Sudbury & District Board of Health

Thursday, May 18, 2017, 1:30 p.m.
SDHU Boardroom
1300 Paris Street
1.0 CALL TO ORDER

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

Agenda Page 7

4.0 DELEGATION / PRESENTATION

i) Preventing and Controlling the Spread of Infectious Diseases in Our Community
   S. Laclé, Director Clinical and Family Services and S. Laforest, Director Environmental Health

5.0 CONSENT AGENDA

i) Minutes of Previous Meeting
   a. Third Meeting – April 20, 2017 Page 12

ii) Business Arising From Minutes

iii) Report of Standing Committees
   a. Board of Health Finance Standing Committee, Unapproved Minutes dated May 4, 2017 Page 23

iv) Report of the Medical Officer of Health / Chief Executive Officer
   MOH /CEO Report, May 2017 Page 28
   Financial Statement ending March 31, 2017 Page 37

v) Correspondence
   a. Opioid
   Letter from the Simcoe Muskoka District Board Vice-Chair to the Minister of Health dated April 19, 2017 Page 40
b. Low-Income Dental Program for Adults and Seniors

Letter from the Durham Regional Council to the Premier dated April 13, 2017 Page 44

Letter from the Peterborough Public Health Board Chair to the Minister of Health and Long-Term Care dated April 25, 2017 Page 46

Letter from the Porcupine Health Unit Chief Administrator Officer to the Minister of Health and Long-Term Care dated May 1, 2017 Page 47

c. Tobacco Endgame for Canada

Letter from the Peterborough Public Health Board Chair to the Minister of Health and the Minister of Health and Long-Term Care dated May 2, 2017 Page 49

d. Support for Stop Marketing to Kids Coalition’s Ottawa Principles and Further Action on Sugary Drinks

Letter from the Peterborough Public Health Board Chair to the Minister of Health dated May 5, 2017 Page 51

e. Ontario Public Health Standards Modernization

Letter from the Porcupine Health Unit Chief Administrator Officer to the Minister of Health and Long-Term Care dated May 1, 2017 Page 52

f. Human Papillomavirus (HPV) Immunization

Letter from the Durham Regional Council to the Premier dated April 13, 2017 Page 54

Letter from the Wellington-Dufferin-Guelph Health Unit Board Chair to the Minister of Health and Long-Term Care dated May 3, 2017 Page 56

g. Provincial Alcohol Strategy

Letter from the Wellington-Dufferin-Guelph Health Unit Board Chair to the Minister of Health and Long-Term Care dated May 3, 2017 Page 58

h. Enactment of Legislation to Enforce Infection Prevention and Control Practices within Personal Service Settings
under the HPPA

Letter from the Grey Bruce Health Unit Medical Officer of Health to the Premier of Ontario dated May 2, 2017

i. 2017 Ontario Budget

Letter and Summary from the Association of Local Public Health Agencies (alPHA) President to the Minister of Finance dated May 4, 2017

alPHA Summary, 2017 Ontario Budget

Letter from the alPHA President to the Minister of Finance re Children and Youth Pharmacare dated May 4, 2017

Letter from the alPHA President to the Minister of Finance re Healthy Babies Health Children 100% funding dated May 4, 2017

j. Tools for Skills and Competency Based Boards

Letter from alPHA Board President to the MOHLTC Assistant Deputy Minister dated May 3, 2017

k. Funding

Letter from Minister of Health and Long-Term Care to the Sudbury & District Board of Health Chair received April 27, 2017

l. Healthy Babies Healthy Children Program Funding

Letter from the Board of Health for Wellington-Dufferin-Guelph Public Health to the Minister of Health and Long-Term Care dated May 3, 2017

m. Fluoride Varnish Programs for Children at Risk for Dental Caries

Letter from the Board of Health for Wellington-Dufferin-Guelph Public Health to alPHA dated May 3, 2017

vi) Items of Information

a. Minister of Health and Long-Term Mandate Letter to the North East Local Health Integration Network dated May 1, 2017

c. Evidence to Guide Action: Comprehensive Tobacco Control in Ontario (2016), Smoke-Free Ontario Scientific Advisory Committee, Public Health Ontario

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d. Spread the Facts, Not the Germs, Sudbury & District Health Unit

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MOTION: Approval of Consent Agenda

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6.0 NEW BUSINESS

i) Risk Management Annual Report

Briefing Note from the MOH / CEO to the Board Chair dated May 11, 2017

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Risk Management Ratings

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Organizational Risk Management Annual Report: July to December 2016

Page 98

ii) 2016 Audited Financial Statements

Sudbury & District Health Unit Financial Statements of year ended December 31, 2016

Page 99

MOTION: Adoption of the 2016 audited Financial Statements

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iii) alPHA Annual General Meeting (AGM) and Conference - June 2017

MOTION: alPHA Conference

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7.0 ADDENDUM

MOTION: Addendum

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8.0 IN CAMERA

MOTION: In Camera

Page 121

- Labour Relations or Employee Negotiations

9.0 RISE AND REPORT

MOTION: Rise and Report

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10.0 ANNOUNCEMENTS / ENQUIRIES

Evaluation for completion  Page 123

11.0 ADJOURNMENT

MOTION: Adjournment  Page 124
1. CALL TO ORDER

2. ROLL CALL

3. REVIEW OF AGENDA / DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION / PRESENTATION
   i) Preventing and Controlling the Spread of Infectious Diseases in Our Community
      – S. Laclé, Director Clinical and Family Services
      – S. Laforest, Director Environmental Health

5. CONSENT AGENDA
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      a. Third Meeting – April 20, 2017
   ii) Business Arising From Minutes
   iii) Report of Standing Committees
      a. Board of Health Finance Standing Committee, Unapproved Minutes dated May 4, 2017
   iv) Report of the Medical Officer of Health / Chief Executive Officer
      a. MOH/CEO Report, May 2017
   v) Correspondence
      a. Opioid
         – Letter from the Simcoe Muskoka District Board Vice-Chair to the Minister of Health dated April 19, 2017
         – Letter from Durham Regional Council to the Premier dated April 13, 2017
      b. Low-Income Dental Program for Adults and Seniors
         – Letter from the Durham Regional Council to the Premier dated April 13, 2017
         – Letter from the Peterborough Public Health Board Chair to the Minister of Health and Long-Term Care dated April 25, 2017
         – Letter from the Porcupine Health Unit Chief Administrator Officer to the Minister of Health and Long-Term Care dated May 1, 2017
c. Tobacco Endgame for Canada
   – Letter from the Peterborough Public Health Board Chair to the Minister of Health and the Minister of Health and Long-Term Care dated May 2, 2017

d. Support for Stop Marketing to Kids Coalition’s Ottawa Principles and Further Action on Sugary Drinks
   – Letter from the Peterborough Public Health Board Chair to the Minister of Health dated May 5, 2017

e. Ontario Public Health Standards Modernization
   – Letter from the Porcupine Health Unit Chief Administrator Officer to the Minister of Health and Long-Term Care dated May 1, 2017

f. Human Papillomavirus (HPV) Immunization
   – Letter from the Durham Regional Council to the Premier dated April 13, 2017
   – Letter from the Wellington-Dufferin-Guelph Health Unit Board Chair to the Minister of Health and Long-Term Care dated May 3, 2017

g. Provincial Alcohol Strategy
   – Letter from the Wellington-Dufferin-Guelph Health Unit Board Chair to the Minister of Health and Long-Term Care dated May 3, 2017

h. Enactment of Legislation to Enforce Infection Prevention and Control Practices within Personal Service Settings under the HPPA
   – Letter from the Grey Bruce Health Unit Medical Officer of Health to the Premier of Ontario dated May 2, 2017

i. 2017 Ontario Budget
   – Letter and Summary from the Association of Local Public Health Agencies (alPHa) President to the Minister of Finance dated May 4, 2017
   – Letter from the alPHa President to the Minister of Finance re Children and Youth Pharmacist dated May 4, 2017
   – Letter from the alPHa President to the Minister of Finance re Healthy Babies Health Children 100% funding dated May 4, 2017

j. Tools for Skills and Competency Based Boards
   – Letter from the alPHa Board President to the MOHLTC Assistant Deputy Minister dated May 3, 2017

k. Funding
   – Letter from the Minister of Health and Long-Term Care to the Sudbury & District Board of Health Chair received April 27, 2017

l. Healthy Babies Healthy Children Program Funding
   – Letter from the Board of Health for Wellington-Dufferin-Guelph Public Health to the Minister of Health and Long-Term Care dated May 3, 2017
m. Fluoride Varnish Programs for Children at Risk for Dental Caries
   – Letter from the Board of Health for Wellington-Dufferin-Guelph Public Health to
     the Association of Local Public Health Agencies dated May 3, 2017

   vi) Items of Information
      a. Minister of Health and Long-Term Mandate Letter
         to the North East Local Health Integration Network dated
         May 1, 2017
      c. Evidence to Guide Action: Comprehensive Tobacco Control in
         Ontario (2016), Smoke-Free Ontario Scientific Advisory
         Committee, Public Health Ontario
      d. Spread the Facts, Not the Germs, Sudbury & District Health Unit

APPROVAL OF CONSENT AGENDA

MOTION:

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

6. NEW BUSINESS

   i) Risk Management Annual Report
      – Briefing Note from the Medical Officer of Health and Chief Executive Officer to
        the Board Chair dated May 11, 2017
      – Risk Management Ratings
      – Organizational Risk Management Annual Report: July to December 2016

   ii) 2016 Audited Financial Statements
      – Sudbury & District Health Unit Financial Statements of year ended December 31,
        2016

ADOPTION OF THE 2016 AUDITED FINANCIAL STATEMENTS

MOTION:

WHEREAS at its May 4, 2017, meeting, the Board Finance Standing
Committee reviewed the 2016 audited financial statements and
recommended them to the Board for the Board's approval;

THEREFORE BE IT RESOLVED THAT the 2016 audited financial statements
be approved as distributed.

   iii) aIPHa Annual General Meeting (AGM) and Conference - June 2017
ALPHA CONFERENCE

MOTION:
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: _______________________________________________________.

7. ADDENDUM

ADDENDUM

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

8. IN CAMERA

IN CAMERA

MOTION:
THAT this Board of Health goes in camera. Time: ____ p.m.

- Labour Relations or Employee Negotiations

9. RISE AND REPORT

RISE AND REPORT

MOTION:
THAT this Board of Health rises and reports. Time: ____ p.m.

10. ANNOUNCEMENTS / ENQUIRIES
11. ADJOURNMENT

ADJOURNMENT
MOTION:

THAT we do now adjourn. Time: ____ p.m.
MINUTES – THIRD MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM
THURSDAY, APRIL 20, 2017, AT 1:30 P.M.

BOARD MEMBERS PRESENT
Maigan Bailey          René Lapierre          Richard Lemieux
Stewart Meikleham     Paul Myre               Ken Noland
Rita Pilon            Mark Signoretti         Carolyn Thain

BOARD MEMBERS REGRETS
Janet Bradley          Jeffery Huska          Robert Kirwan

STAFF MEMBERS PRESENT
Sandra Laclé          Nicole Frappier         Rachel Quesnel
France Quirion        Renée St Onge          Dr. P. Sutcliffe
Dr. A. Zbar

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

J. Beyers and T. Haslehurst were invited to describe accessibility at the Sudbury & District Health Unit (SDHU) and how the SDHU has moved beyond the legislated requirements under the Accessibility for Ontarians with Disabilities Act (AODA) in order to make a difference for people in our communities.

T. Haslehurst outlined the SDHU’s compliance with the AODA legislation that sets out the requirements to improve accessibility to services for people with disabilities. As part of the AODA legislation, the SDHU has developed an Accessibility Plan.
with stakeholder input that outlines how the SDHU is working towards barrier-free public health services and providing an inclusive environment for all by 2025. The health unit is fully compliant with the requirements under AODA and is committed to going beyond AODA by eliminating or reducing barriers as part of the planning process.

J. Beyers was invited to share with the Board what it means to go beyond the legislation.

People with disabilities are a priority population and experience poorer health outcomes. Compared to people without disabilities, they are less likely to engage in health promoting behaviours such as physical activity and smoking abstinence, and less likely to participate in screening for cancer, oral health, cholesterol, blood pressure, and vision and hearing. The Board was encouraged to view a poster developed by the SDHU that captures the unjust, avoidable, and socially constructed health inequities faced by those with disabilities.

The meaning of people with disabilities was described as well as the medical, functional and social models that are used by different people and organizations for different purposes. By including the social model of disability into SDHU's AODA work, we hope to go beyond this to what is referred to as Accessibility by removing potential barriers before they become a problem for people.

Bias, stigma, and discrimination toward people with disabilities can be reduced through the use of respectful language. Person-first language to discuss disabilities and the use of identity first language were described.

In today's agenda package, Board members will be asked to support a motion and position statement recommending the following three actions:

1) When possible, we should ask the individual or the group representative how they would like to refer to themselves and use the language they request.
2) If that is not possible, we should use person-first language.
3) Since language is constantly shifting, we need to remain up to date with these changes.

Questions were entertained and the presenters were thanked.

5.0 CONSENT AGENDA

There were no consent agenda items identified for discussion.

i) Minutes of Previous Meeting
   a. Second Meeting – February 16, 2017
ii) Business Arising From Minutes
None

iii) Report of 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, 2017
   – Letter from the Member of Parliament, Algoma-Manitoulin-Kapuskasing dated March 8, 2017

   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

17-17 APPROVAL OF CONSENT AGENDA

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

CARRIED

J. Bradley’s appointment as provincial appointment has been extended to February 21, 2020. The Board Secretary will connect with the Public Appointment Secretariat regarding the status of a provincial appointment for the replacement of C. Belcourt who resigned in May 2016.

6.0 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

Dr. Sutcliffe indicated that 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 Symposium focused on the updated Ontario
Public Health Standards as the modernized Standards for Programs and Services had just been released. There was a presentation from MOHLTC and opportunity for dialogue. The Council of Ontario Medical Officers of Health (COMOH) also discussed the standards at their face-to-face meeting on February 24, 2017.

M. Bailey summarized the Symposium panel discussions relating to Local Public Health in a Transformed Health System; Public Health Ontario’s presentation on their contributions to supporting the new role of local public health in a transformed health system, MOHLTC presentation on the Updated Ontario Public Health Standards and facilitated discussions with B. Moloughney, Public Health Consultant on the updated Public Health Standards. She also provided an update regarding the alPHa Board Section meeting on February 24, 2017.

The next alPHa Conference is scheduled from June 11 to 13, 2017, and will include the Annual General Meeting (AGM). The SDHU has four votes at the AGM which is normally attended by MOH and AMOH.

Board members agreed that the following motion be deferred to the May 2017 Board meeting to give members an opportunity to review their schedules and availability.

**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:

| DEFERRED |

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
The briefing note provides a summary of the activities that have taken place since the release of the revised Standards for Public Health Programs and Services Consultation Document on February 17 and the February 19 Board of Health meeting.

Dr. Sutcliffe noted that this item builds on M. Bailey's report relating to the alPHa Winter Symposium on the updated Standards as the Standards were presented by the Ministry and discussed by the membership at the February 23 alPHa Symposium. alPHa requested an extension to the original April 3, 2017, deadline for comments and the MOHLTC extended the deadline to April 21, 2017.

A comprehensive committee structure was established by the MOHLTC for the review of the Standards. Dr. Sutcliffe participated on the Practice and Evidence Program Standards Advisory Committee (PEPSAC) and S. Laclé on the Executive Steering Committee (ESC).

The MOHTLC also held various regional consultation sessions throughout March, including a northeast session hosted by the SDHU on March 27. 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.

This is happening in the context of change, Patients First legislation and requirements for board and LHIN engagement.

On the financial side, health units have been informed by the MOHTLC that the modernization of the OPHS was to be a revenue neutral process. An assessment or projection of the resource implications of the Standards at the local level cannot be undertaken as the reporting and accountability framework has not been developed or communicated. Since the implementation of the Public Health Funding model, many health units are operating under significant financial constraints.

Included in the numerous attachments for this agenda item is a draft letter from the Board Chair along with an appendix that outlines the SDHU’s operational/programming feedback. The recommended action is that the Board, having reviewed the contents of the briefing note, endorse the March 17, 2017, feedback to the MOHLTC from alPHa and communicate its overarching and program-specific operational feedback to the MOHLTC by the April 21, 2017, deadline.
Questions were entertained and discussion ensued regarding funding. The Board concurred with the approach and requested emphasis be placed in the letter regarding the Board’s concerns regarding implementation implications on capacity and funding.

18-17 STANDARDS FOR PUBLIC HEALTH PROGRAMS AND SERVICES CONSULTATION DOCUMENT

Moved by Lemieux – Noland: 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.

CARRIED

iii) Performance Monitoring Plan
- Strategic Priorities: Narratives Report, April 2017

In J. Bradley’s absence, R. Pilon presented the 2017 Strategic Priorities: Narrative Report on behalf of the Joint Board of Health/Staff Performance Monitoring Working Group. The report includes five programs/services stories that outline each of the SDHU’s strategic priorities in action and are very reflective of the staff’s daily work.

Narrative topics are sought out by divisional Directors three times per year and narratives are selected from across all divisions and varying service scopes. The Working Group, for which J. Bradley and C. Thain are also members, is responsible for providing interpretive comments on the performance monitoring reports. The working group ensures that the narratives that are selected are timely and represent diverse examples from district offices and across all program areas.

The narrative report is part of a broader SDHU performance monitoring plan which is presented to the Board every February. The next Strategic Priority Narratives Report will be shared in June 2017.
It was clarified that there is a slight modification to priority three with more detail being provided relating to the methodology. The updated version will be posted on the SDHU website.

iv) People with Disabilities Person-Centered Language

Further to today’s delegation on this topic and due to the staff’s commitment, Dr. Sutcliffe noted that the SDHU has raised the bar on this important topic.

During the Board manual review, consideration will be given to whether this Position Statement and perhaps others should be incorporated into the manual.

19-17 PEOPLE WITH DISABILITIES PERSON-CENTERED LANGUAGE POSITION STATEMENT

Moved by Meikleham – Lemieux: 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.

CARRIED

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

The consumption of caffeinated energy drinks (CEDs) by children and adolescents is a public health concern and the health risks are outlined in the briefing note provided in today’s agenda package. 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.

Today’s motion is consistent with the Board’s previous support on this matter. Toronto Public Health has led important work on this topic and have produced helpful information for other health units. It is recommended that this Board of Health support the call on the federal and provincial governments to enact regulations to restrict the sale of caffeinated energy drinks to children and youth.

20-17 REGULATIONS TO RESTRICT THE SALE OF CAFFEINATED ENERGY DRINKS TO CHILDREN AND YOUTH

Moved by Noland – Lemieux: 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).

CARRIED

7.0 ADDENDUM

No addendum.

8.0 IN CAMERA

21-17 IN CAMERA

Moved by Pilon – Meikleham: THAT this Board of Health goes in camera.

Time: 2:31 p.m.

CARRIED

- Labour Relations or Employee Negotiations
9.0 RISE AND REPORT

22-17 RISE AND REPORT
Moved by Meikleham – Pilon: THAT this Board of Health rises and reports. Time: 3:09 p.m.

CARRIED

It was reported that one labour relation / employee negotiation matter was discussed. The following motion emanated from the closed session:

23-17 APPROVAL OF BOARD IN-CAMERA MEETING NOTES
Moved by Myre – Lemieux: THAT this Board of Health approve the meeting notes of the January 19, 2017, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the Municipal Freedom of Information and Protection of Privacy Act.

CARRIED

10.0 ANNOUNCEMENTS / ENQUIRIES

Board members were encouraged to complete the strategic plan survey sent via email.

R. Lapierre shared that the Health Sciences North (HSN) invited the SDHU Chair and Vice-Chair to join a new HSN Chair and Vice-Chair Committee. R. Lapierre and J. Huska have attended three meetings to date.

Board members were reminded of an upcoming strategic plan session the morning of September 28 and of a Bridges Out of Poverty training opportunity the afternoon of September 28.

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

11.0 ADJOURNMENT

24-17 ADJOURNMENT
Moved by Meikleham – Myre: THAT we do now adjourn. Time: 3:14 p.m.

CARRIED

______________________________  ______________________________
(Chair)                         (Secretary)
MEETING NOTES  
BOARD OF HEALTH FINANCE STANDING COMMITTEE  
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM  
THURSDAY, MAY 4, 2017, AT 9 A.M.

BOARD MEMBERS PRESENT  
Carolyn Thain  René Lapierre  Paul Myre

REGRETS  
Mark Signoretti

STAFF MEMBERS PRESENT  
Colette Barrette  Rachel Quesnel  France Quirion  
Dr. P. Sutcliffe

GUEST: Derek D’Angelo, KPMG ~  
~via teleconference

R. LAPIERRE PRESIDING

1.0 CALL TO ORDER  
The meeting was called to order at 9:03 a.m.

2.0 ROLL CALL

3.0 ELECTION OF BOARD FINANCE STANDING COMMITTEE CHAIR FOR 2017

3.1 Board of Health Finance Standing Committee Terms of Reference

01-17 ELECTION OF BOARD OF FINANCE STANDING COMMITTEE CHAIR FOR 2017  
Moved by Lapierre – Myre: THAT the Standing Committee appoint Carolyn Thain as the Finance Standing Committee Chair for 2017.  
CARRIED

4.0 REVIEW OF AGENDA / DECLARATION OF CONFLICT OF INTEREST

There were no declarations of conflict of interest.

5.0 APPROVAL OF BOARD OF HEALTH FINANCE STANDING COMMITTEE MEETING NOTES

5.1 Board of Health Finance Standing Committee Notes dated November 2, 2016

02-17 APPROVAL OF MEETING NOTES  
Moved by Myre – Lapierre: THAT the meeting notes of the Board of Health Finance Standing Committee meeting of November 2, 2016, be approved as distributed.  
CARRIED
6.0 NEW BUSINESS

6.1 2016 Audited Financial Statements

a) Briefing Note from the Medical Officer of Health and Chief Executive Officer on the 2016 Financial Statements

Dr. Sutcliffe noted that the Ministry of Health and Long-Term Care (MOHTLC) requires each health unit to have their financial records audited by an external auditing firm annually. The MOH thanked F. Quirion and her team for their work on the audit and for working with the new auditor, KPMG.

b) Review of the 2016 Audit Report and Audited Financial Statements
   – D. D’Angelo, KPMG
   – C. Barrette, Manager, Accounting Services

Derek D’Angelo joined the meeting via teleconference for this agenda item and was invited to summarize the independent auditor’s report.

KPMG conducted its audit in accordance with Canadian Auditing Standards. The Auditors’ Report includes management and the auditors’ responsibilities in conducting the audit and auditor delivering its opinion as per the procedures during the course of the audit. The auditor was pleased to re-affirm its opinion for a clean audit for 2016 noting the statements will be dated with the date of approval. To finalize the audit, confirmation of approval of the 2016 audit must be provided to KPMG and the management representation letter signed before the final statements will be released.

