to the province to increase economic security and, ultimately, reduce health inequities for all Ontarians.



### Strategic Priority: Champion and lead equitable opportunities for health

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

## SDHU's Baby-Friendly Initiative Journey

The SDHU has partnered with Health Sciences North to carry out collaborative activities as part of the Baby-Friendly Initiative (BFI). BFI is a community based strategy that has been shown to improve the health and well-being of children and families by increasing the number of women who start breastfeeding as well as the length of time they maintain breastfeeding.

The hospital has been a member of the SDHU's BFI network from the start, but a unique opportunity arose when a labour and delivery nurse from Health Sciences North (BFI lead for the hospital) accepted a BFI lead position at the Health Unit. An agreement between the agencies allows the nurse to continue to work at the hospital in the BFI lead role strengthening the continuum of care for mothers and infants in our community, while reinforcing essential partnerships in this community based strategy.

This partnership has positively influenced culture in our community, provided a stronger support base for breastfeeding, and improved the delivery of health services for infants and their families. In addition, this partnership will continue to inspire the entire community on our journey toward baby friendliness and normalizing breastfeeding.

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### Strategic Priority: Strengthen relationships

- Invest in relationships and innovative partnerships based on community needs and opportunities
- Help build capacity with our partners to promote resilience in our communities and neighbourhoods
- Monitor our effectiveness at working in partnership
- Collaborate with a diverse range of sectors



## Ridgecrest Playground Research Study – Utilizing Evidence to Promote Accessible Playgrounds

Ridgecrest Park is the only neighbourhood playground in Greater Sudbury that has been redesigned to be accessible for people with disabilities. Laurentian University and the Sudbury & District Health Unit partnered together to study the impact of this unique space on individuals, families and the community. Results from interviews and household questionnaires showed that the new playground improved accessibility for people with disabilities and for families facing financial barriers as well as strengthened the sense of community in this neighbourhood, even by those who did not use the space.

This is one example of where research can shape public health practice, in particular, public health promotion and advocacy efforts. The role of public health in the promotion of playgrounds has traditionally been aimed at increasing rates of physical activity within the population. These findings support a broader role for public health in the advocacy and promotion of inclusive and accessible playgrounds, not only to effectively impact the physical health of individuals, but the social and emotional health of a vulnerable population and the communities in which they live.



### Strategic Priority: Strengthen evidence-informed public health practice

- Implement effective processes and outcomes to use and generate quality evidence
- Apply relevant and timely surveillance, evaluation, and research results
- Exchange knowledge internally and externally

## Youth in Crisis: Employability Partnership with the Sudbury Food Bank

In 2016, the Banque d'aliments Sudbury Food Bank (BDSFB) created a community training kitchen that offered a hands-on program that teaches participants healthy meal preparations and food safety skills in a simulated industrial kitchen setting. To launch this new kitchen, the BDSFB engaged community partners, including staff in the SDHU's Environmental Health Division, to deliver a program that encourages youth from various local community agencies to participate. The goal of the program is to increase their skills to find and keep employment in the food industry. The program also empowers participants to use these skills in their own homes.

Between September and December 2016, eight different community groups took part in this initiative. Using non-traditional means of delivering food skills and food safety messaging, 30 participants were effectively taught healthy behaviours and became certified food handlers.

The success of this program and the increased opportunities for local community agencies has led the BDSFB to partner again with the Health Unit in 2017 to deliver more sessions.

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### Strategic Priority: Support community actions promoting health equity

- Facilitate diverse community engagement
- Support awareness, education, advocacy and policy development at local, provincial, and federal levels
- Tailor programs and services to reflect community voices and needs
- Seek community input on issues that impact health equity



## Risk Management @ SDHU

In the spring of 2016, the Sudbury and District Board of Health and members of Senior Management proactively initiated a risk management process with support from the Treasury Board Secretariat.

The Health Unit was one of the first public health organizations in Ontario to adopt and implement a five-step risk management process, which resulted in the development of an organization wide risk management framework, related policy, and a risk management plan—all of which were approved by the Board of Health in October 2016. The risk management plan ensures that the SDHU has a framework to systematically identify and assess risks and controls, and evaluate, monitor, and report the risks regularly.

The Health Unit's organization wide risk management plan, which includes a progress update that highlights the mitigation strategies that are put in place to reduce risks, is reported to the Executive Committee quarterly and reported annually to the Board of Health.

Management teams are currently completing division specific risk assessments and will monitor their risks regularly.

