Sudbury & District Board of Health

Thursday, September 21, 2017, 1:30 p.m.

SDHU Boardroom

1300 Paris Street

Sudbury & District Board of Health Meeting - September 21, 2017

Sudbury & District Board of Health Meeting #06-17

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) Sudbury & District Health Unit (SDHU) Vaccination Coverage Rates for School Pupils
Stephanie Hastie, Infection Control Nurse, Clinical Services Division

5.0 CONSENT AGENDA

i) Minutes of Previous Meeting

a. Fifth Meeting – June 15, 2017 Page 12

ii) Business Arising From Minutes

iii) Report of Standing Committees

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

MOH/CEO Report, September 2017 Page 21

Financial Statements ending July 31, 2017 Page 38

v) Correspondence

a. Inclusion of Smoke-Free Clauses in the Standard Lease under the Residential Tenancies Act

Letter from the Middlesex-London Board of Health dated June 16, 2017 Page 41

b. Opioids Addiction and Overdose

Sudbury & District Health Unit
Service de santé publique

AGENDA – SIXTH MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT
THURSDAY, SEPTEMBER 21, 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) Sudbury & District Health Unit (SDHU) Vaccination Coverage Rates for School Pupils

- Stephanie Hastie, Infection Control Nurse, Clinical Services Division

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Fifth Meeting – June 15, 2017

ii) Business Arising From Minutes

None

iii) Report of Standing Committees

None

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

a. MOH/CEO Report, September 2017

v) Correspondence

a. Inclusion of Smoke-Free Clauses in the Standard Lease under the Residential Tenancies Act

- Letter from the Middlesex-London Board of Health dated June 16, 2017

b. Opioids Addiction and Overdose

- Letter from the Renfrew Country District Board of Health to the College of Physician and Surgeons of Ontario dated June 8, 2017

c. Anti-Contraband Tobacco Campaign

- Letter from the North Bay Parry Sound District Board of Health to the Minister of Health and Long-Term Care dated July 6, 2017

d. Ontario's Opioid Strategy

- Letter from the Minister of Health and Long-Term Care to the Sudbury & District Board of Health Chair re additional funding to support local opioid response initiatives dated June 20, 2017
- Ministry of Health and Long-Term Care News Release dated September 7, 2017

e. Human Papillomavirous (HPV) Immunization Catch-Up for Boys

- Letter from the Regional Municipality of Durham Council to Premier of Ontario dated June 15, 2017
- Letter from the Grey Bruce Board of Health to the Minister of Health and Long-Term Care dated June 29, 2017

f. Healthy Babies Healthy Children Program Targets and Funding

- Letter from the Regional Municipality of Durham Council to the Premier of Ontario dated June 15, 2017

g. Provincial Alcohol Strategy

- Letter from the Regional Municipality of Durham Council to the Premier of Ontario dated June 15, 2017
- Letter from the Grey Bruce Board of Health to the Minister of Health and Long-Term Care dated June 29, 2017
- Letter from the Middlesex-London Board of Health to Minister of Health and Long-Term Care dated August 8, 2017
- Letter from the Middlesex-London Board of Health to Ontario Public Health Association dated August 8, 2017

h. Advocacy Health Promotion Resource Centres

- Letter from the Leeds, Grenville & Lanark District Board of Health to Minister of Health and Long-Term Care dated July 5, 2017

i. Low Income Adult Dental Programs

- Letter from the Middlesex-London Board of Health to Minister of Health and Long-Term Care dated August 8, 2017

j. Municipal Levy Apportionment

- Letter from the Leeds, Grenville & Lanark Districts Board of Health to Minister of Health and Long-Term Care dated June 1, 2017

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

- Letter from the Association of Local Public Health Agencies (alPHa) to Minister of Health and Long-Term Care dated July 21, 2017

l. The Fair Workplaces, Better Jobs Act, 2017 (Bill 148)

- Letter from the Northwestern Board of Health to Ontario Boards of Health dated September 1, 2017

m. 2017 Public Health Funding and Accountability Agreement Indicators

- Memo from the Ministry of Health and Long-Term Care to Ontario Board of Health Chairs, MOHs, CEOs and Business Administrators dated June 12, 2017

n. Legal Access to Non-Medical Cannabis: Approaches to Protect Health and Minimize Harms of Use
- Letter from the Toronto Board of Health to interested parties dated June 21, 2017

o. Support for Enactment of Legislation under the HPPA to Allow for the Inspection and Enforcement Activities of Personal Service Settings
- Letter from the Elgin St. Thomas Board of Health to Minister of Health and Long-Term Care dated June 5, 2017
- Letter from the Niagara Region Board of Health to Minister of Health and Long-Term Care dated June 14, 2017

vi) Items of Information

a. Letters from the Minister of Health re appointment for N. Sykes and J. Crispo	June 16, 2017
b. Announcement from alPHa re Executive Leadership for 2017-18	June 19, 2017
c. alPHa Information Break	July 18, 2017 August 17, 2017

APPROVAL OF CONSENT AGENDA

MOTION:

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

6. NEW BUSINESS

i) Expert Panel Report

- Briefing Note from the Medical Officer of Health/Chief Executive Officer to the Sudbury & District Board of Health Chair dated September 14, 2017, and attachments:
  - Letter from the Minister of Health and Long-Term Care dated July 20, 2017
  - Report of the Minister's Expert Panel on Public Health: *Public Health within an Integrated Health System* dated June 9, 2017
  - AMO bulletin dated July 20, 2017
  - alPHa summary of the Report of the Minister's Expert Panel on Public Health
  - Email from the alPHa regional Board of Health representative dated August 31, 2017
  - Email invitation to Board Chairs and CEOs for in-person information session on the Expert Panel report dated August 31, 2017
  - Email invitation to MOHs for in-person information session on the Expert Panel report dated August 31, 2017

- North Bay Nugget article dated September 12, 2017

EXPERT PANEL CONSULTATION

MOTION:

THAT the Sudbury & District Board of Health receive for information the Medical Officer of Health's briefing note concerning the Expert Panel Report and consultation process; and

THAT the Board of Health authorize the Chair of the Board of Health to work with the Medical Officer of Health on a submission for the alPHa Board; and

THAT the Board of Health authorize the Chair of the Board of Health to work with the Medical Officer of Health on a draft submission for the Province of Ontario for the Board's approval at its October 2017 meeting.

ii) Annual Board Self-Evaluation

- 2017 Board Self-Evaluation Questionnaire (Survey in BoardEffect)

iii) Board of Health Manual

- By-Law G-I-30

BOARD OF HEALTH MANUAL

MOTION:

THAT the Board of Health, having reviewed the revised By-Law 04-88 approves the contents therein for inclusion in the Board of Health Manual.

7. ADDENDUM

ADDENDUM

MOTION:

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

8. ANNOUNCEMENTS / ENQUIRIES

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

9. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time:

Sudbury & District Health Unit
Service de santé publique

MINUTES – FIFTH MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
SUDBURY & DISTRICT HEALTH UNIT, BOARDROOM
THURSDAY, JUNE 15, 2017, AT 1:30 P.M.

BOARD MEMBERS PRESENT

Maigan Bailey
Janet Bradley
James Cisco *(via t/c)*
René Lapierre
Paul Myre
Ken Noland
Rita Pilon
Mark Signoretti
Nicole Sykes
Carolyn Thain

BOARD MEMBERS REGRETS

Jeffery Huska
Robert Kirwan
Richard Lemieux
Stewart Meikleham

STAFF MEMBERS PRESENT

Sandra Laclé
Nicole Frappier
Rachel Quesnel
France Quirion
Dr. P. Sutcliffe
Dr. A. Zbar

GUEST

Dr. P. Donnelly, President and Chief Executive Officer, Public Health Ontario

R. LAPIERRE PRESIDING

1.0 CALL TO ORDER

The meeting was called to order at 1:31 p.m.

i) Letters from the Executive Council of Ontario Order in Council dated May 31, 2017, Regarding Appointments – Nicole Sykes and James Crispo

A warm welcome was extended to the two newly appointed provincial members: Nicole Sykes and James Crispo.

Dr. P. Donnelly, President and Chief Executive Officer of Public Health Ontario was also welcomed. Board members had an opportunity to meet Dr. Donnelly for lunch today.

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) Overview of Public Health Ontario

- Dr. Peter Donnelly, President and Chief Executive Officer, Public Health Ontario

Dr. Sutcliffe introduced Dr. Donnelly outlining his credentials, experience and achievements and invited him to speak about Public Health Ontario (PHO).

PHO was established following the SARS outbreak and in response to the call for a public health agency that would support Ontario's public health system with evidence and professional support. PHO links public health practitioners, front-line health workers, and researchers to scientific intelligence and knowledge. PHO provides scientific and technical advice and support to clients and enable action in public health. PHO also runs the Public Health Laboratories (PHL), with Sudbury being the home to one of its regional PHLs. Several examples of expertise services were outlined, including laboratory testing, outbreak investigation advice and support, and surveillance. Dr. Donnelly also noted the expertise of PHO in areas of chronic disease and injury prevention and in health equity and health promotion and shared that these areas are relatively underfunded as compared with the health protection portfolios.

Dr. Donnelly was thanked for his presentation.

ii) French Language Services at the Sudbury & District Health Unit

- Nicole Frappier, Assistant Director, Strategic Engagement Unit, Resources, Research, Evaluation and Development Division

N. Frappier was introduced to talk about the importance of delivering French language services in our context.

Although the SDHU is in a designated area, the French Language Services Act does not apply to boards of health because they obtain municipal funding. However, the Ontario Public Health Standards state that: *Boards of health should bear in mind that in keeping with the French Language Services Act, services in French should be made available to French-speaking Ontarians located in designated areas*.

In the SDHU area more than 24% of residents report French or French and English combined as their mother tongue as compared to only 4% with the same characteristics in the province. This further underscores the importance of the delivery of French language services in our community.

To action the Board's recognition and commitment to ensure that every reasonable effort is made to provide francophone residents within the SDHU catchment area with access to culturally competent French public health services (per Board Policy B-I-13), various supports at the policy, management and staff

level as well as, external supports have been put in place at the SDHU. Examples described include designating certain positions as French language required depending on operational requirements and the population being served, and an interdisciplinary Francophone Advisory Committee (FAC). The FAC was established with the function to identity and advise regarding issues affecting service delivery to the Francophone population within our catchment area. *Active Offer* of French Language services is another example where SDHU staff proactively offer services in both languages, creating an environment that is conducive to demand and that anticipates the specific needs of Francophones in their community.

Next steps will be to enhance *Active Offer* components by increasing bilingual services, signage and greetings at various touch points and providing bilingual staff with identification to show that they can provide services in French, and by continuing to provide linguistic and cultural sensitivity training.

Questions and comments were entertained and suggestions were provided such as bilingual email signatures and voice messages. N. Frappier was thanked for her presentation.

5.0 CONSENT AGENDA

There were no consent agenda items identified for discussion.

i) Minutes of Previous Meeting

a. Fourth Meeting – May 18, 2017

ii) Business Arising From Minutes

None

iii) Report of Standing Committees

a. Joint Board/Staff Performance Monitoring Working Group Unapproved Meeting Notes dated May 23, 2017

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

a. MOH/CEO Report, June 2017

v) Correspondence

a. Honorary Doctorate

- Letter from Laurentian University Re: Honorary Doctorate of Letters to Louise Picard, retired SDHU Director of Resources, Research, Evaluation and Development Division dated April 28, 2017

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

- Letter from the Elgin St Thomas Public Health Board of Health to the Minister of Health and Long-Term Care dated May 15, 2017

c. Energy Drinks

- Email from Jim Sheppard to the SDHU dated May 29, 2017

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

- Resolution from The Corporation of the Township of Chamberlain to Dr. Sutcliffe dated May 2, 2017

e. Low Income Adult Dental Program

- Letter from the Leeds, Grenville and Lanark Board of Health to the Minister of Health and Long-Term Care dated June 7, 2017

f. Healthy Menu Choices Act

- Letter from the Peterborough Board of Health to the Minister of Health and Long-Term Care dated June 7, 2017

g. Federal Opioid Strategy

- Letter from the Peterborough Board of Health to the Federal Minister of Health dated June 7, 2017

vi) Items of Information

a. North East LHIN News Release:
Changes at the North East
LHIN
May 30, 2017
b. alPHa Announcement: Executive Director
Retirement
May 29, 2017
c. alPHa Information
Break
May 18, 2017

Board members were reminded to complete the value-for-money audit on Public Health: Chronic Disease Prevention from the Office of the Auditor General of Ontario. The electronic survey is due June 21, 2017.

34-17 APPROVAL OF CONSENT AGENDA

Moved by Bradley – Bailey: THAT the Board of Health approve the consent agenda as distributed.

CARRIED

6.0 NEW BUSINESS

i) 2013-2017 Performance Monitoring Plan

- Narrative Report

Joint Board/Staff Performance Monitoring Working Group member, J. Bradley, shared highlights of the Summer 2017 Strategic Priorities: Narrative Report. The report presents five stories about programs or services that show each of the SDHU's strategic plan priorities in action and demonstrate how the SDHU strategic priorities are integrated into staff members' daily work.

The Joint Board of Health/Staff Performance Monitoring Working Group, which also includes C. Thain and R. Pilon, provides interpretive comments on the performance monitoring reports and ensures that the narratives that are selected are timely and represent diverse examples from district offices and across all program areas.

This reporting period's narratives include:

1. Supporting Indigenous Partners to Address Factors that Impact Health
2. Partnering with Greater Sudbury Housing Corporation on Bedbug Education for Tenants
3. Sharing Our Research Knowledge
4. Nourishing the Future of Our School Communities
5. Building Opportunities for Student Placement in Rural Areas.

Staff's work and openness to feedback was commended. The Board members who are on the Working Group were thanked for their valuable contributions.

ii) Board of Health Manual

- Briefing Note to the Sudbury & District Board of Health Chair dated June 8, 2017

Dr. Sutcliffe referred to the briefing note which describes the process and proposed revisions from this year's review of the Board Manual.

Many of the proposed changes are straightforward and housekeeping in nature. These include changes in language, updates to reflect the Patients First Act, name changes and updated list of names of individuals that need to be named under the Building Code. Proposed changes to G-I-30 reflect recent changes to the Municipal Act with regard to electronic participation at meetings. Revisions reflect that electronic participation at public meetings do not count for quorum or votes. The Municipal Act also stipulates that electronic participation is not permitted at closed meetings. The Board supported the following addition to G-I-30: *Further, electronic participation shall not be permitted for a meeting which is closed to the public.*

The Board also agreed to replace the number of Board members listed under number 2. under General of G-I-30 with the legislative membership requirement.

Once approved by the Board, the revisions will be posted to Board Manual in BoardEffect.

The Board thanked staff for ensuring a regular review and keeping the manual current.
The Board agreed to the following motion with the two friendly amendments to G-I-30 to comply with the recent Municipal Act changes.

35-17 BOARD OF HEALTH MANUAL

Moved by Myre – Noland: THAT the Board of Health, having reviewed the Board of Health Policy & Procedure Manual, approves the contents therein.
CARRIED with friendly amendments

iii) 2017 Public Health Champion Awards

- Public Health Champion Awards Nomination Package

The 2017 Public Health Champion Awards was launched today with a news release and call for nominations. The 2017 Public Health Champion award will recognize one individual/organization that has made outstanding contributions to take action in the program areas related to Clinical and Family Services: promoting the health of families, oral health, healthy sexuality, vaccinations, infectious/ communicable diseases and/or Indigenous engagement.

This is the third Public Health Champion award. Last year's award focused on social and economical inequities in health and the year prior was on environmental health.

The deadline for Call for Nominations is September 8, 2017. Another social media push will take place towards the end of summer as a reminder. A Joint Board/Staff Public Health Champion Working Group meeting will be scheduled for September for the selection of the award and the awards ceremony will be held in October.

iv) 2017 alPHa Conference / Annual General Meeting (AGM)

- alPHa Conference Program-at-a-Glance
- alPHa Board of Health Section Agenda, June 13, 2017
- Summary of Resolutions for Consideration at the June 2017 alPHa AGM

R. Lapierre was pleased to display a plaque that he accepted on behalf of the SDHU at this year's alPHa conference for the Annual alPHa Fitness Challenge. The SDHU had 100% staff participation in 30 minutes of physical activity at this year's Challenge on May 11.

R. Lapierre, M. Signoretti, P. Myre, Dr. Sutlciffe, Dr. Zbar and S. Laclé attended the annual alPHa conference and AGM in Chatam June 11 to 13.

P. Myre summarized conference proceedings, including keynote speakers, resolution session, and Board of Health section meeting. Board members shared that Dr. Sutcliffe is a well respected professional at the provincial level.

Individual updates were provided for each of these concurrent conference sessions attended by:
P. Myre: *Flourishing under the 2018 budget – understanding program based marginal analysis.*
R. Lapierre: *The road ahead – CQI, Organizational change and change management.*
M. Signoretti: *Age friendly framework – fostering the health and well being of people as they age.*

Dr. Sutcliffe added that while Board of Health members were at the Board of Health section meeting, she and Dr. Zbar were at the Council of Ontario Medical Officers of Health (COMOH). Dr. Sutcliffe added that she will continue as the COMOH Chair until the incoming Chair returns from leave.

The presentation from the outgoing alPHa Executive Director will be shared with the Board. The conference notes prepared by alPHa will also be shared with the Board once they are available.

7.0 ADDENDUM

36-17 ADDENDUM

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

CARRIED

DECLARATION OF CONFLICT OF INTEREST

There are no declarations of conflict of interest.

i) Opioids

- Ministry of Health and Long-Term Care News Release: *More Front-Line Workers for Every Community in Ontario to Combat Opioid Crisis*, June 12, 2017

On Monday, the provincial government announced new funding to Boards of Health for new front-line addiction and mental health workers for every community in the province and the distribution of almost 80,000 additional naloxone kits per year to front-line organizations. Dr. Sutcliffe indicated that, although details are not yet known, the Ministry of Health and Long-Term Care (MOHLTC) hosted a half hour teleconfence to advise there would be an increase of 1.5 FTE per HU to conduct this work. It was clarified that the funding is 100% provincial additional base funding.

ii) alPHa Survey of Board of Health Funding

- Survey on the impacts of the current approach to BOH provincial budget grants

alPHa conducted a survey with all Boards of Health to identify impacts of the public health funding model for cost-shared mandatory programs that was implemented by the Province of Ontario effective 2015.

Discussion followed regarding the program delivery and human resources impact the funding formula has and will continue to have.

iii) The Fair Workplaces, Better Jobs Act (Bill 148)

- Briefing Note from the Sudbury & District Health Unit Medical Officer of Health/Chief Executive Officer to the Board Chair dated June 13, 2017
- SDHU Letter to the Editor submitted to the Sudbury Star, June 14, 2017, We cannot afford *not to act – minimum wage and basic income*

Dr. Sutcliffe reviewed contents of the briefing note and noted that this matter is timely for the Board's consideration. Bill 148 is getting a a fair bit of media attention recently.