The auditor provided an overview of their procedures, including the assessment of the risks of material misstatement of the financial statements, and their findings. KMPG concluded that, in their opinion, these financial statements present fairly, in all material respects, the financial position of Sudbury & District Health Unit as at December 31, 2016 and its results of operations and accumulated surplus, changes in net financial assets and its cash flows for the year then ended in accordance with Canadian Public Sector Accounting Standards.

Highlights were provided from the accompanying notes to the financial statements. KPMG appreciated the assistance of SDHU staff in conducting the audit.

Questions and comments were entertained.

C. Barrette reviewed the draft statement ending December 31, 2016.
Notes to Financial Statements were reviewed and questions entertained. The variance in professional fees as well as the financial impacts of the Healthy Smiles Ontario program integration were explained. In response to questions, clarification was provided regarding staff education allocations based on cost reduction initiative, internal decision making relating to transfers to reserve, internal processes relating to monitoring and reporting of variances for revenues and expenses as well as the implementation of the vacancy management policy where collectively, management looks at competing priorities within the organization before filling a vacancy.

03-17 2016 AUDITED FINANCIAL STATEMENTS

Moved by Lapierre – Myre: THAT the Board of Health Finance Standing Committee recommend to the Sudbury & District Board of Health the adoption of the 2016 audited financial statements.

CARRIED

6.2 Annual Insurance Review

a) Frank Cowan Company Summary of the SDHU’s 2016 Insurance Program

F. Quirion reviewed the SDHU’s insurance coverage. This year, changes to our policy include removal of deductible for sewer back-up per claimant and increased blanket limits for the equipment breakdown. Sexual Abuse Therapy/Counselling coverage have been added to comply with a new College of Dental Hygienists requirement.

The emerging topic of openness and transparency leads to risks as it relates to stolen personal information and ransomware; therefore, a quote has been requested for cyber liability.

b) Frank Cowan Company Summary of the SDHU’s Claims update for 2016

Last year, the Finance Standing Committee (FSC) received a summary of insurance claims. An updated summary included in today’s agenda package shows the one still active claim.

It was questioned whether implications of a growing number of SDHU short-term disability claims need consideration from an insurance coverage perspective. Although the numbers are currently higher, it is difficult to predict trends year over year.

6.3 Year to Date Financial Statements
a) March 2017 Financial Statements

The financial statements ending March 31, 2017, were shared for information and are comparative with last year's year-to-date statements. There is a slight shift in that this year’s gapping is occurring less in salary and more in operating. Discussion ensued regarding short-term disability leaves and their impacts on the budget and operations. The SDHU’s return to work and employee assistant programs were noted and data sources indicate that same sick time trends are being seen in other sectors.

Dr. Sutcliffe flagged the unknowns with the current modernization of the Standards and noted that the Senior Management Executive Committee will be carefully looking at the cost reduction initiatives for 2018 and beyond during its budget deliberations.

b) MOHLTC Funding Approval – Schedule A6

Schedule A-6 was reviewed and explained. One-time funding requests were approved as submitted.

6.4 Financial Management Policy Review

a) Briefing Note from the Medical Officer of Health and Chief Executive Officer on the Financial Management Policy Review
b) By-laws and Regulatory Requirements Power Point Presentation
c) Schedule of Policy Review
    - BOH By-Laws

In November 2016, the FSC requested to receive the review schedule of financial management administrative policies and be apprised of key findings as appropriate.

The briefing note provides a detailed description of the review requirements for management as well as management’s internal process for the Board’s awareness.

The FSC reviewed the Regulatory Requirements: By-laws and Policies Review presentation, providing an overview of financial administration requirements set out by the MOHLTC and SDHU compliance with these requirements. Financial administrative requirements are specified in the following:

- Health Protection and Promotion Act - HPPA
- Ontario Public Health Organizational Standards – OPHOS
- Public Health Funding and Accountability Agreement - PHFAA
The review did not find any gaps in meeting the governance or operational policy requirements. Management will continue to annually review the by-laws and policies as per the BOH Manual review process ensuring advisement of FSC (for recommendation to the BOH as appropriate). The FSC will review relevant by-laws at its spring meeting as part of the Board of Health Manual Review process.

FSC will annually receive the review schedule of financial management administrative policies including any changes and/or recommendations.

The review schedules for the relevant financial Policies, Procedures and By-Laws in the Board of Health Manual and in the General Administrative Manual were included in the agenda package. The MOH recommended that only proposed revisions that are substantive from the management review come forward. The SDHU is currently exploring automating the review dates with electronic alerts. The overview was found helpful.

The internal process for new policies was also outlined.

Questions and comments were entertained. The FSC members appreciated the overview for reassurances that there are sound internal processes to ensure these requirements are being met.

The next FSC meeting will be held in the fall.

5.0 ADJOURNMENT

04-17 ADJOURNMENT

Moved by Lapierre – Myre: THAT we do now adjourn. Time: 10:40 a.m.  

CARRIED

_________________________  _________________________
(Chair)  (Secretary)
Tobacco continues to be a leading cause of preventable death in Ontario. Approximately two million Ontarians still smoke and tobacco use is responsible for 13,000 deaths per year. That’s 36 deaths per day.

PHO is pleased to announce the release of our new tobacco control report *Evidence to Guide Action: Comprehensive Tobacco Control in Ontario (2016)*, a report of the Smoke-Free Ontario Scientific Advisory Committee (SFO-SAC 2016). The Report provides up-to-date evidence on 56 interventions for reducing tobacco use in Ontario and covers the four pillars of tobacco control: industry, prevention, protection and cessation.

The findings from this Report will help guide evidence-informed decision making on:  
• comprehensive tobacco control program planning and evaluation  
• developing tobacco policies and strategies  
• opportunities for future tobacco research

The SFO-SAC 2016 is a committee made up of top tobacco control scientists and experts in Ontario, with an international Chair.

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**Chair and Members of the Board,**

The Smoke-Free Ontario Strategy has been in existence for over 10 years. In that time, Ontario has seen a decrease in the number of people who smoke. Yet, approximately two million people are current smokers and tobacco use is responsible for over 13,000 deaths per year. In the Sudbury & District Health Unit area, 25% of adults aged 20 years and older report being current smokers (CCHS 2013/14). While our rates have consistently been similar to that reported in northeastern Ontario, they are higher than Ontario overall. The far-too-high burden of tobacco-related illness and death remains, despite our collective best efforts to get tobacco use under control. Groups most at risk include people who identify as Indigenous, the LGBTQ community, and people with low socio-economic status.

In 2015, the MOHLTC asked Public Health Ontario to reconvene the Smoke-free Ontario Scientific Advisory Committee (SFO-SAC), to update the evidence from their 2010 report, and to identify which interventions or set of interventions would have the greatest impact on reducing tobacco use in Ontario. The Ministry also asked that equity and implementation considerations be embedded within the report.
This updated SFO-SAC report – *Evidence to Guide Action: Comprehensive Tobacco Control in Ontario (2016)* was released on May 2, 2017. Many of the interventions in the report align with the work of public health under the pillars of preventing young people from starting to smoke, supporting those wanting to quit, and protecting people from the effects of second-hand smoke.

Ontario remains committed to the goal of achieving the lowest smoking rates in Canada. The release of this new report is timely as the Ministry is undergoing the modernization of the Smoke-Free Ontario Strategy.

**GENERAL REPORT**

1. **Local and Provincial Meetings**

I was very pleased to join members of the senior management team in celebrating the fourth graduating Cohort of the Northern Leadership Program (NLP) on May 8, 2017. This date also marked the beginning of our own participation in this unique northern leadership initiative. I am pleased to share that two senior management members, R. St Onge and S. Laforest, are entering the fifth cohort of the one-year NLP.

I continue to co-lead the Community Drug Strategy with Greater Sudbury Police Service, Chief Pederson. We held our latest Executive Committee on May 10.

The Northern MOH’s held our monthly teleconference on May 16. This group connects MOHs and AMOHs across the north in order to share information, provide mutual assistance, and identify potential collaborations. With Timiskaming’s Acting MOH, only one vacancy remains in northern Ontario. I expect that formal announcements will be made shortly about AMOH recruitment successes in neighbouring health units.

2. **Board of Health**

We have been in contact with the Ministry of Health and Long-Term Care’s Agency Liaison and Public Appointments Unit Corporate Management Branch regarding our current provincial appointment vacancy since C. Belcourt’s resignation. They confirmed that they have applications on file and will be in touch with us.

3. **Human Resources**

It is with regret that I inform you of Megan Dumais’ decision to resign from her position as Director, Health Promotion Division, effective June 7, 2017. Megan is leaving to pursue other life goals and opportunities. I know you join me in wishing her the very best in her next steps.

Please also be advised that in addition to her Director role, Clinical and Family Services, Sandra Laclé will take on the role of Interim Director, Health Promotion Division. My thanks to Sandra and to the Executive Committee team for their ongoing support.

4. **Sudbury & District Health Unit’s 2017 Staff Day**

On April 26, the Sudbury & District Health Unit (SDHU) hosted its 2017 Staff Day. The focus this year was on building staff members’ Indigenous cultural competencies and relationships with Indigenous partners, and engaging staff on strategic planning for 2018 and beyond. The day was opened by Chief Steve Miller and Elder Mary Elliott from Atikameksheng Anishnawbek First Nation, who provided territorial acknowledgements and an opening prayer. Dawn Madahbee-Leach, a local Indigenous
leader in economic development spoke about the Truth and Reconciliation Commission recommendations related to health and provided concrete steps for us to begin reconciliation with Indigenous peoples. The morning session also highlighted local community partners and how they plan for and engage with Indigenous peoples. Board Vice-Chair, Jeff Huska, joined Health Unit staff to recognize a total of 32 staff members and 6 volunteers for their contributions and years of service. Staff then participated in a World Café style exercise to help shape the next iteration of the SDHU’s Strategic Plan.

5. Financial Report

The March year-to-date mandatory cost-shared financial statements report a positive variance of $205,865 for the period ending March 31, 2017. Gapped salaries and benefits account for $61,965 or 30%, with operating expenses and other revenue accounting for $143,900 or 70% of the variance. The operating expenses and revenue variance is attributable to timing and calendarization of revenues and programming activities.

A number of one-time operating pressures were identified, approved and processed, and are reflected within the March 2017 financial reporting in the amount of $196,000, which consists of the following:
- Staffing – in year back-fill of vacancies ($131,940)
- Staff development – .25% of salaries ($38,537)
- Programming and research – related to Ontario Public Health Standards ($25,523)

6. 2016 Audited Financial Statement

The audit of the SDHU’s financial statements for the year ending December 31, 2016, is complete. The audit was conducted by KPMG, which is in its first year of a three-year service agreement.

We are pleased to report another successful audit, noting no reporting issues and no internal control recommendations. The auditors issued an unqualified report on the statements pending approval of the draft statements by the Board of Health. Included in the Board agenda package are the auditor’s 2016 draft report and financial statements. The audit report was presented to the Board of Health Finance Standing Committee (FSC) at its May 4 meeting during which the auditors provided their report and the FSC members reviewed the financial statements.

Following are the divisional program highlights.

**CLINICAL AND FAMILY SERVICES DIVISION**

1. Control of Infectious Diseases

*Influenza:* There have been a total of 157 positive influenza results in the community to date this season. Of those, 144 were influenza A and 13 influenza B.

*Respiratory Outbreaks:* Outbreaks attributed to influenza A and B as well as parainfluenza 3 virus continue. Since January 1, 2017, there have been a total of 20 respiratory outbreaks in long-term care homes. Currently there are 3 active outbreaks. This is comparable to the same timeframe in the previous year.

*Vaccine Preventable Disease:* Since September, over 26,000 student immunization records for all school-aged children up to 18 years of age have been reviewed to ensure compliance with the *Immunization of Schools Pupils Act* (ISPA). Additional immunization clinics were offered at the Health
Unit on several Wednesdays and Saturdays to facilitate increased access for students requiring immunization. Of 105 schools, student immunization in 80 schools has been brought up-to-date. First and second notices to inform students of missing vaccinations have been sent to the remaining 25 schools. Additional clinics continue to be offered to increase access for these students.

2. **Family Health**

*Prenatal Education:* 26 individuals participated in the in-class prenatal class in April. Eight expectant mothers signed up for the online version of the class.

*Positive Parenting Program (Triple P):* Sixteen parents participated in group and/or transitions sessions in the month of April. A Triple P display was also set up for Conseil scolaire public du Grand Nord de l’Ontario (CSPGNO) parent night at MacDonald Cartier School. At this event more than 150 families participated. In a new initiative, the SDHU is collaborating with the Rainbow District School Board to offer services for student parents. In the school setting, positive parenting programming is being offered in the form of tip sheet discussions and referrals into the HBHC program.

*Child Health Community Events:* In collaboration with Children’s Treatment Centre (CTC) staff, presentations on resiliency were provided to 20 parents at the CTC who were attending the ‘Move to Improve’ program. Several SDHU staff also were participants in a focus group held by the City of Greater Sudbury with regard to utilization of the Sudbury Families website. The team provided feedback on partnership and utilization of the current website and offered suggestions for website improvements (e.g. identifying youth as a gap).

*Baby Friendly Initiative (BFI):* The Sudbury & District BFI Network screened the film ‘Milk’ at Sheridan Auditorium. ‘Milk’ is a documentary that explores concepts of infant feeding from across the globe and encourages discussion regarding informed decision making and the commercialization of formula. In addition to the SDHU, community partners in attendance included Health Sciences North, Blissful Doula, Breastworks and local parents. The Network members lead a discussion after the screening.

3. **Sexual Health / Sexually Transmitted Infections (STI) Including HIV and Blood Borne Infections**

In April, the Sexual Health team responded to five requests for community presentations. Topics included healthy relationships, safe sex practices and prevention of STIs. Requesting agencies were Jeunes de la rue, Rock Haven, HSN-Mental Health and Addictions Program, and the City of Greater Sudbury Youth Program (Chelmsford location).

The Sexual Health team at the Rainbow Centre was established to better meet the needs of priority populations. In March we responded to 346 drop-in clients who presented with requests ranging from STIs counselling, testing, and treatment; initiation of birth control; emergency contraception; anonymous HIV testing; and other sexual-health related concerns. One hundred clients purchased low-cost birth control at the Rainbow Centre during the month of March.

*Harm Reduction Supplies and Services Program:* In March, the program distributed 78,861 needles through 1,575 fixed-site and outreach contacts, and 59,420 needles were returned for disposal achieving a 75% return rate for the month of March.

*Substance Misuse and Community Drug Strategy:* The Opioid Forum was held on April 14, the first of its kind in our community. The Forum brought together 68 individuals from more than 25 different agencies to discuss the needs and opportunities for an opioid plan for our community.
4. Indigenous Engagement

Further to the Board's direction on Indigenous engagement, activities underway include community engagement, language translation policy, and tobacco and territorial acknowledgement protocol development. At the annual Staff Day, referenced above, we were very pleased to welcome keynote speaker Dawn Madahbee-Leach and representatives from the N'Mninoeyaa Aboriginal Health Access Centre, Greater Sudbury Police Service, and Health Sciences North. In addition, 11 pieces of Indigenous artwork, which were officially unveiled on April 20, were displayed at Staff Day to showcase our commitment to creating a more welcoming and culturally safe environment within our work and public spaces. The Public Health Ontario funded Locally Driven Collaborative Project, which seeks to explore principles of engagement with First Nations, is now underway with initial project team meetings, completion of a literature review, and selection of an Indigenous Circle to guide the project.

ENVIRONMENTAL HEALTH DIVISION

1. Control of Infectious Diseases

During the month of April, nine sporadic enteric cases, and one infection control complaint were investigated. Two enteric outbreaks were declared in institutions.

2. Food Safety

During the month of April, three food product recalls prompted public health inspectors to conduct checks of 920 local premises. All affected establishments had been notified and subsequently had removed the recalled products from sale. The recalled food products included Wholesome Farms brand Strawberry Sundae cups and Yoso brand Soygo Fermented Cultured Soy products, both of which were recalled due to the possible contamination with Listeria monocytogenes; and Robin Hood brand All Purpose Flour, recalled due to possible E. coli O121 contamination. Due to the expansion of this recall, an SDHU public service announcement (PSA) was issued to all media outlets on April 13, 2017. The PSA also encouraged members of the general public and food premises operators to register to receive email notifications of food recalls.

During the month of April, 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 the premises allowed to reopen.

Staff issued 20 special event food service permits to various organizations in the month of April. In addition to this, staff issued a total of 63 special event food service permits for the Flanagan Trade / Food Show that took place on April 26, 2017.

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

On April 19, 2017, a public health inspector participated in the City of Greater Sudbury's Permit-Palooza and provided information to attendees regarding the special event food service permit application process. The purpose of this event was to support members of the public who intend to host special events to learn the permitting processes required by various agencies.

In response to a large power outage that affected many sections of the Greater Sudbury, the Health Unit issued a PSA on April 28, 2017, reminding the public of food safety best practices during and after a power outage. Public health inspectors also attended affected food premises to ensure that proper food safety practices were followed during and after the power outage.
3. **Health Hazard**

In April, 18 health hazard complaints were received and investigated. One of these complaints involved marginalized populations.

4. **Ontario Building Code**

During the month of April, 14 sewage system permits, 12 renovation applications, 1 zoning, and 2 consent applications were received.

5. **Rabies Prevention and Control**

Seventeen rabies-related investigations were carried out in the month of April. Three specimens were submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis and were subsequently reported as negative.

One individual received rabies post-exposure prophylaxis following an exposure to a wild animal.

6. **Safe Water**

During April, 30 residents were contacted regarding adverse private drinking water samples and public health inspectors investigated 3 regulated adverse water sample results. Furthermore, 1 drinking water advisory was issued, and 1 drinking water order was rescinded.

7. **Tobacco Enforcement**

In April, tobacco enforcement officers charged 8 individuals for smoking in an enclosed workplace, 2 individuals for smoking on school property, and 3 individuals for smoking on hospital property.

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**HEALTH PROMOTION DIVISION**

1. **Healthy Eating**

A public health nurse from Manitoulin Island and a public health nutritionist from Sudbury supported Noojmowin Teg Health Centre in submitting a successful Grow Grant application to the Ontario Trillium Foundation. The focus of the grant is to expand on the Island-wide work of the Child Poverty Task Force. The funding, over three years, will enhance food literacy for communities through growing, cooking, and traditional food teachings.

2. **Injury Prevention**

Public health nurses supported N’Swakamok Friendship Centre in implementing the Stand UP! falls prevention program.

On March 30, Mindemoya staff delivered a falls prevention presentation, titled “Stay on Your Feet”, to 19 Elders on the Wikwemikong reserve.

On March 16, a public health nurse from the Mindemoya office submitted a Road Safety Community Partnership Program Application on behalf of the Manitoulin Injury Prevention Coalition. This will help to create awareness about Bill 31, which focuses on Impaired & Distracted Driving.
In April, a public health nurse trained six new technicians from the Sudbury & District Health Unit, Wikwemikong Health Centre, M’Chiigeeng community, and Mnaamodzawin Health Services. The training was delivered in Little Current.

In April, several public health nurses provided a series of brief car seat safety in-services with 42 staff, including a manager at Health Sciences North: Birthing, Pediatric and Neonatal Intensive Care Units. The goal is to reach all staff from these units.

In April, staff from the Espanola office provided assistance to the Ontario Provincial Police, Police Chief Steve Edwards with Proceeds of Crime, Front Line Policing Grant Application that would support the Lacloche area. If successful the grant would provide funding to establish a Rapid Mobilization Table, which would bring together multiple sectors who would work collaboratively to address immediate needs of vulnerable populations at elevated risk.

3. **Physical Activity**

On March 17, a PHN from the Sudbury East office worked in partnership with the Municipality of French River and the Village Amis des Ainés committee to submit a grant application for the Rick Hansen Foundation for the development of a senior’s trail.

4. **Prevention of Substance Misuse**

In April, SDHU staff hosted a Workplace Health Network Meeting with five workplaces in attendance. A presentation entitled "A Drug Called Alcohol" was delivered and attendees participated in a "Pour Challenge" to learn about standard drink sizes. The feedback received from participants was very positive and they expressed interest in attending future meetings.

5. **School Health**

The SDHU partnered with the Conseil scolaire public du Grand Nord de l’Ontario to organize its third family fair, entitled EXPLO! Une foire pour faire étinceler les familles (Making Families Shine). This event is part of a wider initiative that promotes resiliency and positive relationships between parents and children. This year’s theme was “It starts with you” and offered workshops to approximately 250 school community members that promoted well-being, fun and relaxation techniques for families. Guest speaker Stephan Maighan spoke to parents during his workshop called “The hidden force of attitude” and provided tools to maintain a positive attitude and how it could help them make the most out of any opportunity.

The School Health Promotion team has been working with the Conseil scolaire public du Grand-Nord de l’Ontario to create healthy school nutrition environments. In partnership with a local food service provider “Ça sent bon” and with funds from the Farm 2 School grant, work is being done to offer a salad bar, which includes local vegetables, in the cafeterias of École secondaire Hanmer and École secondaire Macdonald-Cartier. The launch of the weekly salad bar program took place in April. As the initiative grows, more local produce will be sourced, and the salad bar will also feature some vegetables from the Hanmer community garden (Jardin du Village) starting in the fall. As part of the project, food literacy components will also be included for school community members.

The School Health Promotion team continues to collaborate with all school boards to strengthen partnerships and take part in joint planning, implementation and evaluation of health promotion programs. Thus far, consultations have taken place with all four boards to plan initiatives for the next school year. Team members continue to work towards creating healthy school environments by providing skill building opportunities for school staff, such as training sessions and workshops on various topics such as resiliency, mental health and healthy eating. The team has also provided...
support with the implementation of the Health and Physical Education Curriculum through the provision of up-to-date resources and skill building opportunities for students in the classroom. The team is actively working with 11 elementary schools and 9 secondary schools.

6. Tobacco Control

The Tobacco team delivered a community-based presentation to participants of the Positive Steps Community Mental Health and Addictions Program on tobacco use cessation. Specific topics related to tobacco cessation strategies were discussed and how they can be applied in other areas of life. The team continues to actively participate in NE TCAN meetings to align local planning activities with the Smoke-Free Ontario Strategy.

SDHU staff continued to provide services to the community through the Quit Smoking Clinic and Telephone Information Line. Staff received 80 calls and 27 visits to the clinic in March. Also, 25 Nicotine Replacement Treatment vouchers were distributed and redeemed.

RESOURCES, RESEARCH, EVALUATION AND DEVELOPMENT (REED) DIVISION

1. Health Equity

The Health Equity team has established a partnership with faculty members from Laurentian University’s School of Education to pilot and evaluate a module on health equity and the social determinants of health. Education students will pilot the module in their placements with elementary school students (Grades 4 to 6) in November 2017 and March 2018.

