Sudbury & District Board of Health

Thursday, May 18, 2017, 1:30 p.m.

SDHU Boardroom

1300 Paris Street

Sudbury & District Board of Health Meeting - May 18, 2017

Meeting #04-17

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

Sudbury & District Health Unit
Service de santé publique

AGENDA – FOURTH MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT
THURSDAY, MAY 18, 2017 – 1:30 P.M.

1. CALL TO ORDER

2. ROLL CALL

3. REVIEW OF AGENDA / DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION / PRESENTATION

i) 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

i) Minutes of Previous Meeting

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 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 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

b. Canadian Journal of Public Health, Vol. 108, NO.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) alPHa 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.

Sudbury & District Health Unit
Service de santé publique

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 the 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

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

Sudbury & District Board of Health Motion #04-17

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

d. Expert Panel on Public Health

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

- Letter from the alPHa Board to the Public Health Expert Panel dated March 15, 2017

e. Boards of Health Budgets 2016

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

f. Basic Income

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

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

Sudbury & District Board of Health Motion #60-16

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

h. Anti-Contraband Tobacco Campaign

Sudbury & District Board of Health Motion #03-17

- Letter from the Township of Nairn and Hyman to the Minister of Finance dated February 17, 2017

i. HPV Immunization Programs

- Letter from the Simcoe Muskoka Board of Health to the Minister of Health and Long-Term Care dated January 18, 2017

j. Low-Income Dental Program for Adults and Seniors

- Letter from the Porcupine Unit Board of Health to the Minister of Health and Long-Term Care dated March 28, 2017

k. Stop Marketing to Kids Coalition's Ottawa Principles and Further Action on Sugary Drinks

- Letter from Middlesex-London Board of Health to the Ontario Boards of Health dated March 28, 2017

l. Tobacco Endgame

- Letters from the Simcoe Muskoka Board of Health to the Federal Minister of Health and Provincial Minister of Health and Long-Term Care dated March 15, 2017

m. Support for Legislation under the HPPA to allow for the Inspection and Enforcement Activities of Personal Service Settings

- Letter from the Wellington-Dufferin-Guelph Board of Health to the Premier of Ontario dated January 4, 2017
- Letter from the Algoma Board of Health to the Premier of Ontario dated March 29, 2017

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

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

o. HIV/AIDS Strategy to 2026

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

vi) Items of Information

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

vii) Approval of Consent Agenda

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

- Letter from the Sudbury & District Board of Health dated April 21, 2017, and Appendix A: Standards for Public Health Programs and Services, Sudbury & District Board of Health Overarching Issues and Detailed Operational Feedback

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

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

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)

Sudbury & District Health Unit
Service de santé publique

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)

Sudbury & District Health Unit
Service de santé publique

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

Words for thought…

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.

Source: Public Health Ontario Website
Date: May 2017

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.

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, Wikwimekong 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

Sudbury & District Health Unit

STATEMENT OF REVENUE & EXPENDITURES

For The 3 Periods Ending March 31, 2017

Cost Shared Programs

	Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOHLTC - General Program	14,687,000	3,671,750	3,671,750	0	11,015,250
MOHLTC - Unorganized Territory	819,400	204,850	204,850	0	614,550
MOHLTC - VBD Education & Surveillance	65,000	16,250	16,250	0	48,750
MOHLTC - SDWS	106,000	26,500	26,500	0	79,500
Municipal Levies	6,943,298	1,735,822	1,735,822	0	5,207,477
Municipal Levies - Small Drinking Water Syste	47,222	11,806	11,806	(0)	35,416
Municipal Levies - VBD Education & Surveille	21,646	5,412	5,412	(0)	16,234
Interest Earned	85,000	17,051	17,051	0	67,949
Total Revenues:	$22,774,566	$5,689,440	$5,689,441	$(1)	$17,085,125
Expenditures:					
Corporate Services:					
Corporate Services	4,387,620	1,340,105	1,333,370	6,735	3,054,250
Print Shop	152,774	37,927	16,866	21,061	135,908
Espanola	120,973	28,882	28,071	811	92,902
Manitoulin	124,624	29,886	27,872	2,015	96,753
Chapleau	99,667	23,597	22,136	1,461	77,530
Sudbury East	16,486	4,121	4,197	(75)	12,289
Intake	318,239	73,968	73,972	(4)	244,267
Volunteer Services	5,711	171	36	135	5,675
Total Corporate Services:	$5,226,094	$1,538,656	$1,506,518	$32,138	$3,719,575
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	149,515	149,698	(183)	508,618
Risk Reduction	124,408	41,840	22,145	19,695	102,263
Clinical Preventative Services - Outreach	141,610	33,692	31,915	1,777	109,695
Sexual Health	952,320	220,867	203,591	17,276	748,729
Influenza	0	0	0	(0)	(0)
Meningittis	0	0	1	(1)	(1)
HPV	0	0	1	(1)	(1)
Dental - 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	$1,435,490	$1,338,557	$96,933	$4,929,065
* Program activities reported to individual department 220 only					
Environmental Health:					
General	794,321	168,210	167,248	962	627,073
Enviromental	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	$6,083	$2,815,682
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	262,717	61,624	59,871	1,753	202,846
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	352,735	69,683	61,683	7,999	291,052
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
RRED:					
General	1,454,823	350,202	336,335	13,867	1,118,488
Workplace Capacity Development	23,507	350	311	39	23,196
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 RRED:	$2,090,211	$479,489	$452,495	$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

	BOH Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:					
Funding	22,998,576	5,860,125	5,853,535	6,590	17,145,041
Other Revenue/Transfers	846,680	219,202	247,835	(28,632)	598,846
Total Revenues & Expenditure Recoveries:	23,845,256	6,079,327	6,101,369	(22,042)	17,743,887
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	264,004	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	9,982	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	

Sudbury & District Health Unit
SUMMARY OF REVENUE & EXPENDITURES
For the Period Ended March 31, 2017

100% Funded Programs

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End
Pre/Postnatal Nurse Practitioner	704	139,000	33,157	105,843	23.9%	*Dec 31*
OTF - Getting Ahead and Cirlcles	706	-	3,255	(3,255)	0.0%	*Mar 31/17*
SFO -TCAN - E-Cigarettes - 1-time	721	30,000	23,699	6,301	79.0%	*Mar 31/17*
SFO - Electronic Cigarette Act - New Nov./15 - Base Fndg	722	36,700	5,448	31,252	14.8%	*Dec 31*
SFO -TCAN - Prevention	724	97,200	7,472	89,728	7.7%	*Dec 31*
SFO - Tobacco Control Area Network - TCAN	725	285,800	52,479	233,321	18.4%	*Dec 31*
SFO - Local Capacity Building: Prevention & Protection	726	259,800	42,092	217,708	16.2%	*Dec 31*
SFO - Tobacco Control Coordination	730	104,442	24,102	80,340	23.1%	*Dec 31*
SFO - Youth Engagement	732	80,000	17,862	62,138	22.3%	*Dec 31*
Infectious Disease Control	735	479,100	110,363	368,737	23.0%	*Dec 31*
LHIN - Falls Prevention Project & LHIN Screen	736	110,450	109,265	1,185	98.9%	*Mar 31/17*
MOHLTC - Special Nursing Initiative	738	180,500	41,654	138,846	23.1%	*Dec 31*
MOHLTC - Northern Fruit and Vegetable Funding	743	156,600	1,679	154,921	1.1%	*Dec 31*
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		

simcoe muskoka
DISTRICT HEALTH UNIT

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.