Bill 148 outlines proposed amendments to the Employment Standards Act and the Labour Relations Act identified through the Changing Workplaces Review of 2015-16, an independent and systematic review of Ontario's labour laws initiated in part to respond to issues related to the growth of precarious employment in Ontario in recent decades. Dr. Sutcliffe participated in the Changing Workplaces Review public consultation session in 2015 and also made a written submission in response to the Interim Report in October of 2016.

The Changing Workplaces Review was designed to identify options for labour law reform to improve security and opportunity for those made vulnerable by the structural economic pressures and changes being experienced by Ontarians.

37-17 THE FAIR WORKPLACES, BETTER JOBS ACT (BILL 148)

Moved by Signoretti – Thain: WHEREAS the Sudbury & District Board of Health has a mandate to decrease health inequities such that everyone has equal opportunities for health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances; and

WHEREAS the Board of Health discharges this mandate through a long history of strategies including advocacy, strategic direction, policy development and program interventions; and

WHEREAS the Sudbury & District Board of Health participated in the 2015 Changing Workplaces Review public consultations and recommended that the provincial government strengthen minimum employment standards and reduce barriers to collective bargaining for all workers, especially those in precarious employment, to ultimately improve health outcomes;

THEREFORE BE IT RESOLVED that the Sudbury & District Board of Health commend the provincial government's actions to address the root causes of precarious work through the Changing Workplaces Review of 2015-16 and subsequent introduction of Bill 148; and

FURTHER THAT the Board of Health support the proposed changes to the Employment Standards Act that expand the pay equity provisions and increase the minimum wage for workers and the proposed changes to the Labour Relations Act that better support precarious workers' rights; and

FURTHER THAT the Board of Health urge the provincial government to adopt the World Health Organization (WHO) definition of a healthy workplace; and

THAT the Sudbury & District Board of Health share this motion and supporting materials with SDHU community agencies, municipalities and elected representatives, and the Association of Local Public Health Agencies (alPHa), Ontario Boards of Health and others as appropriate.

CARRIED

Dr. Sutcliffe expressed her thanks to key SDHU staff for the quick and responsive work in preparing the detailed materials for this agenda item.

8.0 ANNOUNCEMENTS / ENQUIRIES

Board members were encouraged to complete the Board evaluation regarding today's Board meeting. The link will be emailed to everyone as there were challenges in accessing the electronic survey.

Dr. Sutcliffe was proud to share a print copy of the SDHU's 2016 Annual Report, *Connections.* The report is available in English and in French and will be circulated mostly electronically. A brief video promoting the 2016 annual report, hosting the Board Chair and MOH/CEO is available for viewing on the SDHU website. The Board recognized the staff who pull the data and design the report. Dr. Sutcliffe concluded that much attention is paid to the readability, messaging and literacy level to ensure accessibility.

9.0 ADJOURNMENT

38-17 ADJOURNMENT

Moved by Thain – Sykes: THAT we do now adjourn. Time: 2:57 p.m.

CARRIED

_____ _____

(Chair) (Secretary)

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

Words for thought…

The Impact of Public Health within an Integrated System

What impact will the strengthened relationship between public health and LHINs have on all health system partners and on Ontarians?

Strong relationships outside the health system to protect and promote health.
Public health works with municipal governments, community organizations, schools, and local services outside the health system – to influence the social, environmental and structural factors that can lead to poor health. Public health can broker relationships between health care, social services, municipal governments, and other sectors to create healthier communities.

More focus on the social determinants of health and greater health equity.
Some Ontarians are at greater risk of poor health because of social determinants such as poverty, precarious housing, poor working conditions, and a lack of social support networks. Public health can embed a population health approach into health service planning and delivery to close these health gaps and enhance health equity.

More comprehensive targeted health interventions.
Although chronic diseases are among the most common and costly health problems facing Ontarians, they are also among the most preventable. Interventions targeting chronic disease risk factors can be successful in mitigating and preventing the burden of chronic diseases. Public health can identify high risk communities and offer targeted interventions that can prevent or delay the onset of these diseases and their complications.

Better care pathways and health outcomes.
A person's ability to follow a care pathway after surgery or treatment is affected by factors outside the health system. For example, if an individual is discharged from the hospital and returns to precarious housing and food security challenges, their recovery will be negatively impacted and they may have a higher likelihood of being re-admitted to the hospital than someone who has stable housing and access to healthy food. Public health can help the health system develop care pathways that take into account the social factors that affect health outcomes.

Greater recognition of the value of public health.
With public health as part of an integrated health system, Ontarians will better understand the importance of investing in health protection and promotion across the life course. They will see how public health benefits themselves, their families and their communities and, at the same time, helps contain health care costs and make the universal health care system more sustainable.

Improving access to care is one priority for the integrated system, but the vision of Patients First is much broader. It is also about promoting health, reducing health disparities and helping all Ontarians lead long healthy lives.

Source: Public Health within an Integrated Health System
Report of the Minister's Expert Panel on Public Health
Date: June 9, 2017

Chair and Members of the Board,

Welcome back to all Board members from a Northern Ontario summer!

There have been many developments at the provincial level relating to the public health system. At the local level, public health staff continue to make strides in areas of health equity, Indigenous engagement, and mental health to name a few.

Accountability framework review, Auditor General Audit and modernization of the Ontario Public Health Standards, are just a few of the current provincial initiatives that are occurring within the context of the Ministry of Health and Long-Term Care's health transformation agenda. The most significant initiative currently at the provincial level is the Minister's Expert Panel on Public Health, for which there is a separate agenda item in today's package.

GENERAL REPORT

1. Local and Provincial Meetings

I have been heavily involved in provincial meetings over the summer months due my tenure as the Chair of the Council of Ontario Medical Officers of Health (COMOH) and to the recently released Expert Panel Report. A face-to-face COMOH meeting is scheduled for September 13 for the group to discuss a COMOH response to the Expert Panel. The COMOH executive has also been busy over the summer with teleconferences. The Ministry of Health and Long-Term Care (MOHLTC) has scheduled a short information session with COMOH members regarding the Expert Panel the morning of September 15.

I will also participate in the MOHLTC information session scheduled for the boards of alPHa (Association of Local Public Health Agencies) and the Ontario Public Health Association the afternoon of September 15.

I participated in the Public Health Work Stream meeting on June 19. The document related to this work was released for consultation in June, and it is expected to be released in its final form this fall. The Work Stream was focused on how to implement the requirements under Patients First on MOH/LHIN CEO engagement and population health.

The MOHLTC Mental Health Prevention, Promotion and Early Intervention Working Group met on July 11 and September 5, 2017.

I also participated in the MOHTLC Working Team to develop the Mental Health Promotion Guideline to support the modernized Standards for Public Health Programs and Services. The first meeting was held July 19 and subsequent meetings were held on August 2, September 7, and September 19, 2017. The SDHU also is contributing to two additional working groups in support of the modernized Standards.

On July 25, 2017, the Sudbury & District Health Unit (SDHU) convened a meeting with key community partners to discuss community mental health and addictions and explored system pressures. The SDHU agreed to coordinate a second meeting, which is scheduled for September 22.

I am a member of the Accountability Implementation Task Force and to date we have had one meeting on August 4.

A Northern Medical Officers of Health teleconference is scheduled for the morning of September 18 and I note that the northeast MOHs/AMOHs are organizing a meeting with the NELHIN for the end of September.

2. Human Resources Update

Further to the June Board report update, as a result of ongoing EC discussions on the revised Standards for Public Health Programs and Services and in the context of ongoing and anticipated future fiscal constraints, recruitment for the Director position was halted and as of July 31, 2017, Sandra Laclé assumed the role of Director, Health Promotion, in addition to her Chief Nursing Officer role. Dr. Ariella Zbar assumed the role of Director, Clinical Services, in addition to her Associate Medical Officer of Health role. The Clinical and Family Services Division's name has returned to its previous name of Clinical Services.

The changes strike a balance between ensuring capacity, leadership, and the need for fiscal restraint. Staff continue to be encouraged to submit cost-saving ideas.

3. Board of Health

Board members are thanked for having completed the Office of the Auditor General of Ontario's value for money audit. We have received no further information regarding the audit.

A half-day Board orientation session was held on July 12 for James Crispo and Nicole Sykes where an overview of the Ontario public health system was provided as well as a snapshot of public health funding, Board liabilities, operational processes and performance monitoring.

The SDHU is participating in Cooper Equipment Rental's Winter Clothing Drive for 2017. Winter clothing for all ages will be collected by partner agencies between now and October 30. All donated clothing will be donated to individuals, families, and community partners through an open house at the Rainbow Centre from November 1 to 8. Last year clothing was distributed to 3600 individuals and the goal this year is to collect clothing for 4500 individuals. The collection bin for this initiative is located in the lobby of the SDHU office at 1300 Paris Street and Board members are welcome to make a contribution.

Friendly reminders for <u>all Sudbury & District Board of Health members</u>:

- ✓ Strategic Planning Workshop: Thursday, September 28, 2017, from 9 a.m. to noon in the Ramsey Room at the SDHU followed by lunch

- ✓ Bridges out of Poverty training: Thursday, September 28, 2017, from 1 p.m. to 4 p.m. in the Ramsey Room at the SDHU

4. Public Health Champion Award – 2017

In the spring of 2015, the SDHU introduced the Public Health Champion recognition program. This exciting initiative allows the SDHU to recognize organizations and individual members of our community for their tireless and outstanding work in making our communities healthier.

The 2017 nomination campaign was launched on June 15, 2017, and closed on September 12, 2017. This initiative is currently under discussion. The Board of Health will be updated on this initiative following the Joint Board of Health/Staff Public Health Champions Selection Committee meeting, which is being held following the September 21, 2017, Board meeting.

5. Annual Board Self-Evaluation

As part of the Sudbury & District Board of Health's commitment to good governance and continuous quality improvement and in accordance with Board of Health Manual policy C-I-12 and C-I-14, the Board of Health has committed to carrying out a self-evaluation of its governance practices and outcomes.

The yearly Sudbury & District Board of Health Member Self-Evaluation of Performance is used as a data source for the SDHU 2013–2017 Annual Performance Monitoring Report. The Performance Monitoring Plan was developed in order to provide the Board of Health with accountability measures on a number of key focus areas from the 2013–2017 Strategy Map.

Leadership excellence, one of the focus areas, includes Board of Health commitment and satisfaction. The rate of completion of the annual self-evaluation questionnaire is one component of the Board of Health Commitment Index. The Board of Health Members' Satisfaction Index combines information on three aspects of Board of Health members' satisfaction: their individual performance as a Board member; Board processes; and overall Board performance.

The Board of Health members are asked to complete the self-evaluation questionnaire in BoardEffect (under the Sudbury & District Board of Health workroom – Collaborate – Surveys) by Tuesday, October 24, 2017. The questionnaire will be used to obtain valuable and comparative data for the 2013–2017 period and identify possible areas for improvement in Board effectiveness and engagement.

Results of the annual Board of Health member self-evaluation of performance evaluation will be presented at the November Board meeting.

6. Harm Reduction Program Enhancement

On June 16, 2017, the Minister of Health and Long-Term Care announced the provision of funding to boards of health to build on existing harm reduction programs and services and improve local opioid response capacity and initiatives. In response to increasing opioid use and opioid-related harms, the MOHLTC has provided funding called the "Harm Reduction Program Enhancement" (HRPE). Public Health Units are to apply this funding towards (1) local opioid response, (2) naloxone distribution and training, and (3) opioid overdose early warning and surveillance. While SDHU already meets some requirements of the HRPE through its Community Drug Strategy work, the allocation of $150,000 per year will ensure BOH compliance with these three specific requirements. Staff recruitment is underway.

7. Financial Report

The July year-to-date mandatory cost-shared financial statements report a positive variance of $483,799 for the period ending July 31, 2017. Gapped salaries and benefits account for $356,824 or 74%. This year, a significant portion of the gapped salaries is the result of the staff retirements and resignations that were not replaced given the cost saving measures that were put in place. Operating expenses and other revenue account for $126,975 or 26% of the variance. Monthly reviews of the financial statements ensure that shifting demands are adjusted to account in order to mitigate the variances caused by timing of activities.
In the month of June a total of $40,713 in available gapped funding was reallocate towards one-time operational pressures identified and approved. The one-time pressures to date consisted of the following categories:

- Staffing – Program support ($16,002)
- Poverty Training – ($21,711)
- Infrastructure – Small equipment, minor renovations ($3,000)

Additional items have since been identified to ensure efficient use of resources and reduce future operating costs.

8. Quarterly Compliance Report

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

The SDHU has paid all payable remittances for employee income tax deductions and Canada Pension Plan and Employment Insurance premiums, as required by law to August 25, 2017, on August 25, 2017. The Employer Health Tax has been paid as required by law, to August 31, 2017, with a cheque dated September 15, 2017. Workplace Safety and Insurance Board premiums have also been paid, as required by law, to August 31, 2017, with a cheque dated September 30, 2017. There are no outstanding issues regarding compliance with the *Occupational Health & Safety Act, Ontario Human Rights Code,* or *Employment Standards Act*.

9. Program-Based Grant

Local Public Health Units throughout the province have not yet heard back from the MOHLTC regarding their 2017 provincial grant. Last year, we received notice from the MOHLTC of our 2016 provincial grant on September 23. Planning for the 2018 budget is currently underway.

Following are the divisional program highlights since the June Board of Health meeting. The report is lengthy due to both the busy summer and the time period covered.

CLINICAL SERVICES DIVISION

1. Control of Infectious Diseases (CID)

Influenza: There have been no cases of influenza A or B identified in the area. This was expected as SDHU is currently between influenza seasons.

Preparation for Universal Influenza Immunization Program (UIIP): Preparation for the 2017–2018 influenza season is underway. Fifty-three pharmacies are currently preparing to receive influenza vaccine as part of the UIIP. Since the program's implementation in 2014, the number of participating pharmacies has increased from 49 to 58 pharmacies for the 2016–2017 season.

Influenza vaccine clinics are currently being planned for our main and district offices for this season. Since the UIIP has increased access to the vaccine in the community, the SDHU has scaled-back the number of community clinics, concentrating more on providing the vaccine at the main and district offices.

During July and August 2017, CID staff have been conducting "cold chain" visits at all health care provider clinics and offices that administer publicly-funded vaccines in the SDHU area. "Cold chain" refers to maintaining vaccines within the required range of 2° to 8°C at all times during handling, storage, and transport. Breaks in the cold chain can result in reduced vaccine effectiveness, diminishing the protection for the person receiving the vaccine. One hundred and forty-eight (148) of 200 cold chain inspections were completed as of September 1. Public health nurses will continue the inspections until all cold chain sites are completed.

Respiratory Outbreaks: There have been no respiratory outbreaks. The CID team continues to monitor all reports of respiratory illness.

Daycares: Over the summer months, the CID team reviewed immunization records from 68 licenced child care centres according to the requirement under the *Child Care and Early Years Act*. For 2017, a total of 2026 children have had their immunization records reviewed and updated in Panorama.

Vaccine Preventable Disease: In September, public health nurses will be providing vaccines in schools for the following infectious diseases: meningococcus, human papillomavirus (HPV 4 and 9) and hepatitis B. HPV 9 is a new vaccine provided to Grade 7 students (male and female) that helps protect against HPV, a virus associated with several anogenital and oropharyngeal cancers. HPV 9 protects against the four strains covered by the HPV 4 vaccine plus five additional strains of the virus.

Effective September 1, 2017, Bill 87 (*Protecting Patients Act*) under the *Immunization of School Pupils Act* will require parents or legal guardians of school age students to complete an immunization education session prior to filing a *Statement of Conscience or Religious Belief*, exempting their children from mandatory school immunizations. The education session is provided by the MOHLTC to all 36 local public health units to ensure that information is delivered in a consistent manner. The session is in-person at our main and district offices and takes approximately one hour to complete.

Panorama: The new provincial online immunization reporting system, *Immunization Connect Ontario*, is available on the SDHU website as of September 13, 2017. The new system allows the public to see and update their own immunization records and print immunization cards for themselves and their dependents.

2. Oral Health

The Oral Health team participated in two back-to-school events and one pre-school screening program where children participated in screening programs to assist in preparing them for school.

The Smile Care brushing program is being expanded in the fall to French language childcare centres. Oral Health program staff collaborate with child care providers and parents to encourage daily tooth brushing to reduce the incidence of tooth decay.

The preventive clinic offered services at the main and district offices throughout the summer months. Eligible children received routine preventive care such as scaling, polishing, pit and fissure sealants, and fluoride varnish.

The Healthy Smiles Ontario program was promoted to families in collaboration with community partners and through all elementary schools in September. This promotional initiative encourages enrolled families to utilize the available services as utilization rates across the province can be improved. In addition, promotional activities targets new families who may not be aware of the program for children under the age of 17.

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

The Sexual Health Clinic provided seven presentations as requested by community members. A total of 58 attendees were present. Topics included prevention of STIs, birth control methods, and safe needle disposal.

Three staff members attended the ribbon cutting ceremony at the opening of Réseau ACCESS Network's new location at 200 Larch Street. The launch was well-attended with the presence of Mayor Brian Bigger and MPPs France Gélinas and Glenn Thibeault.

The *MyTest* on-line testing program was discontinued in August at the request of Public Health Ontario Laboratories. Clients continue to be encouraged to access the sexual health clinic or their health care provider for STI testing.

An ad promoting sexual health clinic services ran during the month of August at the "Imagine Cinemas" located in the Rainbow Centre Mall. The ad ran during the pre-show of all movies rated 18+ and promoted free condoms, low cost birth control, free STI testing and treatment, pregnancy testing and options counselling services.

Needle Exchange Program (NEP): As of July 10, 2017, access to harm reduction supplies was extended to clients in the Espanola and Mindemoya district offices.

Effective August 1, 2017, the SDHU's Rainbow Centre site for *The Point* took over the fixed-site needle exchange from Sudbury Action Centre for Youth (SACY). It is now one of three fixed sites for needle exchange in the downtown area in addition to Réseau ACCESS Network and Ontario Aboriginal HIV/AIDS Strategy. The SDHU continues to support SACY's outreach program in its distribution of harm reduction supplies.

The POINT distributed 107 864 syringes during the month of June and 89 922 syringes during the month of July through fixed sites and outreach initiatives. As of July 31, the total number of syringes distributed in 2017 was 644 765 and the average return rate was 70%.

ENVIRONMENTAL HEALTH DIVISION

1. Control of Infectious Diseases

During the months of June, July, and August, 35 sporadic enteric cases and 6 infection control complaints were investigated. One enteric outbreak was declared in an institution.