RRED Division staff continue to lead work on the development of a Health Equity Strategy for Northern Ontario, which is funded by Health Quality Ontario. A report summarizing over 30 engagement sessions with over 200 participants across northeastern and northwestern Ontario was finalized in April. The report provides insight into things like acting on social determinants of health; equitable access to high-quality and appropriate health services; Indigenous health, healing, and wellbeing; and data availability for equity decision making. The findings will inform a Northern Ontario Health Equity Strategy Summit, which will be held on May 25.

2. Population Health Assessment and Surveillance

A section on Infectious and Communicable Diseases (2006 to 2015) has been added to the SDHU's Population Health Profile. The report contains data on foodborne illnesses, sexually transmitted and bloodborne illnesses, as well as vaccine preventable illnesses. An accompanying infographic lists the top 10 infectious diseases reported in the SDHU service area and features some highlights from the full report. The full report and infographic are available at sdhu.com.

3. Research and Evaluation

Staff from the RRED Division co-facilitated two research-focused workshops at the Northern Ontario School of Medicine (NOSM) Northern Constellations 2017 Faculty Development Conference on April 21 and 22. The purpose of the annual conference is to assist and further develop NOSM faculty for their varied roles and responsibilities. The SDHU presented, along with other NOSM faculty members, on “getting your research project started” and on “successfully disseminating your research findings and results”, bringing a public health perspective to the participants.
4. **Student Placement Program**

The SDHU is actively participating in an elective course offered by Laurentian University to provide education and public health experience in rural and northern areas to nursing students. The SDHU is providing 80 hours of placement experience to two third year nursing students in our Espanola and Mindemoya offices.

In 2016 a total of 23 students completed evaluations of their placement experiences at the SDHU. Overall, respondents enjoyed the friendly and welcoming atmosphere of the health unit and felt that they had a positive learning experience where their learning objectives were met. They identified being well supported by their preceptors and team. As a result of their enriching experience, their knowledge of public health increased, and most agreed that they would recommend the SDHU as a placement site for other students.

5. **Presentations**

Staff from the RRED Division, in collaboration with members of a provincial project team, presented a poster entitled “Beyond BMI: Partnering to Build a Childhood Healthy Weights Surveillance System (HWSS) in Ontario” at The BORN Ontario 2017 Conference (Better Outcomes Registry & Network), which was held April 24 and 25 in Toronto. The theme for the conference was “Unlocking the Value of Data”.

Respectfully submitted,

*Original signed by:*

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer
## Cost Shared Programs

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<tr>
<td>Manitoulin</td>
<td>124,624</td>
</tr>
<tr>
<td>Chapleau</td>
<td>99,607</td>
</tr>
<tr>
<td>Sudbury East</td>
<td>16,486</td>
</tr>
<tr>
<td>Intake</td>
<td>318,239</td>
</tr>
<tr>
<td>Volunteer Services</td>
<td>5,771</td>
</tr>
<tr>
<td><strong>Total Corporate Services:</strong></td>
<td><strong>$5,226,094</strong></td>
</tr>
</tbody>
</table>

| Clinical and Family Services: | |
| General | 923,880 | 207,344 | 185,309 | 22,036 | 738,572 |
| Clinical Services | 1,355,527 | 312,932 | 314,039 | (1,107) | 1,041,488 |
| Branches | 272,222 | 59,894 | 57,676 | 2,218 | 214,547 |
| Family | 658,316 | 149,315 | 149,098 | (183) | 508,018 |
| Risk Reduction | 124,408 | 41,840 | 42,165 | 3,255 | 82,253 |
| Clinical Preventive Services - Outreach | 141,610 | 33,692 | 31,915 | 1,777 | 109,695 |
| Sexual Health | 952,320 | 220,867 | 203,391 | 17,276 | 748,729 |
| Influenza | 0 | 0 | 0 | (0) | 0 |
| Meningitis | 0 | 0 | 1 | (1) | (1) |
| HPV | 0 | 0 | 1 | (1) | (1) |
| Dengue - Clinic | 500,484 | 106,014 | 99,951 | 6,063 | 400,533 |
| Family - Repro/Child Health | 1,176,292 | 265,579 | 240,031 | 25,549 | 936,261 |
| Substance Misuse Prevention | 162,563 | 37,812 | 34,202 | 3,610 | 128,361 |
| Indigenous Engagement Initiative | 0 | 0 | 0 | (0) | (0) |
| **Total Clinical Services:** | **$6,267,621** | **$1,455,490** | **$1,338,557** | (96,933) | **$4,929,065** |

| Environmental Health: | |
| General | 794,321 | 168,210 | 167,248 | 962 | 627,073 |
| Environmental | 2,578,893 | 610,219 | 602,336 | 7,883 | 1,976,558 |
| Vector Borne Disease (VBD) | 86,667 | 5,826 | 8,894 | (3,068) | 77,773 |
| Small Drinking Water System | 174,185 | 40,213 | 39,906 | 306 | 134,278 |
| **Total Environmental Health:** | **$3,634,065** | **$824,467** | **$818,384** | (5,083) | **$2,815,082** |

| Health Promotion: | |
| General | 1,165,814 | 265,833 | 264,114 | 1,720 | 901,701 |
| School | 1,368,575 | 285,612 | 276,965 | 8,647 | 1,091,610 |
| Healthy Communities & Workplaces | 181,274 | 40,508 | 37,726 | 2,782 | 143,548 |
| Branches - Espanola / Manitoulin | 202,717 | 61,624 | 59,871 | 1,753 | 202,864 |
| Nutrition & Physical Activity | 1,265,383 | 261,178 | 250,677 | 10,501 | 1,014,706 |
| Branches - Chapleau / Sudbury East | 374,021 | 82,275 | 77,787 | 4,489 | 296,234 |
| Injury Prevention | 468,504 | 103,457 | 89,534 | 13,923 | 378,970 |
| Tobacco By-Law | 352,755 | 69,893 | 61,483 | 7,999 | 281,052 |
| Alcohol Misuse | 117,551 | 32,626 | 40,724 | (8,099) | 76,827 |
| **Total Health Promotion:** | **$5,556,574** | **$1,202,796** | **$1,159,080** | (43,716) | **$4,397,494** |

| RRID: | |
| General | 1,454,823 | 350,202 | 336,335 | 13,867 | 1,118,488 |
| Workplace Capacity Development | 23,507 | 350 | 311 | 39 | 22,196 |
| Health Equity Office | 14,440 | 2,255 | 2,132 | 123 | 12,308 |
| Strategic Engagement | 597,441 | 126,681 | 113,717 | 12,964 | 483,724 |
| **Total RRID:** | **$2,090,211** | **$479,489** | **$452,405** | (26,993) | **$1,637,716** |

| Total Expenditures: | |
| **$22,774,566** | **$5,480,899** | **$5,275,035** | **$205,864** | **$17,499,531** |

| Net Surplus/(Deficit) | |
| $0 | $208,541 | $414,406 | $205,865 |
Sudbury & District Health Unit 2015 - current

Cost Shared Programs
STATEMENT OF REVENUE & EXPENDITURES
Summary By Expenditure Category
For The 3 Periods Ending March 31, 2017

<table>
<thead>
<tr>
<th></th>
<th>BOH Annual Budget</th>
<th>Budget YTD</th>
<th>Current Expenditures YTD</th>
<th>Variance YTD (over) / (under)</th>
<th>Budget Available</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues &amp; Expenditure Recoveries:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding</td>
<td>22,998,576</td>
<td>5,860,125</td>
<td>5,853,535</td>
<td>6,590</td>
<td>17,145,041</td>
</tr>
<tr>
<td>Other Revenue/Transfers</td>
<td>846,680</td>
<td>219,202</td>
<td>247,835</td>
<td>(28,632)</td>
<td>598,846</td>
</tr>
<tr>
<td><strong>Total Revenues &amp; Expenditure Recoveries:</strong></td>
<td>23,845,256</td>
<td>6,079,327</td>
<td>6,101,369</td>
<td>(22,042)</td>
<td>17,743,887</td>
</tr>
</tbody>
</table>

| **Expenditures:**            |                   |            |                          |                               |                 |
| Salaries                     | 15,759,563        | 3,585,805  | 3,514,358                | 71,446                        | 12,245,205      |
| Benefits                     | 4,341,926         | 1,034,741  | 1,044,223                | (9,482)                       | 3,297,703       |
| Travel                       | 265,186           | 44,572     | 31,930                   | 12,641                        | 233,256         |
| Program Expenses             | 977,233           | 226,004    | 197,001                  | 67,003                        | 780,231         |
| Office Supplies              | 71,564            | 14,976     | 9,418                    | 5,558                         | 62,145          |
| Postage & Courier Services   | 72,730            | 18,091     | 12,817                   | 5,274                         | 59,914          |
| Photocopy Expenses           | 33,487            | 8,250      | 5,284                    | 2,966                         | 28,204          |
| Telephone Expenses           | 60,600            | 14,991     | 13,637                   | 1,353                         | 46,963          |
| Building Maintenance         | 398,767           | 171,333    | 168,216                  | 3,117                         | 230,551         |
| Utilities                    | 205,097           | 64,274     | 64,161                   | 114                           | 140,936         |
| Rent                         | 251,803           | 69,955     | 71,255                   | (1,300)                       | 180,548         |
| Insurance                    | 103,774           | 92,184     | 92,172                   | 12                            | 11,602          |
| Employee Assistance Program (EAP) | 34,969        | 8,742      | 7,891                    | 851                           | 27,078          |
| Memberships                  | 31,166            | 12,877     | 12,359                   | 517                           | 18,807          |
| Staff Development            | 144,568           | 35,392     | 31,689                   | 3,704                         | 112,879         |
| Books & Subscriptions        | 11,875            | 2,605      | 734                      | 1,871                         | 11,141          |
| Media & Advertising          | 108,788           | 24,065     | 11,371                   | 12,693                        | 97,416          |
| Professional Fees            | 203,512           | 57,233     | 36,461                   | 20,772                        | 167,051         |
| Translation                  | 48,100            | 9,822      | 9,403                    | 579                           | 38,698          |
| Furniture & Equipment        | 14,270            | 4,909      | 3,856                    | 1,052                         | 10,414          |
| Information Technology       | 706,278           | 331,808    | 348,728                  | (16,920)                      | 357,550         |
| **Total Expenditures**       | 23,845,255        | 5,870,786  | 5,686,963                | 183,823                       | 18,158,292      |
| **Net Surplus (Deficit)**    | 0                 | 208,541    | 414,406                  | 205,865                       |                 |

Page 38 of 124
### 100% Funded Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>FTE</th>
<th>Annual Budget</th>
<th>Current YTD</th>
<th>Balance Available</th>
<th>% YTD</th>
<th>Program Year End</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pro/Postnatal Nurse Practitioner</td>
<td>704</td>
<td>139,000</td>
<td>33,157</td>
<td>105,843</td>
<td>23.9%</td>
<td>Dec 31</td>
</tr>
<tr>
<td>OTF - Getting Ahead and Circles</td>
<td>706</td>
<td>-</td>
<td>3,255</td>
<td>(3,255)</td>
<td>0.0%</td>
<td>Mar 31/17</td>
</tr>
<tr>
<td>SFO - TCAN - E-Cigarettes - 1-time</td>
<td>721</td>
<td>30,000</td>
<td>23,699</td>
<td>6,301</td>
<td>79.0%</td>
<td>Mar 31/17</td>
</tr>
<tr>
<td>SFO - Electronic Cigarette Act - New Nov./15 - Base Fndg</td>
<td>722</td>
<td>36,700</td>
<td>5,448</td>
<td>31,252</td>
<td>14.8%</td>
<td>Dec 31</td>
</tr>
<tr>
<td>SFO - TCAN - Prevention</td>
<td>724</td>
<td>97,200</td>
<td>7,472</td>
<td>89,728</td>
<td>7.7%</td>
<td>Dec 31</td>
</tr>
<tr>
<td>SFO - Tobacco Control Area Network - TCAN</td>
<td>725</td>
<td>285,800</td>
<td>52,479</td>
<td>233,321</td>
<td>18.4%</td>
<td>Dec 31</td>
</tr>
<tr>
<td>SFO - Local Capacity Building: Prevention &amp; Protection</td>
<td>726</td>
<td>259,800</td>
<td>42,092</td>
<td>217,708</td>
<td>16.2%</td>
<td>Dec 31</td>
</tr>
<tr>
<td>SFO - Tobacco Control Coordination</td>
<td>730</td>
<td>104,442</td>
<td>24,102</td>
<td>80,340</td>
<td>23.1%</td>
<td>Dec 31</td>
</tr>
<tr>
<td>SFO - Youth Engagement</td>
<td>732</td>
<td>80,000</td>
<td>17,862</td>
<td>62,138</td>
<td>22.3%</td>
<td>Dec 31</td>
</tr>
<tr>
<td>Infectious Disease Control</td>
<td>735</td>
<td>479,100</td>
<td>110,363</td>
<td>368,737</td>
<td>23.0%</td>
<td>Dec 31</td>
</tr>
<tr>
<td>LHIN - Falls Prevention Project &amp; LHIN Screen</td>
<td>736</td>
<td>110,450</td>
<td>109,265</td>
<td>1,185</td>
<td>98.9%</td>
<td>Mar 31/17</td>
</tr>
<tr>
<td>MOHLTC - Special Nursing Initiative</td>
<td>738</td>
<td>180,500</td>
<td>41,654</td>
<td>138,846</td>
<td>23.1%</td>
<td>Dec 31</td>
</tr>
<tr>
<td>MOHLTC - Northern Fruit and Vegetable Funding</td>
<td>743</td>
<td>156,600</td>
<td>1,679</td>
<td>154,921</td>
<td>1.1%</td>
<td>Dec 31</td>
</tr>
</tbody>
</table>
| Beyond BMI - LDCP                                                     | 747 | 110,000       | 50,033      | 59,967            | 45.5% | "May/16 to June’17"
| Food Safety - Haines Funding                                          | 750 | 36,500        | 85          | 36,415            | 0.2%  | Dec 31          |
| Triple P Co-Ordination                                                | 766 | 20,502        | 20,501      | 1                 | 100.0%| Dec 31          |
| Healthy Babies Healthy Children                                       | 778 | 1,476,897     | 334,186     | 1,142,711         | 22.6% | Dec 31          |
| Healthy Smiles Ontario (HSO)                                          | 787 | 612,153       | 106,982     | 505,171           | 17.5% | Dec 31          |
| Anonymous Testing                                                     | 788 | 59,393        | 59,393      | -                 | 100.0%| Mar 31/17       |
| HQO - Northern Health Equity                                          | 791 | 141,815       | 42,880      | 98,935            | 30.2% | Mar 31/17       |
| MHPS- Diabetes Prevention Program                                     | 792 | 175,000       | 16,014      | 158,986           | 9.2%  | Dec 31          |
| **Total**                                                             |     | **4,591,852** | **1,102,601**| **3,489,251**      |       |                 |
April 19, 2017

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

Dear Minister Philpot:

Re: Moving forward on the Federal Opioid Strategy

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I would like to take this opportunity to commend you, and the Ministry of Health, in releasing Health Canada’s Action on Opioid Misuse ¹ in response to the issue of opioid use and its devastating effects throughout Canada.

Ontario has one of the highest provincial opioid prescription rates and has experienced thirteen years of increasing and record-setting opioid overdose fatalities, which now rank as the third leading cause of accidental death, and more than double the number of people killed in motor vehicle collisions. More than 5000 Ontarians have died of an opioid overdose since 2000, the vast majority unintentionally.²

The opioid issue is of particular concern to us locally, as the opioid poisoning emergency visit rates in Simcoe Muskoka have been increasing since 2003, and have been significantly higher than the provincial rates since 2004.³ SMDHU staff have been involved in a number of activities to date to help address opioid related harms in Simcoe Muskoka including promotion of fentanyl patch for patch programs, coordination of local drug strategy coalitions and provision of naloxone kits and training to people who use opioids and their friends and family. In addition, SMDHU is co-hosting an inaugural meeting of key stakeholders for the purpose of creating a Simcoe Muskoka Opioid Strategy on May 25, 2017, along with the North Simcoe Muskoka Local Health Integration Network and the Simcoe Muskoka Alcohol and Other Drug Strategy Working Group.

In response to the significant harms associated with both prescription and illicit opioid use in Simcoe Muskoka, the SMDHU Board of Health strongly urges the Federal Ministry of Health to further develop the recommendations within the federal document entitled Action on Opioid Misuse, with targets, timelines and deliverables, and to communicate developments with key stakeholders in a timely way. This will support efforts occurring locally and provincially to address the issue, and will have the greatest opportunity to realize decreases in opioid related harm. Given the pressing nature of this continually evolving issue, we strongly urge the federal government to move quickly in mitigating further harms.
Leadership and action at all levels of government and across sectors are urgently needed. We appreciate your actions to date and look forward to your continued leadership in addressing the morbidity and mortality associated with opioid use, misuse, and addictions.

Sincerely,

**ORIGINAL SIGNED BY**

Barry Ward  
Vice Chair, Board of Health  
Simcoe Muskoka District Health Unit  

BW:CG:mk

c. Association of Local Public Health Agencies  
   Boards of Health in Ontario  
   North Simcoe Muskoka LHIN  
   Central LHIN  
   Simcoe Muskoka Alcohol and Other Drug Strategy  
   Dr. Kellie Leitch, MP  
   Tony Clement, MP  
   Alex Nuttall, MP  
   John Brassard, MP  
   Bruce Stanton, MP  
   Peter Van Loan, MP

References:
April 13, 2017

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

RE: Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health re: Opioid Addiction and Overdose
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on April 12, 2017, Council adopted the following recommendations of the Committee:

A) That the correspondence from the Chair of the Grey Bruce Board of Health urging the College of Physicians and Surgeons of Ontario to consider issuing guidance to Ontario physicians about counselling their patients about the risk of opioid addiction and overdose and the importance of having naloxone at home if it is needed, be endorsed; and

B) That the Premier of Ontario, Minister of Health and Long-Term Care, Durham's MPPs, Registrar, College of Physicians and Surgeons of Ontario, Chief Medical Officer of Health and all Ontario boards of health be so advised.

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health, dated April 5, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

c. The Honourable Eric Hoskins, Minister of Health and Long-Term Care
   Joe Dickson, MPP (Ajax/Pickering)

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 2009.
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP, (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP, (Haliburton/Kawartha Lakes/Brock)
Registrar, College of Physicians and Surgeons on Ontario
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health
April 13, 2017

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

RE: Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health re: Adult and Older Adult Oral Health
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on April 12, 2017, Council adopted the following recommendations of the Committee:

A) That the correspondence from the Warden of Lambton County Council urging the Ontario government to accelerate its commitment to expand Ontario’s provincially funded dental benefits programs to cover low-income adults and older adults, be endorsed; and

B) That the Premier of Ontario, Ministers of Community and Social Services, Finance, and Health and Long-Term Care, Durham’s MPPs and all Ontario boards of health be so advised.

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health, dated April 5, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

c. The Honourable Helena Jaczek, Minister of Community and Social Services

The Honourable Charles Sousa, Minister of Finance

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 2009.
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP, (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP, (Haliburton/Kawartha Lakes/Brock)
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health
April 25, 2017

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

Dear Minister Hoskins:

Re: Low-Income Dental Program for Adults and Seniors

At its meeting held on April 12, 2017, the Board of Health for Peterborough Public Health considered correspondence from Porcupine Health Unit regarding the above noted matter.

Oral health is essential to overall health and quality of life at every stage of life and has been recognized as a basic human right. The Board echoes the recommendations outlined in their resolution (attached), and urges the Ministry for more urgent implementation of expanded public dental programs to include adults and seniors living on low incomes.

We appreciate your attention to this important public health issue.

Yours in health,

Original signed by

Mayor Mary Smith
Chair, Board of Health

/ag
Encl.

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, MOHLTC
Association of Local Public Health Agencies
Ontario Boards of Health
May 1, 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,

At its meeting held on April 21, 2017, the Board of Health for the Porcupine Health Unit passed the attached resolutions regarding the following:

- Ontario Public Health Standards Modernization
- Low-Income Dental Program for Adults and Seniors

Thank you for your attention to these important public health issues.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc
R-2017 - 21

MOVED BY: Veronica Farrell
SECONDED BY: Drago Stefanic

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

WHEREAS the lack of access to dental care leads to increased use of acute health care services and negatively impacts individual patients. Pain, low self-esteem, potentially unnecessary antibiotic treatment with side effect risks; and infections that may be serious and progress rapidly are all complications of a lack of dental care; and

WHEREAS the need to access acute health care services is extremely costly to the Ontario health care system. Over 60,000 visits to emergency departments across Ontario in 2015 were due to oral health concerns (Ontario Oral Health Alliance, 2017); and

WHEREAS the majority of these acute dental complications are avoidable with timely and appropriate dental care; and

WHEREAS financial barriers prevent many marginalized and low-income adults from accessing preventive and acute dental care; and

WHEREAS the Ministry of Health and Long Term Care (MOHLTC) has promised to expand the oral health program to include low-income adults in 2025;

NOW THEREFORE BE IT RESOLVED THAT, the Association of Local Public Health Agencies (alPHA) request the Ministry of Health and Long Term Care (MOHLTC) to address this important public health issue and urgently implement an expanded public dental program for low income adults and seniors, before the proposed 2025 timeline; 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, and Dr. David Williams, Chief Medical Officer of Health for the Ministry of Health and Long-Term Care.

(circle as appropriate)

CARRIED
DEFEATED

Chair - Board of Health

President
May 2, 2017

The Honourable Dr. Jane Philpott
Minister of Health
Government of Canada
House of Commons
Ottawa, ON K1A 0A6
Hon.Jane.Philpott@Canada.ca

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

Dear Ministers:

At its meeting held on April 12, 2017, the Board of Health for Peterborough Public Health endorsed the motion passed by Simcoe Muskoka District Health Unit to:

- support the federal government’s proposal to commit to a target of less than 5% tobacco use by 2035;
- recommend that government approaches include those identified at the 2016 summit, A Tobacco Endgame for Canada; and,
- recommend that the Smoke-Free Ontario Strategy be aligned with the proposed tobacco endgame in Canada.

This endorsement is in recognition that tobacco use is still the most important cause of death in Canada, and that different approaches as identified in A Tobacco Endgame for Canada are needed to make a substantial change in tobacco use rates.

The Board strongly encourages the inclusion of the tobacco endgame strategies proposed in the aforementioned document including increased tobacco taxation, restrictions on marketing, implementing an 18A rating for movies that depict smoking, strategies to reduce the production, supply and distribution of tobacco and holding the tobacco industry accountable for its impact on health. These progressive and evidence informed strategies will help achieve health for residents.