❑ **Barrie:** 15 Sperling Drive, Barrie, ON, L4M 6K9, 705-721-7520, FAX: 705-721-1495
❑ **Collingwood:** 280 Pretty River Pkwy., Collingwood, ON, L9Y 4J5, 705-445-0804, FAX: 705-445-6498
❑ **Cookstown:** 2-25 King Street S., Cookstown, ON, L0L 1L0, 705-458-1103, FAX: 705-458-0105
❑ **Gravenhurst:** 2-5 Pineridge Gate, Gravenhurst, ON, P1P 1Z3, 705-684-9090, FAX: 705-684-9887
❑ **Huntsville:** 34 Chaffey St., Huntsville, ON, P1H 1K1, 705-789-8813, FAX: 705-789-7245
❑ **Midland:** B-865 Hugel Ave., Midland, ON, L4R 1X8, 705-526-9324, FAX: 705-526-1513
❑ **Orillia:** 120-169 Front St. S., Orillia, ON, L3V 4S8, 705-325-9565, FAX: 705-325-2091

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:

1. http://healthycanadians.gc.ca/healthy-living-vie-saine/substance-abuse-toxicomanie/misuse-plan-abus-index-eng.php
2. http://www.drugstrategy.ca/uploads/5/3/6/2/53627897/prescription_for_life_june_1_2015.pdf
3. Ambulatory Visits & Population Estimates (2003-2015). Ontario Ministry of Health and Long-term Car, IntelliHEALTH, Ontario, Date Extracted: (Jan13, 2017. ICD-10codes(Any Dx):T400-T404;T406: Age standardized using the 20011 Canadian Standard Population.

DURHAM REGION

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 ROSSLAND ROAD EAST
PO BOX 623
WHITBY, ON L1N 6A3
CANADA

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

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

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.

"Service Excellence for our Communities"

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

DURHAM REGION

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 ROSSLAND ROAD EAST
PO BOX 623
WHITBY, ON L1N 6A3
CANADA

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

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

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.

"Service Excellence for our Communities"

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

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

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

Porcupine
Health Unit • Bureau de santé

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

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

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

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

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

Date: 17 / 04 / 21
y m d

Porcupine
Health Unit • Bureau de santé

R-2017 - 21

MOVED BY: Veronica Farrell

SECONDED BY: Drago Stefanic

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

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

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

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**

Gilles Chartrand

Chair - Board of Health

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

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

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

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

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

Porcupine
Health Unit • Bureau de santé

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

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

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

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

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

Date: 17 / 04 / 21
y m d

Porcupine
Health Unit • Bureau de santé

R-2017 - 20

MOVED BY: Michael Shea

SECONDED BY: Rick Lafleur

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

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

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

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

Gilles Bisson
Chair - Board of Health

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

DURHAM REGION

The Regional Municipality of Durham

Corporate Services
Department
Legislative Services

605 ROSSLAND ROAD EAST
PO BOX 623
WHITBY, ON L1N 6A3
CANADA

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

www.durham.ca

Matthew L. Gaskell
Commissioner of
Corporate Services

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.

"Service Excellence for our Communities"

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

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

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.

.../2

160 Chancellors Way, Guelph, ON N1G 0E1
T: 1-800-265-7293 | **F:** 519-836-7215 | **wdgpublichealth.ca**

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

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

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: 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.

.../2

160 Chancellors Way, Guelph, ON N1G 0E1
T: 1-800-265-7293 | **F:** 519-836-7215 | **wdgpublichealth.ca**

PublicHealth
WELLINGTON·DUFFERIN·GUELPH
Stay Well.

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.

alPHa
Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

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

May 4th 2017

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 alPHa 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: alPHa 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 alPHa 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,

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.

alPHa Summary
Budget 2017:
A Stronger, Healthier Ontario

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 are 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.

alPHa
Association of Local
PUBLIC HEALTH
Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

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

May 4th 2016

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 Budged 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,

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

Encl.

alPHa
Association of Local
PUBLIC HEALTH
Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

May 5th 2017

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,

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.

alPHa
Association of Local
PUBLIC HEALTH
Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

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.

alPHa 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 alPHa'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 alPHa 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,

Dr. Valerie Jaeger,
President

Copy: Dr. David Williams, Chief Medical Officer of Health, MOHLTC

Ministry of Health
and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel 416-327-4300
Fax 416-326-1571
www.ontario.ca/health

Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

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

Ontario

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

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

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, WDGPH Board of 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

160 Chancellors Way, Guelph, ON N1G 0E1
T: 1-800-265-7293 | **F:** 519-836-7215 | **wdgpublichealth.ca**

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

May 3, 2017

DELIVERED 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 alPHa 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

160 Chancellors Way, Guelph, ON N1G 0E1

DRAFT RESOLUTION FOR alPHa 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 (alPHa) 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 alPHa 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

1. WDGPH BOH Report BH.01.03.02.1711 Evaluation of the Fluoride Varnish Program at Centre Peel Public School. June 2011. Available from: https://wdgpublichealth.ca/content/boh-report-bh0103021711-june-1-2011
2. WDGPH BOH Report BH.01.FEB0415.R03 Fluoride Varnish Initiative. February 2015. Available from: https://wdgpublichealth.ca/content/boh-report-%E2%80%93-bh01feb0415r03-february-4-2015
3. WDGPH BOH Report BH.01.NOV0216.R18 Fluoride Varnish program in High Risk Elementary Schools. Available from: https://www.wdgpublichealth.ca/board-health/board-health-meetings/november-2-2016-agenda/fluoride-varnish-program-high-risk
4. Ito D. Summary of 2009-15 Oral Health Screening: Results from Participating Ontario Health Units. Ontario Association of Public Health Dentistry. November 2015.
5. King A. Oral Health – More Than Just Cavities. A Report by Ontario's Chief Medical Officer of Health. April 2012.
6. Canadian Institute for Health Information. Treatment of Preventable Dental Cavities in Preschoolers: A Focus on Day Surgery under General Anaesthesia. 2013.
7. Marinho VCC, Worthington HV, Walsh T, Clarkson JE. Fluoride varnishes for preventing dental caries in children and adolescents. Cochrane Database of Systematic Reviews. 2013, Issue 7.
8. Centers for Disease Control and Prevention. Recommendations for using fluoride to prevent and control dental caries in the United States. Morbidity and Mortality Weekly Reports 2001;50 (RR-14): 1-42.
9. U.S. Preventive Services Task Force. Final Update Summary: Dental Caries in Children from Birth Through Age 5 Years: Screening. September 2016.

Ministry of Health and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel 416-327-4300
Fax 416-326-1571
www.ontario.ca/health

Ministère de la Santé et des Soins de longue durée

Bureau du ministre

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

Ontario

May 1, 2017

HLTC5865IT-2017-25

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.

…/2

- 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.

…/3

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.

…/4

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.

…/5

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.[1] 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".[2]

But 15 years after SARS and the call of the landmark *Naylor Report*[3] 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,[4] 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",[2] 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 (CPHOC) 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 et de la longévité[1]. 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 »[2].