2. Food Safety

During the months of June, July, and August, 3 food product recalls prompted public health inspectors to conduct checks of a total of 547 local premises. All affected establishments had been notified and subsequently had removed the recalled products from sale.

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

Staff issued 296 special event food service permits to various organizations during the summer months.

Through Food Handler Training and Certification Program sessions offered in June, July, and August, 131 individuals were certified as food handlers.

3. Health Hazard

In June, July, and August, 95 health hazard complaints were received and investigated. Seven of these complaints involved marginalized populations.

In the month of June, a media release was issued to provide the public with tips to prevent heat-related illness. A public service announcement was also issued to raise awareness of blastomycosis, including precautions to take to reduce exposure to the fungus.

4. Ontario Building Code

During the months of June, July, and August, 138 sewage system permits, 63 renovation applications, 2 zoning, 1 other government agency, and 10 consent applications were received.

5. Rabies Prevention and Control

One hundred and twenty-two rabies-related investigations were carried out in the months of June, July, and August. One animal was submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis, and was subsequently reported as negative.

Five individuals received rabies post-exposure prophylaxis following exposure to wild or stray animals.

6. Safe Water

In June, a media release was issued to notify the public that seasonal beach water testing had begun and to remind the public of safety practices for children in and around recreational water.

During the months of June, July, and August, 35 public beaches were sampled with a total of 2500 samples collected during 422 visits. Re-sampling was conducted in response to 54 sampling results that exceeded the recreational water quality standard of 100 *E.coli* per 100 mL of water. In June, July, and August,14 beaches were posted as unsafe for swimming due to elevated levels of *E.coli*. Media releases were issued to inform the public both when the beach water quality was not suitable for recreational use and when it was suitable again. All beach sample results have since returned to levels that are deemed to be acceptable for the public to swim in.

In the months of June, July and August, 29 small drinking water system assessments were completed.

Public health inspectors investigated eight blue-green algae complaints during the summer months, three of which were subsequently identified as blue-green algae capable of producing toxin. Media releases were issued to inform the public of the importance of taking precautions and being on the lookout for algal blooms. Seven public beaches were posted due to blue-green algae.

During June, July, and August, 208 residents were contacted regarding adverse private drinking water samples. Public health inspectors investigated 16 regulated adverse water sample results, as well as drinking water lead exceedances at 25 local schools.

Twenty-two boil water orders and two drinking water advisories were issued. Furthermore, 17 boil water orders and 2 drinking water advisories were rescinded.

One pool closure order was issued due to an adverse bacteriological water sample result. The order has since been rescinded following corrective action and the pool has been allowed to reopen.

7. Tobacco Enforcement

In June, July, and August, tobacco enforcement officers charged four individuals for smoking in an enclosed workplace, three of these charges were the result of smoking in a workplace vehicle. Two individuals were charged for smoking on hospital property. Three retail employees were charged for selling tobacco to a person who is less than 19 years of age, and two retail employees were charged with selling e-cigarettes to a person who is less than 19 years of age.

8. Vector Borne Diseases

In the month of June, media releases were issued to increase the public's awareness of the vector borne diseases West Nile virus and Lyme disease. These media releases included general information as well as precautions to be taken to avoid being bitten by mosquitoes and ticks.

In June, July, and August, a total of 28 581 mosquitoes were trapped and sent for analysis. During this time, a total of 360 mosquito pools were tested, four for Eastern Equine Encephalitis virus, and 356 for West Nile virus. All pools tested negative for West Nile virus and Eastern Equine Encephalitis.

In June, July and August, a total of 21 ticks were submitted and sent for analysis. To date, four of these ticks have been identified as *Ixodes scapularis*, one of which tested positive for *Borrelia burgdorferi,* the bacteria that can cause Lyme disease. In response to this report, a media release was issued on August 24, 2017, reminding the public to protect themselves and those in their care from ticks and Lyme disease.

On September 1, 2017, the Health Unit received laboratory results confirming West Nile virus (WNv) in an adult from the Sudbury East area. In response to this report, a media release was issued to remind the public of the importance of continuing to practice personal protection measures.

HEALTH PROMOTION DIVISION

1. Family Health

Over the summer, two in-class prenatal sessions were held for a total of 38 clients and 11 clients were issued online prenatal codes to participate in online classes. Three breastfeeding support group meetings were held, and 13 clients were assisted with car seat inspections and adjustments.

A NutriSTEP introduction presentation was provided to the Capreol Nurse Practitioner Clinic and Healthy Eating resources were shared.

In partnership with Child and Family Center, a Triple P (Positive Parenting Program) presentation was provided to parents of a summer education program. Fourteen one-on-one teen Triple P sessions were provided over the summer.

Staff attended the Kitchen Table Conversation Leader Orientation hosted by Better Beginnings Better Futures, led by Healthy Communities Link. Many community partners participated including Better Beginnings Better Futures, two local school boards, the Children's Aid Society, Greater Sudbury Police Services and Metis Nation of Ontario. The focus was on Aboriginal diversity sensitivity training.

Staff attended the Aboriginal Day event. Activities included traditional ceremonies, networking with a Sudbury Youth Rocks Program coordinator and the Greater Sudbury Police Services community mobilization team officer regarding community programming for youth.

Staff provided a positive parenting display at le Magasin-partage de la rentrée scolaire 2017 (a back-to-school event), where over 100 families participated.

The Valley East Neighbourhood Team hosted a Back-to-School Community Event on August 16. Several community partners and agencies worked together to provide more than 100 children with essential back to school supplies. During the event, community agencies, including the Family Health team, were present to provide families with information on health and social services.

2. Healthy Eating

On July 18, a registered dietitian attended a partnership meeting to begin planning for an eSCREEN© pilot using tablets in 5 to 6 Family Health Teams in the Northeast this fall. Attendees included: (1) the City of Lakes Family Health team; (2) NE LHIN; (3) Oceanwave, the software developer; (3) Heather Keller, PhD, SCREEN© developer; and (4) Celia Laur, PhD candidate. The Espanola & Area Family Health Team is the second site in our district area. The SDHU's registered dietitian is reviewing and preparing key messages for the customized handout that will be available on the Oceanwave platform for non-nutrition health care providers.

Over the summer months, the Diabetes Prevention Program leads and district office staff met and facilitated community consultations with key representatives and partnering agencies of the Sudbury & Manitoulin Districts Diabetes Prevention Program Advisory Committee. Information gathered from the consultation process was used for planning culturally-appropriate behaviour change programs and guiding partnership engagement activities as part of the longer-term funded Diabetes Prevention Program.

3. Healthy Weights

On August 19, the SDHU and Rainbow Routes Association hosted a "Sleep Walk" to help raise awareness for the importance of sleep health. A guest speaker from Health Sciences North's sleep clinic also presented briefly on sleep. Approximately 10 community members were in attendance. A sleep questionnaire was also developed by the SDHU to gather local sleep information to help us improve future programming. This questionnaire was officially launched during the walk and will be available online within the next few weeks.

In the months of June and July, SDHU staff delivered three Weight Bias workshops to staff that will be leading theme 3 initiatives for the City of Greater Sudbury's Healthy Kids Community Challenge.

4. Indigenous Engagement

In July, a public health nurse from the Sudbury East office provided SDHU programming information and resources to the Enaahtig Healing Lodge to enhance and support their existing programming.

In keeping with the work plan developed with support from the Indigenous Engagement Steering Committee, the following has been completed:

Communications: Five Inside Edition/Insight articles were prepared and submitted in April, May, June, and August to communicate to all staff the work involved in the development of the Indigenous Engagement strategy. Two Indigenous Engagement presentations have been developed for the purposes of communications with First Nation communities.

Relationship Building Internally: Throughout the months of April, May and June, interviews were completed with two directors, and six managers across the Environmental, Health Promotion, and Clinical and Family Services divisions. The purpose of these interviews was to identify past local public health and Indigenous community engagements, including what has worked well and to glean recommendations for future engagement. .

Relationship Building with Communities: Throughout June, July and August, fourteen (14) First Nation community visits have been completed or scheduled. These visits entailed communicating about the work underway in developing the Indigenous Engagement strategy, as well as learning about the health programs, services and priorities of each community. Managers and directors from each division were invited to attend these meetings alongside the Manager, Indigenous Engagement.

Strategy Development: An internal Indigenous Engagement Steering Committee has met twice and will meet again on September 25, 2017. An External Indigenous Engagement Advisory Group is presently being recruited. Summary reports describing findings from the management interviews; community visits, key insights from the Staff Day World Café group work and specific recommendations from the 2015 Cultural Competency Staff Circles will be developed. These will inform the next steps of the strategy's development. These next steps include a staff survey to be completed this fall, front line focus groups and a winter Relationship Principles workshop involving the External Advisory Group.

Organizational Strengthening: The development of a territorial acknowledgement and translation protocol have been completed.

*Implementation***:** The approach involves ensuring that managers have opportunities to work alongside the Manager, Indigenous Engagement to support knowledge transfer, the building and strengthening of relationships such that they are not dependent on a single manager, i.e. that of Indigenous Engagement and ensuring that knowledge and capacity is built within the

organization via the tracking of inquiries and sharing of sources of knowledge (beyond that of the Manager, Indigenous Engagement and Health Promoter).

5. Injury Prevention

*Falls Prevention***:** In May 2017, SDHU staff in partnership with our local Stay on Your Feet (SOYF) Sudbury Manitoulin Coalition members presented to Parkside Centre for Older Adult members on medication cleanout and the 9 steps to preventing falls. The SOYF orientation session was also delivered to eight new and existing SOYF Sudbury Manitoulin Coalition members.

In June 2017, SDHU staff in partnership with our local SOYF Sudbury Manitoulin Coalition members offered information on nutrition to participants at the Aging in Place conference held at Pioneer Manor. SDHU staff also took part in a booth at the Blueberry Festival focused on the 9 steps to preventing falls. Approximately100 visitors visited the booth.

In June, SDHU staff delivered a presentation to 48 Manitoulin Island students in Grades 4 to 6 on bike helmet safety and drowning prevention. After the presentation several students were fitted and provided with helmets.

In June, the Espanola public library was successful with their grant application for Android tablets and workshops for seniors. The SDHU assisted with this grant application.

In August 2017, SDHU staff in partnership with our local SOYF Sudbury Manitoulin Coalition members organized a Stand Up! Refresher training at the Lexington Hotel. Thirteen (13) facilitators attended the refresher training.

Road Safety: In May and August 2017, a public health nurse who is a Certified Child Passenger Safety Technician (CCPST) provided instructor mentorship to a public health nurse from the Timiskaming Health Unit and Algoma Public Health Unit.

In June, the CCPST trained four new Child Passenger Safety Technicians (two from Nogdawindamin Family and Community Services, one from Sudbury Manitoulin Children's Aid Society, and one from Porcupine Health Unit).

In early July, several presentations were delivered by SDHU Espanola staff in partnership with Espanola Police Services to attendees of the Our Children, Our Future playgroup in Espanola and Massey about local bylaws, safe riding on the road and proper helmet use.

In June and July 2017, SDHU staff organized and delivered a car seat inspection clinic at a local retail store and supported a car seat inspection clinic in Dowling.

Concussion Prevention: In June 2017, SDHU staff delivered a presentation about concussions to approximately 100 City of Greater Sudbury youth counsellors for the summer day camp programming.

6. Mental Health and Addictions

In July 2017, the SDHU was one of two health units invited to participate in the MOHLTC's Mental Health Promotion Guideline Working Group to develop the Mental Health Promotion Guideline that accompanies the modernized Standards for Public Health Programs and Services. To date, the group has convened twice to discuss and review content for the guidelines including; background literature, the context of mental health promotion in public health settings and best practices and approaches for planning and implementation. The group is currently consulting with additional public health units as well as with staff from the SDHU to collect additional feedback on the draft guidelines. The next Working Group meeting is scheduled for early September. It is anticipated that a draft guideline document will be completed in October 2017.

The Proceeds of Crime grant application submitted to establish a Community Mobilization, Situation Table has been approved for the Espanola area. Staff from the Espanola and Sudbury offices supported the completion of this grant application that will help support community members at elevated risk.

Shana Calixte started with the SDHU on August 28 as the Manager, Mental Health and Addictions.

7. Physical Activity

The SDHU partnered with the City of Greater Sudbury and the Sudbury Cyclists Union again this year to coordinate two children's bike exchanges in Greater Sudbury. A total of 73 bicycles were retrofitted and given out to children who either did not have a bicycle or outgrew their previous bicycle. Helmets were also provided to those children who did not already have one.

8. Prevention of Substance Misuse

The SDHU Chapleau staff have had conversations with community stakeholders over the summer months, including the Ontario Provincial Police, regarding substance use concerns in the community. Discussions regarding a potential Community Drug Strategy are being explored.

On July 5, 2017, in Espanola, a presentation was delivered to the Best Start Hub's Creating Healthy Babies program on Substance Misuse in Pregnancy. Topics covered included tobacco, alcohol, and cannabis. Resources were provided to accompany the presentation.

In mid-July, staff facilitated a discussion with 15 staff members from the N'Swakamok Native Friendship Centre. Topics discussed included opioids, signs and symptoms of overdoes, the Needle Exchange Program out of the Rainbow Centre, sharps safety, the Good Samaritan Act, and local alcohol misuse rates.

On August 3, 2017, a SDHU public health nurse from Sudbury East presented the bilingual draft Sudbury East Drug Strategy leaflet and progress report to the members of the Sudbury

East Municipal Association (SEMA). The SEMA members motioned to establish an official Drug Strategy committee with a linkage to the Community Policing Advisory Committee.

On August 17, 2017, staff attended in partnership with five GSPS officers a community meeting in the Mount Adam area to listen and address residents' concerns on drug users and dealers, needle waste on property (City and private), and human trafficking. SDHU staff provided an overview of the Community Drug Strategy, harm reduction education, local statistics, initiatives, and promoted the Needle Exchange Program.

On August 23, 2017, The Community Drug Strategy for the City of Greater Sudbury (CDSCGS) had a special meeting to re-prioritize action items and discuss strategies for next steps in 2017–2018. Outcomes included a preliminary workplan, re-affirmation of commitment, and a strengthening of the partnerships within the CDSCGS coalition.

As part of the three year alcohol strategy, the alcohol working group, consisting of SDHU staff and other members, continues to try and initiate community conversation around alcohol use in our area via the *Alcohol Let's Get Real* social media campaign.

On June 2017, SDHU staff met with members of Laurentian University Student Residence Program to plan for the upcoming school year. Planning includes how the SDHU can collaborate with LU to help denormalize alcohol use and reduce the use of alcohol on campus. Topics discussed at this meeting included alcohol trends from last year, what has worked, what has not worked, are they seeing an increase in alcohol misuse on campus etc. SDHU staff will continue to set up booths during key weeks and promote the Low-Risk Alcohol Drinking Guidelines (LRADG). SDHU staff also responded to two media requests from Radio Canada and Manitoulin Expositor. The topics discussed were excessive drinking and high rate of hospitalizations in NE Ontario, graduation parties and drinking, and drugs (parenting information).

On August 28, 2017, the SDHU presented to LU Resident Assistants (RA) on LRADG including signs and symptoms of alcohol intoxication and talking about what to do in emergency situations such as the Bacchus maneuver. Approximately 50 RA's and porters attended this presentation.

9. School Health

Throughout the 2017–2018 school year, the School Health Promotion team reached a total of 17 828 school community members. Through various activities such as presentations, workshops/skill development sessions, direct client services, meetings, events and youth engagement activities, the team was able to reach 12 673 students, 150 principals/vice-principals, 358 support/admin staff, 1 185 teachers, 682 parents and 527 undergraduate students. The team addressed topics such as resiliency, mental health, healthy eating, tobacco and sexual health.

In June, staff from the Manitoulin and Sudbury offices began planning with key Indigenous stakeholders to implement the Northern Fruit and Vegetable Program within First Nation schools in the LaCloche and Manitoulin areas. Every school within the Manitoulin district

registered and are eager to partner with us with this program. They are scheduled to receive fruit and vegetables as of January 2018.

10. Tobacco Control

On June 27, the SDHU and the Centre for Addiction and Mental Health (CAMH) held *a Smoking Treatment for Ontario Patients on the Road* smoking cessation workshop at our Paris Street location. There were six participants in total, of whom three were eligible for receiving five weeks of free nicotine patches from CAMH.

SDHU staff continued to provide services to the community through the Quit Smoking Clinic (QSC) and Telephone Information Line, having received 90 calls, 36 visits to the clinic and distributing 25 nicotine replacement therapy vouchers during the months of June and July.

In July, the SDHU implemented a QSC client follow-up process using a Clinic Information System. As such, clients are called at 1, 3, 6, 9 and 12 months from their initial visit at the clinic. The follow-up calls assess their quit/smoking status and offers ongoing support to our client population.

The Tobacco team continues to support agencies and institutions with Smoke-Free Housing policy development and with the implementation of Smoke-Free Hospital properties. Also, the team continues to offer ongoing support of the *Leave the Pack Behind Make it Memorable* campaign with internal digital lobby screens for the Civic Holiday, Labour Day and Thanksgiving.

In August, the SDHU Youth Group met with local MPPs France Gélinas and Glenn Thibeault to discuss the issue of commercial tobacco imagery in movies. They provided an overview on the overall harmful effects associated with commercial tobacco imagery in movies and the benefits of supporting adult rating requirements for movies with any commercial tobacco imagery.

RESOURCES, RESEARCH, EVALUATION AND DEVELOPMENT (REED) DIVISION

1. Health Equity

The Health Equity team launched a video in July featuring the two Public Health Champion award winners from the 2016 theme *You Can Create Change* - Monique Mercier and Our Children, Our Future. The video has been posted on the SDHU's website in English and in French and YouTube channel. It features introductions by R. Lapierre, Board of Health Chair and Dr. P. Sutcliffe, MOH/CEO, along with motivational statements by the Champions that challenge the public to make health equity actions in their community.

In August, a member from the Health Equity team supported the Back-to-School Community Store organized by the Valley East Neighbourhood Team. The Health Equity team provided a factsheet to participating families (nearly 100 families and 107 children) about tax credits and benefits available when you file an income tax return.

Through the Local Poverty Reduction Fund grant that includes the Bridges out of Poverty training initiative, 8 workshops (five 6-hour and three 3-hour sessions) have been delivered in the community to 129 individuals from 24 community agencies as well as the general public. Training has been delivered by staff from the SDHU, the Canadian Mental Health Association, and Our Children, Our Future.

2. Population Health Assessment and Surveillance (PHAS)

As part of the development of the Ontario Standards of Public Health Programs and Services, the Manager, Population Health Assessment and Surveillance (PHAS) is participating in the MOHLTC-led PHAS Protocol Working Group. The work of this group is expected to be completed in the fall of 2017.