Yours in health,

Original signed by

Mayor Mary Smith
Chair, Board of Health
/ag
Encl.

cc: Chief Public Health Officer of Canada
Chief Medical Officer of Health of Ontario
Assistant Deputy Minister, Population and Public Health, MOHLTC
Local Members of Parliament
Local Members of Provincial Parliament
Association of Local Public Health Agencies
Ontario Boards of Health
Friday, May 5, 2017

The Honourable Dr. Jane Philpott
Minister of Health
Government of Canada
House of Commons
Ottawa, ON K1A 0A6
Hon.Jane.Philpott@Canada.ca

Dear Minister Philpott:

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

At its meeting on April 12, 2017, the Board of Health for Peterborough Public Health considered correspondence from the Middlesex-London Health Unit regarding the Marketing to Kids Coalition’s Ottawa Principles, and Further Action on Sugary Drinks (see attached). The board endorsed this letter, and supports the Stop Marketing to Kids Coalition’s Ottawa Principles.

Our board believes that restrictions are needed to stop marketing to children. Sugary drinks and foods high in sugar, salt, and fat, are heavily marketed to children and youth through social media, television, websites, video games, apps, and other evolving marketing techniques. Beverages are the source of almost half of the sugar children and youth consume daily. Action is needed at this time. For this reason, we are supporting the Ottawa Principles and hope that your government will take them into account when formulating policy.

Peterborough Public Health is committed to promoting health and well-being of residents. A comprehensive strategy, including restrictions on marketing to children, is needed to make the healthy choice easier for children, youth, and families.

Yours in health,

Original signed by

Mayor Mary Smith
Chair, Board of Health

/ag
Encl

cc: Local MPs
Dr. Theresa Tam, Interim Chief Public Health Officer
Association of Local Public Health Agencies
Ontario Boards of Health
May 1, 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,

At its meeting held on April 21, 2017, the Board of Health for the Porcupine Health Unit passed the attached resolutions regarding the following:

- Ontario Public Health Standards Modernization
- Low-Income Dental Program for Adults and Seniors

Thank you for your attention to these important public health issues.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc
R-2017 - 20

MOVED BY: ____________________________
Michael Shea

SECONDED BY: ____________________________
Rick Lafleur

WHEREAS, the Board of Health for the Porcupine Health Unit appreciates the work of the Ministry of Health and Long-Term Care in the development of the Modernized Ontario Public Health Standards (OPHS); and

WHEREAS, the Board of Health for the Porcupine Health Unit appreciates the opportunity for Porcupine Health Unit staff to provide feedback at the regional consultation in Sudbury on March 27, 2017; and

WHEREAS, the Board of Health for the Porcupine Health Unit recognizes the strengths in the increased flexibility to address local priorities, address health equity and further engage with indigenous partners; and

WHEREAS, the Board of Health for the Porcupine Health Unit is concerned about the potential for increased equity gaps and significant strain on staff resources to ensure local needs are met in communities where there may be a lack of partners to collaborate with; and

WHEREAS, the Board of Health for the Porcupine Health Unit is concerned about capacity with limited funds under the current funding formula;

NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for the Porcupine Health Unit endorses the letter provided by the Association of Local Public Health Agencies (alPHA) dated March 17, 2017 regarding Public Health Programs and Services Consultation; 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.

(circle as appropriate)

CARRIED

DEFEATED

______________________________
Chair - Board of Health
April 13, 2017

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

RE: Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health re: Vaccine Preventable Diseases Program Funding
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on April 12, 2017, Council adopted the following recommendations of the Committee:

A) That the correspondence from the Chair of the Simcoe Muskoka Board of Health urging the Ontario government to increase its annual funding of the Vaccine Preventable Diseases program to support program enhancements such as the expanded HPV Immunization program, be endorsed; and

B) That the Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham MPPs, Chief Medical Officer of Health and all Ontario boards of health be so advised.

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health dated April 5, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

c. The Honourable Charles Sousa, Minister of Finance
   The Honourable Eric Hoskins, Minister of Health and Long-Term Care

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 2009.
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP, (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP, (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health
May 3, 2017

DELIVERED VIA E-MAIL & REGULAR MAIL

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

Attention: The Honourable Eric Hoskins
Office of the Minister

Dear Hon. Hoskins:

Re: Human Papillomavirus (HPV) Immunization Catch-up for Boys

The Board of Health (BOH) for Wellington-Dufferin-Guelph Public Health (WDGPH) would like to request that the Ontario Government implement a publicly-funded human papillomavirus (HPV) immunization catch-up program for boys similar to the catch-up program implemented for girls in 2012. It is important to close this gap in publicly-funded vaccine eligibility for boys.

In 2012, NACI recommended HPV vaccination for all males between the ages of 9 and 26 and for all men who have sex with men (MSM) aged 9 and older. PIDAC-I also recommends publicly-funded Gardasil for MSM or males who identify as homosexual up to the age of 26 years. As the most common preventable sexually-transmitted infection (STI), HPV has been directly linked to serious health conditions such as cervical, oral, penile and anal cancers, as well as abnormal cell growth in these areas of the body that are causally associated with various cancers and anal warts.

Some families with health benefit coverage may have the opportunity to purchase the vaccine. However, lower income families and families without extended health benefits are not afforded equal opportunity to be protected from HPV-related cancers. Universal funding would also protect the highly vulnerable group of boys who will go on to identify as MSM but are currently not identifying their eligibility for the publicly-funded vaccine.
The WDGPH BOH would like to request that the Ministry of Health and Long-Term Care address this public health concern by expanding the publicly-funded HPV immunization programs to include a catch-up program for boys. We believe this is the approach that aligns with the Ontario Government’s stance on health equity and would reduce the burden of HPV-related cancers in Ontario.

Sincerely,

Nancy Sullivan
Chair, WDGHU Board of Health

c.c. alPHA – via e-mail

c.c. Liz Sandals, MPP (Guelph) – via e-mail

c.c. Ted Arnott, MPP (Wellington-Halton Hills) – via e-mail

c.c. Sylvia Jones, MPP (Dufferin-Caledon) – via e-mail

c.c. Randy Pettapiece, MPP (Perth-Wellington) – via e-mail

c.c. Ontario Public Health Units – via e-mail
May 3, 2017

DEVELOPED VIA E-MAIL & REGULAR MAIL

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

Attention: The Honourable Eric Hoskins
Office of the Minister

Dear Hon. Hoskins:

Re: Provincial Alcohol Strategy

The Board of Health (BOH) for Wellington-Dufferin-Guelph Public Health (WDGPH) would like to urge the Ontario Government to develop a comprehensive, province-wide strategy to support the safe consumption of alcohol. The health harms associated with alcohol consumption impact tens of thousands of individuals in Ontario every year. With the increasing availability of alcohol in the province, it is important that the government move forward with the commitment it made to social responsibility in the 2015 Ontario Budget to correspond with the increasing availability of alcohol.

Since 2014, Ontarians have been able to purchase alcohol at grocery stores, farmers’ markets, online sales through the LCBO and the expansion of bars and restaurants permitted at alcohol manufacturing sites. This increased availability has not been accompanied by a strategy to address the harms associated with alcohol use and misuse.

It is well established that an increase in the availability of alcohol leads to an increase in alcohol-related harms. Alcohol misuse is responsible for addiction, disease, social disruption and is one of the leading risk factors for disability and death in Canada. The health and financial costs to the individual and society are significant and include health care, law enforcement, lost productivity and premature mortality.
For the health of our communities, there is a need for a provincially led alcohol policy that mitigates the health harms associated with alcohol. A comprehensive, evidence-based approach will limit the harmful effects of alcohol to individuals and our communities.

Effective interventions to reduce alcohol-related problems include: (1) socially responsible pricing of alcohol; (2) limits on the number of retail outlets and hours of sale; and (3) alcohol marketing controls. There is strong evidence that these three policy levers are among the most effective interventions available, especially when they are paired with targeted interventions such as drinking and driving counter measures and enforcement of the minimum drinking age.

In order to support healthy outcomes for Ontarians and to reduce health care costs associated with alcohol consumption, a comprehensive, evidenced-based alcohol strategy is required as soon as possible. With the expansion of alcohol sales in the province, the current lack of a province-wide strategy to promote the safe consumption of alcohol is cause for concern. The WDGPH BOH urges the Ontario Government to move forward with this important priority for the health and well-being of our communities.

Sincerely,

Nancy Sullivan
Chair, WDGHU Board of Health

c.c. alPHa – via e-mail
c.c. Liz Sandals, MPP (Guelph) – via e-mail
c.c. Ted Arnott, MPP (Wellington-Halton Hills) – via e-mail
c.c. Sylvia Jones, MPP (Dufferin-Caledon) – via e-mail
c.c. Randy Pettapiece, MPP (Perth-Wellington) – via e-mail
c.c. Ontario Public Health Units – via e-mail
May 2, 2017

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

Dear Premier Wynne:

Re: Enactment of legislation to enforce infection prevention and control practices within personal service settings under the HPPA

On March 24, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Wellington Dufferin Guelph Public Health regarding enactment of legislation to enforce infection prevention and control practices (IPAC) within personal service settings (PSS) under the Health Protection and Promotion Act (HPPA). The following motion was passed:

Moved by: Arlene Wright  Seconded by: Al Barfoot

Whereas no provincial legislation currently exists that requires Personal Service Settings (PSS) operators to comply with infection prevention and control (IPAC) best practices, and;

Whereas, legislation specific to PSS premises would increase the enforcement abilities of public health staff and provide an incentive for operators to comply with IPAC best practices;

Therefore, the Board of Health for the Grey Bruce Health Unit formally request the Honourable Kathleen Wynne, Premier of Ontario, to enact legislation specific to PSS in support of the creation of wording under the Provincial Offences Act (POA) that would allow public health staff additional enforcement options when dealing with infractions in these premises.

Carried

Sincerely,

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

Cc: All Ontario Boards of Health

Encl.
Hon. Charles Sousa  
Minister of Finance  
Hepburn Block  
80 Grosvenor Street, 109th Floor  
Toronto, ON M7A 2C4  

Dear Minister Sousa,

Re. Ontario Budget 2017

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 comment on several aspects of this year’s Ontario Budget that are related to our members’ work.

We congratulate you on bringing forward Ontario’s first balanced budget in nearly a decade, but agree with the observation in your speech that a balanced budget is not an end in itself. We are pleased to see that you have characterized a balanced budget as an opportunity to make significant new investments in areas such as child and seniors care, education, income supports and health.

More specifically, there are several items in this year’s budget that are aligned with our interests, and to which our members will have important contributions to make:

**Strengthening Health Care:** An additional $7 Billion investment is being made in health care over the next three years, which represents a 3.3% annual increase to the health budget. No specific mention is made of increasing investments in local public health, but as the Ministry of Health and Long-Term Care seeks to solidify public health’s position within the health care system, alPHA will be carefully monitoring the Ministry-approved budgets of its members to ensure that they are also receiving the increases they need after two years at 0% to deliver on their new and existing mandated programs and services. Our 2015 resolution on this subject is attached.

**OHIP+: Children and Youth Pharmacare:** We are extremely supportive of your announcement to provide universal drug coverage for all Ontarians 24 years of age and under starting in January of next year. alPHA’s 2015 resolution, which calls for a National Universal Pharmacare Program, is attached.

**Promoting Healthy and Active Aging:** The government’s $8M investment over the next three years for Elderly Persons Centres, which provide social and recreational programs that promote seniors’ wellness aligns well with our position that health and wellness must be promoted at all ages and stages.
Acting on Ontario’s Opioid Strategy: We agree that taking immediate and robust action to address the opioid use / overdose crisis in Ontario is required. We have already congratulated the Minister of Health and Long-Term Care for implementing a provincial opioid overdose strategy as well as for the recently-announced expansion of naloxone availability. Our Council of Ontario Medical Officers of Health (COMOH) expressed its support for Safe Injection Sites as a harm-reduction measure via a letter to the Minister in 2013. We are therefore pleased to see a specific commitment to fund four such sites.

Preventing Fetal Alcohol Spectrum Disorder: This is a welcome investment of $26M over four years to support children, youth and families affected by FASD. The World Health Organization has identified alcohol as the world’s third largest risk factor for disease burden and we support measures that are aimed at reducing alcohol-related harms. We hope that this will become a part of a broader provincial alcohol strategy, which aPHa first called for via its attached 2011 Resolution.

Improving Care for Mothers, Babies and Children: We are pleased that improving care for mothers, babies and children is explicitly included this year’s Budget. Early childhood development is a key determinant of health, and health promotion and protection interventions during the earliest stages of life yield the greatest benefits later on. We are therefore supportive of the commitments to increasing access to prenatal screening, a new infant hearing screen, enhancing midwifery services and improving care for children and families. That said, we are very concerned that no mention is made of strengthening Ontario’s Healthy Babies Healthy Children (HBHC) program, which we believe is one of the most critical ways of identifying children who may be exposed to a host of social and economic risk factors that are known to have cumulative negative impacts on health and development throughout the lifespan. Our ability to deliver HBHC, a provincially mandated program, has severely eroded after nearly a decade of zero funding increases. Our 2016 resolution on this subject is also attached.

Tobacco: aPHa supports any effort to reduce the use and impact of tobacco industry products in Ontario. Pricing of such products has been clearly demonstrated as an effective tool to achieve this, and we thank you for the immediate $2 per carton levy that will increase to $10 over the next three years. We also note your pledge to modernize the Smoke-Free Ontario Strategy, and we look forward to lending our input and expertise to this process.

Basic Income: Having passed aPHa Resolution A15-4 (Public Health Support for a Basic Income Guarantee, attached) two years ago, we have expressed our support for the Government’s progress on this, and we are delighted that the details of the pilot project have been released. We will of course be monitoring the outcomes of this initiative with great interest.

Taken together, the above items are representative of the breadth of opportunities to give a central role to the health promotion and disease prevention activities that are the core business of Ontario’s public health system. Many of these are requirements under The Ontario Public Health Standards (OPHS), and Ontario’s Boards of Health are already delivering related programs and services. In other areas, they are engaged with community partners in policy, programming and advocacy that are aimed at keeping people well.

We offer our congratulations on this year’s budget, and we look forward to repeating them in the future as the value of Ontario’s public health system and the importance of its goals and objectives are recognized and fully supported.
Sincerely,

[Signature]

Dr. Valerie Jaeger,
President

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

Encl.
This year’s Ontario budget is the first to be balanced since the 2008 economic downturn, and the stronger than expected growth combined with what are billed as successful management measures during the austerity years have presented the Province with opportunities to make significant new investments in the areas such as child and seniors care, education, income supports and health.

Some of the significant measures in this budget have already been announced or at least reported in the media, such as lowering hydro rates, the announcement of a Basic Income Pilot program to be launched this spring in three communities, the creation of 24K new child care spaces and the provision of additional subsidies to make them more affordable.

There is a strong focus on health, with the announcement of an additional three-year investment of $7 Billion in various elements of the health care system, including a surprising yet welcome announcement of a universal pharmacare program for all Ontarians under the age of 25.

There is no specific mention of Ontario’s public health system, but there are nonetheless a good number of items of interest that have some bearing on its mandate.

The following summarizes the items that are likely of most interest to alPHA’s members, whether they directly affect their business, are related to resolutions and positions that alPHA and its members have taken, or are items in which our members have demonstrated a keen interest.

alPHA will continue its strategy of using the language and commitments found in these documents to advance our own advocacy efforts by underscoring that the work of public health is well-aligned with Government priorities.

- Headings and page numbers refer to the 2017 Budget Papers document, which you can download by clicking the link.
- The Minister’s speech is here.
- Online Highlights of the Budget are available here.

CHAPTER 1: RESTORING BALANCE – ONTARIO’S ECONOMIC AND FISCAL STRENGTH

This is an introductory chapter that summarizes the path to this year’s balanced budget and outlines the opportunities for investment that a balanced budget and growing economy present.

CHAPTER 2: HELPING YOU AND YOUR FAMILY

This is the chapter that contains most of the “pocketbook” measures that are designed to have a direct effect on household finances. These include recently-announced strategies to cool the housing market
in hot areas, restructure OSAP to make tuition more affordable, and lower hydro rates. There are also some items here that will be of particular interest to alPHA’s members:

HELPING PARENTS

**OHIP+: Children and Youth Pharmacare**: Starting January 1 2018, the Province will provide universal drug coverage for all Ontarians 24 years of age and under. There will be no deductible and no co-payment (p. 25). alPHA will be sending a letter of congratulations to the Minister for this measure, as it partially fulfils the operative clause of **alPHA Resolution A15-2**, National Universal Pharmacare Program.

HELPING SENIORS

**Promoting Healthy and Active Aging**: The government is providing $8M over the next three years to allow the establishment of an additional 40 new Elderly Persons Centres, which are community centres that provide social and recreational programs that promote seniors’ wellness (P. 33).

CHAPTER 3: CREATING OPPORTUNITIES AND SECURITY

This chapter deals primarily with strategies to support economic prosperity through job creation, skills development, business sector investment and supports for a low-carbon economy. This chapter also covers measures intended to improve retirement security as Ontario’s population ages.

CHAPTER 4: PUBLIC SERVICES YOU CAN COUNT ON

**STRENGTHENING HEALTH CARE**

The government is investing an additional $7 Billion in health care over the next three years. This is intended to reduce wait times, improve access to care and enhance the patient experience. Growth in health care spending is now expected to average 3.3% over the medium term (P. 105). Much of this is focused primary care and clinical services. There is no specific mention of investments in local public health, but alPHA will be carefully monitoring the Ministry-approved budgets of its members to ensure that they also receiving the increases they need to deliver on their mandated programs and services.

**Acting on Ontario’s Opioid Strategy**: This section outlines some of the previously-announced measures to address the opioid use / overdose crisis in Ontario, including the recently-announced expansion of naloxone availability (alPHA has written a letter on this). The Province also plans to fund 4 Safe Injection Sites (one in Ottawa and three in Toronto) pending granting of federal exemptions. It will also set up a review panel that will consider additional ones on a case-by-case basis (pp. 116-117).

**Preventing Fetal Alcohol Spectrum Disorder**: This is an investment of $26M over four years to support children, youth and families affected by FASD. It will include information and training resources, 56 FASD support workers, support for parent networks, support for FASD initiatives developed by indigenous partners, the establishment of a consultation group and a research fund (p. 117).

**Improving Care for Mothers, Babies and Children**: Ontario will be investing in new and existing programs to improve child and maternal health. These include a new infant hearing screening program, improvements to the existing prenatal screening program, improved supports for premature babies,
support for families who have experienced pregnancy or infant loss and increased investments in midwifery services (pp. 126-127). There is no mention of the Healthy Babies Healthy Children program. alPHa will be sure to highlight this omission in its response to the budget.

**Protecting Health Care for Tomorrow:** This section includes a reference to modernizing the Smoke-Free Ontario Strategy for 2017, and an increase of the tobacco sales tax by $10 per carton over the next three years, beginning with a $2 per carton tax effective immediately (p. 129). Further details are presented on p. 285.

**Health Innovation:** A box on this page refers to a pilot project on Accessing Digitized Health Data, which will see the development of a “proof-of-concept” digital registration and authentication service that will allow for the secure access by parents to their kids’ immunization records electronically, using banking credentials. This may be expanded to access other types of health records. The idea will receive a one-time investment of $1M in 2017-18 (p. 131)

**INVESTING IN EDUCATION**

**Promoting Student Well-Being:** The government will be investing $49M over three years to develop and strengthen programs to improve students’ cognitive, emotional social and physical development through Equity and Inclusive education, Safe and Accepting Schools, Healthy Schools, and Positive Mental Health (p. 140).

**BUILDING INCLUSIVE COMMUNITIES AND IMPROVING THE JUSTICE SYSTEM**

**Introducing a Basic Income Pilot:** This is a previously-announced three-year pilot program based on the idea that providing people with a basic income could be a reasonable way to reduce poverty. Please proceed to alPHa’s Determinants of Health Resolutions Page for links to details of the program and related alPHa correspondence.

**Improving Social Assistance Benefits:** The government will be increasing social assistance rates by 2% this year (p. 166). This is a larger increase than was provided in the last few budgets, which was only 1%.

**CHAPTER 5: WORKING WITH OUR PARTNERS**

This chapter outlines Ontario’s relationship with municipalities and the federal government, but alPHa’s members may wish to examine the section entitled **Partnerships with Indigenous Communities** (beginning on p. 190). This is a brief reference to “The Journey Together: Ontario’s Commitment to Reconciliation with Indigenous Peoples. alPHa based a [recent conference](#) around Truth and Reconciliation and will be continuing to explore ways to support its members in their own engagement with indigenous organizations and communities.

**CHAPTER 6: RESPONSIBLE FISCAL MANAGEMENT**

This chapter includes a section on **Addressing Unregulated Tobacco**, which “undermines the Province’s health objectives and results in less revenue for important public services”. It outlines the measures that have been taken since the 2016 Budget to address this issue (pp. 210-211).
CHAPTER 7: A FAIR AND SUSTAINABLE TAX SYSTEM

This chapter includes a section on Supporting a Smoke-Free Ontario, which provides further details on the tax increase on cigarettes (p. 285).

We hope that you find this information useful.
Hon. Charles Sousa  
Minister of Finance  
Hepburn Block  
80 Grosvenor Street, 109th Floor  
Toronto, ON M7A 2C4  

Dear Minister Sousa,  

Re: Ontario Budget 2017 – Children and Youth Pharmacare  

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 congratulate you on taking a significant step towards providing universal pharmacare in Ontario.

We are extremely pleased that the 2017 Ontario Budget includes the provision of universal drug coverage for all Ontarians 24 years of age and under starting in January of next year under the “OHIP+: Children and Youth Pharmacare” program. This was indeed an unexpected and most welcome announcement.

Our members strongly support the idea of universal pharmacare, as demonstrated in the passage of our attached 2015 resolution (Resolution A15-2, National Universal Pharmacare Program). In passing this resolution, alPHa joined the growing ranks of economists and medical, health & business organizations that are calling for the immediate implementation of public coverage for prescription drugs across Canada, which remains the only country with a publicly-insured health-care system that does not cover the cost of the prescription medications.

The consequences of Canada’s decision not to include prescription medications in the coverage provisions of the Canada Health Act are far reaching. Canadians pay the highest per-capita prices for pharmaceuticals (over 40% higher than the average) of the members of the OECD that have public health care, and there is evidence that this is leading to poorer patient outcomes among individuals who cannot afford their treatment.

Ontario’s decision to implement a universal program for everyone 24 years of age and under is a dramatic step forward, and we are confident that it will demonstrate once and for all that including medications in our publicly-funded health care will yield a significant return on investment in the form of improving health outcomes and reducing strain on clinical health services.