Mais 15 ans après le SRAS et l'appel à renforcer la SP dans le document phare que fut le *Rapport Naylor*[3], 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[4], 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']avoir des populations en meilleure santé et [d']assurer la viabilité de notre réseau public de la santé[2] », 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-hygiéniste 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,

† Nous employons ici les titres de directeur provincial/directrice provinciale de la santé publique (DPS) et de directeur/directrice de la santé publique ou médecin-hygiéniste (DSP-MH), mais nous reconnaissons que ces titres peuvent varier selon la province.

Drastic centralization of PH occurred in Alberta (2008) and Nova Scotia (2015).[5] 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.

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[6] – a situation in keeping with the muzzling of federal health scientists during the tenure of the Harper Government.[7] 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[8] and a duty for PH.[9] 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.

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

Il y a eu une centralisation drastique de la SP en Alberta (2008) et en Nouvelle-Écosse (2015)[5]. À la suite de ces réformes, de nombreux spécialistes de la SP sont devenus des cadres supérieurs au sein des ministères de la Santé, et luttent pour protéger leur indépendance scientifique contre les ingérences politiques, un défi qui hante aussi le bureau de l'administratrice en chef de la santé publique du Canada.

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 iniquités en matière de santé, entre autres).
  - Songer à retirer les unités de SP des autorités sanitaires et à les reloger dans les administrations municipales ou en association étroite avec elles.

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[6] – une situation qui s'inscrit dans la logique du musèlement des chercheurs fédéraux en santé durant le mandat du gouvernement Harper[7]. 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 affectés 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[8] et un devoir pour la SP[9]. 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.[10] 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,[11] 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 level.

- 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.[3,12] 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%.[13] 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%,[14] 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",[15] the share of the health budget going to PH has remained low and even declined in some HAs between 2008/2009 and 2011/2012.[16] In Ontario, the implementation of a new funding model in 2015 has resulted in flat-line funding,

législative, 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[10]. 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[11], les ISP se disent démoralisées par les coupes dans leurs responsabilités traditionnelles de SP auprès des communautés et des populations (p. ex., le développement communautaire, le plaidoyer pour la santé, le travail de coalition) au profit de tâches cliniques axées sur l'individu. 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 n'ont pas le pouvoir de 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[3,12]. 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 promotion[19] 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.

Ak'ingabe Guyon, MSc, 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

de résultats ciblés en santé des populations – et d'en assumer la responsabilité.

Plus inquiétant encore, il y a des compressions sans précédent et un désinvestissement chronique en SP dans plusieurs provinces. En 2015, les directions régionales de SP du Québec ont été touchées par des compressions budgétaires record de 33 %[13]. Aucune justification sérieuse n'a été avancée pour ces compressions arbitraires, sauf l'idée fausse et dangereuse que les services régionaux de SP ne sont guère plus que de la bureaucratie en période d'austérité présumée. En Nouvelle-Écosse, malgré un rapport ministériel complété en 2005 qui énonçait une cible d'investissement de 4 % à 5 %[14], le financement de la SP est resté inchangé à 1,3 % des dépenses en soins de santé – l'un des plus bas niveaux au pays. En Colombie-Britannique, malgré les rapports de deux comités spéciaux recommandant d'accroître le financement de la SP à 6 % du budget des soins de santé[15], la part du budget de la santé allouée à la SP est restée faible et a même diminué dans certaines autorités sanitaires entre 2008–2009 et 2011–2012[16]. En Ontario, l'application d'un nouveau modèle de financement en 2015 a fait stagner ce financement, ce qui a considérablement réduit les capacités dans la majorité des 36 unités de santé publique de la province[17].

- 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 reconnaisse 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 vigoureux[18]. 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'il est temps de mener 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 « pangouvernementale » à l'égard de la promotion de la santé des populations[19] 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 SP[20] 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, CCMF, FRCPC,
Spécialiste en santé publique et médecine préventive, Département clinique de santé publique, Montréal (Québec) et professeure de clinique adjointe, École de santé publique, Université de Montréal, Montréal (Québec)

Trevor Hancock, M.B., B.Sc., M.Sc.S., HonFFPH (Royaume-Uni),
Professeur et chercheur-boursier principal, École de santé publique et de politique sociale, Université de Victoria,
Victoria (Colombie-Britannique)

Gaynor Watson-Creed, MSc, MD, CCFP, FRCPC,
Adjunct Professor, Department of Community Health and Epidemiology, Dalhousie University, Halifax, NS

Correspondence: Dr. Ak'ingabe Guyon, E-mail: Akingabe.guyon@mail.mcgill.ca

doi: 10.17269/CJPH.108.6143

REFERENCES

1. Rutty C, Sullivan S. *This is Public Health: A Canadian History*. Ottawa, ON: Canadian Public Health Association, 2010. Available at: http://www.cpha.ca/uploads/history/book/historybook-print_all_e.pdf. See especially *History of Public Health: 12 Great Achievements*. Available at: http://www.cpha.ca/en/programs/history/achievements.aspx (Accessed February 26, 2017).
2. Ministers of Health and Health Promotion/Healthy Living. *Creating a Healthier Canada: Making Prevention a Priority. A Declaration on Prevention and Promotion from Canada's Ministers of Health and Health Promotion/Healthy Living*. Ottawa, ON: Public Health Agency of Canada, 2010. Available at: http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/declaration/pdf/dpp-eng.pdf (Accessed March 5, 2017).
3. National Advisory Committee on SARS and Public Health. *Learning from SARS: Renewal of Public Health in Canada*. Health Canada, 2003.
4. Potvin L. Canadian public health under siege. *Can J Public Health* 2014;105(6): e401–3. doi: 10.17269/cjph.105.4960.
5. National Collaborating Centre for Healthy Public Policy. *Structural Profile of Public Health in Canada*. Quebec, QC: The Centre, 2015. Available at: http://ncchpp.ca/76/Multimedia.ccnpps?id_article=205 (Accessed March 5, 2017).
6. New Brunswick Medical Society. *Strong, Independent, Medical Officers of Health*. Fredericton, NB: The Society, 2014. Available at: http://www.nbms.nb.ca/assets/Care-First/MedicalOfficersofHealthPaper.pdf (Accessed March 5, 2017).
7. Russell E. We deserve a government that respects scientific integrity. *CMAJ* 2015;187(15):1107. PMID: 26391718. doi: 10.1503/cmaj.151006. Available at: http://www.cmaj.ca/content/early/2015/09/21/cmaj.151006.full.pdf (Accessed March 5, 2017).
8. Public Health Agency of Canada. *Core Competencies for Public Health in Canada, Release 1.0*. Ottawa, ON: The Agency, 2008. Available at: http://www.phac-aspc.gc.ca/php-psp/ccph-cesp/pdfs/cc-manual-eng090407.pdf (Accessed March 5, 2017).
9. Hancock T. Advocacy: It's not a dirty word, it's a duty. *Can J Public Health* 2015;106:e86–88. PMID: 26125246. doi: 10.17269/cjph.106.5094.
10. World Health Organization. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. Geneva, Switzerland: Commission on the Social Determinants of Health, 2008.
11. Kirk M, MacDonald M, Schreiber R, Kothari A. Exploring the changing nature of public health nursing practice. Presented at the 22nd International Union for Health Promotion and Education World Conference on Health Promotion, Curitiba, Brazil, May 22–26, 2016.
12. Ballinger G. Refining estimates of public health spending as measured in National health expenditure accounts: The Canadian experience. *J Public Health Manag Pract* 2007;13(2):115–20. PMID: 17299314. doi: 10.1097/00124784-200703000-00006.
13. Guyon A, Perreault R. Public health systems under attack in Canada: Evidence on public health system performance challenges arbitrary reform. *Can J Public Health* 2016;107(3):e326–29. PMID: 27763850. doi: 10.17269/cjph.107.5273.
14. Moloughney BW. *The Renewal of Public Health in Nova Scotia: Building a Public Health System to Meet the Needs of Nova Scotians*. Halifax, NS: Ministry of Health, 2005. Available at: http://novascotia.ca/dhw/publichealth/documents/Renewal-of-Public-Health-Report.pdf (Accessed March 5, 2017).
15. Select Standing Committee on Health. *The Path to Health and Wellness: Making British Columbians Healthier by 2010*. Victoria, BC: The Legislative Assembly of British Columbia, 2004. Available at: https://www.leg.bc.ca/content/legacy/web/cmt/37thparl/session-5/health/reports/PDF/Rpt-HEALTH-37-5-1stRpt-PathToHealthWellness-2004-NOV-25.pdf (Accessed March 5, 2017) and Select Standing Committee on Health. *A Strategy for Combating Childhood Obesity and Physical Inactivity in British Columbia*. Victoria, BC: The Legislative Assembly of British Columbia, 2006. Available at: https://www.leg.bc.ca/content/legacy/web/cmt/38thparl/session-2/health/reports/Rpt-Health-38-2-29Nov2006.pdf (Accessed March 5, 2017).
16. Auditor General of BC. *Health Funding Explained*. Victoria, BC: The Auditor General, 2013.
17. Association of Local Public Health Agencies. *Letter to Hon. Eric Hoskins, Minister of Health and Long-Term Care, Re: Public Health Funding Model*, November 3, 2015. Available at: http://c.ymcdn.com/sites/www.alphaweb.org/resource/collection/72B0AB89-895D-4FCB-BB76-856482D6E54D/alPHa_Letter_PHFM_031115_FINAL.pdf (Accessed March 5, 2017).
18. Sudbury and District Health Unit. *2017 Pre-Budget Consultation: Investing in Public Health*. Sudbury, ON: SDHU.