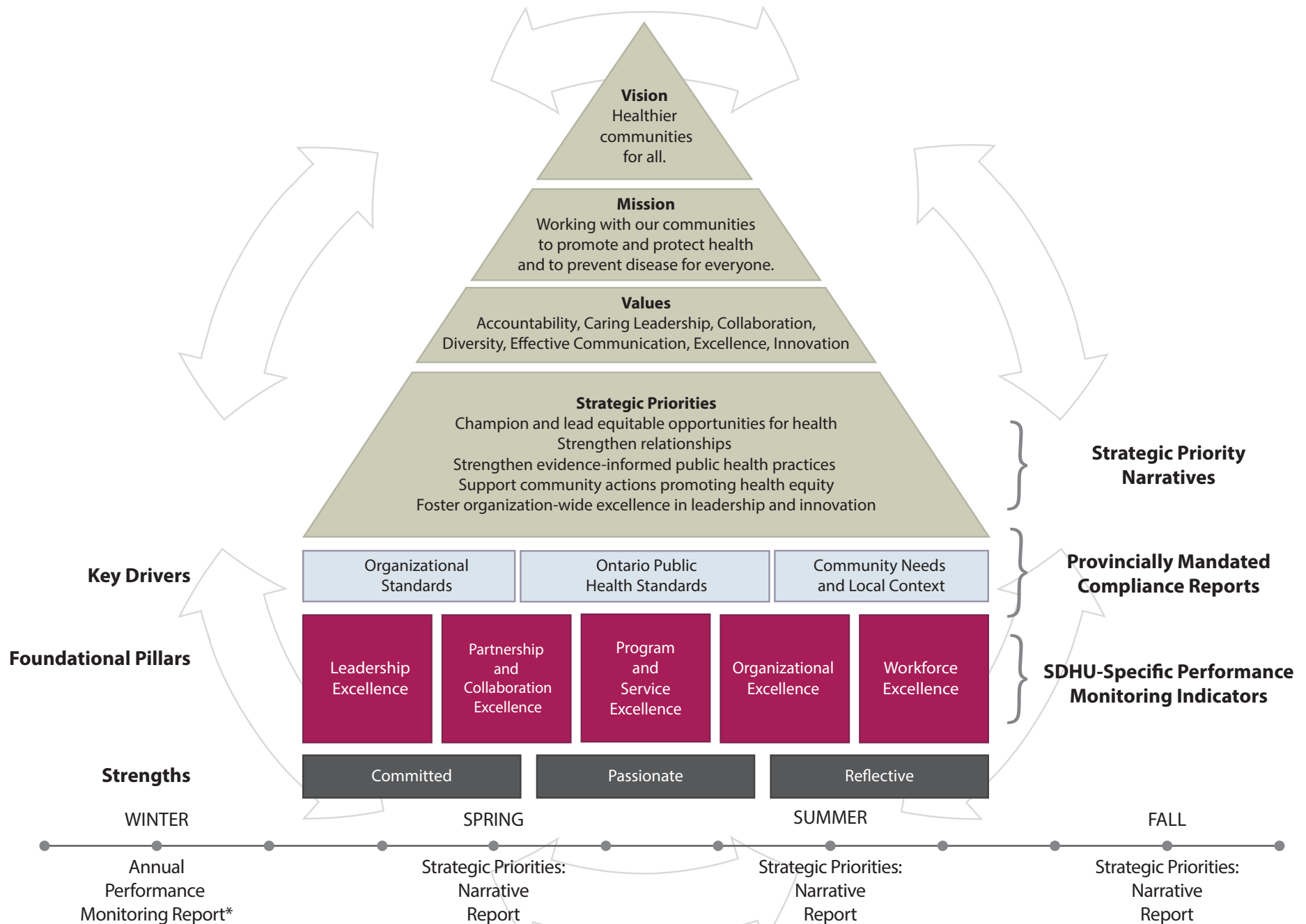


### Strategic Priority: Foster organization-wide excellence in leadership and innovation

- Cultivate a skilled, diverse, and responsive workforce
- Promote staff engagement and support internal collaboration
- Invest resources wisely
- Build capacity to support staff and management core competencies
- Ensure continuous improvement in organizational performance
- Promote a learning organization



# 2013–2017 Sudbury & District Board of Health Strategy Map



\* Includes Strategic Priority Narratives “roll-up”, Organizational Standards Compliance Report, Accountability Indicator Compliance Report, and SDHU-Specific Performance Monitoring Indicators Report

## Sudbury & District Board of Health People with Disabilities Person-Centered Language Position Statement - 2017

### Position

**The Sudbury & District Board of Health values diversity and effective communication.<sup>i</sup> We understand that bias, stigma, and discrimination towards people with disabilities can be reduced through the use of respectful language and we are committed to the following:**

- (1) Inquiring with individuals with disabilities and representative groups how they wish to identify; and**
- (2) Using person-first language, which puts the person before the disability, when it is not possible to inquire or when the response is mixed; and**
- (3) Remaining up to date with the evolution of language about disabilities.**

### Background

Many people consider disabilities to be a weakness, but people are increasingly defining disabilities in positive and affirming ways. Disabilities can also be seen as natural variations in human abilities – a type of diversity that we can take pride in.<sup>ii</sup>