A new Injuries and Poisonings (2006 to 2015) section has been added to the SDHU Population Health Profile. It contains information on injuries and poisonings (leading causes, deaths, etc.), including in children and youth, and unintentional and intentional injuries. Information is presented by age, sex, and geography where practicable. This section can be found at www.sdhu.com/resources/research-statistics/health-statistics/sdhu-population-health-profile/injuries-and-poisonings.

The Population Health Assessment and Surveillance team and the Clinical Services Division compiled the Quarterly Reportable Diseases Report for April to June, 2017. The report was circulated to the SDHU Outbreak team, specialists, program managers, and the Senior Management Executive Committee. Data from the integrated Public Health Information System (iPHIS) include reported and confirmed cases diagnosed in the SDHU area

3. Presentations

In June, the manager of Population Health Assessment and Surveillance delivered a webinar-based presentation titled *Implementation and use of GIS in a small-medium sized public health agency* to a national audience hosted by the Canadian Council on Social Development's Community Data Program.

Respectfully submitted,

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

Sudbury & District Health Unit

STATEMENT OF REVENUE & EXPENDITURES

For The 7 Periods Ending July 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	8,567,417	8,567,417	(0)	6,119,583
MOHLTC - Unorganized Territory	819,400	477,983	477,983	0	341,417
MOHLTC - VBD Education & Surveillance	65,000	37,917	37,917	(0)	27,083
MOHLTC - SDWS	106,000	61,833	61,833	0	44,167
Municipal Levies	6,943,298	4,050,252	4,050,253	(0)	2,893,046
Municipal Levies - Small Drinking Water Syste	47,222	27,546	27,546	0	19,676
Municipal Levies - VBD Education & Surveilla	21,646	12,627	12,627	(0)	9,019
Interest Earned	85,000	40,539	40,539	0	44,461
Total Revenues:	$22,774,566	$13,276,115	$13,276,115	$0	$9,498,451
Expenditures:					
Corporate Services:					
Corporate Services	4,339,763	2,755,411	2,728,353	27,058	1,611,410
Print Shop	152,774	59,469	39,791	19,678	112,983
Espanola	120,973	69,968	68,003	1,965	52,970
Manitoulin	124,624	70,862	67,559	3,304	57,066
Chapleau	99,667	57,512	56,645	867	43,022
Sudbury East	16,486	9,617	9,760	(143)	6,726
Intake	318,239	184,109	175,325	8,784	142,914
Volunteer Services	5,508	690	236	454	5,272
Total Corporate Services:	$5,178,033	$3,207,638	$3,145,672	$61,966	$2,032,362
Clinical Services:					
General	971,264	509,822	505,361	4,461	465,903
Clinical Services	1,383,928	823,176	823,274	(99)	560,653
Branches	259,622	141,479	125,826	15,653	133,796
Family	658,316	385,048	373,393	11,655	284,923
Risk Reduction	124,408	60,369	60,181	188	64,227
Clinical Preventative Services - Outreach	141,610	80,435	78,454	1,980	63,156
Sexual Health	942,028	526,558	512,957	13,601	429,071
Influenza	0	0	430	(430)	(430)
Meningittis	0	0	(331)	331	331
HPV	0	0	(842)	842	842
Dental - Clinic	500,484	276,116	260,224	15,891	240,259
Family - Repro/Child Health	646,798	646,798	634,782	12,017	12,017
Substance Misuse Prevention	80,894	75,712	77,189	(1,477)	3,705
Total Clinical Services:	$5,709,352	$3,525,513	$3,450,900	$74,613	$2,258,453
Environmental Health:					
General	806,321	444,308	440,173	4,135	366,148
Enviromental	2,571,182	1,434,299	1,337,729	96,570	1,233,454
Vector Borne Disease (VBD)	86,667	49,710	42,653	7,057	44,014
Small Drinking Water System	174,185	101,750	95,214	6,535	78,970
Total Environmental Health:	$3,638,355	$2,030,067	$1,915,769	$114,298	$1,722,586
Health Promotion:					
General	1,190,767	683,496	647,956	35,540	542,811
School	1,379,637	747,665	720,113	27,553	659,524
Healthy Communities & Workplaces	181,274	97,692	94,529	3,164	86,745
Branches - Espanola / Manitoulin	280,717	162,146	158,055	4,091	122,662
Nutrition & Physical Activity	1,184,744	665,800	606,900	58,901	577,844
Branches - Chapleau / Sudbury East	371,021	209,612	204,521	5,091	166,500
Injury Prevention	457,504	255,818	244,461	11,357	213,043
Tobacco By-Law	352,735	193,070	170,644	22,426	182,092
Family - Repro/Child Health	529,494	0	395	(395)	529,099
Substance Misuse Prevention	81,669	0	0	0	81,669
Alcohol Misuse	140,805	93,143	82,844	10,299	57,961
Total Health Promotion:	$6,150,367	$3,108,442	$2,930,416	$178,026	$3,219,950
RRED:					
General	1,454,823	837,917	790,490	47,427	664,333
Workplace Capacity Development	27,609	18,652	16,472	2,180	11,137
Health Equity Office	27,586	6,773	6,325	449	21,262
Strategic Engagement	588,441	313,246	308,405	4,841	280,035
Total RRED:	$2,098,459	$1,176,588	$1,121,692	$54,896	$976,767
Total Expenditures:	$22,774,566	$13,048,247	$12,564,448	$483,799	$10,210,118
Net Surplus/(Deficit)	$(0)	$227,868	$711,666	$483,799	

Sudbury & District Health Unit 2015 - current

Cost Shared Programs

STATEMENT OF REVENUE & EXPENDITURES
Summary By Expenditure Category
For The 7 Periods Ending July 31, 2017

	BOH Annual Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:					
Funding	22,958,113	13,430,037	13,453,041	(23,005)	9,505,072
Other Revenue/Transfers	913,002	546,228	595,391	(49,163)	317,611
Total Revenues & Expenditure Recoveries:	23,871,115	13,976,264	14,048,432	(72,168)	9,822,683
Expenditures:					
Salaries	15,776,088	9,036,249	8,717,945	318,305	7,058,143
Benefits	4,360,025	2,581,939	2,543,420	38,519	1,816,605
Travel	260,709	114,073	106,967	7,106	153,742
Program Expenses	930,587	419,415	394,679	24,736	535,908
Office Supplies	70,912	37,908	38,925	(1,016)	31,987
Postage & Courier Services	73,374	31,999	32,082	(83)	41,292
Photocopy Expenses	33,487	18,569	14,184	4,385	19,303
Telephone Expenses	60,506	34,965	32,457	2,508	28,049
Building Maintenance	416,377	288,528	275,421	13,107	140,955
Utilities	205,097	120,640	123,199	(2,559)	81,898
Rent	242,657	141,630	142,540	(910)	100,117
Insurance	103,774	92,184	92,172	12	11,602
Employee Assistance Program (EAP)	34,969	17,484	23,902	(6,418)	11,067
Memberships	31,666	27,328	27,101	227	4,565
Staff Development	147,755	93,323	90,014	3,310	57,741
Books & Subscriptions	11,875	4,960	2,582	2,378	9,293
Media & Advertising	108,342	30,138	28,838	1,300	79,504
Professional Fees	197,256	90,946	78,445	12,501	118,811
Translation	48,101	23,584	21,505	2,078	26,596
Furniture & Equipment	20,981	8,842	8,220	621	12,761
Information Technology	717,278	533,691	542,166	(8,475)	175,112
Total Expenditures	23,851,816	13,748,397	13,336,766	411,631	10,515,051
Net Surplus (Deficit)	19,299	227,868	711,666	483,799	

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

100% Funded Programs

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
MOHLTC Local Model for Indigenous Engagement	703	227,718	52,239	175,479	22.9%	*Mar 31/18*	33.3%
Pre/Postnatal Nurse Practitioner	704	139,000	81,023	57,977	58.3%	*Dec 31*	58.3%
OTF - Getting Ahead and Cirlcles	706	216,800	17,108	199,692	7.9%	*Mar 31/2020*	33.3%
CGS - Local Poverty Reduction Evaluation	707	44,897	6,305	38,592	14.0%	*Dec 31*	58.3%
SFO - Electronic Cigarette Act - New Nov./15 - Base Fndg	722	36,700	13,271	23,429	36.2%	*Dec 31*	58.3%
SFO -TCAN - Prevention	724	97,200	29,063	68,137	29.9%	*Dec 31*	58.3%
SFO - Tobacco Control Area Network - TCAN	725	285,800	141,941	143,859	49.7%	*Dec 31*	58.3%
SFO - Local Capacity Building: Prevention & Protection	726	259,800	110,430	149,370	42.5%	*Dec 31*	58.3%
SFO - Tobacco Control Coordination	730	104,442	60,304	44,138	57.7%	*Dec 31*	58.3%
SFO - Youth Engagement	732	80,000	44,188	35,812	55.2%	*Dec 31*	58.3%
Infectious Disease Control	735	479,100	275,521	203,579	57.5%	*Dec 31*	58.3%
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	18,902	81,098	18.9%	*Mar 31/18*	33.3%
MOHLTC - Special Nursing Initiative	738	180,500	104,135	76,365	57.7%	*Dec 31*	58.3%
MOHLTC - Northern Fruit and Vegetable Funding	743	156,600	63,907	92,693	40.8%	*Dec 31*	58.3%
Beyond BMI - LDCP	747	150,000	83,023	66,977	55.3%	*"May/16 to May/18*	54.2%
Food Safety - Haines Funding	750	36,500	7,590	28,910	20.8%	*Dec 31*	58.3%
Triple P Co-Ordination	766	31,804	31,802	2	100.0%	*Dec 31*	58.3%
CGS - Healthy Kids Bright Bites Project	772	23,136	3,555	19,581	15.4%	*Dec 31*	58.3%
CGS - Food Skills for Kids & Families Project	773	31,755	4,853	26,902	15.3%	*Dec 31*	58.3%
Healthy Babies Healthy Children	778	1,476,897	855,474	621,423	57.9%	*Dec 31*	58.3%
Healthy Smiles Ontario (HSO)	787	502,600	283,616	218,984	56.4%	*Dec 31*	58.3%
Anonymous Testing	788	59,393	19,863	39,530	33.4%	*Mar 31/18*	33.3%
PHO/LDCP First Nations Engagement	790	108,713	11,828	96,885	10.9%	*May/17 to May/18*	16.7%
HQO - Northern Health Equity	791	135,000	117,008	17,992	86.7%	*"Oct./16 to Oct./17*	66.7%
MHPS- Diabetes Prevention Program	792	175,000	33,141	141,859	18.9%	*Dec 31*	58.3%
Total		5,139,355	2,470,090	2,669,265			

The Honourable Chris Ballard
Minister of Housing / Minister Responsible for the Poverty Reduction Strategy
17th Floor, 777 Bay Street
Toronto, Ontario, M5G 2E5

Dear Minister,

The Middlesex-London Board of Health applauds the Government of Ontario for considering possible amendments to the *Residential Tenancies Act, 2006* (RTA) to encourage the participation of small landlords and private homeowners in the rental housing market, while maintaining strong protections for tenants. The introduction of Bill 124, the *Rental Fairness Act*, enabled the Government to entertain amendments to the RTA to meet goals related to increasing the availability and the affordability of housing. Although Bill 124 does not include any amendments related to no-smoking provisions, the provision of smoke-free clause options in the proposed "prescribed form of tenancy agreement" (Standard Lease), created under Bill 124, warrants consideration.

At its June 15, 2017 meeting, the Middlesex London Board of Health considered Report No. 033-17 "**Smoke-Free Clauses in the Standard Lease Under the Residential Tenancies Act**" and voted to:

1. Receive Report No. 033-17 re: Smoke-Free Clauses in the Standard Lease Under the *Residential Tenancies Act* (*RTA*);
2. Communicate its support for the inclusion of smoke-free clauses in the Standard Lease under the *RTA* by sending a letter to the Honourable Chris Ballard, Minister of Housing/Minister Responsible for the Poverty Reduction Strategy;
3. Forward Report No. 033-17 to Ontario Boards of Health and the Smoke-Free Housing Ontario Coalition to communicate its support for smoke-free housing policy measures; and
4. Direct staff to participate in consultation processes to inform regulatory changes under the *RTA* to increase the availability and enforceability of smoke-free clauses within tenancy agreements.

According to an Ipsos Reid study conducted in 2010, when given a choice, 80% of multi-unit residents would choose a smoke-free building, and in 2011, data from the Rapid Risk Factor Surveillance System (RRFSS) showed nearly two-thirds of those living in multi-unit housing in Middlesex-London supported prohibiting smoking everywhere within multi-unit housing. Nonetheless, despite strong public support and demand for smoke-free accommodations, there are very few smoke-free housing options available. Low-income families have even less choice in the housing market, and often must take whatever housing is available. Those fortunate enough to find subsidized housing may not be able to relocate easily when faced with smoke infiltration from other units. As a result, individuals in our community continue to be exposed to second-hand smoke on a regular basis in their home environments.

No-smoking provisions offer many benefits, including a healthier environment, reduced exposure to second-hand smoke, reduced risk of fire, and lower cleaning and insurance costs. Therefore, smoke-free multi-unit housing should be made available for those who want it, and be offered by those providing private and community/non-profit multi-unit housing.

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In order to make the development of no-smoking provisions more appealing to landlords and increase the smoke-free housing options available in our community, no-smoking clause options should be added to the "Prescribed form of tenancy agreement" (Standard Lease) prescribed by regulation under Bill 124. The proposed "Prescribed form of tenancy agreement" (Standard Lease) described in Bill 124 clearly outlines the agreement between the housing provider and the tenant, including all of the conditions under which occupancy can be terminated. Inclusion of no-smoking clause options to the Standard Lease created under Bill 124 would make it clear to landlords that they can offer no-smoking provisions, and would create a consistent approach to the implementation and enforcement of no-smoking clauses within multi-unit housing tenancy agreements. This would provide landlords with the tools they need and make it as easy as possible to offer smoke-free housing, and would support landlords in ensuring compliance with this expectation between tenant and landlord. If the Standard Lease does not provide an option for smoke-free housing, most landlords and tenants will be under the impression that smoke-free clauses are not allowed. As a result, landlords will be far less inclined to include them and tenants less likely to ask for them.

The health effects from second-hand tobacco smoke exposure are widely known, and the evidence is quite clear that second-hand smoke can drift from one unit to another in multi-unit housing. In fact, the best science indicates that there is no safe level of exposure to second-hand tobacco smoke. About one in five Ontarians (21%) who live in multi-unit housing report exposure to second-hand smoke coming from outside their units. This exposure causes short-term harm, such as exacerbation of asthma or COPD, as well as longer-term health problems. However, tobacco is not the only substance that can affect the reasonable enjoyment and health of tenants within multi-unit housing.

The smoking of cannabis (recreational and medicinal) is a growing concern and a common complaint that the Middlesex-London Health Unit receives from tenants and landlords. When speaking with landlords, property management groups and condo corporations, and tenants within multi-unit housing complexes, the use of marijuana is a growing concern. The health effects from exposure to marijuana smoke is similar to the health effects from tobacco smoke. Regular marijuana smoking has been associated with chronic bronchitis and reduced lung function. The combustion of marijuana creates a smoke that contains many of the same carcinogens as tobacco smoke. While there is some evidence that marijuana smoking can be a risk factor for lung, head, neck and throat cancers, the association is unclear because of dual use of marijuana and tobacco smoking. Exposure to second-hand marijuana smoke has been studied less than second-hand tobacco smoke; however, due to the similarities in composition between tobacco and marijuana smoke, marijuana smoke is likely to be a similar public health concern. Exposure in an unventilated room can cause non-smokers to experience drug effects, including minor problems with memory and coordination, and, in some cases, testing positive for the drug in a urinalysis. The harmful health effects from exposure to second-hand marijuana smoke, regardless of whether or not the marijuana smoked is for medical purposes, warrants health protective regulations. With the coming legalization and regulation of cannabis in 2018, this issue may become even more prominent across the province.

A hookah (also known as a waterpipe, narghile, goza, or hubble-bubble) is a device used to smoke specially made tobacco and non-tobacco (herbal) products called shisha. Hookah is an alternative form of smoking whereby the shisha is heated with charcoal, the smoke from which travels down through the body of the apparatus into a water-filled chamber, which cools the smoke before it is inhaled. Hookah users will then inhale the smoke through hoses attached to the apparatus. Hookah sessions are generally longer and involve deeper inhalation than cigarette smoking. Under the *Smoke-Free Ontario Act* (SFOA), the prohibition on smoking only applies to hookah use if the shisha contains tobacco, and only applies to the common areas of multi-unit housing; however, like cigarettes, a hookah also produces second-hand

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smoke that can be harmful whether or not the shisha contains tobacco or not. Studies of both tobacco-based shisha and "herbal" shisha show that the smoke from both preparations contains many of the same chemicals as cigarettes, such as carbon monoxide and other toxic agents associated with smoking-related cancer, respiratory illness and heart disease. Furthermore, a study of second-hand smoke exposure in Toronto water-pipe cafes showed that indoor air quality values for $PM_{2.5}$, ambient carbon monoxide and air nicotine are hazardous to human health.

Therefore, due to the negative health consequences from exposure to second-hand smoke, the Middlesex London Board of Health encourages the Government of Ontario to consider the need for smoke-free clause options to include tobacco, marijuana and shisha smoke. Additionally, the Middlesex-London Health Unit recommends that any no-smoking clause options indicate the maximum protection possible from second-hand smoke exposure. The language should state what provisions are covered under existing legislation, such as the *Smoke-Free Ontario Act* (SFOA), and what additional provisions are legal, permitted and enforceable under the no-smoking clause. The language should also state examples of the most protective provisions feasible, such as the entire building and property being smoke-free, and include other provisions, such as setbacks from entrances and exits, no smoking on balconies or patios, and designated outdoor smoking areas. These provisions should also state that if the landlord permits a designated outdoor smoking area on the property, it must be far enough away to ensure that second-hand smoke cannot drift into private units or balconies.

Smoke-free multi-unit housing is a critical policy issue and the Ministry of Housing is in a powerful position to signal to the housing community that smoke-free housing is a preferred option and offers tremendous health and property benefits. Adding no-smoking clause options that specify where no-smoking provisions can and cannot be made, and that include all forms of smoking in the "Prescribed form of tenancy agreement" (Standard Lease) created by regulation under Bill 124, would encourage landlords to create spaces where tenants can live without involuntary exposure to second-hand smoke from any source of smoke, whether from tobacco, marijuana, or shisha.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc. The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
The Honourable Kathleen Wynne, Premier of Ontario
Andrew Noble, Chair, Smoke-Free Housing Ontario Coalition
Ontario Boards of Health

June 8, 2017

College of Physicians and Surgeons of Ontario
Attention: Registrar
80 College Street
Toronto, ON M5G 2E2

Dear Registrar,

Re: Opioid Addiction and Overdose

At the Regular Board meeting of May 30, 2017, the Renfrew County and District Board of Health supported the position set forward in the attached letter and Report No. 062-16 re: "Opioid Addiction and Overdose" from Dr. Christopher Mackie, Medical Office of Health and CEO of Middlesex-London Health Unit. The letter requested that the College of Physicians and Surgeons of Ontario consider issuing guidance that Ontario physicians have a conversation with each patient that receives opioids about the risk of both addiction and overdose for themselves and their families, and also prescribing naloxone to have in the home of each such.