Megan Kirk, inf. aut., B.Sc.Inf., M.Sc.,
Université de Victoria, Victoria (Colombie-Britannique)

Marjorie MacDonald, inf. aut., Ph.D.,
Professeure, École des sciences infirmières, et codirectrice de l'initiative Research in Public Health Systems and Services, Université de Victoria, Victoria (Colombie-Britannique)

Cory Neudorf, B.Sc., M.Sc.S., M.D., FRCPC,
Professeur agrégé, Université de la Saskatchewan, et médecin-hygiéniste en chef, Région sanitaire de Saskatoon, Saskatoon (Saskatchewan)

Penny Sutcliffe, M.D., M.Sc.S., FRCPC,
Médecin hygiéniste et chef de la direction, Service de santé publique de Sudbury et du district, Sudbury (Ontario)

James Talbot, M.D., Ph.D., FRCPC,
Professeur associé, École de santé publique, Université de l'Alberta, Edmonton (Alberta)

Gaynor Watson-Creed, M.Sc., M.D., CCMF, FRCPC,
Professeure associée, Département de santé communautaire et d'épidémiologie, Université Dalhousie, Halifax (Nouvelle-Écosse)

Correspondance : D[re] Ak'ingabe Guyon, courriel : Akingabe.guyon@mail.mcgill.ca

doi: 10.17269/CJPH.108.6143

RÉFÉRENCES BIBLIOGRAPHIQUES

1. Rutty C, Sullivan S. *La santé publique : une histoire canadienne*. Ottawa, ON: Association canadienne de santé publique, 2010. Sur Internet : http://www.cpha.ca/uploads/history/book/history-book-print_all_f.pdf. Voir surtout *L'histoire de la santé publique : 12 grandes réalisations*. Sur Internet : http://www.cpha.ca/fr/programs/history/achievements.aspx (consulté le 26 février 2017).
2. Ministres de la Santé, de la Promotion de la santé et du Mode de vie sain. *Pour un Canada plus sain : faire de la prévention une priorité, Déclaration sur la prévention et la promotion de la part des ministres canadiens de la Santé, de la Promotion de la santé et du Mode de vie sain*. Ottawa, ON: Agence de la santé publique du Canada, 2010. Sur Internet : http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/declaration/pdf/dpp-fra.pdf (consulté le 5 mars 2017).
3. Comité consultatif national sur le SRAS et la santé publique. *Leçons de la crise du SRAS : Renouvellement de la santé publique au Canada*. Santé Canada, 2003.
4. Potvin L. La santé publique canadienne en état de siège. *Rev can santé publique* 2014;105(6):e401–3.
5. Centre de collaboration nationale sur les politiques publiques et la santé. *Profil structurel de la santé publique au Canada*. Québec, QC: le Centre, 2015. Sur Internet : http://www.ccnpps.ca/83/multimedia.ccnpps?id_article=204 (consulté le 5 mars 2017).
6. Société médicale du Nouveau-Brunswick. *Des voix plus fortes pour la santé publique : les médecins-hygiénistes de la santé publique*. Fredericton, NB: la Société, 2014. Sur Internet : http://smnb.ca/assets/News/20140525MOHfr.pdf (consulté le 5 mars 2017).
7. Russell E. We deserve a government that respects scientific integrity. *CMAJ* 2015;187(15):1107. PMID: 26391718. doi: 10.1503/cmaj.151006. Sur Internet : http://www.cmaj.ca/content/early/2015/09/21/cmaj.151006.full.pdf (consulté le 5 mars 2017).
8. Agence de la santé publique du Canada. *Compétences essentielles en santé publique au Canada, version 1.0*. Ottawa, ON: l'Agence, 2008. Sur Internet : http://www.phac-aspc.gc.ca/php-psp/ccph-cesp/pdfs/cc-manual-fra090407.pdf (consulté le 5 mars 2017).
9. Hancock T. Advocacy: It's not a dirty word, it's a duty. *Rev can santé publique* 2015;106:e86–88. PMID: 26125246. doi: 10.17269/cjph.106.5094.
10. Organisation mondiale de la santé. *Combler le fossé en une génération : Instaurer l'équité en santé en agissant sur les déterminants sociaux*. Genève, Switzerland: Commission des déterminants sociaux de la santé, 2008.

19. The Senate of Canada. *A Healthy, Productive Canada: A Determinant of Health Approach*. Ottawa, ON: Sub-Committee on Population Health, 2009.
20. Accreditation Canada. *Standards for Public Health Services*. Ottawa, ON: Accreditation Canada, 2017. Available at: https://accreditation.ca/public-health-services (Accessed March 5, 2017).