The SDHU is committed to improving the health of our populations using a health equity lens by acting on socially produced determinants of health. People living with disabilities and/or mental illness are examples of priority populations that may be at increased risk for health inequities.<sup>iii</sup>

### Healthy Equity

The Human Rights Commission estimates that one in seven Ontarians lives with one or more disabilities.<sup>iv</sup> People with disabilities are a priority population that is less likely to engage in health promoting behaviors such as physical activity and smoking abstinence, and to participate in screening for cancer, oral health, cholesterol, blood pressure, and vision and hearing than people without disabilities.<sup>v</sup> People with disabilities also experience poorer health outcomes such as hypertension, diabetes, chronic pain, obesity, heart disease, falls-related injuries, depression, and suicide compared with other adults.<sup>vi</sup>

Historically, people with disabilities have experienced abuse, neglect, exclusion, marginalization and discrimination.<sup>vii</sup> The employment rate of Canadians living with a disability is significantly lower than that of Canadians without disability.<sup>viii</sup> Of those that were employed, 27% reported that their employer was unaware of their limitations. More than half (54%) of Ontarians with mental health and addiction disabilities are not in the labour force, compared to 43% of those with other disabilities and 21% of those with no disability.<sup>ix</sup>

People with disabilities experience unjust, avoidable, and socially constructed exclusion resulting in health inequities.

## Language

The language that we use everyday shapes our understanding of the world around us. It influences how people feel about themselves as well as how they are perceived by others.<sup>x</sup> Using certain words, even in ways that are well-intentioned, can lead to stigma and further health disparities. Changing our language can lead to more autonomy, respect, understanding, and empathy.

Since the civil rights movements of the 1970s, we have made changes in the way we talk about gender (fireman vs firefighter), age (elderly vs older adult) race and ethnicity, social class (poor people vs people who live in poverty), and many other social groups. The new language is developed by people who identify as part of the group and by experts in the field. Similarly, the way we talk about people with disabilities is shifting in important ways.

## Person-First or Identity-First Language

In Canada, organizations have used person-first language to discuss disabilities since the 1980s.<sup>xi</sup> This practice was used on the premise that language used to refer to people with disabilities should be objective and respectful. Recently, there has been some debate within the disability community about whether it is most appropriate to use person-first or identity-first language. Person-first language puts the person before the disability; for instance, instead of saying disabled, one would say people with disabilities. Identity-first language puts the identity first, using terms like “disabled” without negative connotations. Critics of person-first language believe that it does not align with the concept of disability as socially produced, and implies that disability is an individual medical characteristic as opposed to a public issue.<sup>xii</sup>

### Person-First language

Person-first language considers the disability to be a label, not a defining characteristic of the person.<sup>xiii</sup> People with disabilities are, first and foremost, people. The person is not a disability, they *have* a disability. This language was designed to emphasize the value of the individual by seeing them as a person, not a condition and to promote respect and autonomy.

### Identity-First Language

Advocates of identity-first language argue that putting the person first is only necessary if disabilities are seen as inherently negative.<sup>xiv</sup> Person-first language doesn't remove the stigma from the disability, but removes the disability from the person. It is also not the language we use to talk about other identities. For instance, we say a person *is* male or Caucasian, not a person *with* maleness or person *with* Caucasian ancestry. Some people with disabilities see their disability as an essential part of their identity and culture, particularly people in the Deaf community and autistic people. According to this position, person-first language can come across as saying that the person matters despite the presence of disability. Identity-first language is a disability affirming statement. Disabilities become neutral or positive identities as opposed to limitations, constraints, or diagnostic conditions.

## Appropriate use of language

Person-first language is generally the accepted way for professionals and organizations to speak and write to and about people with disabilities.<sup>xv</sup> When possible, ask the individual or the group representative how they would like to refer to themselves and use the language they request. If that is not possible, use person-first language.

Table 1: Guidelines for speaking and writing about disabilities

Guideline	Rationale	Examples	
		Say this	Not this
Use person-first language if you cannot ask how the person/group wishes to identify	To emphasize the person, not the disability	People with Disabilities	The Disabled
		Person with paraplegia	Paraplegic
		Person who is blind / person with low vision	Blind / visually impaired / without sight
Use active language	Emphasize autonomy and ability, not dependence and disability	Wheelchair user	Wheelchair-bound or confined to a wheelchair
Avoid everyday phrases that may stigmatize people with disabilities	Some common sayings are based in ableist language and can unintentionally marginalize people with disabilities	That's outrageous / ridiculous / unfair	That's crazy / insane / lame
		Accessible parking / bathrooms	Handicapped parking / bathrooms
Do not conflate lack of disability with normalcy	Calling one group of being 'normal' sets everyone who is not part of that group as "abnormal"	People without disabilities	Normal / healthy / able-bodied
Avoid patronizing remarks	People with disabilities are just like anyone else; only complement in ways appropriate for adults without disabilities	Congratulations / Good job on [achievement]	You're so inspirational / brave
Use balanced language	Language with negative connotations emphasizes passivity and stigmatizes people with disabilities	Diagnosed with [condition]	Suffers from / victim of [condition]
		Person living with AIDS	AIDS victim
If you make a mistake, apologize and move on	We all make mistakes. It is part of learning. If you do make a mistake and a person with disability corrects the language that you use (even if it is different from what is written here), apologize briefly but sincerely, and try to switch to their preferred language. Do not dwell on it, as that can be uncomfortable.		