We agree with Dr. Mackie that the current climate of significant opiate use provides an opportune time for physicians to be speaking about the risks of opioids with their patients, and also ensuring that each patient who uses opioids has access to naloxone.

Sincerely,

Janice Visneskie Moore

Janice Visneskie Moore
Chair, Renfrew County and District Board of Health

cc. Dr. Robert Cushman, Acting Medical Officer of Health
Ms. Heather Daly, Director, Corporate Service/Acting Chief Executive Officer

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
681 Commercial Street, North Bay, ON P1B 4E7 TEL: 705 474 1400
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL: 705 746 5801
myhealthunit.ca
TOLL FREE: 1 800 563 2808

July 6, 2017

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

Dear Minister Hoskins:

Subject: The Revealing of Imperial Tobacco Canada Ltd.'s Anti-Contraband Campaign – BOH Resolution #BOH/2017/06/11

On June 28, 2017, at a meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board approved the following motion #BOH/2017/06/11:

***Whereas**, a 2012 slide deck from Imperial Tobacco Canada Ltd. (ITCL) demonstrates that the National Coalition Against Contraband Tobacco (NCACT) and the Ontario Convenience Stores Association (OCSA) have worked on behalf of ITCL to convince Ontario municipalities of the importance of the contraband tobacco problem; and*

***Whereas,** the 2012 ITCL slide deck makes clear that the anti-contraband campaign pursued by the NCACT and the OCSA in Ontario is designed in part to block tobacco excise tax increases and regulation of tobacco products generally; and*

***Whereas**, these other campaign objectives were either not communicated to municipalities by either the NCACT or the OCSA during meetings with municipal staff or councillors; and*

***Whereas**, the North Bay Parry Sound District Health Unit supports tobacco excise tax increases as a proven effective means of encouraging tobacco cessation; and*

***Whereas**, contrary to tobacco industry messaging, impartial research by the Ontario Tobacco Research Unit at the University of Toronto has shown that tobacco excise tax increases do not lead to large increases in contraband; and*

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

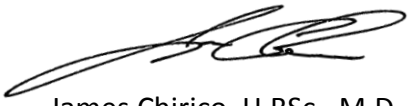
***Whereas**, the North Bay Parry Sound District Health Unit previously passed a smoke-free bylaw and supports protection of the public from second-hand tobacco smoke, protection of our youth from tobacco industry products, and tobacco tax increases to encourage smokers to quit and to raise revenue to offset the healthcare costs of tobacco use, which are more than double the current revenue raised from provincial tobacco taxes;*

***Therefore Be It Resolved**, that elected representatives and staff of the North Bay Parry Sound District Health Unit will have no further meetings or discussions about any tobacco-related issue with representatives of the NCACT, the OCSA, or individuals otherwise representing the tobacco industry, but forward any communication to the medical officer of health or designate;*

***Furthermore Be It Resolved,** that the North Bay Parry Sound District Health Unit commends the Ontario Ministry of Finance for raising tobacco excise taxes in the recent budget, and encourages this Ministry to enhance enforcement activities designed to reduce the presence of contraband tobacco in Ontario communities;*

***Furthermore Be It Resolved,** that a copy of this resolution be forwarded to the Minister of Health and Long-Term Care, the Association of Local Public Health Agencies, the Ontario Campaign for Action on Tobacco, MPP Victor Fedeli, and Premier of Ontario, Kathleen Wynne.*

Sincerely,



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

/sb

C: Hon. Kathleen Wynne, Premier of Ontario
Victor Fedeli, MPP, Nipissing
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Campaign for Action on Tobacco

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

JUN 2 0 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 $150,000 in additional base funding for staff positions to support local opioid response initiatives, including naloxone distribution to community-based organizations and work on early warning and surveillance of opioid overdoses.

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 harm reduction and public health.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Dr. Penny Sutcliffe, Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division

From: Ontario News [mailto:newsroom@ontario.ca]
Sent: Thursday, September 7, 2017 5:03 PM
To: Penny Sutcliffe <sutcliffep@sdhu.com>
Subject: Statement from Minister of Health and Long-Term Care on Ontario's Opioid Strategy

Ontario Newsroom

Statement

Statement from Minister of Health and Long-Term Care on Ontario's Opioid Strategy

September 7, 2017

Today, Dr. Eric Hoskins, Minister of Health and Long-Term Care, issued the following statement:

"Today, Premier Kathleen Wynne, Marie-France Lalonde, Minister of Community Safety and Correctional Services, and I met with the Chief Medical Officer of Health and Provincial Overdose Coordinator Dr. David Williams, and Dr. Dirk Huyer, Chief Coroner for Ontario, to discuss Ontario's comprehensive Opioid Strategy and how to further expedite initiatives underway to support communities across the province.

As the government rolls out $222 million in new investments to fight the opioid crisis that were announced last week, the Premier and I have directed that the flow of funding for harm reduction initiatives be accelerated. This will ensure that the individuals who are most at risk can get the help they need in their communities as quickly as possible. Ensuring that patients, families, and caregivers have the most up to date information available, as well as supporting front-line workers, organizations and clinicians with the resources they need to raise awareness and prevent overdoses, is also a top priority.

Over the past week, Premier Wynne and I have also met with harm reduction workers, health care advocates, people with lived experience and front line staff from across the province who have been working to help keep people at risk of opioid overdose safe. These meetings provided a valuable opportunity to hear firsthand from those closest to the crisis gripping communities. Our government will continue to look to their wisdom as we fight this crisis together.

Any life lost as a result of opioid use disorder is a needless, preventable tragedy. All of us must continue to work together to end the stigma that remains around mental illness and addiction so that everyone in Ontario has equal opportunity to live healthy lives and thrive."

CONTACTS

David Jensen
Communications and Marketing Division-MOHLTC
416-314-6197
media.moh@ontario.ca

For public inquiries call ServiceOntario, INFOline
(Toll-free in Ontario only)
1-866-532-3161
ontario.ca/health-news

Laura Gallant
Minister's Office
416-327-4450

Media Line
Toll-free: 1-888-414-4774
GTA: 416-314-6197
media.moh@ontario.ca

Ministry of Health and Long-Term Care
http://ontario.ca/health

DURHAM REGION

The Regional Municipality of Durham

Corporate Services
Department
Legislative Services

605 ROSSLAND ROAD EAST
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CANADA

905-668-7711
1-800-372-1102
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Matthew L. Gaskell
Commissioner of
Corporate Services

June 15, 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. R. Kyle, Commissioner and Medical Officer of Health, re: Human Papillomavirus (HPV) Immunization Catch-up for Boys
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on June 14, 2017, Council adopted the following recommendations of the Committee:

A) That the correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health urging the Government of Ontario to expand the publicly-funded HPV immunization program to include a catch-up program for boys, currently in grades 8 to 12, similar to the catch-up program implemented for girls in 2012, be endorsed; and

B) That the Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham's 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 June 7, 2017.

RLWalton

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

c. The Honourable Charles Sousa, Minister of Finance
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)
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

HEALTH DEPARTMENT

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Whitby ON
Canada

Mailing Address
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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: June 7, 2017

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

---

On May 3, 2017, the Chair of the Wellington-Dufferin-Guelph Board of Health sent the attached correspondence to all Ontario boards of health for support.

In essence, the correspondence urges the Government of Ontario to expand the publicly-funded HPV immunization program to include a catch-up program for boys, currently in grades 8 to 12, similar to the catch-up program implemented for girls in 2012. Currently the publicly-funded HPV immunization program applies to boys born on or after 2004/Jan/01 and males ages 9 to 26 that meet high risk eligibility criteria.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health as regards HPV Immunization Catch-up for boys is endorsed; and

b) The Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health are so advised.

Respectfully submitted,

Original signed by

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

June 29, 2017

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

Dear Honourable Hoskins:

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

On May 26, 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 implementation of a publically-funded human papillomavirus (HPV) immunization catch-up program for boys. The following motion was passed:

Motion No: 2017-56

Moved by: Al Barfoot Seconded by: Laurie Laporte

"In support of equity of access to publically funded human papillomavirus immunization, the Board of Health for the Grey Bruce Health Unit supports the call by Wellington Dufferin Guelph Public Health that the Ontario government implement a publically funded HPV immunization catch-up program for boys similar to catch up program undertaken for girls in 2012."

Carried

Sincerely,

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

Encl.

Cc: Ontario Public Health Units

DURHAM REGION

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

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Matthew L. Gaskell
Commissioner of
Corporate Services

June 15, 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. R. Kyle, Commissioner and Medical Officer of Health, re: Healthy Babies Healthy Children Program (HBHC) Targets and 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 June 14, 2017, Council adopted the following recommendations of the Committee:

A) That the correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health urging the Government of Ontario to align program service delivery expectations with annual funding; and to fully fund all program costs related to the HBHC, including all staffing, operating and administrative costs, as well as the annual increases in cost to deliver services, be endorsed; and

B) That the Premier of Ontario, Ministers of Children and Youth Services, Finance and Health and Long-Term Care, Durham's 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 June 7, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

c. The Honourable Michael Coteau, Minister of Children and Youth Services
The Honourable Charles Sousa, Minister of Finance
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)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: June 7, 2017

Re: Healthy Babies Healthy Children Program (HBHC) Targets and Funding

---

On May 3, 2017, the Chair of the Wellington-Dufferin-Guelph Board of Health sent the attached correspondence to all Ontario boards of health for support.

In essence, the correspondence urges the Government of Ontario to align program service delivery expectations with annual funding; and to fully fund all program costs related to the HBHC, including all staffing, operating and administrative costs, as well as the annual increases in cost to deliver services.

Support for this correspondence is consistent with Council's role as Durham's board of health to provide all components of HBHC.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health as regards Healthy Babies Healthy Children program targets and funding is endorsed; and

b) The Premier of Ontario, Ministers of Children and Youth Services, Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health are so advised.

Respectfully submitted,

Original signed by

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

DURHAM REGION

June 15, 2017

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

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

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Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Provincial Alcohol Strategy
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on June 14, 2017, Council adopted the following recommendations of the Committee:

A) That the correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health urging the Government of Ontario to develop a provincial alcohol strategy to mitigate the health harms associated with alcohol use and misuse to accompany the increased access to alcohol in the province since 2014, be endorsed; and

B) That the Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham's 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 June 7, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

"Service Excellence for our Communities"

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c. The Honourable Charles Sousa, Minister of Finance
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)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health

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MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: June 7, 2017

Re: Provincial Alcohol Strategy

On May 3, 2017, the Chair of the Wellington-Dufferin-Guelph Board of Health sent the attached correspondence to all Ontario boards of health for support.

In essence, the correspondence urges the Government of Ontario to develop a provincial alcohol strategy to mitigate the health harms associated with alcohol use and misuse to accompany the increased access to alcohol in the province since 2014.

Support for this correspondence is consistent with Council's role as Durham's board of health to influence the development of healthy policies that address alcohol use and misuse.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health as regards Provincial Alcohol Strategy is endorsed; and

b) The Premier of Ontario, Ministers of Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health and all Ontario boards of health are so advised.

Respectfully submitted,

Original signed by

R.J. Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health

June 29, 2017

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

Dear Honourable Hoskins:

Re: Provincial Alcohol Strategy

On May 26, 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 development of a comprehensive, province-wide strategy to support the safe consumption of alcohol. The following motion was passed:

Motion No: 2017-55

Moved by: David Shearman Seconded by: Mike Smith

"Recognizing that increased availability of alcohol since new regulations in 2014 has not been accompanied by a strategy to address harms. The Board of Health for the Grey Bruce Health Unit supports the call by Wellington Dufferin Guelph Public Health that the Ontario government develop a comprehensive province-wide strategy to support safe consumption of alcohol. And that the strategy encompass 1) Socially responsible pricing of alcohol; 2) Limit of retail outlets and hours of sale; and, 3) Alcohol marketing controls."

Carried

Sincerely,

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

Encl.

Cc: Ontario Public Health Units

August 8, 2017

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

Dear Minister Hoskins:

Re: Modernization of alcohol sales in Ontario

On behalf of the Middlesex-London Board of Health, I am writing to call on the Government of Ontario to fulfil its commitment to develop a comprehensive, province wide strategy to minimize harm and support the safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario. Alcohol remains the most harmful drug in society, impacting tens of thousands of Ontarians every year.

The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians.

It is well established that increased alcohol availability leads to increased consumption and alcohol-related harms. A comprehensive, provincially led alcohol strategy can help mitigate the harms of alcohol. Effective policy interventions include socially responsible alcohol pricing, limits on the number of retail outlets and hours of sale, and restrictions on alcohol marketing. Strong evidence shows that these three policy levers are among the most effective interventions especially when paired with targeted interventions such as drinking and driving countermeasures, enforcement of the minimum legal drinking age and referral activities.

In order to address the health and social harms of alcohol, and the impact of increased access, a comprehensive strategy is needed. The Middlesex-London Board of Health calls on the government to prioritize the health and wellbeing of Ontarians by enacting a comprehensive, evidence-based alcohol strategy to minimize harms.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Premier Kathleen Wynne
The Ontario Public Health Association

August 8, 2017

The Ontario Public Health Association
44 Victoria Street, Suite 502
Toronto, ON M5C 1Y2

Re: Modernization of alcohol sales in Ontario

At its July 20, 2017 meeting, under Correspondence item e), the Middlesex-London Board of Health considered correspondence from the Ontario Public Health Association and voted to endorse the following:

e) Date: June 8, 2017
Topic: Modernization of Alcohol Sales in Ontario
From: Ontario Public Health Association
To: All Health Units

Background:
The Ontario Public Health Association (OPHA) Alcohol Workgroup recently created and advocacy package highlighting the ongoing modernization of retail alcohol sales in Ontario. The workgroup prepared a briefing note, template cover letter and infographic to help engage
senior leadership and Boards of Health to help facilitate advocacy efforts on this issue.

Recommendation:
Endorse.

It was moved by Mr. Ian Peer, seconded by Ms. Maureen Cassidy, *that the Board of Health endorse item e)*
Carried

The Middlesex-London Board of Health supports the Ontario Public Health Association's advocacy package highlighting the ongoing modernization of retail alcohol sales in Ontario and calls on the government to enact a comprehensive alcohol strategy to minimize harms.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Ontario Boards of Health

July 5, 2017

VIA EMAIL

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

Dear Minister Hoskins:

On March 31, 2017, many agencies funded as Health Promotion Resource Centres were informed that their funding for the Resource Centre would end as of March 2018. These Resource Centres provide crucial support to our local level work in tobacco, alcohol and nutrition, including access to data, research, and evaluation support.

- The Training Enhancement in Applied Cessation Counselling program (TEACH) provides the high level, in-depth cessation training needed by the frontline staff at health units.
- The Program Training and Consultation Centre (PTCC) provides training, education, and knowledge sharing to ensure our activities are evidence based, new staff are knowledgeable, and current staff stay informed.
- The Ontario Tobacco Research Unit (OTRU) provides the expertise in monitoring and evaluation that is needed to ensure that objectives are realistic and activities are effective.
- The effect that the Youth Advocacy Training Institute (YATI) has had on youth tobacco prevention in Ontario is extremely significant. Their collective experience and knowledge of youth engagement and training is why there are so many passionate youth advocates in tobacco control today!
- The Smoking and Health Action Foundation (SHAF) provides supports for smoke-free housing Ontario and support for tenants and landlords looking to make a positive change in their environment when living in a multi-unit dwelling whether it be an apartment, a condo, rental unit, or supportive housing.
- The Health Promotion Capacity Building-Alcohol Policy Centre (HPCB-AP) addresses alcohol-related harm in communities across Ontario. HPCB-AP supports the development, implementation, assessment, and coordination of alcohol policies across different settings and levels (e.g., schools, colleges, workplaces, municipalities, provinces, etc.).
- The Nutrition Resource Centre (NRC) provides training, education, and knowledge sharing to ensure program and policy development are evidence-based and can be tailored to meet local needs.

Our local health promotion work is more effective and efficient because of the dedicated and proficient staff at these centres. These Resource Centres support cross-pillar work and have been very useful in collaborative campaigns at the provincial, regional, local, and even federal level.

The substitute of having a Health and Wellness grant available to fill the void left by these Resource Centres is not a viable alternative. Annual competitive grants do not offer the stability needed for any kind of sustainable resources or support. The projects that are supported by the Resource Centres can span several years from planning to evaluation.

I would appreciate it if you could reconsider the decision to eliminate the funding for the Health Promotion Resource Centres, and I look forward to your response.

Sincerely,

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

AW/hb

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

August 8, 2017

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

Dear Minister Hoskins,

Re: Support of Low Income Adult Dental Program in Ontario

At its July 20, 2017 meeting, under Correspondence item b), the Middlesex-London Board of Health considered the attached correspondence from the Leeds, Grenville and Lanark Board of Health regarding the support of low income adult dental programs in Ontario and voted to endorse the following:

b) Date: June 7, 2017
Topic: Letter in Support of Low Income Adult Dental Program in Ontario
From: Leeds, Grenville & Lanark District
To: The Honourable Eric Hoskins

Background:
The Leeds, Grenville & Lanark District Health Unit sent correspondence encouraging the Ministry of Health and Long-Term Care to consider the funding of low income adult dental programs in Ontario. The Middlesex-London Board of Health passed a motion at the January 2014 meeting to send a letter to the Minister of Health and Long-Term Care and local Members of Provincial Parliament, copied to the Association of Local Public Health Agencies and all Ontario Boards of Health to advocate for a program that provides both publicly-funded dental treatment and prevention to low-income adults, including seniors. At this juncture, it is important to reaffirm this position.

Recommendation:
Endorse.

It was moved by Mr. Ian Peer, seconded by Ms. Maureen Cassidy, *that the Board of Health endorse item b).*
Carried

The Middlesex-London Board of Health supports extending dental programs to low-income adults and redirecting the funds currently spent in emergency rooms and physician's offices to preventive care and dental treatment.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Anne Warren, Chair, Board of Directors, Leeds, Grenville and Lanark District Health Unit
Ontario Boards of Health

June 1, 2017

VIA EMAIL

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

Dear Minister Hoskins:

RE: Municipal Levy Apportionment

The Health Protection and Promotion Act (appended) stipulates that municipalities must decide how to apportion the municipal component of the expenses of the Board of Health among obligated municipalities. All of the obligated municipalities will have to agree with this change before it can be implemented according to the Health Protection and Promotion Act, and Ontario Regulation 489/97 (*See Appendix #1*). The regulations state that the default is to use the Ontario Population Report of the Municipal Property Assessment Corporation (MPAC) which is the current method being used to apportion the levy.