11. Kirk M, MacDonald M, Schreiber R, Kothari A. Exploring the changing nature of public health nursing practice. présenté à la 22e Conférence mondiale sur la promotion de la santé de l'Union internationale de promotion de la santé et d'éducation pour la santé, Curitiba, Brésil, 22–26 mai 2016.
12. Ballinger G. Refining estimates of public health spending as measured in National health expenditure accounts: The Canadian experience. *J Public Health Manag Pract* 2007;13(2):115–20. PMID: 17299314. doi: 10.1097/00124784-200703000-00006.
13. Guyon A, Perreault R. Public health systems under attack in Canada: Evidence on public health system performance challenges arbitrary reform. *Rev can santé publique* 2016;107(3):e326–29. PMID: 27763850. doi: 10.17269/cjph.107.5273.
14. Moloughney BW. *The Renewal of Public Health in Nova Scotia: Building a Public Health System to Meet the Needs of Nova Scotians*. Halifax, NS: ministère de la Santé, 2005. Sur Internet : http://novascotia.ca/dhw/publichealth/documents/Renewal-of-Public-Health-Report.pdf (consulté le 5 mars 2017).
15. Colombie-Britannique. Select Standing Committee on Health. *The Path to Health and Wellness: Making British Columbians Healthier by 2010*. Victoria, BC: The Legislative Assembly of British Columbia, 2004. Sur Internet : https://www.leg.bc.ca/content/legacy/web/cmt/37thparl/session-5/health/reports/PDF/Rpt-HEALTH-37-5-1stRpt-PathToHealthWellness-2004-NOV-25.pdf (consulté le 5 mars 2017) et Select Standing Committee on Health. *A Strategy for Combating Childhood Obesity and Physical Inactivity in British Columbia*. Victoria, BC: The Legislative Assembly of British Columbia, 2006. Sur Internet : https://www.leg.bc.ca/content/legacy/web/cmt/38thparl/session-2/health/reports/Rpt-Health-38-2-29Nov2006.pdf (consulté le 5 mars 2017).
16. Colombie-Britannique. Auditor General. *Health Funding Explained*. Victoria, BC: The Auditor General, 2013.
17. Association of Local Public Health Agencies. *Lettre à Eric Hoskins, ministre de la Santé et des Soins de longue durée, au sujet du modèle de financement de la santé publique*, 3 novembre 2015. Sur Internet : http://c.ymcdn.com/sites/www.alphaweb.org/resource/collection/72B0AB89-895D-4FCB-BB76-856482D6E54D/alPHa_Letter_PHFM_031115_FINAL.pdf (consulté le 5 mars 2017).
18. Service de santé publique de Sudbury et du district. *2017 Pre-Budget Consultation: Investing in Public Health*. Sudbury, ON: SSPSD.
19. Sénat du Canada. *Un Canada en santé et productif : une approche axée sur les déterminants de la santé*. Ottawa, ON: Sous-comité sénatorial sur la santé des populations, 2009.
20. Agrément Canada. *Normes pour les services de santé publique*. Ottawa, ON: Agrément Canada, 2017. Sur Internet : https://accreditation.ca/fr/services-de-sant%C3%A9-publique (consulté le 5 mars 2017).

EVIDENCE TO GUIDE ACTION:

Comprehensive Tobacco Control in Ontario (2016)

Smoke-Free Ontario Scientific Advisory Committee

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

Smoking rates have been **decreasing** from **19.3%** (2010) to **17.4%** (2014)[1]

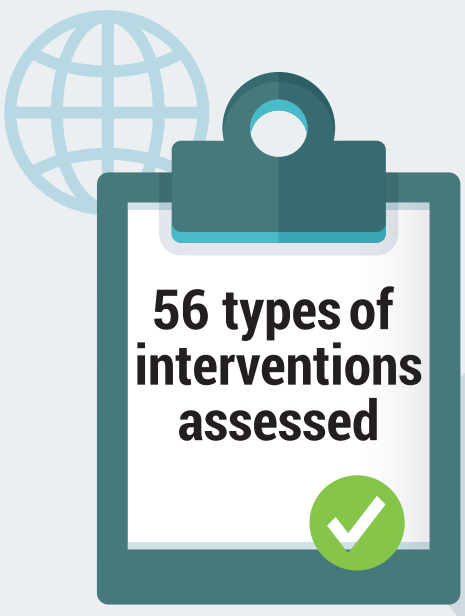
Two million Ontarians smoke[2]

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]

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

SOURCES

[1]Statistics Canada. Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2013 boundaries) and peer groups, occasional [Internet]. Ottawa, ON: CANSIM; 2016 [updated 2016 Apr 21; cited 2015 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

For more information on this Report, visit:
www.publichealthontario.ca/tobaccocontrol

Public Health Ontario
PARTNERS FOR HEALTH
Santé publique Ontario
PARTENAIRES POUR LA SANTÉ
Ontario Agency for Health Protection and Promotion
Agence de protection et de promotion de la santé
www.publichealthontario.ca

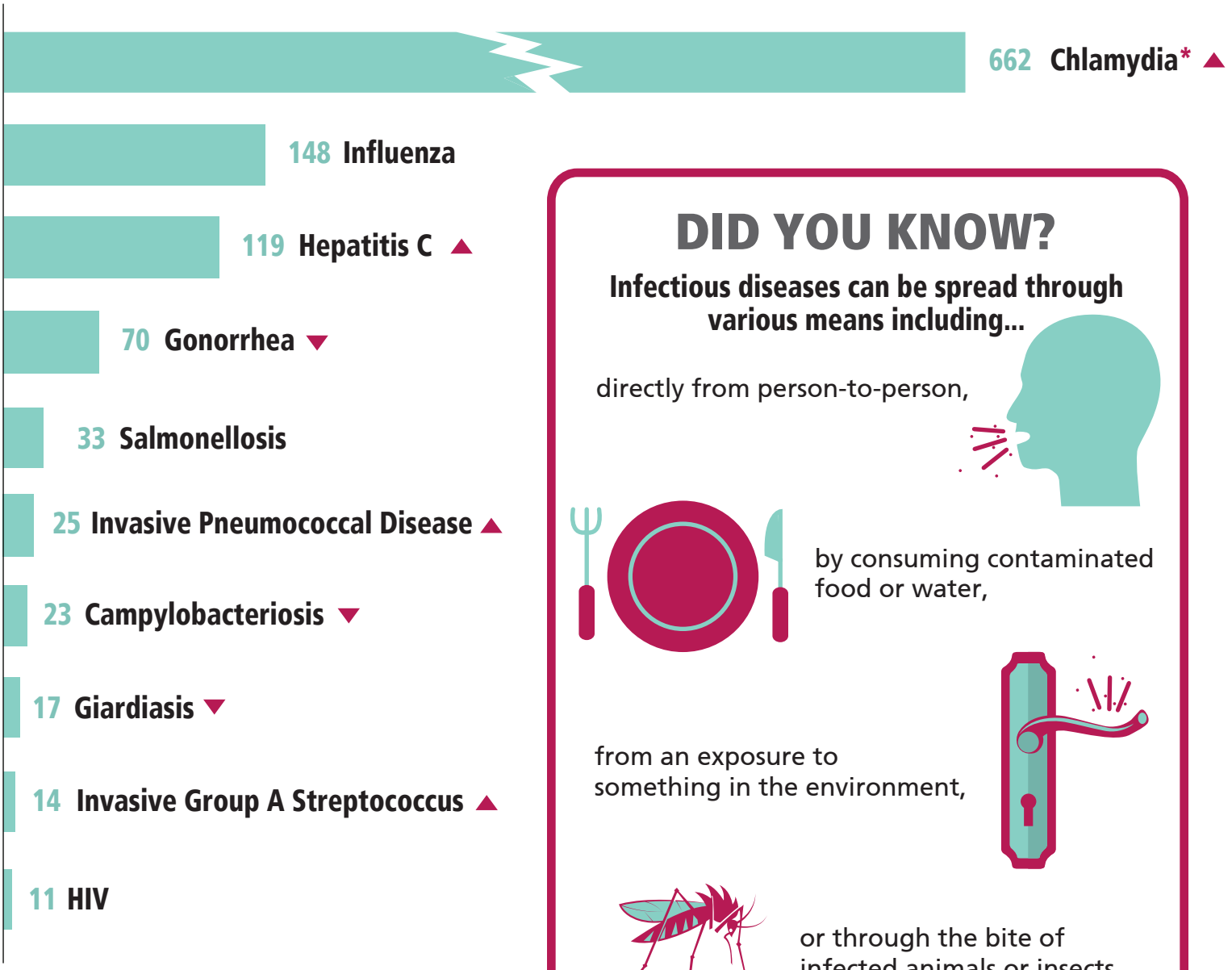
SPREAD THE FACTS, NOT THE GERMS

A look at reportable infectious diseases in the Sudbury & District Health Unit service area