## Images

It is important to include images of people with visible disabilities in order to normalize their presence in everyday situations, even when the topics do not involve disability. These images should portray people with disabilities as actively engaged with the world around them. Individuals with disabilities should be portrayed in a variety of activities, careers, and behaviors without emphasis on the disability.

For instance, the following images are symbols for accessible accommodations in the built environment, such as accessible washrooms, seating, or ramps.<sup>xvi</sup> In the image on the left, which is commonly used, the person is sitting in a chair as though waiting to be pushed. In the other, it is clear that the person is actively moving through the world. These small changes can have a lasting impact on attitudes, values, and beliefs about disability.



1968: The International  
Symbol of Access



2013: The Accessible Icon  
Project

## Conclusion

The language that we use to talk about people with disabilities has shifted over the past few decades and will likely continue to change. People with disabilities are not a homogeneous group and the language they use may shift for some and not others. For instance, people with autism and the Deaf community are much more likely to use identity-first language than other people with cognitive disabilities (although service providers and parents of children with autism tend to use person-first language).

The Sudbury & District Health Unit recognizes the importance of using sensitive and respectful communication practices. Ongoing engagement with local dis/ability groups and associations will ensure that programs and services are fully accessible and inclusive to all.

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- <sup>i</sup> Sudbury & District Health Unit. (nd). Strategic Plan 2013-2017. *Sudbury & District Health Unit*.
- <sup>ii</sup> Dunn DS & Hammer ED. (2014). On teaching multicultural psychology. *APA Handbook of multicultural psychology, Theory and Research*, (p.43-58). Washington DC: APA.
- <sup>iii</sup> Sudbury & District Health Unit. 2009. Priority Populations Primer: A few things you should know about social inequities in health in SDHU communities.
- <sup>iv</sup> Ontario Human Rights Commission. (2016). By the Numbers: A statistical profile of people with mental health and addiction disabilities in Ontario
- <sup>v</sup> AUCD. (2016). Including People with Disabilities: Public Health Workforce Competencies. *Association of University Centers on Disabilities (AUCD), National Center for Birth Defects and Developmental Disabilities (NCBDDD), Office of the Director, Centers for Disease Control and Prevention (ODCDC), and the Office for State, Tribal, Local, and Territorial Support (OT)*; Havercamp SM. & Scott, HM. (2015). National health surveillance of adults with disabilities, adults with intellectual and developmental disabilities, and adults with no disabilities. *Disability and Health Journal*, 8(1), 165-172.
- <sup>vi</sup> AUCD, 2016; Lunksy Y, Klein-Geltink JE & Yates, EA. (2013). Atlas on the Primary Care of Adults with Developmental Disabilities in Ontario. *Institute for Clinical Evaluative Sciences and Centre for Addiction and Mental Health*. Toronto, ON.
- <sup>vii</sup> Ontario Human Rights Commission, 2016.
- <sup>viii</sup> Arim, R (2015). Statistics Canada's Canadian Survey on Disability, 2012. Retrieved March 15 2017 from: <http://www.statcan.gc.ca/pub/89-654-x/89-654-x2015001-eng.pdf>
- <sup>ix</sup> Ontario Human Rights Commission, 2016.
- <sup>x</sup> Titchkosky T (2001). Disability: A Rose by Any Other Name? "People-First" Language in Canadian Society, *CRSA/RCSA*, 38(2): pp 125-140
- <sup>xi</sup> Titchkosky, 2001
- <sup>xii</sup> *ibid*
- <sup>xiii</sup> Dunn, DS & Andrews EE. (2015). Person-First and Identity-First Language: Developing psychologists' cultural competence using disability language. *American Psychologist*, 70(3): pp. 255-264.
- <sup>xiv</sup> *ibid*
- <sup>xv</sup> See American Psychological Association (<http://www.apa.org/pi/disability/resources/choosing-words.aspx>), The Americans with Disabilities Act National Network (<https://adata.org/factsheet/ADANN-writing>), The Canadian Journalism Project (<http://www.j-source.ca/article/five-things-journalists-should-keep-mind-when-writing-about-autism>).
- <sup>xvi</sup> The Accessible Icon Project. 2017. Redesigned Accessibility Symbol Coming to New York, Image from HandiLift. <http://www.handi-lift.com/articles/redesigned-accessibility-symbol-coming-to-new-york/>