Recently, the Board of Health for the Leeds, Grenville and Lanark District Health Unit received information from the Municipal Property Assessment Corporation (MPAC) (*See Appendix #2*) that stated:

> "The Ontario Population Report (OPR) is based on information contained in MPAC's Names Database and is produced upon conclusion of each municipal enumeration which correlates with the timing of regular municipal and school board elections that now occur every 4 years. The Report is distributed to all municipalities, certain provincial ministries and other stakeholders.
>
> "The OPR figures are developed from information gathered for assessment and enumeration purposes. These figures should not be confused with population data published by Statistics Canada that are produced from dedicated population counting and estimating processes conducted every 5 years."
>
> "The most accurate municipal population numbers are produced by Statistics Canada based on the most recent census."

Given MPAC states that the population numbers produced by Statistics Canada are more accurate than those produced by MPAC, the Board requests that Ontario Regulation 489/97 Allocation of Board of Health expenses be amended as follows:

> **1.** (1) If the obligated municipalities in a health unit fail to agree on the proportion of the expenses referred to in subsection 72 (1) of the Act to be paid by each of them, each obligated municipality in the health unit shall pay the proportion of the expenses that is determined by dividing its population by the sum of the populations of all the obligated municipalities in the health unit. O. Reg. 489/97, s. 1 (1).
>
> (2) In this section,
>
> "population" means, with respect to an obligated municipality, the population of the obligated municipality as determined from the most recent Census conducted by Statistics Canada.

The Board of Health looks forward to hearing from you regarding this important issue.

Sincerely,

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

AW/hb

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

HEALTH PROTECTION AND PROMOTION ACT

Payment by obligated municipalities

72. (1) The obligated municipalities in a health unit shall pay,

(a) the expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under this or any other Act; and

(b) the expenses incurred by or on behalf of the medical officer of health of the board of health in the performance of his or her functions and duties under this or any other Act. 1997, c. 30, Sched. D, s. 8.

Agreement

(3) The obligated municipalities in a health unit shall pay the expenses referred to in subsection (1) in such proportion as is agreed upon among them. 1997, c. 30, Sched. D, s. 8.

If no agreement

(4) If the obligated municipalities in a health unit fail to agree on the proportion of the expenses referred to in subsection (1) to be paid by each of them, each obligated municipality in the health unit shall pay the proportion of such expenses that is determined in accordance with the regulations. 1997, c. 30, Sched. D, s. 8.

ONTARIO REGULATION 489/97

ALLOCATION OF BOARD OF HEALTH EXPENSES

Consolidation Period: From April 1, 2005 to the e-Laws currency date.

1. (1) If the obligated municipalities in a health unit fail to agree on the proportion of the expenses referred to in subsection 72 (1) of the Act to be paid by each of them, each obligated municipality in the health unit shall pay the proportion of the expenses that is determined by dividing its population by the sum of the populations of all the obligated municipalities in the health unit. O. Reg. 489/97, s. 1 (1).

(2) In this section,

"population" means, with respect to an obligated municipality, the population of the obligated municipality as determined from the most recent enumeration conducted under section 15 of the *Assessment Act*. O. Reg. 489/97, s. 1 (2).

(3) In this section,

"assessment", with respect to real property, means the assessment for the real property made under the *Assessment Act* according to the last returned assessment roll;

"population" means population as determined from the most recent enumeration conducted under section 15 of the *Assessment Act*. O. Reg. 142/05, s. 1.

Appendix #2

MUNICIPAL PROPERTY ASSESSMENT CORPORATION

ONTARIO POPULATION REPORT

What is the OPR?

The Ontario Population Report (OPR) is based on information contained in MPAC's Names Database and is produced upon conclusion of each municipal enumeration which correlates with the timing of regular municipal and school board elections that now occur every 4 years. The Report is distributed to all municipalities, certain provincial ministries and other stakeholders. The OPR is not an 'estimate'. The OPR (and any adhoc population count done between enumeration years and/or obtained through the Population Report option provided via Municipal Connect™) is based on actual point-in time counts of current names in MPAC's database.

Note: *The OPR figures are developed from information gathered for assessment and enumeration purposes. These figures should not be confused with population data published by Statistics Canada that are produced from dedicated population counting and estimating processes conducted every 5 years (see* Factors Affecting Population Counts *below).*

Information Sources and Collection Methods

The primary source of **owner names** is the land transfer process. This results in a high degree of accuracy and currency for owner information but does not include other family members. The primary source of **tenant names** has traditionally been through the Tenant Information Program (TIP) where landlords with seven or more residential units are obliged to annually supply MPAC with the names of the tenants in their buildings. Landlords usually supply MPAC with whatever names are on their rent roll, typically one name per unit. This source does not include children or other occupants. Beginning in 2014, tenant names are also being received from the National Register of Electors and during an enumeration event, via MPAC's voterlookup.ca online elector update/confirmation website. Name information is no longer collected through the mailout of 'Municipal Enumeration Forms' (MEFs) during municipal election years. To collect names of **children** and other occupants, including the missing birth dates, citizenship confirmations and school support of tenants and owners, MPAC traditionally mailed out 'Request for Occupant Information' (ROI) forms. Compliance is voluntary and returns as low as 20%. In addition, owners and tenants have the option of updating their household occupant information when calling MPAC's Customer Contact Centre.

Factors Affecting Population Counts

In comparison to Statistics Canada, MPAC typically under-reports population numbers for Ontario, primarily in the under 20 to 25 year-old range. The reasons for this are:

- There is no legislated requirement for owners of rental properties with fewer than seven units to supply MPAC with tenant names.
- Historically, although approximately **50%** of owners respond to Occupancy Questionnaires, compliance for tenants has been approximately **20%**.
- When in receipt of properly documented information, MPAC is obliged to change its database accordingly which usually requires the removal of existing names from a property record and replacing them with the new name(s). The process of removing names automatically includes

any children or other occupants currently listed at the identified address. These names are recovered, only if they reappear at a future point through other source data/data-matching.

- Under instructions from Ontario's Deputy Registrar, municipal clerks no longer send MPAC the names of newborns. The cumulative effect since the early 90's has been the slow degradation of OPR numbers, particularly those under the age of 20.

The most accurate municipal population numbers are produced by Statistics Canada based on the most recent census.

(From Beverley Disney
Account Manager, Municipal and Stakeholder Relations Department
Municipal Property Assessment Corporation)

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

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

alPHa Sections:

- Boards of Health Section
- Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

- Association of Ontario Public Health Business Administrators
- Association of Public Health Epidemiologists in Ontario
- Association of Supervisors of Public Health Inspectors of Ontario
- Health Promotion Ontario
- Ontario Association of Public Health Dentistry
- Ontario Association of Public Health Nursing Leaders
- Ontario Society of Nutrition Professionals in Public Health

alPHa 30 YEARS 1986-2016 Association of Local PUBLIC HEALTH Agencies

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

July 21 2017

Dear Minister Hoskins,

Re: alPHa RESOLUTION A17-6, Fluoride Varnish Programs for Children at Risk for Dental Caries

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 inform you of the attached resolution, which was adopted by our members at our annual general meeting on June 12 2017.

This resolution calls on the Government of Ontario to to provide funding through the Healthy Smiles Ontario program for the implementation of school and community-based programs to use fluoride varnish to reduce the risk of tooth decay among children at risk for dental caries.

The topical application of fluoride to teeth is a well-known and effective means of preventing dental decay. The application of fluoride varnish is safe, easy and 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) in a variety of settings without the use of specialized equipment.

We see this as an important opportunity to further reduce the risk and incidence of dental caries in Ontario, thereby reducing the costs of expensive and preventable dental treatments.

We hope you will give this serious consideration as an important addition to Ontario's Healthy Smiles Program.

Yours sincerely,

Carmen McGregor
alPHa President

COPY: Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Division
Chairs, Ontario Boards of Health

alPHa Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A17-6

TITLE: **Fluoride Varnish Programs for Children at Risk for Dental Caries**
SPONSOR: **Board of Health for Wellington-Dufferin-Guelph Public Health**

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);

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; and

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; and

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. This review found a 43% reduction in decayed, missing and filled tooth surfaces among permanent teeth and a 37% reduction among primary teeth; and

WHEREAS Biannual topical fluoride applications are recommended by the Centres of Disease Control and Prevention for the prevention of dental caries in children at risk. 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; and

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); and

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

WHEREAS By reducing the risk and incidence of dental caries, Fluoride Varnish Programs (FVPs) 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; and

WHEREAS Ontario public health units conduct annual screening of elementary schools in order to classify 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 Healthy Smiles Ontario 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 Fluoride Varnish Program for children at risk, if they have not already done so.

ACTION FROM CONFERENCE: **Resolution CARRIED**

Northwestern Health Unit
www.nwhu.on.ca

210 First Street North
Kenora, ON P9N 2K4

September 1, 2017

The Fair Workplaces, Better Jobs Act, 2017 (Bill 148)

The Northwestern Health Unit expects Provincial Bill 148: Fair Workplaces, Better Jobs Act, 2017 will lead to significantly improved health outcomes for many residents in the region. As such, the Board of Health has shown its support of the Bill by passing a resolution (attached) at its August 28th meeting commending the provincial government for taking steps to improve income levels and working conditions.

Decades of research show that people with lower incomes have poorer physical and mental health and higher rates of mortality. The poorer you are, the more likely you are to have health risks in your daily life, and difficulties accessing adequate healthy food or affordable safe housing. It is estimated that the changes to the minimum wage outlined in Bill 148 will increase the wages and improve the working conditions of more than one quarter of Ontario workers.

The Bill, now under consideration by the Standing Committee on Finance and Economic Affairs, will move into Second Reading in September 2017, and must go through Third Reading and Royal Assent prior to the proposed implementation date of January 1st, 2018. As the Bill proceeds, it is important to be aware of the potential health, social and economic benefits this significant piece of legislation may provide for local families, employers and the community as a whole. The attached Public Health Communique provides further details regarding these benefits and outlines the rationale for the Board of Health support for this Bill.

If you have any questions please feel free to contact me at 807-468-3147 or email kyounghoon@nwhu.on.ca.

Sincerely,

K. Young Hoon.

Dr. Kit Young Hoon, MBBS, MPH, MSc, FRCPC
Medical Officer of Health
Northwestern Health Unit

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT
BOARD OF HEALTH
MOTION/RESOLUTION

No. 64 -2017

Moved by .....

Seconded by .....

WHEREAS, the Northwestern Health Unit Board of Health has a mandate to decrease health inequities such that everyone has equal opportunities for health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances; and

WHEREAS, a day's work deserves a fair day's pay and no one working full-time to support a family should have to live in poverty; and

WHEREAS, the current minimum wage is not adequate to cover basic needs, and low-income individuals and families are more likely to be challenged with social factors such as low education, precarious employment, inadequate housing, and social exclusion; and

WHEREAS, the costs of food, housing, child care and transportation make it increasingly difficult for low-wage workers to make ends meet; and

WHEREAS, over 1 in 10 people in the NWHU catchment area (11.1%) are in low-income households and nearly 1 in 5 children (19.4%) live in low-income houses compared with 18.1% provincially; and

WHEREAS, the NWHU region has a higher proportion of the population considered to have lower socioeconomic status when compared with the rest of the province, and this population is at risk of experiencing health inequities, both in terms of health outcomes and access to care; and

WHEREAS, evidence confirms that people with lower incomes have higher rates of mortality, and poorer physical and mental health; and
WHEREAS, through the proposed amendments to the Employment Standards Act and the Labour Relations Act, it is estimated that more than one quarter of Ontario workers will receive an increase in their wages, along with more stable and fair employment conditions; and
WHEREAS, Bill 148 will help to assure health, social and economic benefits for the communities as a whole;

THEREFORE BE IT RESOLVED that the Northwestern Board of Health commend the provincial government's actions to address the root causes of precarious work through the Changing Workplaces Review of 2015-16 and subsequent introduction of Bill 148; and

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT
BOARD OF HEALTH
MOTION/RESOLUTION

FURTHER BE IT RESOLVED THAT the Board of Health support the proposed changes to the Employment Standards Act that expand the pay equity provisions and increase the minimum wage for workers and the proposed changes to the Labour Relations Act that better support precarious workers' rights; and that the Northwestern Board of Health share this motion and supporting materials with community agencies, municipalities and elected representatives, and the Association of Local Public Health Agencies (alPHa), Ontario Boards of Health and others as appropriate.

carried ✓ Aug. 25/17.

Paul Pope
Chair

Ministry of Health and Long-Term Care

Planning and Performance Branch
Population and Public Health Division

777 Bay Street, 19th Floor, Suite 1903
Toronto ON M7A 1S5
Telephone: 416-314-2130

Accountability and Liaison Branch
Population and Public Health Division

393 University Avenue, 21st Floor
Toronto ON M7A 2S1
Telephone: 416-327-8808

Ministère de la Santé et des Soins de longue durée

Direction de la planification et de la performance
Division de la santé de la population et de la santé publique

777, rue Bay, 19e étage, Suite 1903
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Direction de la responsabilisation et de la liaison
Division de la santé de la population et de la santé publique

393, avenue University, 21e étage
Toronto ON M7A 2S1
Téléphone : 416-327-8808

Ontario

June 12, 2017

MEMORANDUM TO: Board of Health Chairs
Medical Officers of Health
Chief Executive Officers
Business Administrators

RE: 2017 Public Health Funding and Accountability Agreement Indicators

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Given the current state of transformation within the public health sector, the ministry's approach for the 2017 indicators is to minimize the impact of change on boards of health while at the same time continuing to ensure accountability.

The suite of indicators for the 2017 Public Health Funding and Accountability Agreement has been reduced to an essential set of monitoring indicators. Please refer to Appendix A.

If you have any questions, please send them to PHUIndicators@ontario.ca or contact us directly. We look forward to continuing to work with you throughout 2017.

Yours truly,

Original signed by

Jackie Wood
Director
Planning and Performance Branch
Population and Public Health Division

Original signed by

Elizabeth Walker
Director
Accountability and Liaison Branch
Population and Public Health Division

Attachment

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

APPENDIX A – 2017 ACCOUNTABILITY INDICATORS

Program	#	2017 Indicators
Chronic Diseases	1.4	% of tobacco vendors in compliance with youth access legislation at the time of last inspection
	1.7	% of tobacco retailers inspected once per year for compliance with display, handling and promotion sections of the Smoke-Free Ontario Act (SFOA)
Food Safety	2.1	% of high-risk food premises inspected once every 4 months while in operation
Safe Water	2.3	% of Class A pools inspected while in operation
Infectious Diseases	3.1	% of personal services settings inspected annually
	3.6	% of laboratory confirmed gonorrhea cases treated according to guidelines
Vaccine Preventable Diseases	4.1	% of HPV vaccine wasted that is stored/administered by the public health unit
	4.3	% of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection
	4.4	% of school-aged children who have completed immunizations for hepatitis B
	4.5	% of school-aged children who have completed immunizations for HPV
	4.6	% of school-aged children who have completed immunizations for meningococcus
	4.7	% of MMR vaccine wasted
	4.8	% of 7 or 8 year old students in compliance with the ISPA
	4.9	% of 16 or 17 year old students in compliance with the ISPA
	4.10	% of influenza vaccine wasted[1]

[1] Similar to the % of MMR vaccine wasted, this indicator will monitor the percentage of wastage of publicly funded influenza vaccine that is stored, transported, or administered by public health units and health care providers. This indicator relates to the effectiveness of vaccine storage, handling and management practices by the public health unit and health care providers. It is believed there are significant opportunities for cost savings by implementing efforts to reduce vaccine wastage, and this is a priority for the ministry. The *Vaccine Storage and Handling Protocol, 2008* (or as current) requires that vaccine wastage should not exceed five percent for any one product. The formula and report will be similar to the MMR indicator and the data source will be from Panorama.

TORONTO

Ulli S. Watkiss
City Clerk

City Clerk's Office

Secretariat
Dela Ting
Board of Health
City Hall, 10th Floor, West
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Toronto, Ontario M5H 2N2

Tel: 416-397-4592
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Web: www.toronto.ca

June 21, 2017

VIA ELECTRONIC MAIL

To Interested Parties:

Subject: Legal Access to Non-Medical Cannabis: Approaches to Protect Health and Minimize Harms of Use - Item HL20.3

The Toronto Board of Health on June 12, 2017 amended and adopted item HL20.3, and forwarded the report (May 29, 2017) from the Medical Officer of Health:

1. To the Council of Ontario Medical Officers of Health, the Urban Public Health Network, the Council of Chief Medical Officers of Health, Canadian Public Health Association, the Association of Local Public Health Agencies, Federation of Canadian Municipalities, Association of Municipalities of Ontario, the Ontario Public Health Association, the federal Cannabis Legalization and Regulation Secretariat, the Ontario Legalization of Cannabis Secretariat, Toronto Police Services Board, the public and separate English and French school boards, and the Executive Director, Municipal Licensing and Standards, for information.

The Board of Health also:

2. Requested the Province of Ontario to:

   a. Set the minimum age of purchase for cannabis at 19 years of age to align with the minimum age for legal purchase of alcohol in Ontario;

   b. Establish a provincially-controlled agency for the retail sale and distribution of non-medical cannabis, separate from that for alcohol, and establish a comprehensive social responsibility program;

   c. Prohibit smoking and vaping of cannabis in public places in alignment with restrictions on tobacco use in the Smoke-Free Ontario Act and the Electronic Cigarettes Act;

   d. Prohibit cannabis use in motor vehicles similar to restrictions on liquor use in motor vehicles in the Liquor Licence Act;

   e. Establish requirements for cannabis law enforcement, such as equity training, to ensure fair treatment of population groups disproportionately represented in the criminal justice system; and

   f. Conduct formal consultations with municipalities and local public health agencies in the development of provincial legislation related to non-medical cannabis.

3. Requested the Government of Canada to:

   a. Immediately decriminalize the possession of non-medical cannabis for personal use until legislation to legalize and regulate cannabis comes into force;

   b. Require comprehensive “plain packaging” rules for all cannabis product packaging and labelling as are currently being proposed in federal Bill S-5 - An Act to amend the Tobacco Act and the Non-smokers' Health;

   c. Establish measures for cannabis law enforcement such as equity training, to ensure fair treatment of population groups disproportionately represented in the criminal justice system;

   d. Strengthen regulations on marketing and promotion of cannabis with more comprehensive prohibitions that address advertising in movies, video games and other media accessible to youth; and

   e. Regulate edible forms of cannabis as per the recommendations made by the federal Task Force on Cannabis Legalization and Regulation.