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

Number of new cases ▲ Higher than Ontario rate ▼ Lower than Ontario rate



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,

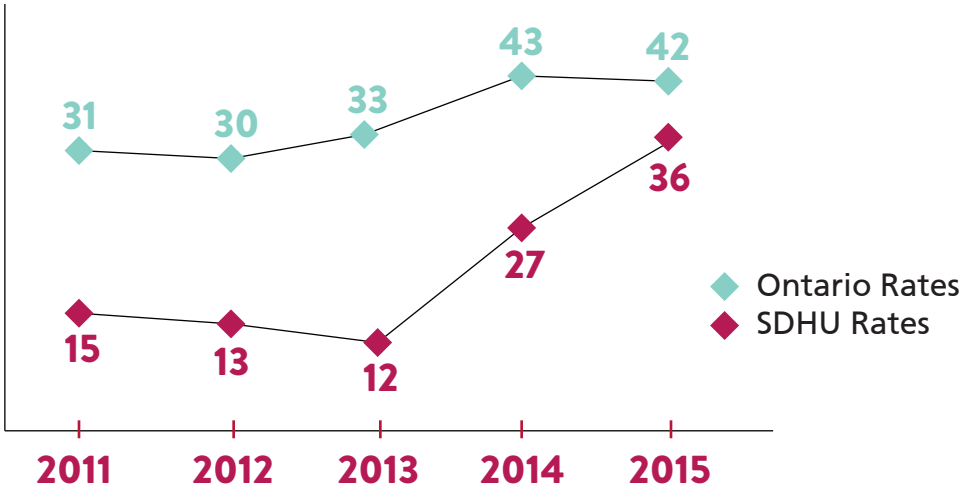
♂ 220

♀ 421

and was highest in the **15–24 AGE GROUP.**

THE RATE OF GONORRHEA...

increased locally,



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,

♂ 68

♀ 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)

Sudbury & District Health Unit
Service de santé publique

APPROVAL OF CONSENT AGENDA

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

Sudbury & District Health Unit
Service de santé publique

Briefing Note

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

☒ For Information ☐ For Discussion ☐ For a Decision

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.

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

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

	Risk Categories	Rating Scale
1. Financial Risks		
1.1	The SDHU may be at risk as budget pressures are expected to increase over the next several years.	L5 I5
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.	L4 I4
1.3	The SDHU may be at risk as internal controls do not ever fully eliminate all potential risks of fraud.	L1 I3
2. Governance / Organizational Risks		
2.1	The SDHU may be at risk as BoH members, individually or collectively, may not have the required competencies for effective Board Governance.	L4 I5
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.	L3 I3
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.	L1 I2
3. Human Resources		
3.1	The SDHU may be at risk as a result of an insufficient investment in succession and business continuity planning.	L4 I4
3.2	The SDHU may be at risk as staff may not have all of the necessary competencies to meet evolving Public Health needs.	L4 I4
3.3	The SDHU may be at risk related to varying levels of staff engagement in the work of the organization.	L2 I3
3.4	The SDHU may be at risk as some staff work offsite in uncontrolled environments.	L2 I4
4. Knowledge / Information		
4.1	The SDHU may be at risk due to incomplete/inadequate information to make decisions or plan programs and services.	L3 I3
5. Technology		
5.1	The SDHU may be at risk of a network outage.	L3 I5
5.2	The SDHU may be at risk of not having a comprehensive and future oriented information technology plan and planning processes.	L4 I3
6. Legal / Compliance		
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.	L2 I2
7. Service Delivery / Operational		
7.1	The SDHU may be at risk of our service not being perceived as a value add to our clients.	L3 I4
8. Environment		
8.1	The SDHU may be at risk of natural and anthropogenic disasters or hazards.	L2 I3
9. Political		
9.1	The SDHU may be at risk of significant disruptions and high opportunity costs related to health system transformation.	L5 I5
10. Stakeholder / Public Perception		
10.1	The SDHU may be at risk of poorly defined relationships with indigenous communities.	L5 I5
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.	L3 I2
11. Strategic / Policy		
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.	L3 I2
12. Security Risks		
12.1	The SDHU may be at risk of threats to network security.	L2 I4
12.2	The SDHU staff and visitors may be at risk if security systems are offline.	L2 I3
13. Privacy Risks		
13.1	The SDHU may be at risk as internal controls may not be sufficient to fully eliminate all potential risks of privacy breaches.	L4 I2
14. Equity Risks		
14.1	The SDHU may be at risk of not effectively leveling up the health status with priority populations.	L5 I5