We look forward to using Ontario’s leadership on pharmacare to reinforce our call for the development of an equitable, affordable and effective program for all Canadians to access to the medicines that they need, which will result in both a healthier population and a healthier economy.
Yours sincerely,

[Signature]

Dr. Valerie Jaeger  
ALPHA President

COPY: Hon. Kathleen Wynne, Premier of Ontario  
Hon. Eric Hoskins, Minister of Health and Long-Term Care  
Hon. Jane Philpott, Minister of Health (Canada)  
Hon. Bill Morneau, Minister of Finance (Canada)  
Dr. David Williams, Chief Medical Officer of Health  
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Division

End.
Hon. Charles Sousa  
Minister of Finance  
Hepburn Block  
80 Grosvenor Street, 109th Floor  
Toronto, ON M7A 2C4

Dear Minister Sousa,

Re. Ontario Budget 2017 & Healthy Babies Healthy Children 100% Funding

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 reiterate our call for full funding of all program costs related to the Healthy Babies Healthy Children program in context of related announcements that were included in the 2017 Ontario Budget.

We were very pleased to see that improving care for mothers, babies and children was explicitly included in the significant new investments to strengthen health care in Ontario over the coming years. Early childhood development is a key determinant of health, and health promotion and protection interventions during the earliest stages of life yield the greatest benefits later on.

We are therefore supportive of the commitments to increasing access to prenatal screening, a new infant hearing screen, enhancing midwifery services and improving care for children and families.

We are however concerned that your commitment to investing in “new and existing” programs to improve maternal and child health does not include a specific pledge to strengthen the Healthy Babies Healthy Children (HBHC) program, which our members are required to deliver under the Ontario Public Health Standards.

HBHC is a program that our members view as critically important, in that it represents the earliest possible opportunity to identify children who may be exposed to a host of social and economic risk factors that are known to have cumulative negative impacts on health and development throughout the lifespan. Despite its indisputable value, this program has seen significant erosion since its introduction due to nearly two decades of chronic underfunding and political neglect.

We sincerely hope that your 2017 promise to invest in programs to improve maternal and child health will in fact include direction and support to the Ministry of Children and Youth Services to meet its obligations in fully funding the Healthy Babies, Healthy Children program, including all staffing and administrative costs.
Sincerely,

Jaeger

Dr. Valerie Jaeger,
President

Copy: Hon. Michael Coteau, Minister of Children and Youth Services
Hon. Eric Hoskins, Minister of Health and Long-Term Care
Monique Taylor, NDP Critic, Children and Youth Services
Gila Martow, PC Critic, Children, Youth and Families
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division.

Encl.
May 3, 2017

Ms. Roselle Martino
Assistant Deputy Minister
Population and Public Health Division
Ministry of Health and Long Term Care
80 Grosvenor Street, 11th Floor, Hepburn Block
Toronto, Ontario  M7A 1R3

Dear Ms. Martino:

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 provide feedback regarding the set of tools for skill and competency based boards of health developed by the Institute on Governance (IOG) as part of the response to Algoma Public Health’s assessors report and shared with alPHa’s Boards of Health Section last June. I also want to congratulate you on your Division’s attention to this important issue and to thank you for including alPHa and its Boards of Health Section in the review process.

alPHa shares your strong commitment to promoting the objectives of good governance among Ontario’s boards of health. The current composition of boards of health ensures the inclusion of the skills that are inherent in strong representation from elected municipal representatives. Board of health members first and foremost know the communities they serve and have a passionate commitment to the health of the people living in those communities. This understanding of the unique health and social challenges within the local context is among the skills valued on a board of health.

Other valuable board skills, such as human resources, finance, legal, governance, etc., are present to varying degrees among boards of health but are difficult to specifically recruit for. The opportunities for such targeted recruitment may be further complicated by board circumstances such as when a regional or municipal council serves as the board of health or when a board’s jurisdiction is large and/or sparsely populated. For boards of health with participation from provincial appointees, an opportunity to address identified skill gaps may be found within the Public Appointee Secretariat’s recruitment process and we encourage you to explore this avenue further.

Notwithstanding their current strengths, boards of health would benefit from engagement in ways to enhance skills. We firmly believe in the importance of all boards of health possessing the skills that are known to facilitate good governance practices and that a professional development approach is an essential part of ensuring local boards of health have the best opportunity to assess any gaps in governance expertise and, where necessary, build the skills and competencies for strong governance. A professional development approach builds on the work already done by alPHa, the Ontario government, and organizations such as IOG and the Association of Municipalities of Ontario to promote enhanced governance practices by developing tools to support local boards.
Ms. Roselle Martino  
May 3, 2017

aPHa continues to develop its own internal capacity in the area of board development and has identified consulting resources that a number of boards are using for governance training. Boards should be encouraged to continue with this work and to use the tools available such as aPHa’s governance toolkit that contains examples from Ontario’s boards of health to facilitate the sharing of existing strong governance practices. We would propose for aPHa to be provided with more detail about the tools available through IOG so the association can incorporate them into the supports that it provides to boards of health. In this endeavour, we would welcome the input of you and your staff, and request a meeting to discuss further.

Thank you for your ongoing support in the important area of board governance and we look forward to the continuing conversation.

Sincerely,

[Signature]

Dr. Valerie Jaeger,  
President

Copy: Dr. David Williams, Chief Medical Officer of Health, MOHLTC
MAR 3 1 2017

Mr. René Lapierre
Chair, Board of Health
Sudbury and District Health Unit
1300 Paris Street
Sudbury ON P3E 3A3

Dear Mr. Lapierre:

I am pleased to advise you that the Ministry of Health and Long-Term Care will provide the Board of Health for the Sudbury and District Health Unit up to $45,600 in additional base funding for the 2016-17 funding year, which will annualize to up to $156,600 for the 2017-18 funding year and up to $133,400 in additional one-time funding for the 2016-17 funding year to support the provision of mandatory and related public health programs and services in your community.

The Assistant Deputy Minister of the Population and Public Health Division will write to the Sudbury and District Health Unit shortly concerning the terms and conditions governing this funding.

Thank you for your dedication and commitment to Ontario’s public health system.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury and District Health Unit
May 3, 2017

DELIVERED VIA EMAIL & REGULAR MAIL

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

Dear Minister Coteau:

Re: Healthy Babies Healthy Children Program Targets and Funding

On May 3, 2015 at a regular meeting of the Board of Health for Wellington-Dufferin-Guelph Public Health, the Board reviewed the ongoing and increasing challenge to meet Ministry expectations for HBHC service provision within the 100% funding envelope. MCYS program enhancements have increased the range and evidence base for interventions that can be offered by HBHC, however, chronic underfunding continues to challenge program integrity and fidelity as limited resources preclude full compliance and achievement of MCYS implementation targets.

The following motion was passed:

“That the Board of Health for Wellington-Dufferin-Guelph Public Health advocates for the Ministry of Children and Youth Services to commit to aligning program service delivery expectations with the annual budget; and the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs, and the annual increases in cost to deliver services.”

Thank you for giving this request your every consideration.

Sincerely,

Nancy Sullivan  
Chair, WDGP Health

cc via email: MPP Liz Sandals, Guelph MPP Sylvia Jones, Dufferin-Caledon MPP Ted Arnott, Wellington-Halton Hills Dianne Alexander, Director, Healthy Living Policy and Programs Branch, MOHLTC Ontario Boards of Health
May 3, 2017

DEVELOPED VIA EMAIL AND REGULAR MAIL

Linda Stewart
Executive Director
Association of Local Public Health Agencies
2 Carlton Street, Suite 1306
Toronto, ON M5B 1J3

Dear Ms. Stewart:

Re: Fluoride Varnish Programs for Children at Risk for Dental Caries

On May 3, 2017, the Board of Health for Wellington-Dufferin-Guelph Public Health passed the following Motion:

“That the Board of Health submit the resolution “Fluoride Varnish Programs for Children at Risk for Dental Caries to the Association of Local Public Health Agencies, for approval.”

Support from aPHa would assist public health units in their advocacy to have the Ministry of Health and Long-Term Care allow fluoride varnish programs to be funded by the HSO program.

Thank you for your time and consideration to this important public health issue.

Sincerely,

Nancy Sullivan
Chair, WDGPH Board of Health

cc via email: MPP Liz Sandals, Guelph
MPP Sylvia Jones, Dufferin-Caledon
MPP Ted Arnott, Wellington-Halton Hills
Ontario Boards of Health
DRAFT RESOLUTION FOR aPHa RESOLUTIONS SESSION (2017)

TITLE: Fluoride Varnish Programs for Children at Risk for Dental Caries

SPONSOR: Board of Health for Wellington-Dufferin-Guelph Public Health

BACKGROUND

Fluoride varnish is an evidence-based practice that is recognized as safe and effective for reducing the risk of tooth decay. Wellington-Dufferin-Guelph Public Health (WDGPH) currently provides fluoride varnish applications to students in seven high risk elementary schools. These schools were selected because a high proportion of children were identified with urgent dental needs during oral health screenings by WDGPH. This initiative started in the 2007-2008 school year at one school, Centre Peel Public School, which had a high percentage of children with urgent dental needs (30%). After four years, this percentage was reduced to 17% and based on this positive result the program was expanded to additional schools.¹ The percentage of children with urgent dental needs at Centre Peel has continued to fall to approximately 5%. A cost/benefit analysis indicates that considerable savings were achieved in terms of payments to dentists for restorative treatment. From 2008-2014, it is estimated that between 670 and 780 cavities have been prevented in students at Centre Peel. If treatment costs were divided between private (60%) and provincial programs (40%), savings of between $132,000 and $155,000 are estimated.²

On November 2, 2016, the Board of Health for WDGPH was informed of changes in the funding model for oral health programs which occurred as a result of the integration of government-funded dental care for children into the new Healthy Smiles Ontario (HSO) program.³ Two key points of that report were:

- From 2010 to 2015, the costs of WDGPH’s Fluoride Varnish Program (FVP) were paid through the HSO budget which is 100% provincial.
- As of January 1, 2016, population-based or universal interventions such as FVPs are no longer included as eligible expenses under the new HSO program.

Although the Board of Health for WDGPH has decided to fund the FVP through the base budget, the continuation of population based preventive programs needs to be ensured by allowing them to be funded as part of the new HSO program. Not only do these interventions reduce disease prevalence, they also reduce oral health-related costs for individuals, governments and businesses both directly and indirectly (e.g. less time off work and school for dental care).

WHEREAS

In Ontario, 23% of Junior Kindergarten, 31% of Senior Kindergarten and 44% of Grade 2 children have at least one tooth that has experienced tooth decay (i.e., filled or decayed tooth);⁴

WHEREAS

Dental caries is a preventable disease and untreated tooth decay may lead to pain, infection, abscesses, tooth loss, chewing problems, poor nutritional status, poor self-esteem, and may negatively affect school performance, ability to learn, and growth and development.⁵
WHEREAS
Dental surgery to treat severe tooth decay is the leading cause of day surgery among children five years and under. Approximately 19,000 of these operations are performed each year in Canada at a cost of $21.2 million. This cost is only a fraction of the true cost because it does not include the cost of dental treatment or travel.6

WHEREAS
A Cochrane evidence-based review reported that the application of fluoride varnish is an effective intervention to reduce the risk of dental caries and reverse early carious lesions.7 This review found a 43% reduction in decayed, missing and filled tooth surfaces among permanent teeth and a 37% reduction among primary teeth;

WHEREAS
Biannual topical fluoride applications are recommended by the Centres for Disease Control and Prevention for the prevention of dental caries in children at risk.8 Primary care clinicians are also recommended to apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.9

WHEREAS
The application of fluoride varnish is not a regulated act and does not require a lengthy course of training to learn application techniques and contraindications for use. Fluoride varnish is safe, easy to apply, well accepted by young children and can be provided by a variety of public health and primary care workers (e.g. oral health/dental staff, physicians, nurses, medical assistants);

WHEREAS
Fluoride varnish can be readily applied in different community outreach locations and does not require the use of dental equipment or special applicators;

WHEREAS
By reducing the risk and incidence of dental caries, FVP reduce the costs of restorative dental treatment (i.e. dental fillings) and other costly dental treatments, such as root canal therapy, crown and bridge, and dentures;

WHEREAS
Ontario public health units conduct annual screening of elementary schools in order to classifies schools as low, moderate or high screening intensity based on the percentage of Grade 2 children with two or more decayed teeth;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (aPHa) petition the Ontario Government to provide funding through the HSO program for the implementation of school and community-based programs which use fluoride varnish to reduce the risk of tooth decay among children at risk for dental caries;

AND FURTHER that aPHa write to all boards of health in Ontario encouraging them to start a FVP for children at risk, if they have not already done so.
REFERENCES


May 1, 2017

Mr. Ronald Farrell  
Board Chair  
North East Local Health Integration Network  
555 Oak Street East, 3rd Floor  
North Bay ON  P1B 8E3  

Dear Mr. Farrell:

I am pleased to write you in your capacity as Chair of the North East Local Health Integration Network (LHIN). As per the requirements of the Agencies and Appointments Directive, this letter sets out my expectations for the North East LHIN for the 2017-18 fiscal year. Moving forward, I will be issuing a mandate letter every fiscal year.

First, thank you for your extensive efforts during this period of transition. Without your continued leadership and support, we would not be at the state of readiness for transition that we are today. With a strong team behind you, I have no doubt that your LHIN will see a successful transition.

While transition is important for the implementation of the Patients First Act, the opportunity for transformation is paramount, and expected by patients and caregivers, health care partners and the broader public in an effort to build a more sustainable, efficient and accessible health care system for future generations. With the foundation that has been created with the Patients First legislation, this is our opportunity to ensure patients are truly at the centre of the health care system. With this in mind, I believe our collective key priorities as we embark on this transformation phase are to:

- Improve the patient experience by putting the patient voice at the centre of health care planning and by delivering care that is responsive to patients’ needs, values and preferences.
- Address the root causes of health inequities by strengthening the social determinants of health, investing in health promotion, and reducing the burden of disease and chronic illness.
- Create healthy communities by improving access to primary care and reducing wait times for specialist care, mental health & addictions services, home and community care and acute care for patients when they need it, which will reduce variation in access across the province.
- Break down the silos between our health care sectors and providers to ensure seamless transitions for patients, and to ensure that providers work together to provide patient-centred care.
Mr. Ronald Farrell

- Support innovation by delivering new models of care and digital solutions to make accessing care easier for patients and more efficient for health care providers.

Transformation will occur for many years beyond this mandate letter, but these priorities are important to consider when planning for 2017-18.

**Integrated Health Care Planning and Responsible Fiscal Management**

With your new mandate, you will be responsible for creating an integrated service delivery network that includes primary care providers, inter-professional health care teams, hospitals, public health, mental health and addictions and home and community care to ensure a more seamless patient experience.

While undergoing this work, it is also expected that you will remain fiscally responsible but manage your budget in a prudent manner to ensure programs and services are effective, efficient, and sustainable into the future. I also expect the LHIN to further streamline and increase the efficiency of administration and ensure savings are reinvested into front-line patient care.

As a reflection of these responsibilities in 2017-18, the North East LHIN is asked to make progress on the following priorities:

**Transparency and Public Accountability**

- Continue to be accountable for outcomes and report on your progress toward achieving health system performance targets.
- Collaborate with the Ministry to develop performance targets to measure the success of transformational activities and publicly report on progress and outcomes.
- Effectively manage all operational, strategic, and financial risks encountered by the LHIN while ensuring alignment with government priorities and achievement of business objectives.

**Improve the Patient Experience**

- Establish and engage your Patient and Family Advisory Committee(s) to ensure patients and families are involved in health care system decision-making.
- Work towards improving transitions for patients between different health sectors so that patients receive seamless, coordinated care and only tell their story once.
- Support patients and families by implementing initiatives that reduce caregiver distress.

**Build Healthy Communities Informed by Population Health Planning**

- With input from patients, caregivers and partners, assess local population health needs, patient access and wait times and the capacity of health providers to serve the community.
- Through sub-regional (community level) planning, identify how providers will collaborate to address health gaps, and improve patient experience and outcomes.
Equity, Quality Improvement, Consistency and Outcomes-Based Delivery

- Work with the sector to both enhance existing and develop new performance and quality measurement frameworks that are consistent and flexible to address regional priorities.
- Work with local clinicians at a community level to support implementation of quality standards in partnership with Health Quality Ontario.
- Promote health equity and recognize the impact of social determinants of health to reduce or eliminate health disparities and inequities in the planning, design, delivery and evaluation of services by:
  - Identifying high-risk populations and working with public health and local community partners on targeted interventions to improve access to appropriate and culturally sensitive care, and improve health outcomes, including through sub-region planning.
  - Ensuring engagement with Indigenous leaders, providers and patients to guide investments and initiatives.
  - Assessing the capacity of health service providers within LHIN sub-regions and the extent to which Francophone citizens are provided with an active offer of health services in French, and develop a plan to strengthen health services in French.

Primary Care

- Continue to build primary care as the foundation of the health care system and work with health care providers to develop sub-region plans that:
  - Use an equity lens to assess the number and proportion of primary care providers based on the needs of the local population.
  - Improve access to primary care providers, including family doctors and nurse practitioners.
  - Facilitate effective and seamless transitions between primary care and other health and social services.
  - Improve access to inter-professional health care providers to ensure comprehensive care.
- As a priority, develop and implement a plan with input from primary care providers, patients, caregivers and partners that embeds care coordinators and system navigators in primary care to ensure smooth transitions of care between home and community care and other health and social services as required.
- Support the integration of Health Links into sub-regional planning with input from primary care providers.

Hospitals and Partners

- Work with system partners to improve how people move through the health system to avoid unnecessary hospital stays, reduce the length of time people must spend in hospital, including the emergency room, and reduce the number of people who are waiting in a hospital bed for the right level of care.
- Support hospitals to enable the adoption of innovations in patient care, like bundled care.
Specialist Care

- To improve access to specialty care, work with providers to further reduce wait times and drive appropriate care utilization starting with people suffering from musculoskeletal (MSK) pain, and those suffering from mood disorders.
- Support enhanced connections and communications across networks of providers to drive more effective and appropriate specialist referrals.

Home and Community Care

- With input from patients, caregivers and partners:
  - Reduce wait times and improve coordination and consistency of home and community care so that clients and caregivers know what to expect.
  - Continue to implement the initiatives in Patients First: A Roadmap to Strengthen Home and Community Care.
- A key priority for 2017-18 is the completion and consolidation of the transition.

Mental Health and Addictions

- Based on the advice from Ontario’s Mental Health and Addictions Leadership Advisory Council, work with local partners and other sectors to expand access to mental health and addictions services that:
  - Expand access to structured psychotherapy and supportive housing.
  - Establish referral networks with primary care providers.
  - Make access to community mental health services a priority for sub-region planning, in collaboration with community and social service providers and partners.
- Support the provincial opioid strategy, and provide support to connect patients with high quality addictions treatment.

Innovation, Health Technologies and Digital Health

- Champion Ontario as a leading ecosystem to adopt and scale new and innovative health technologies and value-based processes.
- Support the ministry’s Digital Health Strategy, once published, including but not limited to:
  - Ensuring that any hospital information system (HIS) renewal decisions are consistent with HIS Renewal Advisory Panel clustering recommendations and reflect a commitment to reduce the overall number of HIS instances in the province.
  - Implementing or expanding existing virtual models of care or digital self-care models that are consistent with existing provincial initiatives.
  - Supporting the delivery of digital solutions to improve patient access and navigation as well as referrals to specialists, and further expand online consultation between primary care providers and specialists.
Mr. Ronald Farrell

As you deliver on your new mandate, I expect the LHIN to ensure the following key pillars are maintained and strengthened:

- Promote health equity, and reduce health disparities and inequities.
- Respect the diversity of communities in the planning, design, delivery and evaluation of services, including culturally safe care for Indigenous people and meeting the requirements of the French Language Services Act.
- Continue to strengthen local engagement with Francophone and Indigenous communities.
- Work with health service providers and communities to plan and deliver health services.

Ontario’s board-governed provincial agencies are vital partners in ensuring the delivery of high quality services to Ontarians. The people of Ontario depend on you to provide leadership to your agency’s board, management and staff. Together with your fellow board members, the people of Ontario rely on you to establish the goals, objectives and strategic direction for the agency consistent with your agency’s mandate, government policies, and my directions, where appropriate.

I thank you for your willingness to serve, as we work together to put patients at the centre of a high performing health care system that is accessible, equitable and integrated, and one that will be there for generations to come.

Yours sincerely,

Original signed by the Minister

Dr. Eric Hoskins
Minister

c: Ms. Louise Paquette, Chief Executive Officer, North East Local Health Integration Network
Dr. Bob Bell, Deputy Minister, MOHLTC
Ms. Nancy Naylor, Associate Deputy Minister, Delivery and Implementation, MOHLTC
Mr. Tim Hadwen, Assistant Deputy Minister, Health System Accountability and Performance Division, MOHLTC
The weakening of public health: A threat to population health and health care system sustainability

We are a group of public health (PH) academics and physician leaders who are passionate about health in our communities and our country. We are alarmed by growing weaknesses in the country’s PH infrastructure and thus in the system’s ability to promote and protect the health of all Canadians. Yet improved population health and reduced health inequalities are key to reducing the burden of disease and ensuring the sustainability of Canada’s health care system.

The evidence is clear that PH – in partnership with citizens, communities, NGOs, municipalities and others – has been central to reductions in disease and injury and improvements in health and longevity. That is why in 2010, Canada’s Ministers of Health stated: “the promotion of health and the prevention of disease, disability and injury are a priority and necessary to the sustainability of the health system” and that “a better balance between prevention and treatment must be achieved”.

But 15 years after SARS and the call of the landmark Naylor Report for PH to be strengthened, those bold aims have not been realized. We are again at a crisis point; PH is under siege in many jurisdictions across Canada, where it has been weakened and marginalized and cannot be fully effective. Without significant change, we believe PH systems across Canada will increasingly underperform and be unable to fully contribute to our need to “create healthier populations, and to sustain our publicly funded health system”, to the detriment of Canadians.

FOUR CRITICAL ISSUES

We identify here four key problems with current government approaches to PH across Canada that are of national concern; taken together they constitute a crisis. Each is addressed below, together with possible responses.

1. Downgrading the status of public health within governments and health authorities

Federally, the Chief Public Health Officer for Canada (CPHO) is no longer the Deputy Minister of the Public Health Agency of Canada (PHAC). This position has been relegated to an advisory role reporting to the President of PHAC, thus undermining the authority and independence of the office, including the ability to speak on matters of public health; this situation also applies generally to Provincial Health Officers (PHOs) across the country. In health authorities (HAs), the senior Medical Officer of Health (MOH) may not even be on the Executive of the HA, which downgrades not only the importance of primary prevention of disease and injury but the effectiveness of PH as a whole, including the ability to contribute to effective planning that also looks at non-clinical solutions.

* While we use here the titles of Provincial Health Officer and Medical Officer of Health, we recognize that different provinces may use different titles.