To view this item and background information online, please visit:
http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2017.HL20.3

Sincerely,

D. Ting

Secretary
Board of Health
Dela Ting/lh

Sent to: Chair, Council of Ontario Medical Officers of Health (COMOH)
Chair, Council of Chief Medical Officers of Health, Canada (CCMOH)
Urban Public Health Network
Executive Director, Canadian Public Health Association
Manager, Public Health Issues, Association of Local Public Health Agencies
Federation of Canadian Municipalities
Association of Municipalities of Ontario
Ontario Public Health Association
Cannabis Legalization and Regulation Secretariat
Acting Executive Director, Ontario Legalization of Cannabis Secretariat
Toronto District School Board
Toronto Catholic District School Board
le Conseil scolaire Viamonde
le Conseil scolaire de district catholique Centre-Sud

c.: Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health
Executive Director, Municipal Licensing and Standards
Toronto Police Services Board

ELGIN ST. THOMAS PUBLIC HEALTH

1230 Talbot Street, St. Thomas, ON N5P 1G9
p: 519.631.9900 | **f:** 519.633.0468
elginhealth.on.ca

June 5, 2017

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

Dear Minister Hoskins:

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

On May 10th, 2017, at a regular meeting of the Board of Health at Elgin St. Thomas Public Health, a letter was brought forward from Wellington-Dufferin-Guelph Public Health asking provincial health units to support enactment of legislation under the *Health Protection and Promotion Act* to allow for inspection of, and enforcement activities in, personal service settings. According to the letter, six provinces and territories currently have specific legislation for the regulation of personal service settings which greatly increases the effectiveness of their public health interventions. The Elgin St. Thomas Board of Health supports the position of Wellington-Dufferin-Guelph Public Health recommending enactment of legislation that increases the enforcement abilities of public health staff and provides incentives for operators to comply with infection prevention and control best practices.

While education is considered an essential and first step in gaining operator compliance, experience has shown that enforcement activities are, at times, the only means of gaining compliance with minimum requirements in order to ensure public safety. In those provinces or territories where regulations exist for personal service settings, no-compliance with the regulations can result in a conviction and/or strict monetary fines, without requiring public health staff to prove the existence of a health hazard. This approach is similar to that used by public health when inspecting and enforcing food premises.

This proposed legislation presents a chance for health units to achieve the goal of reducing the burden of infectious diseases of public health importance.

Thank you,

Dr. Joyce Lock, MD, CCFP (EM), FRCP(C)
Medical Officer of Health

Cynthia St. John, MBA
Executive Director

c. Chief Medical Officer of Health of Ontario
Association of Local Public Health Agencies
Jeff Yurek, MPP Elgin-Middlesex-London
Ontario Boards of Health

Office of the Regional Chair | Alan Caslin
1815 Sir Isaac Brock Way, PO Box 1042 Thorold, ON L2V 4T7
Telephone: 905-980-6000 Toll-free: 1-800-263-7215 Fax: 905-685-6243
Email: alan.caslin@niagararegion.ca
www.niagararegion.ca

June 14, 2017

Hon. Eric Hoskins
Minister of Health & Long Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

Re: Requesting Support for the Enactment of Legislation under the Health Protection & Promotion Act (HPPA) to Allow for Inspection and Enforcement Activities of Personal Service Settings

I am writing to you on behalf of the Board of Health for Niagara Region.

We thank you for your emphasis on transparency and patient safety during your tenure as Minister. Under your leadership, local public health agencies now investigate complaints concerning infection prevention and control (IPAC) in a wider array of facilities, and we disclose our investigation findings in short order to the public. While this work has resulted in considerable additional work for local public health during a time of constrained funding, we think the residents and many visitors to Niagara are safer because of it.

I am writing today to request your government's help in streamlining this work to ensure Ontarians can expect the highest standards of IPAC practices. Specifically, we have endorsed the enclosed requests by Wellington-Dufferin-Guelph Public Health and the Board of Health for the District of Algoma Health Unit to enact a regulation specific to personal service settings (PSS) coupled with the authority to ticket under the Provincial Offenses Act.

Local public health agencies inspect all PSS to ensure adherence to IPAC standards of practice. Whether through these proactive inspections or through complaint investigations, when deficiencies in IPAC practices are identified, we seek to rectify the practices using education in the first instance. While effective in the vast majority of cases, on occasion, repeated attempts to educate prove unsuccessful at bringing about needed changes. In these cases, graduated enforcement processes are needed.

Currently, the only enforcement measures afforded under the HPPA are the closure of the premise and the use of legal orders. These are blunt and coercive tools that are not always proportionate. As well, when a PSS owner/operator does not adhere to a legal order to correct practices, the

process of laying a charge for breach of the order is lengthy, costly, and, most critically, delays correction of the health risk. Where education is ineffective, but the health risk is not sufficiently severe to justify a closure or legal order, there are currently no tailored enforcement tools that would permit a graduated escalation of actions.

Conversely in food premises, where deficiencies in food safety are identified, there is the option of issuing a ticket under Part I of the Provincial Offences Act. This is possible since food safety practices have been embedded in a regulation specific for food safety (Regulation 562: Food Premises) coupled with a schedule of offences listed in a regulation under the Provincial Offences Act (Regulation 950: Proceedings Commenced by Certificate of Offence). The time needed to prepare and serve the ticket is also considerably less than the time required for a closure or legal order under the HPPA. Few tickets are actually issued for food safety; the threat of receiving tickets alone deters owners/operators from operating in contravention of established standards of practice.

A provincial regulation specific to IPAC practices in PSS, coupled with a schedule of offences under the Provincial Offences Act would facilitate adherence to best practice standards, and not impose any new or additional requirements on PSS businesses. More importantly, it would better protect the public by enabling swifter correction of IPAC breeches, reduce the need for heavy-handed enforcement, and reduce expenditure of provincial and local tax dollars on enforcement. Such a PSS enforcement regimen would also align with other public health enforcement regimens.

Thank you for considering this request, and for your ongoing leadership of Ontario's integrated health system.

Yours Truly,

Alan Caslin
Regional Chair

Cc:
David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population & Public Health Division
Association of Local Public Health Agencies
Ontario Boards of Health
Niagara MPPs

Encl.
Wellington-Dufferin-Guelph Public Health Letter to Premier (January 4, 2017)
Algoma Public Health Letter to Premier (March 29, 2017)

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

JUN 16 2017

Dr. James Crispo
2115 South Bay Road
Sudbury ON P3E 6H7

Dear Dr. Crispo:

Congratulations on your appointment to the Board of Health for the Sudbury and District Health Unit. I am very pleased that you have taken on this important responsibility.

As serving the people of Ontario is an honour and a privilege, I know you will be committed to the principles and values of public service and I am confident you will perform your duty with integrity.

I have enclosed a copy of the Order in Council which was approved on May 31, 2017, appointing you for the period May 31, 2017 until May 30, 2020.

Again, please accept my congratulations on your appointment. I am confident you will find this experience both interesting and rewarding.

Yours sincerely,

Dr. Eric Hoskins
Minister

Enclosure

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

Ontario

Executive Council of Ontario
Order in Council

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

Conseil exécutif de l'Ontario
Décret

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

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

James Crispo of Sudbury

be appointed as a part-time member of the Board of Health for the Sudbury and District Health Unit

for a period of three years, effective the date this Order in Council is made.

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

James Crispo de Sudbury

O.C./Décret: 1106/2017

est nommé au poste de membre à temps partiel du Conseil de santé de la circonscription sanitaire de Sudbury et du district pour une durée fixe de trois ans à compter du jour de la prise du présent décret.

Recommended: Minister of Health and Long-Term Care
Recommandé par: le ministre de la Santé et des Soins de longue durée

Deb Matthews

Concurred: Chair of Cabinet
Appuyé par: Le président/la présidente du Conseil des ministres,

Approved and Ordered:
Approuvé et décrété le: MAY 3 1 2017

Lieutenant Governor
La lieutenante-gouverneure

O.C./Décret: 2

Ministry of Health and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
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www.ontario.ca/health

Ministère de la Santé et des Soins de longue durée

Bureau du ministre

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Tél. 416 327-4300
Téléc. 416 326-1571
www.ontario.ca/sante

Ontario

JUN 16 2017

Ms. Nicole Sykes
4429 Long Lake Road
Sudbury ON P3G 1K4

Dear Ms. Sykes:

Congratulations on your appointment to the Board of Health for the Sudbury and District Health Unit. I am very pleased that you have taken on this important responsibility.

As serving the people of Ontario is an honour and a privilege, I know you will be committed to the principles and values of public service and I am confident you will perform your duty with integrity.

I have enclosed a copy of the Order in Council which was approved on May 31, 2017, appointing you for the period May 31, 2017 until May 30, 2020.

Again, please accept my congratulations on your appointment. I am confident you will find this experience both interesting and rewarding.

Yours sincerely,

Dr. Eric Hoskins
Minister

Enclosure

c: Medical Officer of Health
France Gélinas, MPP

Ontario

Executive Council of Ontario
Order in Council

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

Conseil exécutif de l'Ontario
Décret

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

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

Nicole Sykes of Sudbury

be appointed as a part-time member of the Board of Health for the Sudbury and District Health Unit

for a period of three years, effective the date this Order in Council is made.

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

Nicole Sykes de Sudbury

O.C./Décret: 1107/2017

est nommée au poste de membre à temps partiel du Conseil de santé de la circonscription sanitaire de Sudbury et du district pour une durée fixe de trois ans à compter du jour de la prise du présent décret.

Recommended: Minister of Health and Long-Term Care
Recommandé par: le ministre de la Santé et des Soins de longue durée

Concurred: Chair of Cabinet
Appuyé par: Le président/la présidente du Conseil des ministres,

Approved and Ordered: MAY 3 1 2017
Approuvé et décrété le:

Lieutenant Governor
La lieutenante-gouverneure

O.C./Décret: 2

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

alPHa's members are the 36 public health units in Ontario.

alPHa Sections:

- Boards of Health Section
- Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

- Association of Ontario Public Health Business Administrators
- Association of Public Health Epidemiologists in Ontario
- Association of Supervisors of Public Health Inspectors of Ontario
- Health Promotion Ontario
- Ontario Association of Public Health Dentistry
- Ontario Association of Public Health Nursing Leaders
- Ontario Society of Nutrition Professionals in Public Health

June 19, 2017

Association of Local Public Health Agencies Announces Officers for 2017-18

Dear Colleague:

I am pleased to announce the 2017-18 leadership for the Association of Local Public Health Agencies. Please join me in welcoming into their roles:

President	Councillor Carmen McGregor Chatham-Kent Board of Health

Assuming alPHa Section Leadership roles are:

Chair, Board of Health Section	Ms. Trudy Sachowski Board of Health Provincial Appointee Northwestern Board of Health
Chair, Council of Medical Officers of Health (COMOH)	Dr. Penny Sutcliffe Medical Officer of Health & Chief Executive Officer Sudbury & District Health Unit

For a fuller introduction to alPHa's Board, please visit http://www.alphaweb.org/?page=BOD_2017.

Yours truly,

Linda Stewart
Executive Director

alPHa
Association of Local
PUBLIC HEALTH
Agencies

Information Break

July 18, 2017

This monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

2017 Annual Conference Wrap Up

Many thanks to the members, speakers, sponsors and exhibitors who participated at alPHa's 2017 annual conference **Driving the Future of Public Health** last month in Chatham, Ontario. A special shout out to conference co-host Chatham-Kent Public Health who helped organize a successful event. One highlight in particular was the memorable annual awards dinner that was held at the historic Buxton Museum and featured an unforgettable performance by The Friends of Buxton Men's Choir. Our sincerest thanks and gratitude to health unit staffers Lisa Powers, Heather Bakker, Michelle Bogaert and Lyndsay Davidson for making it all happen at the Buxton! For a summary of the conference plenary and breakout sessions, please click on the link below to download proceedings and view slide presentations (login and password required).
2017 alPHa Annual Conference Proceedings & Presentations
Distinguished Service Award 2017 Program

2017-2018 alPHa Executive Committee

At the June annual general meeting, the 2017-2018 slate of officers, the alPHa Executive Committee, were elected as follows:

Carmen McGregor (Chatham-Kent) - President
Dr. Valerie Jaeger (Niagara) - Past President
Dr. Penny Sutcliffe (Sudbury) - Vice President & COMOH Chair
Gilles Chartrand (Porcupine) - Treasurer
Trudy Sachowski (Northwestern) - BOH Section Chair
Paul Sharma (Peel) - Affiliate Representative

For a full list of the 2017-2018 Board of Directors, click here.

Resolutions Passed at Annual Conference

This year, six resolutions were endorsed by the alPHa membership at the June annual conference. Calls to action were made on the following: oral health for low-income Ontarians, Truth and Reconciliation, tobacco endgame, fluoride varnish programs, accessible contraception, and mental health in Ontario workplaces. alPHa will be writing relevant government officials on these resolutions over the summer, and will post responses on the website as they become available.
View the 2017 resolutions here
Visit alPHa's Resolutions home page

Consultation: Cannabis Legalization in Ontario

The Province of Ontario has released a consultation paper on the legalization of cannabis (marijuana) and is currently seeking public input on how it should responsibly approach the regulation and sale of cannabis. Share your health unit's feedback by completing the government's online survey by **July 31, 2017**. Prior to the announcement on Ontario's consultation, alPHa wrote Canada's Attorney General in support of the report *Toward the Legalization, Regulation and Restriction to Access to Marijuana: Submission to Federal Task Force* by the Ontario Public Health Unit Collaboration on Cannabis.
Learn more about Ontario's consultation on cannabis legalization
Read alPHa's letter on cannabis legalization (with report) here

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alPHa Website Feature: Correspondence

In the past couple of months, alPHa has sent letters on a number of important public health issues. alPHa submitted its formal response to the province on the draft Public Health Accountability Framework in June, and wrote a congratulatory letter to Ontario health minister Eric Hoskins on expanded access to naloxone. The Association also wrote Ontario's Chief Medical Officer of Health regarding recommendations on public health requirements for *The Child Care and Early Years Act* and *Immunization of School Pupils Act*.
Visit alPHa's Correspondence home page here

Upcoming Events - Mark your calendars!

November 3, 2017* - Fall alPHa Meeting, DoubleTree by Hilton Downtown Toronto Hotel. Details TBA.
** New date (i.e. changed from previously announced date)*

February 23, 2018 - Winter alPHa Meeting, Novotel Toronto Centre, 45 The Esplanade, Toronto. Details TBA.

March 21-23, 2018 - The Ontario Public Health Convention (TOPHC) 2018, Beanfield Centre, Toronto.

June 10, 11 & 12, 2018 - alPHa Annual General Meeting & Conference, Novotel Toronto Centre, 45 The Esplanade, Toronto.

alPHa is the provincial association for Ontario's public health units. You are receiving this update because you are a member of a board of health or an employee of a health unit.

alPHa
Association of Local
PUBLIC HEALTH
Agencies

Information Break

August 17, 2017

This monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

Report of Minister's Expert Panel on Public Health

On July 20, Ontario released the Report of the Minister's Expert Panel on Public Health, *Public Health within an Integrated Health System*. The report advises the government on ways to strengthen and integrate the public health sector with the rest of the provincial health care system. alPHa has prepared a summary of the report's proposals (see link below), which, if implemented, will have significant implications for Ontario's public health system. alPHa has begun to set up processes for members' feedback to inform the association's input and advice to government once consultations are underway. We will keep members updated on developments as they arise.
View the government's announcement on the Expert Panel's report
Download the Expert Panel report here
Read alPHa's summary of the Expert Panel's report here

Government News: Round Up

As part of its Local Food Strategy, the Ontario government recently launched the campaign *Bring Home the World* to expand consumer access and availability of locally-grown foods that reflect the province's cultural diversity. It is presently seeking the public's feedback on its World Foods discussion paper through an online survey. Responses to the survey should be completed by September 23.

On August 3, the province announced that it would be making the abortion pill Mifegymiso available to women at no cost effective August 10, 2017. Women with a valid health card and a prescription from a doctor or nurse practitioner can get the drug at participating pharmacies across Ontario.
Read the Ontario government news release here

ConnectingOntario: Toward a Single Electronic Health Record

eHealth Ontario has established The ConnectingOntario initiative to create electronic health records for all Ontario patients. There are three regional programs: *ConnectingOntario Greater Toronto Area*, *ConnectingOntario Northern and Eastern Region (NER)*, and *Connecting South West Ontario*. Each regional program is being led by a hospital-based delivery partner to provide clinicians with secure and timely access to electronic patient health information across the continuum of care -- hospitals, community and primary care -- through a clinical viewer. Public health is one of the program's target sectors for clinician adoption. As such, alPHa has started working with ConnectingOntario NER to raise awareness of this initiative among health units over the coming months.
Learn more about ConnectingOntario here

Upcoming Events - Mark your calendars!

November 3, 2017 - Fall alPHa Meeting, DoubleTree by Hilton Downtown Toronto Hotel. Details TBA.

February 23, 2018 - Winter alPHa Meeting, Novotel Toronto Centre, 45 The Esplanade, Toronto. Details TBA.

March 21-23, 2018 - The Ontario Public Health Convention (TOPHC) 2018, Beanfield Centre, Toronto.

June 10, 11 & 12, 2018 - alPHa Annual General Meeting & Conference, Novotel Toronto Centre, 45 The Esplanade, Toronto.

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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: R. Lapierre, Chair, Sudbury & District Board of Health

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

Date: September 14, 2017

Re: Report of the Minister's Expert Panel on Public Health: Update and Consultation Process

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:
The purpose of this briefing note is to update the Sudbury & District Board of Health on the *Report of the Minister's Expert Panel on Public Health* within the context of recent developments associated with the Province's health system transformation agenda. It provides an opportunity for discussion with respect to public health implications in order to inform the Board's input into the Province of Ontario's consultation on this report.

Recommended Action:

THAT the Sudbury & District Board of Health receive this briefing note for information; and

THAT the Board of Health authorize the Chair of the Board of Health to work with the Medical Officer of Health on a submission for the alPHa Board; and

THAT the Board of Health authorize the Chair of the Board of Health to work with the Medical Officer of Health on a draft submission for the Province of Ontario for the Board's approval at its October 2017 meeting.

Background:
The Board has been apprised of key developments of the Ministry of Health and Long Term Care's (MOHLTC) health system transformation agenda. As it impacts on public health, the major developments are in the following three areas:

1. The **modernization of public health standards** through the *Standards for Public Health Programs and Services* consultation document and process;
2. The formal **engagement between the LHINs and public health** units through the *Report Back from the Public Health Work Stream*; and

3. The **role and structure** of *Public Health within an Integrated Health System – Report of the Minister's Expert Panel on Public Health*

SDHU staff continue to be engaged in the Standards modernization process and Dr. Sutcliffe was a member of the Public Health Work Stream. There is currently an opportunity to provide feedback on the recommendations of the Minister's Expert Panel on Public Health, via the Board of Health directly and via our membership with alPHa (Association of Public Health Agencies).