Organizational Risk Management Annual Report: July - December 2016

	CATEGORY	TOP SDHU RISKS (RED)	Status	
1	FINANCIAL	The SDHU may be at risk as budget pressures are expected to increase over the next several years.	1	Activities completed to address this risk include: a) the 2017 Board of Health Budget was approved at its November 17 meeting, b) the continual review of cost saving initiatives, c) cost reduction strategies.
2	FINANCIAL	The SDHU may be at risk of financial forecasting not providing sufficient information for decision making resulting in suboptimal financial management within year.	1	Activities completed to address this risk include: a) Monthly financial statements are generated and distributed to the Executive Committee and management teams for review of variances. Significant variances are investigated and necessary adjustments (i.e. calendarization or reallocation of projected surpluses) are completed in greater detail considering the year-end process, b) Annual expenditure projections have been added to the monthly variance analysis report in order to highlight anticipated surpluses/deficits in a more timely manner.
3	GOVERNANCE ORGANIZATIONAL	The SDHU may be at risk as BoH members, individually or collectively, may not have the required competencies for effective Board Governance.	1	Activities completed to address this risk include: a) Continual orientation provided to new Board members b) In the fall of 2016 a Board of Health member attended the 2016 alPHa Fall Symposium c) The Board of Health approved several motions demonstrating effective stewardship of it's areas of responsibility. Examples of these include, Enterprise Risk Management, Strategic Planning and Engagement with Indigenous Peoples.
4	HUMAN RESOURCES	The SDHU may be at risk as a result of an insufficient investment in succession and business continuity planning.	1	Activities underway to address this risk include: a) Succession planning as part of the overall Workforce Development Framework (includes workforce planning, human resources management and workforce capacity building), b) Updating the Human Resource Plan to fit into the new Workforce Development Framework (includes succession planning and related activities).
5	HUMAN RESOURCES	The SDHU may be at risk as staff may not have all of the necessary competencies to meet evolving Public Health needs.	1	Activities underway to address this risk include: a) As part of the Professional Practice Committee and Leadership Development the Human Resources team is working with the Manager of Professional Practice and Development to integrate core competencies for Public Health into our Human Resources activities at SDHU, b) At a leadership level, the five Leadership Core Competencies have been defined to enable integration into Human Resource functions, c) A Public Health Nursing Core Competency pilot project will be implemented with the Health Promotion division.
6	TECHNOLOGY	The SDHU may be at risk of a network outage.	1	Activities completed to address this risk include: a) A new IT Business Systems Analyst position was created that has access to the offsite server room, b) Notifications are in place for outages (planned and unplanned) for contacting the IT Business Systems Analyst, the Senior IT Business Systems Analyst and the manager of Information Technology, c) The phone system now has one server at each location as opposed to two in one location. d) Agilis has set maintenance in place to monitor batteries.
7	TECHNOLOGY	The SDHU may be at risk of not having a comprehensive and future oriented information technology plan and planning processes.	1	Activities underway to address this risk include: a) Discussions are underway to develop a governance committee. This committee would be responsible for forming a business plan across the organization and would include stakeholders for information management, information technology, human resources, privacy, risk, strategic partners and members from various programs and services.
8	SERVICE DELIVERY/OPERATIONAL	The SDHU may be at risk of our service not being perceived as a value add to our clients.	1	Activities underway to address this risk include: a) The SDHU is assessing client satisfaction via points of contact surveys at our various sites. Clients have the opportunity to provide feedback via these surveys, the results of which are reviewed and acted on regularly. The Strategic Engagement Unit (SEU) and the Clinical and Family Services Division are looking to enhance the reach and accessibility of this survey for the upcoming year, b) Systems have been put in place where the Board of Health packages are available on our website, and participation in events are profiled on social media feeds, c) Discussion is underway to further develop our social media strategy, which will be used to enhance engagement with the community and continue to build the public's knowledge of public health, d) The SEU is finalzing the SDHU community and stakeholder engagement plan which will be a tool to help enhance our clients' perception of the SDHU.
9	POLITICAL	The SDHU may be at risk of significant disruptions and high opportunity costs related to health system transformation.	1	Activities underway to address this risk include: a) The SDHU has been responsive to requests from health system partners, and has engaged strategically and proactively (e.g. meetings with NE LHIN and NE public health units; Public Health Workstream), b) The SDHU continues to seek synergies to address efficiencies (e.g. Indigenous engagement and LDCP project), c) The Assistant Director, SEU, as well as members of the Executive Committee, will continue to provide strategic support to the Medical Officer of Health during this transformation period. Consideration might be given to developing a transformation agenda for the organization and deliberately tracking impact SDHU resources.
10	STAKEHOLDER PUBLIC PERCEPTION	The SDHU may be at risk of poorly defined relationships with indigenous communities.	1	Activities completed to address this risk include: a) An Executive Committee Retreat was held followed by a Board of Health Education Session, b) At the November Board of Health meeting, the Board of Health restated its support for Indigenous Engagement. A one time funding application has been submitted to the MOHLTC to advance this work. At its December meeting, the executive committee of senior staff approved a Manager, Indigenous Engagement position description. The position has been advertised as a one year contract position and a job offer made, c) PHO has supported SDHU leadership for a Locally Driven Collaborative Project to develop a model for Indigenous engagement in the Northeast. Engagement work is getting underway to ensure fullsome representation and engagement by public health units, Indigenous Partners and Academic Partners at a January 10, 2017 meeting scheduled by PHO.
11	EQUITY	The SDHU may be at risk of not effectively leveling up the health status with priority populations.	1	Activities to address this risk are ongoing, including: 1) Successful grant application to the Local Poverty Reduction Fund and work started on collaborative project focusing on Bridges out of Poverty, Circles and Getting Ahead, 2) Collaboration on a Northern Health Equity strategy, 3) Continuation of You Can Create Change campaign and broader health equity communications plan including efforts to strengthen the social determinants of health in existing curricula in Ontario through Ministry of Education engagement (via CODE-COMOH) as well as post-secondary efforts at Laurentian University's School of Education and Science Communications, 4) Participation in local and provincial consultation sessions and submissions in support of basic income pilot for Ontario, 5) Participation in local living wage community event and exploration of SDHU potential as living wage employer or advocate for living wage locally, 6) Continued exploration of other potential intervention research partnerships, etc.

1 - No Concerns **2 - Attention Required** **3 - Concerns**

Financial Statements of

SUDBURY & DISTRICT HEALTH UNIT

Year ended December 31, 2016

KPMG LLP
Claridge Executive Centre
144 Pine Street
Sudbury Ontario P3C 1X3
Canada
Telephone (705) 675-8500
Fax (705) 675-7586

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

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

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

	Budget 2016	Total 2016	Total 2015
Revenue (note 9):			
Provincial grants	$ 19,968,101	$ 19,944,345	$ 20,160,129
Per capita revenue from municipalities (note 7)	6,886,526	6,886,526	6,720,498
Other:			
Plumbing inspections and licenses	257,000	267,040	301,064
Interest	85,000	80,276	83,468
Other	1,126,576	854,973	1,086,396
	28,323,203	28,033,160	28,351,555
Expenses (note 9):			
Salaries and wages (note 6)	18,932,050	18,010,623	18,337,096
Benefits	5,016,470	4,879,420	4,748,177
Transportation	481,083	336,632	352,748
Administration (note 8)	2,160,628	1,919,805	2,422,221
Supplies and materials	1,186,002	1,058,761	1,173,513
Small operational equipment	546,970	377,117	375,133
Amortization of tangible capital assets (note 3)	-	699,482	671,791
	28,323,203	27,281,840	28,080,679
Annual surplus	-	751,320	270,876
Accumulated surplus, beginning of year	12,974,404	12,974,404	12,703,528
Accumulated surplus, end of year	12,974,404	$ 13,725,724	$ 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

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

See accompanying notes to financial statements.

SUDBURY & DISTRICT HEALTH UNIT

Statement of Cash Flows

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

	2016	2015
Cash provided by (used in):		
Cash flows from operating activities:		
Annual surplus	$ 751,320	$ 270,876
Adjustments for:		
Amortization of capital assets	699,482	671,791
Benefit payments related to employee benefit obligations	23,640	(148,272)
Non-cash expenses related to employee benefit obligations	-	204,620
	1,474,442	999,015
Changes in non-cash working capital:		
Accounts receivable	(426,755)	(62,359)
Receivable from the Province of Ontario	(77,175)	(21,903)
Payable to the Province of Ontario	31,191	(6,611)
Accounts payable and accrued liabilities	298,487	(697,034)
Deferred revenue	7,660	(72,129)
Prepaid expenses	(35,965)	96,487
	1,271,885	235,466
Cash flows from investing activity:		
Purchase of tangible capital assets	(462,871)	(348,965)
	(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:

Asset	Basis	Rate
Buildings	Straight-line	2.5%
Parking lot resurfacing	Straight-line	10%
Computer hardware	Straight-line	30%
Leasehold improvements	Straight-line	10%
Website design	Straight-line	20%
Vehicles and equipment	Straight-line	10%
Equipment – Vaccine Refrigerators	Straight-line	20%
Computer software	Straight-line	100%

(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.