L’affaiblissement de la santé publique : une menace pour la santé des populations et la viabilité du système de soins de santé

Nous sommes un groupe d’universitaires et de médecins en santé publique (SP) passionnés par la santé de nos communautés et de notre pays. Nous nous inquiétons des faiblesses croissantes des infrastructures de SP à travers le pays, et donc de la capacité du système de promouvoir et de protéger la santé de tous les Canadiens. Il est pourtant essentiel d’améliorer la santé des populations et de réduire les inégalités de santé pour alléger le fardeau de la maladie et assurer la viabilité du système de soins de santé du Canada.

Il est clairement démontré que la SP – en partenariat avec les citoyens, les communautés, les ONG, les municipalités et d’autres – a joué un rôle central dans la réduction des maladies et des blessures et dans les améliorations de la santé de et de la longévité. C’est pourquoi les ministres de la Santé du Canada déclaraient en 2010 que « la promotion de la santé et la prévention des maladies, des incapacités et des blessures sont prioritaires et nécessaires à la viabilité du système de santé » et que « nous devons atteindre un meilleur équilibre entre la prévention et le traitement ».

Mais 15 ans après le SRAS et l’appel à renforcer la SP dans le document phare que fut le Rapport Naylor, ces objectifs audacieux ne se sont pas concrétisés. Nous sommes de nouveau au bord de la crise; la SP est en état de siège dans de nombreuses provinces au Canada, où elle a été affaiblie et marginalisée au point de ne pas être pleinement efficace. Sans un changement marqué, nous croyons que les systèmes de SP du Canada seront de plus en plus sous-performants et deviendront incapables de répondre entièrement à notre besoin « [d’]assurer des populations en meilleure santé et [d’]améliorer la viabilité de notre réseau public de santé », au détriment des Canadiens.

QUATRE QUESTIONS NÉVRALGIQUES

Nous cernons ici quatre grands problèmes d’importance nationale dans la façon dont les gouvernements actuels abordent la SP au Canada; considérés dans leur ensemble, ces problèmes constituent une crise. Chacun est abordé ci-dessous, avec des réponses possibles.

1. La santé publique est rétrogradée au sein des gouvernements et des autorités sanitaires

Au palier fédéral, l’administratrice en chef de la santé publique du Canada n’est plus sous-ministre de l’Agence de la santé publique du Canada (ASPC). Elle ne joue plus qu’un rôle consultatif auprès de la présidente de l’Agence, ce qui mine le pouvoir et l’indépendance de son poste, notamment sa capacité de s’exprimer sur les enjeux de santé publique; cette situation prévaut aussi fréquemment pour les directeurs/directrices provinciaux de santé publique (DPS). Au sein des autorités sanitaires, le directeur/la directrice de la santé publique ou le médecin-hygieniste en chef (DSP-MH) peut même ne pas siéger au comité exécutif, ce qui réduit non seulement l’importance de la prévention primaire des maladies et des blessures, mais l’efficacité de la SP dans son ensemble,
Drastic centralization of PH occurred in Alberta (2008) and Nova Scotia (2015). Following these reforms, numerous PH experts now practice as senior PH leaders in departments of health, and thus struggle to protect scientific independence from political interference, a challenge that also haunts the CPHOC’s office.

Incorporating PH within health authorities in some cases has led to its dismemberment, with different disciplines moved to different divisions, thus destroying the cohesive whole of a PH unit and impairing its effectiveness.

- **Possible responses:**
  - Make it a policy in every province that the PHO sit on the Ministry’s Executive and that the senior MOH in every health authority sit on the HA’s Executive.
  - Maintain or re-establish PH departments as discrete units within HAs, incorporating all the PH disciplines, with adequate resources and accountability for defined PH outcomes (e.g., disease and injury prevention and decreasing health inequities, among others).
  - Consider removing PH units from health authorities and relocating them in or in close association with municipal governments.

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**2. Eroding the independence of Medical Officers of Health and their ability to speak out on matters of public health concern**

In several provinces, PHOs have been dismissed without cause, seemingly because they dared to speak out and question government policy – a situation in keeping with the muzzling of federal health scientists during the tenure of the Harper Government. In some provinces, MOHs feel less able to speak out because they are subservient to CEOs and bound by communications policies intended to avoid upsetting the government that funds the HA. Even where PHOs and MOHs are not dismissed, the power to marginalize them within the organization and to reduce the funding and staff allocated to PH provides silencing mechanisms.

All of this also contradicts the need for advocacy, which is a core PH competency in Canada and a duty for PH. In fact, MOHs are only explicitly protected in Ontario and British Columbia. In Ontario, the Health Protection and Promotion Act requires a two-thirds vote of the local board of health AND the written permission of the Minister of Health to dismiss a MOH. In BC, the Public Health Act requires the PHO to monitor the health of citizens and independently advise and report in the public interest; local MOHs have similar but more limited protection.

- **Possible responses:**
  - Make the CPHOC and PHOs officers of the legislature, with powers and independence similar to those of the Auditor General, including the duty to report to the legislature and the public on PH matters and government practices.
  - Identify in legislation the duty of MOHs to report publicly on matters of PH and confer upon them protection against arbitrary dismissal similar to that provided in Ontario.

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Y compris sa capacité de contribuer à une planification efficace en envisageant aussi des solutions non cliniques.


Dans certains cas, l’intégration de la SP au sein d’une autorité sanitaire mène à son démembrement, différentes disciplines étant affectées à différentes directions, ce qui détruit la cohésion d’une organisation de SP et entrave son efficacité.

- **Réponses possibles :**
  - Adopter dans chaque province une politique selon laquelle le/la DPS siège au sein de l’équipe de direction du Ministère et le/la DSP-MH de chaque autorité sanitaire siège au comité exécutif de cette autorité.
  - Garder ou rétablir l’unité des services de SP au sein des autorités sanitaires en intégrant toutes les disciplines de la SP et en leur accordant des ressources suffisantes et la responsabilité d’obtenir des résultats de SP bien définis (la prévention des maladies et des blessures et la réduction des inéquités en matière de santé, entre autres).
  - Songer à retirer les unités de SP des autorités sanitaires et à les reloker dans les administrations municipales ou en association étroite avec elles.

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**2. On sape l’indépendance des directeurs de la santé publique/médecins-hygiénistes et leur capacité de s’exprimer sur les questions d’intérêt pour la santé publique**

Dans plusieurs provinces, des DPS ont été démis de leurs fonctions sans motif valable, apparemment pour avoir osé parler et mettre en doute les politiques du gouvernement – une situation qui s’inscrit dans la logique du muséllement des chercheurs fédéraux en santé durant le mandat du gouvernement Harper. Dans certaines provinces, les DSP-MH se sentent moins libres de parler parce qu’ils relèvent de chefs de la direction et sont liés par des politiques de communication dont le but est de ne pas troubler le gouvernement, qui finance l’autorité sanitaire. Même là où les DPS et les DSP-MH ne sont pas congédiés, le pouvoir de les marginaliser au sein de l’organisation et de réduire le financement et le personnel affecté à la SP constitue un mécanisme efficace pour les réduire au silence.

Tout cela va aussi à l’encontre de la nécessité d’exercer la fonction de plaidoyer pour la santé, une compétence essentielle en SP au Canada et un devoir pour la SP. En fait, les DSP-MH ne sont explicitement protégés qu’en Ontario et en Colombie-Britannique. En Ontario, le *Loi sur la protection et la promotion de la santé* exige que la décision de congédier un médecin hygiéniste soit prise par les deux tiers des membres du conseil de santé local et que le ministre de la Santé y donne son consentement écrit. En Colombie-Britannique, la *Public Health Act* exige que le/la DPS surveille la santé des citoyens et offre des conseils et des rapports indépendants dans l’intérêt public; les DSP-MH locaux jouissent d’une protection semblable, quoique plus limitée.

- **Réponses possibles :**
  - Faire de l’administratrice en chef de la santé publique du Canada et des DPS des hauts fonctionnaires de l’assemblée
3. Limiting public health scope by combining it with primary and community care, without regard for the different functions and expertise involved

Public health staff are, and need to be, distinct from primary care staff. While there should be effective collaboration with primary care, that relationship should be only with respect to the core functions of PH; treatment, disease management and care are not core PH functions.

The biggest threat from combining PH with primary and community care is the limits it imposes on PH. Health is mostly created by broad determinants such as an adequate income, access to safe and nutritious food, safe and adequate housing, and living in safe and secure neighbourhoods in ecologically sustainable communities. If public health nurses (PHNs) are expected to function as primary care nurses in clinics, and community nutritionists as patient dietitians, and if environmental health officers are not allowed to inspect public spaces or medical officers of health can only advocate for more illness and injury treatment, PH’s core functions and the health of Canadians are threatened.

In fact, in preliminary research results from BC, PHNs report they are demoralized by cuts to their traditional community and population-level PH responsibilities (e.g., community development, advocacy, coalition work) in favour of individually-focused clinical tasks. Furthermore, managers/directors with PH training have been replaced with supervisors from acute care who do not understand PH. In addition, PHNs perceive that their PH leaders have no power to advocate for public health, so effective programs get cut because they are not a priority at the executive levels.

- Possible responses:
  - Do not integrate PH and primary care.
  - ‘Ring-fence’ PH staff positions and funding and ensure they do not get drawn into primary care services of treatment, disease management and care.

4. Decreasing funding for public health

Tracking PH investments across Canada has remained problematic. This lack of accurate data on PH investments persistently prevents governments from establishing – and being accountable for – PH funding levels needed to achieve targeted population health outcomes.

Even more worrisome, unprecedented cuts and chronic PH disinvestment have occurred in several provinces. In 2015, Quebec regional PH units were hit by record budget cuts of 33%. No serious rationale was offered for these arbitrary cuts, beyond the dangerous misconception that regional PH services are little more than bureaucracy in times of alleged austerity. Despite a 2005 review that named a target of investment of 4%-5%, PH funding in Nova Scotia has remained static at 1.3% of health care spending – one of the lowest levels in the country. In BC, despite two Select Committee reports recommending that PH funding be increased to 6% of the health care budget, thus achieving the “full ounce of prevention”, the share of the health budget going to PH has remained low and even declined in some HAs between 2008/2009 and 2011/2012. In Ontario, the implementation of a new funding model in 2015 has resulted in flat-line funding, legislative, dotés de pouvoirs et d’une indépendance semblables à ceux du vérificateur général, avec l’obligation de rendre des comptes à l’assemblée législative et au public sur les enjeux de SP et les pratiques gouvernementales.

- Inscrire dans les lois l’obligation des DSP-MH de rendre publiquement des comptes sur les enjeux de SP et leur conférer, comme on le fait en Ontario, une protection contre le congédiement arbitraire.

3. On limite la portée de la santé publique en la combinant avec les soins primaires et les soins communautaires, sans égard aux différentes fonctions et compétences spécialisées qui sont en jeu

Les effectifs de la santé publique sont (et doivent être) distincts des effectifs des soins primaires. Il devrait y avoir une collaboration efficace avec les soins primaires, mais seulement en ce qui a trait aux fonctions de base de la SP; le traitement, la gestion des maladies et les soins curatifs n’en font pas partie.

La plus grande menace de la combinaison de la SP et des soins primaires et communautaires est qu’elle impose des limites à la SP. La santé découle principalement des grands déterminants : des revenus suffisants, l’accès à des aliments sains et nutritifs, des logements salubres et adéquats, et le fait de vivre dans des quartiers sécuritaires, au sein de communautés écologiquement durables. Si les infirmières de santé publique (ISP) sont censées fonctionner comme les infirmières en soins primaires dans les cliniques, et les nutritionnistes communautaires comme les diététistes au service de patients, et si les professionnels en santé environnementale n’ont pas le droit d’inspecter les lieux publics ou que les directeurs de la santé publique ou les médecins-hygiénistes peuvent uniquement réclamer plus de traitements pour les maladies et les blessures, alors les fonctions de base de la SP, et la santé de la population canadienne, sont menacées.

De fait, selon les résultats d’une étude préliminaire menée en Colombie-Britannique, les ISP se disent démoralisées par les coupes dans leurs responsabilités traditionnelles de SP auprès des communautés et des populations. De plus, des gestionnaires et directeurs ayant une formation en SP sont remplacés par des superviseurs issus des soins curatifs, qui ne comprennent pas la SP. Les ISP perçoivent que les cadres supérieurs de la santé publique ne veulent pas les pousser à défendre cette dernière; des programmes efficaces se font donc couper parce qu’ils ne sont pas une priorité pour la haute direction.

- Réponses possibles :
  - Ne pas intégrer la SP et les soins primaires.
  - « Isoler » les postes et le financement des effectifs de SP et veiller à ce qu’ils ne soient pas aspirés dans les services de soins de première ligne : le traitement, la gestion des maladies et les soins curatifs.

4. On réduit le financement de la santé publique

La traçabilité des investissements en SP au Canada demeure un problème. Le manque de données exactes sur les investissements en SP empêche constamment les gouvernements d’établir les niveaux de financement de la SP nécessaires à l’atteinte
significantly reducing capacity in the majority of the province’s 36 boards of health.17

- Possible responses:
  - Establish targets for increased funding for PH, and a strategy to achieve them.
  - Establish clear budgets for PH and make the allocation visible. Require provincial and federal PH expenditures to be reported annually to Canadian Institute for Health Information and provincial and federal taxpayers.

The health of Canadians and the sustainability of their health care system depend in part upon recognizing that public health’s “most valuable work lies upstream”, and that governments should be investing in a strong system of public health services as a priority.18 Governments have a duty to ensure such a system is in place, a duty in which they are failing. We therefore believe it is time to undertake a national inquiry into the state of Public Health in Canada.

This proposed review should address the issues raised here and consider the suggested responses, as well as the need for a ‘whole of government’ approach to population health promotion19 and the role of PH in supporting and guiding this approach. It should be informed by existing PH service standards,20 and by the international body of evidence in public health systems and services research, and should address funding, human resource, and structural requirements for a strong Canadian PH system.

- Réponses possibles :
  - Établir des cibles d’accroissement du financement de la SP et une stratégie pour les atteindre.
  - Établir des budgets clairs pour la SP et rendre apparente l’allocation des fonds. Exiger que les dépenses provinciales et fédérales en SP soient déclarées annuellement à l’Institut canadien d’information sur la santé et aux contribuables provinciaux et fédéraux.

La santé des Canadiens et la viabilité de leur système de soins de santé dépendent en partie de ce que l’on reconnaît que le travail le plus précieux de la santé publique se fait en amont, et que les gouvernements devraient investir en priorité dans un système de services de santé publique vigoureux18. Les gouvernements ont le devoir de veiller à ce qu’un tel système soit en place, mais ils manquent à ce devoir. Nous croyons donc qu’ils sont temps de poser une enquête nationale sur l’état de la santé publique au Canada.

Ce projet d’enquête devrait aborder les questions soulevées ici et étudier les réponses suggérées, ainsi que le besoin d’adopter une démarche « pangervernmentale » à l’égard de la promotion de la santé des populations19 et du rôle de la SP pour soutenir et guider une telle démarche. L’enquête devrait être éclairée par les normes existantes pour les services de SP20 et par le corpus de données internationales de recherche sur les systèmes et les services de santé publique, et elle devrait aborder les besoins financiers, structurels et de ressources humaines d’un système de SP vigoureux au Canada.

Ak’ingabe Guyon, M.Sc., MDCM, CCFP, FRCPC, Public Health and Preventive Medicine Specialist, Public Health Clinical Department, Montreal, QC and Assistant Clinical Professor, School of Public Health, Université de Montréal, Montreal, QC

Trevor Hancock, MB, BS, MHSc, HonFFPH (UK), Professor and Senior Scholar, School of Public Health and Social Policy, University of Victoria, Victoria, BC

Megan Kirk, RN, BNSc, MSc, University of Victoria, Victoria, BC

Marjorie MacDonald, RN, PhD, Professor, School of Nursing and Co-Director, Research in Public Health Systems and Services Initiative, University of Victoria, Victoria, BC

Cory Neudorf, BSc, MHSc, MD, FRCPC, Associate Professor, University of Saskatchewan and CMHO, Saskatoon Health Region, Saskatoon, SK

Penny Sutcliffe, MD, MHSc, FRCPC, Medical Officer of Health/CEO, Sudbury & District Health Unit, Sudbury, ON

James Talbot, MD, PhD, FRCPC, Adjunct Professor, School of Public Health, University of Alberta, Edmonton, AB
REFERENCES


18. Sudbury and District Health Unit. 2017 Pre-Budget Consultation: Investing in Public Health. Sudbury, ON: SDHU.


RÉFÉRENCES BIBLIOGRAPHIQUES


Smoking rates have been decreasing from 19.3% (2010) to 17.4% (2014)\(^1\). Two million Ontarians smoke\(^2\). Tobacco use is responsible for approximately 36 deaths per day\(^2\). Disease associated with tobacco use is estimated to cost $7.5 billion annually\(^2\). 

**USE OF THE REPORT**

This report can be used to inform comprehensive tobacco control including:
- program planning
- evaluation
- policy and strategy development
- research opportunities

**WHO SHOULD USE THE REPORT**

- public health units
- policy makers
- researchers
- non-profit organizations
- health care providers

**ONTARIO TOBACCO CONTEXT**

The report assesses tobacco control interventions for their contribution to reduce tobacco use in Ontario.

**PURPOSE OF REPORT**

The report assesses tobacco control interventions for their contribution to reduce tobacco use in Ontario.

**THE REPORT**

- Interventions were assessed by:
  - strength of evidence
  - Ontario context
  - implementation and equity considerations
  - Each intervention has:
    - a summary of the effectiveness of the evidence
    - an assessment of potential contribution for Ontario (10 categories)
    - a key message

**56 types of interventions assessed**

**SOURCES**

\(^1\) Statistics Canada. Health indicators profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2013 boundaries) and peer groups, occasional [Internet]. Ottawa, ON: Canadian Institute for Health Information; 2016 [updated 2016 Apr 21; cited 2016 July 31]. [Figure] Table 105-0501. Available from: http://www5.statcan.gc.ca/cansim/a26?lang=eng&id=1050501

\(^2\) Smoke-Free Ontario: information on places where you can’t smoke, the rules on selling tobacco and how Ontario is working to reduce tobacco use [Internet]. Ottawa, ON: Queen’s Printer for Ontario; 2016 [updated 2016 Aug 16; cited 2016 Nov 25]. Available from: https://www.ontario.ca/page/smoke-free-ontario?_ga=1.221771800.1898918448.1475585651.1475585651-1380901521.1475585651
Infectious diseases are illnesses caused by microorganisms such as bacteria, viruses, parasites or fungi. By law, new cases of certain infectious diseases must be reported to the Health Unit. The statistics found here are based on these reports.

Top 10 Infectious Diseases in 2015

<table>
<thead>
<tr>
<th>Number of new cases</th>
<th>662 Chlamydia* ▲</th>
</tr>
</thead>
<tbody>
<tr>
<td>148 Influenza</td>
<td></td>
</tr>
<tr>
<td>119 Hepatitis C</td>
<td>▲</td>
</tr>
<tr>
<td>70 Gonorrhea</td>
<td>▼</td>
</tr>
<tr>
<td>33 Salmonellosis</td>
<td></td>
</tr>
<tr>
<td>25 Invasive Pneumococcal Disease</td>
<td>▲</td>
</tr>
<tr>
<td>23 Campylobacteriosis</td>
<td>▼</td>
</tr>
<tr>
<td>17 Giardiasis</td>
<td>▼</td>
</tr>
<tr>
<td>14 Invasive Group A Streptococcus</td>
<td>▲</td>
</tr>
<tr>
<td>11 HIV</td>
<td></td>
</tr>
</tbody>
</table>

DID YOU KNOW?

Infectious diseases can be spread through various means including...

- directly from person-to-person,
- by consuming contaminated food or water,
- from an exposure to something in the environment,
- or through the bite of infected animals or insects.

*Not to scale
Highlights from 2011 to 2015:

**THE RATE OF CHLAMYDIA...**

was higher locally,

SDHU | 347
Ontario | 273

was greater among women,

SDHU | 220
Ontario | 421

and was highest in the 15–24 AGE GROUP.

**THE RATE OF GONORRHEA...**

increased locally,

2011 | 31
2012 | 30
2013 | 33
2014 | 43
2015 | 42

Ontario Rates
SDHU Rates

and was highest in the 20–24 AGE GROUP.

**THE RATE OF HEPATITIS C...**

was greater locally,

SDHU | 62
Ontario | 30

was higher among men,

SDHU | 68
Ontario | 47

and was highest in the 20–44 AGE GROUP.

Note: All rates shown are age-standardized rates per 100,000 population using data from 2011–2015.

For additional information on infectious diseases and their prevention, or to view the full Population Health Profile, please visit sdhu.com or contact the Sudbury & District Health Unit, 705.522.9200 (Toll Free: 1.866.522.9200)
APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approve the consent agenda as distributed.
To: René Lapierre, Chair, Sudbury & District Board of Health

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

Date: May 11, 2017

Re: Organization-wide risk management: 2016 annual report

---

**Issue:**
Per the Ontario Public Health Organizational Standards, risk management is a responsibility of the Board of Health.

In October 2016, the Sudbury & District Board of Health approved an organization-wide risk management framework, related policy and a current risk management plan. The risk management plan outlined quarterly reporting timelines to the Senior Management Executive Committee along with a roll-up of all data into an annual report presented to the Board of Health each May.

The 2016 organization-wide risk management annual report includes data collected from the third and fourth quarters of 2016.

**Recommended Action:**
That the Sudbury & District Board of Health receive the 2016 organization-wide risk management annual report.

**Background:**
- The Ontario Public Health Organizational Standards mandates boards of health stewardship and oversight of risk management, delegating to senior staff the responsibility to monitor and respond to emerging issues and potential threats to the organization. Risk management is expected to include, among other issues, financial risks, human resource succession and surge capacity planning, operational risks, and legal issues.

- The details of the risk management plan is captured in a risk management policy and procedure that ensures that the SDHU has a framework to systematically identify/assess risks and controls, and evaluate, monitor and report the risks regularly.

---

2013–2017 Strategic Priorities:

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

O: October 19, 2001  R: October 2013
Financial Implications:
Additional costs may be identified with specific mitigation strategies and will be considered at that time.

Ontario Public Health Standard:
Organizational Standards: 3.1, 4.2, 6.2

Strategic Priority:
#5 – Foster organization-wide excellence in leadership and innovation.

Contact:
France Quirion, Director, Corporate Services Division

2013–2017 Strategic Priorities:
1. Champion and lead equitable opportunities for health.
2. Strengthen relationships.
4. Support community actions promoting health equity.
5. Foster organization-wide excellence in leadership and innovation.