## **MOTION: PEOPLE WITH DISABILITIES PERSON-CENTERED LANGUAGE POSITION STATEMENT**

**WHEREAS the Sudbury & District Board of Health, having considered that bias, stigma, and discrimination towards people with disabilities can be reduced through the use of respectful language, is supportive of the rationale for use of person-centered language;**

**THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the People with Disabilities Person-Centered Language Position Statement; and recognize, apply and promote attitudes and practices that are sensitive and respectful to people with disabilities and to all priority populations; and**

**FURTHER BE IT RESOLVED THAT The Sudbury & District Board of Health share this motion and Position Statement with the Association of Local Public Health Agencies (alPHa), Ontario Boards of Health, Ontario Public Health Association (OPHA)-Advocacy Committee and People with Disabilities Task Group, and alPHa-OPHA Health Equity Working Group.**

# Briefing Note

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

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

**Date:** April 13, 2017

**Re:** Regulations to restrict the sale of caffeinated energy drinks to children and youth

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☒ For Information

☐ For Discussion

☒ For a Decision

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**Issue:**

Caffeinated energy drinks (CEDs) contain elevated levels of caffeine and sugar. They also often contain added vitamins, herbal supplements, and stimulants such as taurine, ginseng, and/or guarana. They are of public health concern when they are mixed with alcohol, and some of the reported side effects include electrolyte disturbances, nausea and vomiting and heart irregularities<sup>1</sup>. Their consumption by children and adolescents is also a public health concern and is not recommended. However, this population is often the target of marketing and consumption of these products is on the rise. Voluntary regulations and education efforts are insufficient to protect this vulnerable population.

**Recommended Action:**

The Sudbury & District Board of Health call on the federal and provincial governments to enact regulations to restrict the sale of caffeinated energy drinks to children and youth.

**Background:**

Energy drinks have been a concern for the Sudbury & District Health Unit for many years. In addition to their sugar content, they contain very high levels of caffeine; much greater than other sources of caffeine such as caffeinated soft drinks, coffee, teas, and some foods such as chocolate. Often mixed with other stimulants, the health impacts of these drinks on growing children and adolescents is not fully understood. There is also concern of the potential for these products to interact with medications<sup>2</sup>.

In recent years, Health Canada has developed and implemented a plan for CEDs which includes classifying them as foods. In 2012, regulations were put in place that required all CEDs to have a Temporary Market Authorization (TMA) and a TMA Letter in order to be sold in the marketplace. CEDs are subject to enforcement by the Canadian Food Inspection Agency to ensure they comply with the following regulations:

- A limit on caffeine of no less than 200 ppm (mg/L), and no more than 400 ppm, and no more than 180 mg/serving.

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2013–2017 Strategic Priorities:

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

O: October 19, 2001  
R: October 2013



- CEDs may contain various vitamins, minerals and amino acids at specified levels (i.e. in accordance with the TMA). The addition of folic acid and vitamin A are not permitted.
- CEDs are prohibited as an ingredient in pre-mixed alcoholic beverages.
- Companies cannot market or provide samples of CEDs to children.
- The label must have statements indicating that the product is a "high source of caffeine"; "not recommended for children, pregnant/breastfeeding women, individuals sensitive to caffeine", and "do not mix with alcohol". The label must also include the amount of caffeine from all sources to be shown in mg per container or per serving size.
- General food labelling provisions (e.g., nutrition facts table, ingredient labelling, allergen labelling etc.).

The Ontario Ministry of Education has recognized the important role they play in helping children and youth lead healthier lives, and in 2010 required all publicly funded elementary and secondary schools to comply with the School Food and Beverage Policy, which outlines nutrition standards for all foods and beverages sold<sup>3</sup>. Efforts to ban the marketing of unhealthy food and beverages to children and youth are key recommendations in the Ontario Healthy Kids Strategy report<sup>4</sup>, the Stop Marketing to Kids Coalition<sup>5</sup>, and Bill S-228<sup>6</sup> submitted by Senator Nancy Greene-Raine to the Senate of Canada.

Despite these and other efforts to create a healthy and supportive food environment, children and youth continue to consume CEDs. The 2015 Ontario Student Drug Use and Health Survey<sup>7</sup> (OSDUHS) found that approximately 35% of students in grades 7 to 12 consumed an energy drink at least once in the past year, including nearly 20% of grade 7 students and 46% of grade 12 students. In addition to education and awareness efforts, policy interventions that prohibit the sale of CEDs to children and youth could have a significant impact. It is therefore recommended that the federal and provincial governments enact safeguards consistent with those of the Ontario Ministry of Education and place regulations on the sale of CEDs in venues where children and youth under the age of majority frequent.