	2016	2015
Accumulated sick leave benefits	$ 827,203	849,339
Other post-employment benefits	1,043,409	994,287
	1,870,612	1,843,626
Vacation pay and other compensated absence	936,293	939,639
	$ 2,806,905	2,783,265

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

	2016	2015
Discount	4.50%	4.50%
Health-care trend rate:		
Initial	5.10%	5.10%
Ultimate	4.00%	4.00%
Salary escalation factor	3.00%	3.00%

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:

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

Accumulated amortization:

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

Net book value

		Land	Building	Leasehold Improvements	Computer Hardware	Computer Software	Website Design	Vehicles and Equipment	Parking Lot Resurfacing	Total
At December 31, 2015	$	26,939	4,578,768	65,800	485,314	-	34,922	325,272	188,946	5,705,961
At December 31, 2016		26,939	4,489,879	22,873	460,833	-	20,953	283,187	164,686	5,469,350

3. Tangible capital assets (continued):

Cost**:**

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

Accumulated amortization:

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

Net book value

	Land	Building	Leasehold Improvements	Computer Hardware	Computer Software	Website Design	Vehicles and Equipment	Parking Lot Resurfacing	Total
At December 31, 2014	26,939	4,678,040	108,727	625,266	-	48,891	364,468	176,456	6,028,787
At December 31, 2015	$ 26,939	4,578,768	65,800	485,314	-	34,922	325,272	188,946	5,705,961

4. Accumulated surplus:

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

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

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:

No later than one year	$ 213,517
Later than one year and no later than 5 years	408,129
Later than five years	595,074
	$ 1,216,720

(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:

	2016	2015
Township of Assiginack	$ 31,471	30,578
Township of Baldwin	21,073	20,363
Township of Billings (and part of Allan)	21,142	20,498
Township of Burpee	11,294	11,089
Township of Central Manitoulin	72,515	70,767
Municipality of St. Charles	47,379	45,565
Township of Chapleau	83,120	81,520
Municipality of French River	98,822	95,431
Township of Espanola	183,388	180,513
Township of Gordon (and part of Allan)	18,180	18,145
Town of Gore Bay	32,504	31,922
Municipality of Markstay-Warren	96,825	94,826
Township of Northeastern Manitioulin & The Islands	91,315	88,845
Township of Nairn & Hyman	16,734	16,264
Municipality of Killarney	14,393	14,180
Township of Sables and Spanish River	114,247	111,896
City of Greater Sudbury	5,917,249	5,773,445
Township of Tehkummah	14,875	14,651
	$ 6,886,526	6,720,498

8. Administration expenses:

	Budget	2016	2015
Professional fees	$ 569,244	297,379	728,204
Advertising	204,319	192,030	241,749
Building maintenance	352,898	400,024	360,473
Staff education	161,163	187,699	233,342
Utilities	195,840	202,485	181,395
Rent	237,884	255,776	249,728
Liability insurance	103,774	91,232	114,454
Postage	88,158	49,127	67,821
Telephone	196,071	199,233	197,243
Memberships and subscriptions	47,277	42,438	45,933
Strategic planning	4,000	2,382	1,879
	$2,160,628	1,919,805	2,422,221

9. Revenues and expenses by funding sources:

	OLHA	SDWS	VBD	Unorganized Territories	MOH/AMOH	CNO	Enhanced Safe-Food	Enhanced Safe Water	HSO	CID	IC-PHN	Needle Exchange	SFO	SDoH Nurses Initiatives	UIIP	Sub-Total
Revenue:																
Provincial grants	$ 14,687,000	106,000	55,899	-	42,753	121,357	29,920	16,200	502,210	389,000	90,100	71,100	735,111	180,500	13,610	17,040,760
Provincial grants - one-time	-	-	-	-	-	-	-	-	-	-	-	-	17,663	-	-	17,663
Unorganized territories	-	-	-	819,400	-	-	-	-	-	-	-	-	-	-	-	819,400
Municipalities	6,817,658	47,222	21,646	-	-	-	-	-	-	-	-	-	-	-	-	6,886,526
Plumbing and inspections	267,040	-	-	-	-	-	-	-	-	-	-	-	-	-	-	267,040
Interest	80,276	-	-	-	-	-	-	-	-	-	-	-	-	-	-	80,276
Other	528,000	-	-	-	-	-	-	-	-	-	-	-	-	-	-	528,000
	22,379,974	153,222	77,545	819,400	42,753	121,357	29,920	16,200	502,210	389,000	90,100	71,100	752,774	180,500	13,610	25,639,665
Expenses:																
Salaries and wages	14,320,457	121,377	25,559	487,479	38,871	95,735	-	12,617	348,916	306,152	71,508	-	437,532	142,881	11,190	16,420,274
Benefits	3,959,278	34,479	2,498	135,248	3,882	25,622	-	3,583	106,956	76,468	18,592	-	120,213	37,619	1,148	4,525,586
Transportation	91,474	2,481	7,020	117,087	-	-	1,437	-	5,677	1,000	-	-	46,790	-	233	273,199
Administration (note 8)	1,606,631	-	1,288	48,693	-	-	18,974	-	10,351	1,157	-	17,775	90,806	-	-	1,795,675
Supplies and materials	650,836	-	38,168	30,893	-	-	9,509	-	30,310	4,223	-	53,325	57,433	-	1,039	875,736
Small operational equipment	287,098	-	-	-	-	-	-	-	-	-	-	-	-	-	-	287,098
Amortization of tangible capital assets	699,482	-	-	-	-	-	-	-	-	-	-	-	-	-	-	699,482
	21,615,256	158,337	74,533	819,400	42,753	121,357	29,920	16,200	502,210	389,000	90,100	71,100	752,774	180,500	13,610	24,877,050
Annual surplus	$ 764,718	(5,115)	3,012	-	-	-	-	-	-	-	-	-	-	-	-	762,615

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 Pipilloma Virus
MCYS - Ministry Children and Youth Services
ECA - E-Cigarettes Act: Protection and Environment
Non-Ministry-Non- Ministry Funded Initiatives

9. Revenues and expenses by funding sources:

	Men C	HPV	MCYS	Local Model: Indigenous Engagement	Generator 2016-15	Generator 2016-17	Vaccine Refrigerators	Building Renovations	Panorma 2015-16	Panorama 2016-17	ECA	Diabetes Prevention	Northern Fruit & Vegetables	HIV-Aids Anonymous Testing	Non-Ministry	Total
Revenue:																
Provincial grants	$ 20,723	22,032	1,593,010	-	-	-	-	-	-	-	26,525	42,944	92,272	52,278	-	18,890,544
Provincial grants - one-time	-	-	1,000	8,743	33,886	17,547	14,953	79,175	16,410	45,024	-	-	-	-	-	234,401
Unorganized territories	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	819,400
Municipalities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6,886,526
Plumbing and inspections	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	267,040
Interest	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	80,276
Other	-	-	-	-	-	-	-	-	-	-	-	-	-	-	326,973	854,973
	20,723	22,032	1,594,010	8,743	33,886	17,547	14,953	79,175	16,410	45,024	26,525	42,944	92,272	52,278	326,973	28,033,160
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	-	-	-	-	-	-	-	3,966	1,703	918	(246)	9,920	336,632
Administration (note 8)	-	-	6,283	8,243	45,181	17,547	-	5,409	-	-	-	(12,074)	1,800	112	51,629	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
	20,723	22,032	1,594,010	8,743	45,181	17,547	14,953	79,175	16,410	45,024	26,525	42,944	92,272	52,278	326,973	27,281,840
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 Pipilloma 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.

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:

_____.

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.