O: October 19, 2001
R: October 2013
### SDHU Organizational Risk Assessment - Annual Report 2016

**Overall Objective:** To identify future events that may impact on the achievement of the SDHU vision and mission

**Subordinate Objective:** To coordinate and align risk mitigation strategies and provide a framework for risk assessment work at different levels within the SDHU

<table>
<thead>
<tr>
<th>Risk Categories</th>
<th>Rating Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Financial Risks</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 The SDHU may be at risk as budget pressures are expected to increase over the next several years.</td>
<td>L5 15</td>
</tr>
<tr>
<td>1.2 The SDHU may be at risk of financial forecasting not providing sufficient information for decision making resulting in suboptimal financial management within year.</td>
<td>L4 14</td>
</tr>
<tr>
<td>1.3 The SDHU may be at risk as internal controls do not ever fully eliminate all potential risks of fraud.</td>
<td>L1 13</td>
</tr>
<tr>
<td><strong>2. Governance / Organizational Risks</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 The SDHU may be at risk as BoH members, individually or collectively, may not have the required competencies for effective Board Governance.</td>
<td>L4 15</td>
</tr>
<tr>
<td>2.2 The SDHU may be at risk of not systematically ensuring that the governance implications of changes in statutes, policies, and directions have been considered.</td>
<td>L3 13</td>
</tr>
<tr>
<td>2.3 The SDHU may be at risk as the appetite for risk culture may not be clearly defined and articulated for staff or Board of Health members.</td>
<td>L1 12</td>
</tr>
<tr>
<td><strong>3. Human Resources</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 The SDHU may be at risk as a result of an insufficient investment in succession and business continuity planning.</td>
<td>L4 14</td>
</tr>
<tr>
<td>3.2 The SDHU may be at risk as staff may not have all of the necessary competencies to meet evolving Public Health needs.</td>
<td>L4 14</td>
</tr>
<tr>
<td>3.3 The SDHU may be at risk related to varying levels of staff engagement in the work of the organization.</td>
<td>L2 13</td>
</tr>
<tr>
<td>3.4 The SDHU may be at risk as some staff work offsite in uncontrolled environments.</td>
<td>L2 14</td>
</tr>
<tr>
<td><strong>4. Knowledge / Information</strong></td>
<td></td>
</tr>
<tr>
<td>4.1 The SDHU may be at risk due to incomplete/inadequate information to make decisions or plan programs and services.</td>
<td>L3 13</td>
</tr>
<tr>
<td><strong>5. Technology</strong></td>
<td></td>
</tr>
<tr>
<td>5.1 The SDHU may be at risk of a network outage.</td>
<td>L3 15</td>
</tr>
<tr>
<td>5.2 The SDHU may be at risk of not having a comprehensive and future oriented information technology plan and planning processes.</td>
<td>L4 13</td>
</tr>
<tr>
<td><strong>6. Legal / Compliance</strong></td>
<td></td>
</tr>
<tr>
<td>6.1 The SDHU may be at risk of not achieving full compliance with the many and varied obligations imposed by statutes and regulations impacting on governance and management of the Health Unit.</td>
<td>L2 12</td>
</tr>
<tr>
<td><strong>7. Service Delivery / Operational</strong></td>
<td></td>
</tr>
<tr>
<td>7.1 The SDHU may be at risk of our service not being perceived as a value add to our clients.</td>
<td>L3 14</td>
</tr>
<tr>
<td><strong>8. Environment</strong></td>
<td></td>
</tr>
<tr>
<td>8.1 The SDHU may be at risk of natural and anthropogenic disasters or hazards.</td>
<td>L2 13</td>
</tr>
<tr>
<td><strong>9. Political</strong></td>
<td></td>
</tr>
<tr>
<td>9.1 The SDHU may be at risk of significant disruptions and high opportunity costs related to health system transformation.</td>
<td>L5 15</td>
</tr>
<tr>
<td><strong>10. Stakeholder / Public Perception</strong></td>
<td></td>
</tr>
<tr>
<td>10.1 The SDHU may be at risk of poorly defined relationships with indigenous communities.</td>
<td>L5 15</td>
</tr>
<tr>
<td>10.2 The SDHU may be at risk of uncertainty around managing the expectations and obligations of the public, ministries, stakeholders, municipalities and/or the media to prevent disruption of service or criticism of Public Health and a negative public image.</td>
<td>L3 12</td>
</tr>
<tr>
<td><strong>11. Strategic / Policy</strong></td>
<td></td>
</tr>
<tr>
<td>11.1 The SDHU may be at risk of developing a Strategic Plan that may need to be modified given the great uncertainty with health system transformation.</td>
<td>L3 12</td>
</tr>
<tr>
<td><strong>12. Security Risks</strong></td>
<td></td>
</tr>
<tr>
<td>12.1 The SDHU may be at risk of threats to network security.</td>
<td>L2 14</td>
</tr>
<tr>
<td>12.2 The SDHU staff and visitors may be at risk if security systems are offline.</td>
<td>L2 13</td>
</tr>
<tr>
<td><strong>13. Privacy Risks</strong></td>
<td></td>
</tr>
<tr>
<td>13.1 The SDHU may be at risk as internal controls may not be sufficient to fully eliminate all potential risks of privacy breaches.</td>
<td>L4 12</td>
</tr>
<tr>
<td><strong>14. Equity Risks</strong></td>
<td></td>
</tr>
<tr>
<td>14.1 The SDHU may be at risk of not effectively leveling up the health status with priority populations.</td>
<td>L5 15</td>
</tr>
<tr>
<td>CATEGORY</td>
<td>TOP SDHU RISKS (RED)</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------</td>
</tr>
<tr>
<td>FINANCIAL</td>
<td>The SDHU may be at risk as budget pressures are expected to increase over the next several years.</td>
</tr>
<tr>
<td>FINANCIAL</td>
<td>The SDHU may be at risk of financial forecasting not providing sufficient information for decision making resulting in suboptimal financial management within year.</td>
</tr>
<tr>
<td>GOVERNANCE/ORGANIZATIONAL</td>
<td>The SDHU may be at risk as Bain members, individually or as a team, may not have the required competencies for effective Board Governance.</td>
</tr>
<tr>
<td>HUMAN RESOURCES</td>
<td>The SDHU may be at risk as a result of an insufficient investment in succession and business continuity planning.</td>
</tr>
<tr>
<td>HUMAN RESOURCES</td>
<td>The SDHU may be at risk as staff may not have all of the necessary competencies to meet evolving Public Health needs.</td>
</tr>
<tr>
<td>TECHNOLOGY</td>
<td>The SDHU may be at risk of a network outage.</td>
</tr>
<tr>
<td>TECHNOLOGY</td>
<td>The SDHU may be at risk of not having a comprehensive and future-oriented information technology plan and planning processes.</td>
</tr>
<tr>
<td>SERVICE DELIVERY/ORGANIZATIONAL</td>
<td>The SDHU may be at risk of not being perceived as a value add to our clients.</td>
</tr>
<tr>
<td>POLITICAL</td>
<td>The SDHU may be at risk of significant disruptions and high-opportunity costs related to health system transformation.</td>
</tr>
<tr>
<td>STAKEHOLDER PUBLIC PERCEPTION</td>
<td>The SDHU may be at risk of poorly defined relationships with Indigenous communities.</td>
</tr>
<tr>
<td>EQUITY</td>
<td>The SDHU may be at risk of our effectively leveling up the health status with priority populations.</td>
</tr>
</tbody>
</table>

**Organizational Risk Management Annual Report: July - December 2016**
INDEPENDENT AUDITORS’ REPORT

To the Board Members of the Sudbury & District Health Unit, Members of Council, Inhabitants and Ratepayers of the Participating Municipalities of Sudbury & District Health Unit

We have audited the accompanying financial statements Sudbury & District Health Unit, which comprise the statement of financial position as at December 31, 2016, the statements of operations and accumulated surplus, changes in net financial assets and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management’s Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors’ Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosure in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity’s preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity’s internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.
Opinion

In our opinion, these financial statements present fairly, in all material respects, the financial position of Sudbury & District Health Unit as at December 31, 2016 and its results of operations and accumulated surplus, changes in net financial assets and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Comparative Information

The financial statements of the Sudbury & District Health Unit as at and for the year ended December 31, 2015 were prepared by another chartered professional accountant dated May 19, 2016.

Chartered Professional Accountants, Licensed Public Accountants

May 4, 2017
Sudbury, Canada
SUDBURY & DISTRICT HEALTH UNIT
Statement of Financial Position

December 31, 2016, with comparative information for 2015

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>$11,739,356</td>
<td>$10,930,342</td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>766,122</td>
<td>339,367</td>
</tr>
<tr>
<td>Receivable from the Province of Ontario</td>
<td>212,664</td>
<td>135,489</td>
</tr>
<tr>
<td></td>
<td><strong>12,718,142</strong></td>
<td><strong>11,405,198</strong></td>
</tr>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>1,226,887</td>
<td>928,400</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>318,310</td>
<td>310,650</td>
</tr>
<tr>
<td>Payable to the Province of Ontario</td>
<td>394,264</td>
<td>363,073</td>
</tr>
<tr>
<td>Employee benefit obligations (note 2)</td>
<td>2,806,905</td>
<td>2,783,265</td>
</tr>
<tr>
<td></td>
<td><strong>4,746,366</strong></td>
<td><strong>4,385,388</strong></td>
</tr>
<tr>
<td><strong>Net financial assets</strong></td>
<td>7,971,776</td>
<td>7,019,810</td>
</tr>
<tr>
<td><strong>Non-financial assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tangible capital assets (note 3)</td>
<td>5,469,350</td>
<td>5,705,961</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>284,598</td>
<td>248,633</td>
</tr>
<tr>
<td></td>
<td><strong>5,753,948</strong></td>
<td><strong>5,954,594</strong></td>
</tr>
<tr>
<td><strong>Commitments and contingencies (note 5)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Accumulated surplus (note 4)</strong></td>
<td>$13,725,724</td>
<td>$12,974,404</td>
</tr>
</tbody>
</table>

See accompanying notes to financial statements.

On behalf of the Board:

_____________________________ Board Member
______________________________ Board Member
### SUDBURY & DISTRICT HEALTH UNIT

#### Statement of Operations and Accumulated Surplus

Year ended December 31, 2016, with comparative information for 2015

<table>
<thead>
<tr>
<th></th>
<th>Budget 2016</th>
<th>Total 2016</th>
<th>Total 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue (note 9):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provincial grants</td>
<td>$19,968,101</td>
<td>$19,944,345</td>
<td>$20,160,129</td>
</tr>
<tr>
<td>Per capita revenue from municipalities (note 7)</td>
<td>6,886,526</td>
<td>6,886,526</td>
<td>6,720,498</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plumbing inspections and licenses</td>
<td>257,000</td>
<td>267,040</td>
<td>301,064</td>
</tr>
<tr>
<td>Interest</td>
<td>85,000</td>
<td>80,276</td>
<td>83,468</td>
</tr>
<tr>
<td>Other</td>
<td>1,126,576</td>
<td>854,973</td>
<td>1,086,396</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>28,323,203</td>
<td>28,033,160</td>
<td>28,351,555</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Budget 2016</th>
<th>Total 2016</th>
<th>Total 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expenses (note 9):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages (note 6)</td>
<td>18,932,050</td>
<td>18,010,623</td>
<td>18,337,096</td>
</tr>
<tr>
<td>Benefits</td>
<td>5,016,470</td>
<td>4,879,420</td>
<td>4,748,177</td>
</tr>
<tr>
<td>Transportation</td>
<td>481,083</td>
<td>336,632</td>
<td>352,748</td>
</tr>
<tr>
<td>Administration (note 8)</td>
<td>2,160,628</td>
<td>1,919,805</td>
<td>2,422,221</td>
</tr>
<tr>
<td>Supplies and materials</td>
<td>1,186,002</td>
<td>1,058,761</td>
<td>1,173,513</td>
</tr>
<tr>
<td>Small operational equipment</td>
<td>546,970</td>
<td>377,117</td>
<td>375,133</td>
</tr>
<tr>
<td>Amortization of tangible capital assets (note 3)</td>
<td>-</td>
<td>699,482</td>
<td>671,791</td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>28,323,203</td>
<td>27,281,840</td>
<td>28,080,679</td>
</tr>
</tbody>
</table>

**Annual surplus**
- 751,320

**Accumulated surplus, beginning of year**
12,974,404

**Accumulated surplus, end of year**
12,974,404

See accompanying notes to financial statements.


**SUDBURY & DISTRICT HEALTH UNIT**

Statement of Changes in Net Financial Assets

Year ended December 31, 2016, with comparative information for 2015

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual surplus</td>
<td>$751,320</td>
<td>$270,876</td>
</tr>
<tr>
<td>Purchase of tangible capital assets</td>
<td>(462,871)</td>
<td>(348,965)</td>
</tr>
<tr>
<td>Amortization of tangible capital assets</td>
<td>699,482</td>
<td>671,791</td>
</tr>
<tr>
<td>Change in prepaid expenses</td>
<td>(35,965)</td>
<td>96,487</td>
</tr>
<tr>
<td><strong>Change in net financial assets</strong></td>
<td>951,966</td>
<td>690,189</td>
</tr>
<tr>
<td>Net financial assets, beginning of year</td>
<td>7,019,810</td>
<td>6,329,621</td>
</tr>
<tr>
<td><strong>Net financial assets, end of year</strong></td>
<td><strong>$7,971,776</strong></td>
<td><strong>7,019,810</strong></td>
</tr>
</tbody>
</table>

See accompanying notes to financial statements.
SUDBURY & DISTRICT HEALTH UNIT

Statement of Cash Flows

Year ended December 31, 2016, with comparative information for 2015

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash provided by (used in):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash flows from operating activities:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual surplus</td>
<td>$ 751,320</td>
<td>$ 270,876</td>
</tr>
<tr>
<td><strong>Adjustments for:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amortization of capital assets</td>
<td>699,482</td>
<td>671,791</td>
</tr>
<tr>
<td>Benefit payments related to employee benefit obligations</td>
<td>23,640</td>
<td>(148,272)</td>
</tr>
<tr>
<td>Non-cash expenses related to employee benefit obligations</td>
<td>-</td>
<td>204,620</td>
</tr>
<tr>
<td><strong>Total Adjustments</strong></td>
<td>1,474,442</td>
<td>999,015</td>
</tr>
<tr>
<td><strong>Changes in non-cash working capital:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts receivable</td>
<td>(426,755)</td>
<td>(62,359)</td>
</tr>
<tr>
<td>Receivable from the Province of Ontario</td>
<td>(77,175)</td>
<td>(21,903)</td>
</tr>
<tr>
<td>Payable to the Province of Ontario</td>
<td>31,191</td>
<td>(6,611)</td>
</tr>
<tr>
<td>Accounts payable and accrued liabilities</td>
<td>298,487</td>
<td>(697,034)</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>7,660</td>
<td>(72,129)</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>(35,965)</td>
<td>96,487</td>
</tr>
<tr>
<td><strong>Total Changes in non-cash working capital:</strong></td>
<td>1,271,885</td>
<td>235,466</td>
</tr>
</tbody>
</table>

| **Cash flows from investing activity:** |        |        |
| Purchase of tangible capital assets  | (462,871) | (348,965) |

|                               |        |        |
| Increase (decrease) in cash    | 809,014 | (113,499) |
| Cash and cash equivalents, beginning of year | 10,930,342 | 11,043,841 |
| **Cash and cash equivalents, end of year** | $ 11,739,356 | $ 10,930,342 |

See accompanying notes to financial statements.
The Sudbury & District Health Unit (the “Health Unit”) was established in 1956, and is a progressive, accredited public health agency committed to improving health and reducing social inequities in health through evidence informed practice. The Health Unit is funded through a combination of Ministry grants and through levies that are paid by the municipalities to whom the Health Unit provides public health services. The Health Unit works locally with individuals, families and community and partner agencies to promote and protect health and to prevent disease. Public health programs and services are geared toward people of all ages and delivered in a variety of settings including workplaces, day care and educational settings, homes, health-care settings and community spaces.

The Health Unit is a not-for-profit public health agency and is therefore exempt from income taxes under the Income Tax Act (Canada).

1. **Summary of significant accounting policies:**

These financial statements are prepared by management in accordance with Canadian public sector accounting standards established by the Public Sector Accounting Board. The principal accounting policies applied in the preparation of these financial statements are set out below.

(a) **Basis of accounting:**

The financial statements are prepared using the accrual basis of accounting.

The accrual basis of accounting recognizes revenues as they are earned. Expenses are recognized as they are incurred and measurable as a result of receipt of goods or services and the creation of a legal obligation to pay.

(b) **Cash and cash equivalents:**

Cash and cash equivalents include guaranteed investment certificates that are readily convertible into known amounts of cash and subject to insignificant risk of change in value.

Guaranteed investment certificates amounted to $2,204,349 as at December 31, 2016 (2015 - $2,188,942) and these can be redeemed for cash on demand.

(c) **Employee benefit obligations:**

The Health Unit accounts for its participation in the Ontario Municipal Employee Retirement Fund (OMERS), a multi-employer public sector pension fund, as a defined contribution plan.

Vacation and other compensated absence entitlements are accrued for as entitlements are earned.

Sick leave benefits are accrued when they are vested and subject to payout when an employee leaves the Health Unit’s employ.
1. Summary of significant accounting policies (continued):

(c) Employee benefit obligations (continued):

Other post-employment benefits are accrued in accordance with the projected benefit method pro-rated on service and management's best estimate of salary escalation and retirement ages of employees. The discount rate used to determine the accrued benefit obligation was determined with reference to the Health Unit's cost of borrowing at the measurement date taking into account cash flows that match the timing and amount of expected benefit payments.

Actuarial gains (losses) on the accrued benefit obligation arise from the difference between actual and expected experiences and from changes in actuarial assumptions used to determine the accrued benefit obligation. These gains (losses) are amortized over the average remaining service period of active employees.

(d) Non-financial assets:

Tangible capital assets and prepaid expenses are accounted for as non-financial assets by the Health Unit. Non-financial assets are not available to discharge liabilities and are held for use in the provision of services. They have useful lives extending beyond the currency year and are not intended for sale in the ordinary course of operations.

(e) Tangible capital assets:

Tangible capital assets are recorded at cost, and include amounts that are directly related to the acquisition of the assets. The Health Unit provides for amortization using the straight-line method designed to amortize the cost, less any residual value, of the tangible capital assets over their estimated useful lives. The annual amortization periods are as follows:

<table>
<thead>
<tr>
<th>Asset</th>
<th>Basis</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings</td>
<td>Straight-line</td>
<td>2.5%</td>
</tr>
<tr>
<td>Parking lot resurfacing</td>
<td>Straight-line</td>
<td>10%</td>
</tr>
<tr>
<td>Computer hardware</td>
<td>Straight-line</td>
<td>30%</td>
</tr>
<tr>
<td>Leasehold improvements</td>
<td>Straight-line</td>
<td>10%</td>
</tr>
<tr>
<td>Website design</td>
<td>Straight-line</td>
<td>20%</td>
</tr>
<tr>
<td>Vehicles and equipment</td>
<td>Straight-line</td>
<td>10%</td>
</tr>
<tr>
<td>Equipment – Vaccine Refrigerators</td>
<td>Straight-line</td>
<td>20%</td>
</tr>
<tr>
<td>Computer software</td>
<td>Straight-line</td>
<td>100%</td>
</tr>
</tbody>
</table>

(f) Prepaid expenses:

Prepaid expenses are charged to expenses over the periods expected to benefit from them.
1. Summary of significant accounting policies (continued):

(g) Accumulated surplus:

Certain amounts, as approved by the Board of Directors, are set aside in accumulated surplus for future operating and capital purposes. Transfers to/from funds and reserves are an adjustment to the respective fund when approved.

The accumulated surplus consists of the following surplus accounts:

- Invested in tangible capital assets:
  This represents the net book value of the tangible capital assets the Health Unit has on hand.

- Unfunded employee benefit obligations:
  This represents the unfunded future employee benefit obligations comprised of the accumulated sick leave benefits, other post-employment benefits and vacation pay and other compensated absences.

The accumulated surplus consists of the following reserves:

- Working capital reserve:
  This reserve is not restricted and is utilized for the operating activities of the Health Unit.

- Public health initiatives:
  This reserve is restricted and can only be used for public health initiatives.

- Corporate contingencies:
  This reserve is restricted and can only be used for corporate contingencies.

- Facility and equipment repairs and maintenance:
  This reserve is restricted and can only be used for facility and equipment repairs and maintenance.

- Sick leave and vacation:
  This reserve is restricted and can only be used for future sick leave and vacation obligations.

- Research and development:
  This reserve is restricted and can only be used for research and development activities.
1. Summary of significant accounting policies (continued):

(h) Revenue recognition:

Revenue from government grants and from municipalities is recognized in the period in which the events giving rise to the government transfer have occurred as long as: the transfer is authorized; the eligibility criteria, if any, have been met except when and to the extent that the transfer gives rise to an obligation that meets the definition of a liability for the recipient government; and the amount can reasonably be estimated. Funding received under a funding arrangement, which relates to a subsequent fiscal period and the unexpended portions of contributions received for specific purposes, is reflected as deferred revenue in the year of receipt and is recognized as revenue in the period in which all the recognition criteria have been met. Other revenues including certain user fees, rents and interest are recorded on the accrual basis, when earned and when the amounts can be reasonably estimated and collection is reasonably assured.

(i) Budget figures:

Budget figures have been provided for comparison purposes and have been derived from the budget approved by the Board of Directors.

(j) Use of estimates:

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of certain assets and liabilities at the date of the financial statements and the reported amounts of certain revenues and expenses during the reporting period. By their nature, these estimates are subject to measurement uncertainty. The effect of changes in such estimates on the financial statements in future periods could be significant. Accounts specifically affected by estimates in these financial statements are allowance for doubtful accounts, employee benefit obligations and the estimated useful lives and residual values of tangible capital assets.
2. **Employee benefit obligations:**

An actuarial estimate of future liabilities has been completed using the most recent actuarial valuation dated December 31, 2015 and forms the basis for the estimated liability reported in these financial statements.

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accumulated sick leave benefits</td>
<td>$ 827,203</td>
<td>$ 849,339</td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>1,043,409</td>
<td>994,287</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,870,612</strong></td>
<td><strong>1,843,626</strong></td>
</tr>
<tr>
<td>Vacation pay and other compensated absence</td>
<td>936,293</td>
<td>939,639</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 2,806,905</strong></td>
<td><strong>2,783,265</strong></td>
</tr>
</tbody>
</table>

The significant actuarial assumptions adopted in measuring the Health Unit's accumulated sick leave benefits and other post-employment benefits are as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discount</td>
<td>4.50%</td>
<td>4.50%</td>
</tr>
<tr>
<td>Health-care trend rate:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial</td>
<td>5.10%</td>
<td>5.10%</td>
</tr>
<tr>
<td>Ultimate</td>
<td>4.00%</td>
<td>4.00%</td>
</tr>
<tr>
<td>Salary escalation factor</td>
<td>3.00%</td>
<td>3.00%</td>
</tr>
</tbody>
</table>

The Health Unit has established reserves in the amount of $675,447 (2015 - $675,447) to mitigate the future impact of these obligations.