The proposed motion calling on the federal and provincial governments to enact regulations to restrict the sale of caffeinated energy drinks to children and youth is based on the Toronto Public Health motion that was adopted (with amendments) on March 20<sup>th</sup> and then adopted (with amendments) by Toronto City Council on March 28<sup>th</sup> 2017. A detailed report from Toronto Public Health – Caffeinated Energy Drinks: Technical Report on Public Health Concerns and Regulations in Canada is available via the following web link: <http://www.toronto.ca/legdocs/mmis/2017/hl/bgrd/backgroundfile-101650.pdf>.

### **Financial Implications: Nil**

### **Ontario Public Health Standard:**

Chronic diseases and injuries program standards  
Family Health program standards

### **Strategic Priority: 1**

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#### 2013–2017 Strategic Priorities:

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

O: October 19, 2001  
R: October 2013

**Contact:**

Lesley Andrade  
Foundational Standard Specialist  
[andradel@sdhu.com](mailto:andradel@sdhu.com)  
705.522.9200 ext. 364

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<sup>1</sup> Health Canada. *It's your health. Safe use of energy drinks*. (2005). Accessed online at [http://publications.gc.ca/collections/collection\\_2007/hc-sc/H50-3-185-2005E.pdf](http://publications.gc.ca/collections/collection_2007/hc-sc/H50-3-185-2005E.pdf) (April 11, 2017).

<sup>2</sup> Canadian Family Physician. *Caffeinated energy drinks in children*. (2013). Accessed online at <http://www.cfp.ca/content/59/9/947.full> (April 11, 2017).

<sup>3</sup> Ontario Ministry of Education. Policy/Program Memorandum No. 150 *School food and beverage policy*. (2010). Accessed online at <http://www.edu.gov.on.ca/extra/eng/ppm/ppm150.pdf> (April 11, 2017).

<sup>4</sup> Healthy Kids Panel (2013). *No Time to Wait: The Healthy Kids Strategy*. Accessed online at [http://www.health.gov.on.ca/en/common/ministry/publications/reports/healthy\\_kids/healthy\\_kids.pdf](http://www.health.gov.on.ca/en/common/ministry/publications/reports/healthy_kids/healthy_kids.pdf) (April 11, 2017).

<sup>5</sup> Stop Marketing to Kids Coalition. *The Ottawa Principles*. Accessed online at <http://stopmarketingtokids.ca/the-ottawa-principles-2/> (April 11, 2017).

<sup>6</sup> Senator Greene-Raine. *Bill S-228: An Act to amend the Food and Drugs Act (prohibiting food and beverage marketing directed at children)*. (2016). Accessed online at <http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=8439399> (April 11, 2017).

<sup>7</sup> Boak A, Hamilton HA, Adlaf EM, Mann RE. 2015. *Drug use among Ontario students, 1977-2015: Detailed OSDUHS findings (CAMH Research Document Series No. 41)*. Toronto, ON: Centre for Addiction and Mental Health. Accessed online at [http://www.camh.ca/en/research/news\\_and\\_publications/ontario-student-drug-use-and-health-survey/Documents/2015%20OSDUHS%20Documents/2015OSDUHS\\_Detailed\\_DrugUseReport.pdf](http://www.camh.ca/en/research/news_and_publications/ontario-student-drug-use-and-health-survey/Documents/2015%20OSDUHS%20Documents/2015OSDUHS_Detailed_DrugUseReport.pdf).

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**2013–2017 Strategic Priorities:**

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

O: October 19, 2001  
R: October 2013



## Tracking Status

- [City Council](#) adopted this item on March 28, 2017 with amendments.
- This item was considered by [Board of Health](#) on March 20, 2017 and was adopted with amendments. It will be considered by City Council on March 28, 2017.

### City Council consideration on March 28, 2017

HL18.2	ACTION	Amended		Ward:All
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## Caffeinated Energy Drinks: Feasibility of Restricting Sales and Marketing to Youth in Toronto

### City Council Decision

City Council on March 28 and 29, 2017, adopted the following:

1. City Council forward this Item to the City's agencies and request them, where applicable, to:
  - a. consider not selling caffeinated energy drinks to individuals under the age of majority; and
  - b. support compliance with Health Canada's conditions regarding the marketing and distribution of caffeinated energy drinks.
2. City Council forward this Item to Toronto's four publicly funded school boards endorsing and supporting their existing policies restricting the sale, marketing, promotion and sampling of Caffeinated Energy Drinks on their properties and facilities.

### Background Information (Board)

(February 16, 2017) Report from the Acting Medical Officer of Health on Caffeinated Energy Drinks: Feasibility of Restricting Sales and Marketing to Youth in Toronto

(<http://www.toronto.ca/legdocs/mmis/2017/hl/bgrd/backgroundfile-101649.pdf>)

Attachment 1: Caffeinated Energy Drinks: Technical Report on Public Health Concerns and Regulation in Canada

(<http://www.toronto.ca/legdocs/mmis/2017/hl/bgrd/backgroundfile-101650.pdf>)

Presentation from the Acting Medical Officer of Health on Caffeinated Energy Drinks

(<http://www.toronto.ca/legdocs/mmis/2017/hl/bgrd/backgroundfile-102095.pdf>)

### Communications (Board)

(September 30, 2015) Letter from Simon Tatz, Manager, Public Health, Australian Medical Association (HL.Main.HL18.2.1)  
<http://www.toronto.ca/legdocs/mmis/2017/hl/comm/communicationfile-67669.pdf>  
 (January 10, 2017) Letter from Dr. John P Higgins, The University of Texas, Health Science Center at Houston (HL.Main.HL18.2.2)  
<http://www.toronto.ca/legdocs/mmis/2017/hl/comm/communicationfile-67670.pdf>  
 (January 11, 2017) Letter from Kathleen E Miller, Senior Research Scientist, Research Institute of Addictions, University of Buffalo (HL.Main.HL18.2.3)  
<http://www.toronto.ca/legdocs/mmis/2017/hl/comm/communicationfile-67671.pdf>  
 (January 23, 2017) Letter from James L Tomarken, Chair, Suffolk County Board of Health (HL.Main.HL18.2.4)  
<http://www.toronto.ca/legdocs/mmis/2017/hl/comm/communicationfile-67672.pdf>  
 (March 6, 2017) E-mail from Maria Fisher (HL.Main.HL18.2.5)  
 (March 13, 2017) Letter from Diane Chevette (HL.New.HL18.2.6)  
 (March 14, 2017) Letter from Corinne Voyer, Director, Quebec Coalition on Weight-Related Problems (HL.New.HL18.2.7)  
<http://www.toronto.ca/legdocs/mmis/2017/hl/comm/communicationfile-67704.pdf>  
 (March 15, 2017) Letter from Simon Tatz, Director, Public Health, Australian Medical Association (HL.New.HL18.2.8)  
<http://www.toronto.ca/legdocs/mmis/2017/hl/comm/communicationfile-67713.pdf>  
 (March 15, 2017) E-mail from Shawn R. Hayter (HL.New.HL18.2.9)  
 (March 15, 2017) E-mail from Donald E. Casebolt, MD (HL.New.HL18.2.10)  
 (March 13, 2017) Submission from James Shepherd (HL.New.HL18.2.11)  
 (March 15, 2017) Letter from Michael Rieder, MD, Interim Chair/Chief, Department of Paediatrics, Western University, Schulich School of Medicine and Dentistry (HL.New.HL18.2.12)  
<http://www.toronto.ca/legdocs/mmis/2017/hl/comm/communicationfile-67727.pdf>  
 (March 17, 2017) Letter from Pat Vanderkooy, Manager, Public Affairs, Dietitians of Canada (HL.New.HL18.2.13)  
<http://www.toronto.ca/legdocs/mmis/2017/hl/comm/communicationfile-67744.pdf>  
 (March 18, 2017) E-mail from Wendy Lane (HL.New.HL18.2.14)  
 (March 20, 2017) Submission from Bill Jeffery, LLB, Centre for Health Science and Law (CHSL) (HL.New.HL18.2.15)  
<http://www.toronto.ca/legdocs/mmis/2017/hl/comm/communicationfile-67733.pdf>  
 (March 17, 2017) Letter from Tracy Alexis Trypuc (HL.New.HL18.2.16)

### **Communications (City Council)**

(March 21, 2017) E-mail from Jane Shearer (CC.Supp.HL18.2.17)  
 (March 27, 2017) E-mail from JP Boucher, Director, Marketing and International, Universal Music Canada (CC.New.HL18.2.18)  
<http://www.toronto.ca/legdocs/mmis/2017/cc/comm/communicationfile-67935.pdf>  
 (March 27, 2017) E-mail from Aaron Miller, Arts & Crafts Productions Inc. (CC.New.HL18.2.19)  
<http://www.toronto.ca/legdocs/mmis/2017/cc/comm/communicationfile-67957.pdf>  
 (March 27, 2017) Letter from Jim Goetz, President, Canadian Beverage Association (CC.New.HL18.2.20)  
<http://www.toronto.ca/legdocs/mmis/2017/cc/comm/communicationfile-68010.pdf>  
 (March 27, 2017) E-mail from Crispin Giles (CC.New.HL18.2.21)

(March 27, 2017) E-mail from Steve Carty (CC.New.HL18.2.22)

(March 28, 2017) Letter from Natasha Udovic, Senior Director, Corporate Partnerships, Luminato Festival (CC.New.HL18.2.23)

(<http://www.toronto.ca/legdocs/mmis/2017/cc/comm/communicationfile-67995.pdf>)

(March 27, 2017) Letter from Gavin Sheppard, Co-Founder and Annalie Bonda, Executive Director, The Remix Project (CC.New.HL18.2.24)