The accrued benefit obligations as at December 31, 2016 are $1,711,172 (2015 - $1,667,050). Total benefit plan related expenses were $165,564 (2015 - $157,317) and were comprised of current service costs of $108,364 (2015 - $101,664), interest of $74,337 (2015 - $72,790) and amortization of actuarial loss of $17,137 (2015 - $17,137). Benefits paid during the year were $138,399 (2015 - $148,272). The net unamortized actuarial gain of $159,439 (2015 - $176,576) will be amortized over the expected average remaining service period.
### 3. Tangible capital assets:

#### Cost:

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Building</th>
<th>Leasehold Improvements</th>
<th>Computer Hardware</th>
<th>Computer Software</th>
<th>Website Design</th>
<th>Vehicles and Equipment</th>
<th>Parking Lot</th>
<th>Resurfacing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance, January 1, 2015</td>
<td>$26,939</td>
<td>6,982,035</td>
<td>391,330</td>
<td>1,362,483</td>
<td>278,364</td>
<td>69,845</td>
<td>2,154,728</td>
<td>242,596</td>
<td>11,508,320</td>
<td></td>
</tr>
<tr>
<td>Additions</td>
<td>-</td>
<td>86,747</td>
<td>5,409</td>
<td>288,214</td>
<td>47,512</td>
<td>-</td>
<td>34,989</td>
<td>-</td>
<td>462,871</td>
<td></td>
</tr>
<tr>
<td>Balance, December 31, 2016</td>
<td>$26,939</td>
<td>7,068,782</td>
<td>396,739</td>
<td>1,650,697</td>
<td>325,876</td>
<td>69,845</td>
<td>2,189,717</td>
<td>242,596</td>
<td>11,971,191</td>
<td></td>
</tr>
</tbody>
</table>

#### Accumulated amortization:

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Building</th>
<th>Leasehold Improvements</th>
<th>Computer Hardware</th>
<th>Computer Software</th>
<th>Website Design</th>
<th>Vehicles and Equipment</th>
<th>Parking Lot</th>
<th>Resurfacing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance, January 1, 2015</td>
<td>$ -</td>
<td>2,403,267</td>
<td>325,530</td>
<td>877,169</td>
<td>278,364</td>
<td>34,923</td>
<td>1,829,456</td>
<td>53,650</td>
<td>5,802,359</td>
<td></td>
</tr>
<tr>
<td>Amortization</td>
<td>-</td>
<td>175,636</td>
<td>48,336</td>
<td>312,695</td>
<td>47,512</td>
<td>13,969</td>
<td>77,074</td>
<td>24,260</td>
<td>699,482</td>
<td></td>
</tr>
<tr>
<td>Balance, December 31, 2016</td>
<td>$ -</td>
<td>2,578,903</td>
<td>373,866</td>
<td>1,189,864</td>
<td>325,876</td>
<td>48,892</td>
<td>1,906,530</td>
<td>77,910</td>
<td>6,501,841</td>
<td></td>
</tr>
</tbody>
</table>

#### Net book value:

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Building</th>
<th>Leasehold Improvements</th>
<th>Computer Hardware</th>
<th>Computer Software</th>
<th>Website Design</th>
<th>Vehicles and Equipment</th>
<th>Parking Lot</th>
<th>Resurfacing</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>At December 31, 2015</td>
<td>$26,939</td>
<td>4,578,768</td>
<td>65,800</td>
<td>485,314</td>
<td>-</td>
<td>34,922</td>
<td>325,272</td>
<td>188,946</td>
<td>5,705,961</td>
<td></td>
</tr>
<tr>
<td>At December 31, 2016</td>
<td>$26,939</td>
<td>4,489,879</td>
<td>22,873</td>
<td>460,833</td>
<td>-</td>
<td>20,953</td>
<td>283,187</td>
<td>164,686</td>
<td>5,469,350</td>
<td></td>
</tr>
</tbody>
</table>
3. Tangible capital assets (continued):

Cost:

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Building</th>
<th>Leasehold Improvements</th>
<th>Computer Hardware</th>
<th>Computer Software</th>
<th>Website Design</th>
<th>Vehicles Equipment</th>
<th>Parking Lot Resurfacings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance, January 1, 2014</td>
<td>$26,939</td>
<td>6,907,685</td>
<td>391,330</td>
<td>1,270,049</td>
<td>258,819</td>
<td>69,845</td>
<td>2,118,573</td>
<td>207,596</td>
<td>11,250,836</td>
</tr>
<tr>
<td>Additions</td>
<td>-</td>
<td>74,350</td>
<td>-</td>
<td>183,915</td>
<td>19,545</td>
<td>-</td>
<td>36,155</td>
<td>35,000</td>
<td>348,965</td>
</tr>
<tr>
<td>Disposals</td>
<td>-</td>
<td>-</td>
<td>(91,481)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(91,481)</td>
</tr>
<tr>
<td>Balance, December 31, 2015</td>
<td>$26,939</td>
<td>6,982,035</td>
<td>391,330</td>
<td>1,362,483</td>
<td>278,364</td>
<td>69,845</td>
<td>2,154,728</td>
<td>242,596</td>
<td>11,508,320</td>
</tr>
</tbody>
</table>

Accumulated amortization:

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Building</th>
<th>Leasehold Improvements</th>
<th>Computer Hardware</th>
<th>Computer Software</th>
<th>Website Design</th>
<th>Vehicles Equipment</th>
<th>Parking Lot Resurfacings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance, January 1, 2014</td>
<td>$-</td>
<td>2,229,645</td>
<td>282,603</td>
<td>644,783</td>
<td>258,819</td>
<td>20,954</td>
<td>1,754,105</td>
<td>31,140</td>
<td>5,222,049</td>
</tr>
<tr>
<td>Amortization</td>
<td>-</td>
<td>173,622</td>
<td>42,927</td>
<td>323,867</td>
<td>19,545</td>
<td>13,969</td>
<td>75,351</td>
<td>22,510</td>
<td>671,791</td>
</tr>
<tr>
<td>Disposals</td>
<td>-</td>
<td>-</td>
<td>(91,481)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(91,481)</td>
</tr>
<tr>
<td>Balance, December 31, 2015</td>
<td>$-</td>
<td>2,403,267</td>
<td>325,530</td>
<td>877,169</td>
<td>278,364</td>
<td>34,923</td>
<td>1,829,456</td>
<td>53,650</td>
<td>5,802,359</td>
</tr>
</tbody>
</table>

Net book value

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Building</th>
<th>Leasehold Improvements</th>
<th>Computer Hardware</th>
<th>Computer Software</th>
<th>Website Design</th>
<th>Vehicles Equipment</th>
<th>Parking Lot Resurfacings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>At December 31, 2014</td>
<td>26,939</td>
<td>4,678,040</td>
<td>108,727</td>
<td>625,266</td>
<td>-</td>
<td>48,891</td>
<td>364,468</td>
<td>176,456</td>
<td>6,028,787</td>
</tr>
<tr>
<td>At December 31, 2015</td>
<td>26,939</td>
<td>4,578,768</td>
<td>65,800</td>
<td>485,314</td>
<td>-</td>
<td>34,922</td>
<td>325,272</td>
<td>188,946</td>
<td>5,705,961</td>
</tr>
</tbody>
</table>
4. **Accumulated surplus:**

The accumulated surplus consists of individual fund surplus accounts and reserves as follows:

<table>
<thead>
<tr>
<th>Account Description</th>
<th>Balance, Beginning of Year</th>
<th>Annual Surplus (Deficit)</th>
<th>In-Year Transfer To (From) Tangible Capital Assets</th>
<th>Balance, End of Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invested in tangible capital assets</td>
<td>$5,705,961</td>
<td>(699,482)</td>
<td>-</td>
<td>5,469,350</td>
</tr>
<tr>
<td>Unfunded employee benefit obligation</td>
<td>(2,783,265)</td>
<td>(23,640)</td>
<td>-</td>
<td>(2,806,905)</td>
</tr>
<tr>
<td>Working capital reserve</td>
<td>4,437,835</td>
<td>1,474,442</td>
<td>(462,871)</td>
<td>5,449,406</td>
</tr>
<tr>
<td>Public health initiatives</td>
<td>1,521,119</td>
<td>-</td>
<td>-</td>
<td>1,521,119</td>
</tr>
<tr>
<td>Corporate contingencies</td>
<td>500,000</td>
<td>-</td>
<td>-</td>
<td>500,000</td>
</tr>
<tr>
<td>Facility and equipment repairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and maintenance</td>
<td>2,860,447</td>
<td>-</td>
<td>-</td>
<td>2,860,447</td>
</tr>
<tr>
<td>Sick leave and vacation</td>
<td>675,447</td>
<td>-</td>
<td>-</td>
<td>675,447</td>
</tr>
<tr>
<td>Research and development</td>
<td>56,860</td>
<td>-</td>
<td>-</td>
<td>56,860</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$12,974,404</strong></td>
<td><strong>751,320</strong></td>
<td>-</td>
<td><strong>13,725,724</strong></td>
</tr>
</tbody>
</table>
5. Commitments and contingencies:

(a) Lines of credit:

As at December 31, 2016, the Health Unit has available an operating line of credit of $500,000 (2015 - $500,000). There is no balance outstanding on the line of credit at year end (2015 - $Nil).

(b) Lease commitment:

The Health Unit enters into operating leases in the ordinary course of business, primarily for lease of premises and equipment. Payments for these leases are contractual obligations as schedule per each agreement. Commitments for minimum lease payments in relation to non-cancellable operating leases at December 31, 2016 are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td>$213,517</td>
</tr>
<tr>
<td>Later than one year and no later than 5 years</td>
<td>$408,129</td>
</tr>
<tr>
<td>Later than five years</td>
<td>$595,074</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,216,720</strong></td>
</tr>
</tbody>
</table>

(c) Contingencies:

From time to time, the Health Unit is involved in lawsuits and claims arising in the ordinary course of business. Management has established policies and procedures to ensure adequate provisions will be made in the accounts where required such that the ultimate resolution with respect to any claims will not have a material adverse effect on the Health Unit's financial position or results of operations. As at December 31, 2015, no such claims exist.

6. Pension agreements:

The Health Unit makes contributions to OMERS, which is a multi-employer plan, on behalf of its members. The plan is a defined contribution plan, which specifies the amount of the retirement benefit to be received by the employees based on the length of service and rates of pay.

The amount contributed to OMERS for 2016 was $1,772,422 (2015 - $1,753,523) for current service and is included within benefits expense on the statement of operations.
7. Per capita revenue from municipalities:

<table>
<thead>
<tr>
<th>Municipality</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Township of Assiginack</td>
<td>$31,471</td>
<td>30,578</td>
</tr>
<tr>
<td>Township of Baldwin</td>
<td>21,073</td>
<td>20,363</td>
</tr>
<tr>
<td>Township of Billings (and part of Allan)</td>
<td>21,142</td>
<td>20,498</td>
</tr>
<tr>
<td>Township of Burpee</td>
<td>11,294</td>
<td>11,089</td>
</tr>
<tr>
<td>Township of Central Manitoulin</td>
<td>72,515</td>
<td>70,767</td>
</tr>
<tr>
<td>Municipality of St. Charles</td>
<td>47,379</td>
<td>45,565</td>
</tr>
<tr>
<td>Township of Chapleau</td>
<td>83,120</td>
<td>81,520</td>
</tr>
<tr>
<td>Municipality of French River</td>
<td>98,822</td>
<td>95,431</td>
</tr>
<tr>
<td>Township of Espanola</td>
<td>183,388</td>
<td>180,513</td>
</tr>
<tr>
<td>Township of Gordon (and part of Allan)</td>
<td>18,180</td>
<td>18,145</td>
</tr>
<tr>
<td>Town of Gore Bay</td>
<td>32,504</td>
<td>31,922</td>
</tr>
<tr>
<td>Municipality of Markstay-Warren</td>
<td>96,825</td>
<td>94,826</td>
</tr>
<tr>
<td>Township of Northeastern Manitoulin &amp; The Islands</td>
<td>91,315</td>
<td>88,845</td>
</tr>
<tr>
<td>Township of Nairn &amp; Hyman</td>
<td>16,734</td>
<td>16,264</td>
</tr>
<tr>
<td>Municipality of Killarney</td>
<td>14,393</td>
<td>14,180</td>
</tr>
<tr>
<td>Township of Sables and Spanish River</td>
<td>114,247</td>
<td>111,896</td>
</tr>
<tr>
<td>City of Greater Sudbury</td>
<td>5,917,249</td>
<td>5,773,445</td>
</tr>
<tr>
<td>Township of Tehkummah</td>
<td>14,875</td>
<td>14,651</td>
</tr>
</tbody>
</table>

$6,886,526 6,720,498

8. Administration expenses:

<table>
<thead>
<tr>
<th>Category</th>
<th>Budget</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional fees</td>
<td>$569,244</td>
<td>297,379</td>
<td>728,204</td>
</tr>
<tr>
<td>Advertising</td>
<td>204,319</td>
<td>192,030</td>
<td>241,749</td>
</tr>
<tr>
<td>Building maintenance</td>
<td>352,898</td>
<td>400,024</td>
<td>360,473</td>
</tr>
<tr>
<td>Staff education</td>
<td>161,163</td>
<td>187,699</td>
<td>233,342</td>
</tr>
<tr>
<td>Utilities</td>
<td>195,840</td>
<td>202,485</td>
<td>181,395</td>
</tr>
<tr>
<td>Rent</td>
<td>237,884</td>
<td>255,776</td>
<td>249,728</td>
</tr>
<tr>
<td>Liability insurance</td>
<td>103,774</td>
<td>91,232</td>
<td>114,454</td>
</tr>
<tr>
<td>Postage</td>
<td>88,158</td>
<td>49,127</td>
<td>67,821</td>
</tr>
<tr>
<td>Telephone</td>
<td>196,071</td>
<td>199,233</td>
<td>197,243</td>
</tr>
<tr>
<td>Memberships and subscriptions</td>
<td>47,277</td>
<td>42,438</td>
<td>45,933</td>
</tr>
<tr>
<td>Strategic planning</td>
<td>4,000</td>
<td>2,382</td>
<td>1,879</td>
</tr>
</tbody>
</table>

$2,160,628 1,919,805 2,422,221
### 9. Revenues and expenses by funding sources:

<table>
<thead>
<tr>
<th></th>
<th>OLHA</th>
<th>SDWS</th>
<th>VBD</th>
<th>Unorganized Territories</th>
<th>MOH/AMOH</th>
<th>CNO</th>
<th>Enhanced Safe-Food</th>
<th>Enhanced Safe Water</th>
<th>HSO</th>
<th>CID</th>
<th>IC-PHN</th>
<th>Needle Exchange</th>
<th>SFO</th>
<th>SDoH Nurses Initiatives</th>
<th>UIIP</th>
<th>Sub-Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provincial grants</td>
<td>14,687,000</td>
<td>106,000</td>
<td>55,899</td>
<td>-</td>
<td>42,753</td>
<td>121,357</td>
<td>29,920</td>
<td>16,200</td>
<td>502,210</td>
<td>389,000</td>
<td>90,100</td>
<td>71,100</td>
<td>735,111</td>
<td>180,500</td>
<td>13,610</td>
<td>17,040,760</td>
</tr>
<tr>
<td>Provincial grants - one-time</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17,663</td>
<td>-</td>
<td>-</td>
<td>17,663</td>
</tr>
<tr>
<td>Unorganized territories</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>819,400</td>
<td>-</td>
<td>-</td>
<td>819,400</td>
</tr>
<tr>
<td>Municipalities</td>
<td>6,817,658</td>
<td>47,222</td>
<td>21,646</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6,886,526</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plumbing and inspections</td>
<td>267,040</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>267,040</td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td>90,276</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>90,276</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>528,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>528,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>22,379,974</td>
<td>153,222</td>
<td>77,545</td>
<td>819,400</td>
<td>42,753</td>
<td>121,357</td>
<td>29,920</td>
<td>16,200</td>
<td>502,210</td>
<td>389,000</td>
<td>90,100</td>
<td>71,100</td>
<td>752,774</td>
<td>180,500</td>
<td>13,610</td>
<td>25,639,665</td>
</tr>
<tr>
<td><strong>Expenses:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>14,320,457</td>
<td>121,377</td>
<td>25,559</td>
<td>487,479</td>
<td>38,871</td>
<td>90,735</td>
<td>-</td>
<td>12,617</td>
<td>348,916</td>
<td>308,152</td>
<td>71,508</td>
<td>-</td>
<td>437,532</td>
<td>142,881</td>
<td>11,190</td>
<td>16,420,274</td>
</tr>
<tr>
<td>Benefits</td>
<td>3,959,278</td>
<td>34,479</td>
<td>2,498</td>
<td>135,248</td>
<td>3,882</td>
<td>25,622</td>
<td>-</td>
<td>3,583</td>
<td>106,956</td>
<td>76,468</td>
<td>18,592</td>
<td>-</td>
<td>120,213</td>
<td>37,619</td>
<td>1,148</td>
<td>4,525,586</td>
</tr>
<tr>
<td>Transportation</td>
<td>91,474</td>
<td>2,481</td>
<td>7,020</td>
<td>117,087</td>
<td>-</td>
<td>-</td>
<td>1,437</td>
<td>-</td>
<td>5,677</td>
<td>1,000</td>
<td>-</td>
<td>-</td>
<td>46,790</td>
<td>-</td>
<td>233</td>
<td>273,199</td>
</tr>
<tr>
<td>Administration (note 8)</td>
<td>1,606,631</td>
<td>-</td>
<td>1,288</td>
<td>48,693</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>18,974</td>
<td>-</td>
<td>10,351</td>
<td>1,157</td>
<td>-</td>
<td>17,775</td>
<td>90,806</td>
<td>-</td>
<td>1,795,675</td>
</tr>
<tr>
<td>Supplies and materials</td>
<td>650,836</td>
<td>-</td>
<td>38,168</td>
<td>30,893</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9,509</td>
<td>-</td>
<td>30,310</td>
<td>4,223</td>
<td>-</td>
<td>53,325</td>
<td>57,433</td>
<td>-</td>
<td>875,736</td>
</tr>
<tr>
<td>Small operational equipment</td>
<td>287,098</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>287,098</td>
<td></td>
</tr>
<tr>
<td>Amortization of tangible capital assets</td>
<td>699,482</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>699,482</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expenses</strong></td>
<td>21,615,256</td>
<td>158,337</td>
<td>74,533</td>
<td>819,400</td>
<td>42,753</td>
<td>121,357</td>
<td>29,920</td>
<td>16,200</td>
<td>502,210</td>
<td>389,000</td>
<td>90,100</td>
<td>71,100</td>
<td>752,774</td>
<td>180,500</td>
<td>13,610</td>
<td>24,877,050</td>
</tr>
<tr>
<td><strong>Annual surplus</strong></td>
<td>764,718</td>
<td>(5,115)</td>
<td>3,012</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>762,615</td>
<td></td>
</tr>
</tbody>
</table>

OLHA - MOHLTC Mandatory Cost-Shared Programs  
SDWS - Small Drinking Water Systems  
VBD - Vector-Borne Diseases  
MOH/AMOH - MOH/AMOH Compensation Initiative  
CNO - Chief Nursing Officer  
HSO - Healthy Smiles Ontario  
CID - Infectious Diseases Control Initiative  
IC-PHN - Infection Prevention and Control Nurses Initiative  
SFO - Smoke Free Ontario  
UIIP - Universal Influenza Immunization Program  
Men C - Meningococcal Vaccine Program  
HPV - Human Papilloma Virus  
MCYS - Ministry Children and Youth Services  
ECA - E-Cigarettes Act: Protection and Environment  
Non-Ministry-Non-Ministry Funded Initiatives
### Revenues and expenses by funding sources:

**Revenue:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 20,723</td>
<td>22,032</td>
<td>1,593,010</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>26,525</td>
<td>42,944</td>
<td>92,272</td>
<td>52,278</td>
<td>-</td>
<td>-</td>
<td>18,890,544</td>
<td></td>
</tr>
</tbody>
</table>

**Expenses:**

| Salaries and wages | 16,616 | 17,657 | 1,231,465 | - | - | - | - | 13,821 | 36,838 | 16,657 | 32,545 | 32,382 | 40,469 | 151,899 | 18,010,623 |
| Benefits | 4,107 | 4,375 | 289,712 | - | - | - | - | 2,589 | 8,186 | 4,067 | 7,594 | 3,344 | 6,257 | 23,603 | 4,879,420 |
| Transportation | - | - | 47,172 | - | - | - | - | - | - | - | - | - | (246) | 9,220 | 336,632 |
| Administration (note 8) | - | - | 6,283 | 8,243 | 45,181 | 17,547 | - | 5,409 | - | - | - | (12,074) | 1,800 | 112 | 1,919,805 |
| Supplies and materials | - | - | 18,078 | 500 | - | - | - | - | - | - | - | - | 1,835 | 13,176 | 53,828 | 5,686 | 89,922 | 1,058,761 |
| Small operational equipment | - | - | 1,300 | - | - | - | 14,953 | 73,766 | - | - | - | - | - | - | 377,117 |
| Amortization of tangible capital assets | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 699,482 |

| Annual surplus | $ | - | - | - | - | (11,295) | - | - | - | - | - | - | - | - | 751,320 |

**OLHA - MOHLTC Mandatory Cost-Shared Programs**

**SDWS - Small Drinking Water Systems**

**VBD - Vector-Borne Diseases**

**MOH/AMOH - MOH/AMOH Compensation Initiative**

**CNO - Chief Nursing Officer**

**HSO - Healthy Smiles Ontario**

**CID - Infectious Diseases Control Initiative**

**IC-PHN - Infection Prevention and Control Nurses Initiative**

**SFO - Smoke Free Ontario**

**UIIP - Universal Influenza Immunization Program**

**Men C - Meningococcal Vaccine Program**

**HPV - Human Papilloma Virus**

**MCYS - Ministry Children and Youth Services**

**ECA - E-Cigarettes Act: Protection and Environment**

**Non-Ministry-Non-Ministry Funded Initiatives**
ADOPTION OF THE 2016 AUDITED FINANCIAL STATEMENTS

MOTION:

WHEREAS at its May 4, 2017, meeting, the Board Finance Standing Committee reviewed the 2016 audited financial statements and recommended them to the Board for the Board's approval;

THEREFORE BE IT RESOLVED THAT the 2016 audited financial statements be approved as distributed.
MOTION:

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 aPHa Annual General Meeting as voting delegates for the Sudbury & District Board of Health:

____________________________________________________________.
ADDENDUM
MOTION: THAT this Board of Health deals with the items on the Addendum.
IN CAMERA
MOTION: THAT this Board of Health goes in camera. Time: _______________ p.m.
RISE AND REPORT
MOTION: THAT this Board of Health rises and reports. Time: ____________ p.m.
ADJOURNMENT
MOTION: THAT we do now adjourn. Time: ________ p.m.