(<http://www.toronto.ca/legdocs/mmis/2017/cc/comm/communicationfile-67996.pdf>)

(March 27, 2017) E-mail from Anthony Sargent, Chief Executive Officer, Luminato Festival (CC.New.HL18.2.25)

(<http://www.toronto.ca/legdocs/mmis/2017/cc/comm/communicationfile-68037.pdf>)

(March 26, 2017) Letter from Ken Avann, Canadian Snowcross Racing (CC.New.HL18.2.26)

(<http://www.toronto.ca/legdocs/mmis/2017/cc/comm/communicationfile-68091.pdf>)

## Motions (City Council)

*1 - Motion to Adopt Item as Amended moved by Councillor Joe Mihevc (Carried)*

That:

1. City Council delete the Board of Health recommendations:

recommendations to be deleted:

1. City Council not permit the sale of Caffeinated Energy Drinks (CEDs), or allow marketing, promotion or sampling of Caffeinated Energy Drinks (CEDs) on any City property or facility that is occupied, leased or licensed by the City in its sole capacity consistent with the restrictions of the Municipal Alcohol Policy.

2. City Council forward the report (February 16, 2017) from the Acting Medical Officer of Health to the City's agencies and Toronto's four public funded school boards and request them not to permit the sale of Caffeinated Energy Drinks (CEDs), or allow marketing, promotion or sampling of Caffeinated Energy Drinks (CEDs) in any of their properties or facilities.

and adopt instead the following recommendations contained in the report (February 16, 2017) from the Acting Medical Officer of Health:

1. City Council forward this report to the City's agencies and request them, where applicable, to:

a. consider not selling caffeinated energy drinks to individuals under the age of majority; and

b. support compliance with Health Canada's conditions regarding the marketing and distribution of caffeinated energy drinks.

2. City Council forward the report (February 16, 2017) from the Acting Medical Officer of Health to Toronto's four publicly funded school boards endorsing and supporting their existing policies restricting the sale, marketing, promotion and sampling of Caffeinated Energy Drinks on their properties and facilities.

**Vote** (Adopt Item as Amended)

Mar-28-2017 6:44 PM

<b>Result: Carried</b>	Majority Required - HL18.2 - Mihevc - motion 1 - Adopt the item as amended
Yes: 37	Paul Ainslie, Maria Augimeri, Ana Bailão, Jon Burnside, John Campbell, Christin Carmichael Greb, Shelley Carroll, Josh Colle, Gary Crawford, Vincent Crisanti, Janet Davis, Justin J. Di Ciano, Frank Di Giorgio, Sarah Doucette, John Fillion, Paula Fletcher, Michael Ford, Mary Fragedakis, Mark Grimes, Stephen Holyday, Jim Karygiannis, Mike Layton, Chin Lee, Pam McConnell, Mary-Margaret McMahon, Joe Mihevc, Denzil Minnan-Wong, Cesar Palacio, James Pasternak, Gord Perks, Anthony Perruzza, Jaye Robinson, Neethan Shan, David Shiner, Michael Thompson, John Tory, Kristyn Wong-Tam
No: 4	Joe Cressy, Glenn De Baeremaeker, Norman Kelly, Frances Nunziata (Chair)
Absent: 4	Michelle Holland, Giorgio Mammoliti, Josh Matlow, Ron Moeser

**Board of Health consideration on March 20, 2017**


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Source: Toronto City Clerk at [www.toronto.ca/council](http://www.toronto.ca/council)

**MOTION: REGULATIONS TO RESTRICT THE SALE OF CAFFEINATED ENERGY DRINKS TO CHILDREN AND YOUTH**

**WHEREAS** the Sudbury & District Board of Health's concerns about caffeinated energy drinks (Motion #13-11), endorsement of Ontario's Healthy Kids Strategy (Motion #19-13), and concerns about marketing to children (Motion #60-16) are part of the public record; and

**WHEREAS** the Board has carefully reviewed health and consumption information about caffeinated energy drinks (CEDs) relevant to its local context;

**THEREFORE BE IT RESOLVED THAT** the Sudbury & District Board of Health urge the provincial and federal Ministers of Health to advance regulations prohibiting the sale of CEDs to children and youth under the age of majority, in venues where they frequent; and

**FURTHER THAT** this motion be forwarded to the federal Minister of Health, the provincial Minister of Health, Ontario boards of health, the Ontario Public Health Association (OPHA), the Association of Local Public Health Agencies (alpha), local Boards of Education, and the Federation of Northern Ontario Municipalities (FONOM).

**ADDENDUM**

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



**IN CAMERA**

**MOTION:**     **THAT this Board of Health goes in camera. Time:\_\_\_\_\_p.m.**

**RISE AND REPORT**

**MOTION:**     **THAT this Board of Health rises and reports. Time: \_\_\_\_\_p.m.**

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.**