Context:

Patients First Discussion Paper: The Ontario government's current health system transformation process dates to December 2015 with the MOHLTC release of the discussion paper, *Patients First, a Proposal to Strengthen Patient-Centred Health Care in Ontario*.

Patients First Act: On December 8, 2016, the Province passed legislation for a more integrated health care system through *Bill 41, the Patients First Act 2016*. The Act implements many but not all of the recommendations of the December 2015 Patients First discussion paper. The Act did not implement the Patients First discussion paper recommendation to transfer funding of public health units from the MOHLTC to the LHINs.

Details of the Act that are relevant to public health units include amendments to establish geographic sub-regions to support planning, funding and service integration; engaging the Medical Officer of Health and boards of health; advancing population health and health promotion; and promoting health equity.

MINISTER'S EXPERT PANEL ON PUBLIC HEALTH

In January 2017, the Minister of Health and Long-Term Care established an Expert Panel on Public Health whose mandate was to provide advice to the Minister on public health governance, organization and structure within the Province's transformation and health care reform agenda. Its goal was to improve the integration of public health perspectives and leadership into the work of LHINs, including incorporating population health in health system planning and decision-making, as well as advancing health equity and social determinants of health considerations. The Expert Panel also sought to improve equity and capacity among public health units across the province.

The Expert Panel released its report, *Public Health within an Integrated Health System*, on July 20, 2017. The report reflects the Expert Panel's recommendations to the Minister. It was released without comments by the MOHLTC, aside from noting that it was being reviewed. On August 4, 2017, the MOHLTC announced that it would receive feedback on the recommendations until October 31, 2017.

The report proposes significant and far-reaching changes to Ontario's public health landscape. The Association of Local Public Health Agencies (alPHa) has provided a summary of the report (attached) and is engaging with its membership to prepare a response to the Ministry, anticipated this fall. Boards have been asked to provide feedback to their regional representative on the alPHa Board (attached from Gilles Chartrand – Porcupine Health Unit) for discussion at the September 29 alPHa Board meeting.

The report recommendations are framed around mandates and the principles that public health would maintain an independent voice and continue to work outside of the health care system to build

collaborative relationships with municipal governments and local organizations. Public Health would also continue to advance the social determinants of health and identify at-risk populations. The report foresees population health perspectives integrated across the delivery of health services, with more connections to health promotion and health protection.

However, the Expert Panel's recommendations outline extensive structural, organizational and governance changes in the delivery of public health programs and services. These include:

1. **Organizational Structure:** Creation of 14 regional level public health entities (from the existing 36 health units) with regional boards. The regional boards of health would be subdivided into Local Public Health Service Delivery Areas, with a local Medical Officer of Health, who would report to the Regional Medical Officer of Health, as well as local program and service management and employees. This model aims to address current challenges associated with the range of critical mass and surge capacity in public health units across Ontario.
2. **Geographic Boundaries**: Establish the boundaries of the 14 regional public health entities such that they align with the LHIN boundaries but also respect municipal boundaries and relationships; moving existing health units in their entirety where possible (or where not possible, divide health units based on municipal boundaries)
3. **Leadership Structure**: Each regional public health entity would have a CEO who reports directly to the regional board. There would be a regional MOH who "has the ability to report to the board on matters of public health and safety". There would also be senior public health leadership at the regional level. It is ambiguous with respect to whether the CEO could also be the MOH as is the current structure in the majority of health units.
4. **Governance:** Given the current variability in governance models across Ontario Health Units, the recommendation is to introduce consistency while maintaining public health autonomy and municipal representation. Regional boards of health, with 12-15 members, would be free-standing and autonomous. They would include municipal representation, provincial appointees, citizen members, as well as, potentially, representatives from other sectors. The provincial appointees would fill key positions (e.g. chair, vice chair, committee chairs, etc.).

The Expert Panel report recognizes that there are significant implementation and organizational change implications. These include: assessing the legislative amendments required; addressing the current public health funding model; developing transition and change management plans; and identifying effective strategies to enhance linkages with LHINs.

NEXT STEPS AND CONSULTATION

The ongoing MOHLTC health system transformation work signals that extensive changes may be forthcoming to the public health sector. The structural changes and new requirements could have wide-reaching impacts on the operations, partnerships and accountabilities of the SDHU and the broader public health sector in Ontario. The SDHU has taken every opportunity to provide feedback to the MOHLTC throughout the transformation process, including submissions on the initial Patients First discussion paper, participation in the Standards Modernization review/consultation and participation in the Public Health Work Stream.

The Board is being asked to consider the following questions to inform the alPHa Board deliberations on September 29:

1. What questions do you have about the Expert Panel report and its recommendations?
2. What in the report and its recommendations is helpful for Ontario's public health sector? Why?
3. What concerns you in the report and its recommendations? Why?
4. What do you believe is absolutely essential for alPHa to be communicating to the government regarding the report of the Expert Panel on Public Health? Why?

In addition to alPHa, the Council of Ontario Medical Officers of Health (COMOH) and the Association of Ontario Municipalities (AMO) are also assessing the impacts of the report recommendations with a view to potentially making submissions to the Ministry. The SDHU is participating in and following these developments.

It is proposed that a subsequent report be brought to the October Board meeting with recommendations for the board to make a submission to the Ministry before the October 31, 2017 deadline.

Ministry of Health and Long-Term Care

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Ontario

July 20, 2017

Dear Colleagues,

In February 2015, the province launched our *Patients First: Action Plan for Health Care* to transform our health care system into one that puts patients at the center by making our health care system more accessible, equitable and integrated. During the last two years, we have made considerable progress to improve the health care experience and outcomes for patients in Ontario. But we know there is still more work that needs to be done in order to make our system truly integrated.

Improving access to care is one priority of Patients First, but the vision is much broader. Patients First is also about promoting health and reducing health disparities. A key factor in achieving this vision is to strengthen linkages and partnerships within the health system, including public health. Patients First includes a requirement for the public health sector and the province's local health integration networks (LHINs) to work together in an integrated health system: one that actively promotes health and reduces health disparities as well as improves access to health care services. As a first step in realizing this requirement, the Government of Ontario established the Expert Panel on Public Health ("Expert Panel") in January 2017. Over the course of five months, the expert panel met to develop recommendations on proposed structural, organizational, and governance changes for Ontario's public health sector.

I am sharing with you the report of the Minister's Expert Panel on Public Health: "*Public Health within an Integrated Health System."* On behalf of the Ministry of Health and Long-Term Care, I would like to thank the expert panel for its important work. The recommendations of the expert panel's report provide a framework for the government to consider as it continues to implement Patients First. I look forward to engaging with you and other stakeholders to discuss the opportunities offered in this report. Details about consultations will be forthcoming.

This report is an important first step to help us realize the vision for all health programs and services – hospitals, home and community care, primary care and public health – to have strong connections and to work together to enhance Ontarians' health and well-being at all ages and stages of life.

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1671-01 (2014/07)

Yours sincerely,

Dr. Eric Hoskins
Minister

Public Health within an Integrated Health System

Report of the Minister's Expert Panel on Public Health

June 9, 2017

Table of Contents

I. About the Expert Panel

In January 2017, the Minister of Health and Long-Term Care established an Expert Panel on Public Health to provide advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system.

Mandate

As part of their recommendation, the Expert Panel was asked to consider:

1. The optimal organizational structure for public health in Ontario to:
   - ensure accountability, transparency and quality of population and public health programs and services
   - improve capacity and equity in public health units across Ontario
   - support integration with the broader health system and the Local Health Integration Networks (LHINs) – the organizations responsible for planning health services
   - leverage public health's expertise and leadership in population health-based planning, decision-making and resource allocation, as well as in addressing health equity and the social determinants of health.
2. How best to govern and staff the optimal organizational structure.

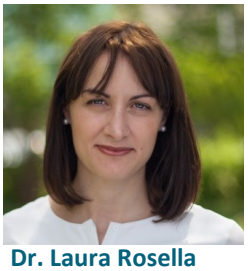
Membership

Members were chosen for their knowledge, expertise and perspectives and appointed by Order in Council. They were appointed as individuals and not as representatives of organizations or associations.

Dr. David Williams
Chief Medical Officer of Health, Ontario

Susan Fitzpatrick
Chief Executive Officer, Toronto Central Local Health Integration Network (LHIN)

Dr. Valerie Jaeger
Medical Officer of Health, Niagara Region Public Health



Dr. Laura Rosella
Canada Research Chair in Population Health Analytics, Assistant professor, Dalla Lana School of Public Health, UofT

Solomon Mamakwa
Health Advisor, Nishnawbe Aski Nation

Dr. Nicola J. Mercer
Medical Officer of Health and CEO, Wellington-Dufferin-Guelph Public Health

Gary McNamara
Mayor of the Town of Tecumseh, Chair of the Windsor Essex Health Unit

Carol Timmings
Director, Child Health and Development, Chief Nursing Officer, Toronto Public Health

Dr. Jeffrey Turnbull
Chief of Staff, The Ottawa Hospital, Chief - Clinical Quality, HQO

Desired Outcome: A Strong Public Health Sector within an Integrated Health System

It is the view of the Expert Panel that Ontario will benefit most from a highly skilled public health sector embedded and highly visible in communities across the province. Public health will continue to nurture strong relationships with municipal governments and other local organizations to positively influence the social determinants of health; and create safe, supportive, healthy environments. Its work will be overseen by boards that reflect the perspectives and diversity of local communities and municipalities and share and promote a strong commitment to public health.

The public health workforce in all parts of the province will have access to specialized public health knowledge and resources. Public health practitioners will share a commitment to evidence-based practice and achieving population health outcomes.

The work of public health will be guided by provincial policy and legislation, and supported by province-wide efforts to collect and analyze data on health status. Public health will continue to champion health equity, identifying groups within the population whose health is at risk and developing targeted universal programs so that all Ontarians have equal opportunity for good health outcomes. Public health will also ensure that Indigenous communities have an active voice.

At the same time, the public health sector will have the capacity to work much more effectively with the rest of the health system. Its understanding of local health needs will help identify health system priorities and shape health policy and services. Stronger relationships with other parts of the health system will make it easier to integrate health protection and promotion into all health services. Working with other parts of the heath system, public health will identify more effective ways to deliver population level interventions that will improve health and reduce health inequities.

Ontarians will recognize and value the work of public health and will access local public health programs and services within an integrated health system.

Goals of Patients First

- Effective integration of services and greater equity
- Timely access to, and better integration of, primary care
- More consistent and accessible home & community care
- Stronger links to population and public health
- Inclusion of Indigenous voices in health care planning

Principles Guiding the Panel's Work

To guide its work and deliberations, the Expert Panel developed the following principles:

- The strong independent public health voice and core public health functions will be preserved and leveraged to help reorient the health system.
- The local strengths of public health – including relationships with municipal and other community partners – will be maintained and enhanced to support integrated planning and service delivery.
- The federal government will continue to have responsibility for health services for Indigenous people in Ontario, including First Nations communities; however Ontario's public health sector also has a responsibility to protect and promote Indigenous health and to ensure Indigenous partners have an active voice.
- Being part of an integrated health system will create opportunities to enhance capacity and improve efficiency– some services may be delivered more effectively by or through other parts of the system.
- Form follows function: structural changes will be based on a clear understanding of the public health sector's role in an integrated health system.
- The organization and distribution of public health expertise, resources and services will reflect local needs and priorities.
- Boundary changes will be necessary to align public health with LHINs, and to support systems planning.

Process and Deliberations

To fulfill its mandate, the Expert Panel:

- reviewed background information, including past reports on Ontario's public health sector
- examined the functions of public health at the regional, local, and provincial levels
- reviewed the current organization of the health system
- discussed possible models and scenarios for reorganizing public health based on input received during consultation for Patients First, and various other submissions, letters, etc.
- looked at ways to align services and determine geographical boundaries
- reviewed the literature on various leadership roles and structures and models for governance
- discussed the potential implications for legislation, including the *Health Protection and Promotion Act* and the *Local Health System Integration Act*, and others.

II. The Opportunity

Public Health as Part of an Integrated Health System

As part of Patients First, all health programs and services – hospitals, home and community care, primary care and public health – are strengthening connections and working together to enhance Ontarians' health and well-being at all ages and stages of life.

Historically, public health and health care have operated as distinct systems. Public health largely focuses on the health of populations and providing upstream community-wide interventions, while health care services are designed to diagnose, treat, and improve individual health outcomes. A key goal of Patients First is to strengthen linkages and partnerships between the health care system and public health.

Close collaboration and formalized relationships between public health and LHINs will mean that:

- A population health approach will be integrated into local planning and service delivery across the continuum of health care
- health services will address and be responsive to population health needs and will seek to promote health and achieve health equity
- health promotion, health protection and health care will be more connected
- public health services and other health services will be better integrated

Preparing Public Health for its role in an Integrated Health System

To maximize its impact in the transformed system, public health must change and the health system must adapt to allow and support true integration.

Over the past year, three public health transformation initiatives have been focused on addressing key questions that will help public health be an effective partner in an integrated health system:

1. **What is the work of public health?**
   The **modernization of the Ontario public health standards** will provide a renewed framework for public health programs, services, and accountability in the 21st century.
2. **What is the role of public health in integrated planning?**
   The **public health work stream** is a collaboration between public health and LHINs working to provide guidance on formal engagement parameters for LHINs and public health across the province.
3. **How should public health be organized across the province to function effectively within an integrated system?**
   The **Expert Panel on Public Health** was asked to provide advice on what the structure and governance of public health should be to enhance its capacity to fulfill its health promotion and protection role and work effectively with partners within a transformed health system.

The Impact of Public Health within an Integrated System

What impact will the strengthened relationship between public health and LHINs have on all health system partners and on Ontarians?

Strong relationships outside the health system to protect and promote health.
Public health works with municipal governments, community organizations, schools, and local services outside the health system – to influence the social, environmental and structural factors that can lead to poor health. Public health can broker relationships between health care, social services, municipal governments, and other sectors to create healthier communities.

More focus on the social determinants of health and greater health equity.
Some Ontarians are at greater risk of poor health because of social determinants such as poverty, precarious housing, poor working conditions, and a lack of social support networks. Public health can embed a population health approach into health service planning and delivery to close these health gaps and enhance health equity.

More comprehensive targeted health interventions.
Although chronic diseases are among the most common and costly health problems facing Ontarians, they are also among the most preventable. Interventions targeting chronic disease risk factors can be successful in mitigating and preventing the burden of chronic diseases. Public health can identify high risk communities and offer targeted interventions that can prevent or delay the onset of these diseases and their complications.

Better care pathways and health outcomes.
A person's ability to follow a care pathway after surgery or treatment is affected by factors outside the health system. For example, if an individual is discharged from the hospital and returns to precarious housing and food security challenges, their recovery will be negatively impacted and they may have a higher likelihood of being re-admitted to the hospital than someone who has stable housing and access to healthy food. Public health can help the health system develop care pathways that take into account the social factors that affect health outcomes.

Greater recognition of the value of public health.
With public health as part of an integrated health system, Ontarians will better understand the importance of investing in health protection and promotion across the life course. They will see how public health benefits themselves, their families and their communities and, at the same time, helps contain health care costs and make the universal health care system more sustainable.

Improving access to care is one priority for the integrated system, but the vision of Patients First is much broader. It is also about promoting health, reducing health disparities and helping all Ontarians lead long healthy lives.

III. A Strong Public Health Sector in an Integrated System

The impetus for the Expert Panel's work is the government's Patients First Strategy. The key question for the Expert Panel was how to best organize public health to function effectively within an integrated system. However, the Expert Panel also viewed their task as an opportunity to strengthen the public health sector and support more efficient and effective operations.

Members worked to identify an optimal structure and governance model for public health in Ontario for the 21st century and beyond. In developing recommendations, the Expert Panel did not attempt to "retrofit" the current system.

1. The Optimal Organizational Structure for Public Health

Background

Ontario currently has 36 public health units. They range in size from 630 to 266,291 square kilometres. The smallest serves only 34,246 people dispersed over a geographic area as large as France, while the largest serves 2,771,770 people concentrated within 630 square kilometres. (See Appendix A: map showing current health unit areas and LHIN boundaries)

Public health units are responsible for delivering programs and services in accordance with standards established by the Ministry of Health and Long-Term Care. Public health units are responsible for identifying local health priorities and population needs and addressing those that fall within their mandate. Much of the work in public health is done in close collaboration with municipal partners. There is a cost-sharing relationship between the Ministry of Health and Long-Term Care and municipalities for delivery of public health programs and services.

Key strengths of the public health sector include its focus on health protection, health promotion, and health equity, its local presence, relationship with municipalities, its highly trained workforce, its collaborative relationships outside the health care system, and its in-depth understanding of and capacity to assess population-level health.

Challenges of the current structure – particularly felt in smaller health units – include a lack of critical mass and surge capacity and challenges recruiting and retaining key skilled public health personnel, which make it difficult to deliver equitable services across Ontario. A lack of mechanisms to coordinate across health units and lack of alignment with LHINs also make it challenging to collaborate, share resources and maximize effectiveness both within the public health sector and within the broader health system.

Criteria

The Expert Panel's goal was to recommend an organizational structure for public health that would:

- Maintain a strong independent public health sector within an integrated health system
- Relate effectively with the LHINs to influence health system planning
- Enhance public health's strong local presence and effective relationships with municipalities
- Ensure Ontarians continue to have access to public health programs and services in their communities
- Create public health organizations large enough to achieve critical mass and retain public health personnel and resources to efficiently operate services in all parts of the province
- Allow for clear definition of public health functions and roles at the provincial, regional and local levels, in order to make more effective use of public health expertise and resources
- Enhance public health practice and ensure more consistent implementation of the public health standards across the province
- Foster collaboration/coordination within the public health sector and with the rest of the health system.

Members of the Expert Panel agreed with findings and observations of a series of reviews over the past 20 years, which all determined that Ontario's public health sector would be stronger if:

* there were fewer health units with greater capacity
* there was a consistent governance model
* the sector was better connected to other parts of the health system.

Responsibilities and Functions

To ensure strong local programs and services, every effort should be made to locate the right mix of management and program staff in local communities. Depending on the size of the communities/populations they serve, local service delivery sites may have public health physicians, directors, managers/program leads, front-line staff and staff responsible for using local population health data to develop local initiatives that are reflective of community needs.

The optimal locations for regional and local public health activities should be determined within the region and based on the distribution of the population and geography. The regional public health entity could potentially look for opportunities to co-locate public health services with other health and/or municipal services, thereby increasing the potential for service integration.

Table 1 on pages 12 –15 outlines public health responsibilities and functions at provincial, regional and local levels.

Figure 1: Organizations Described at Each Level

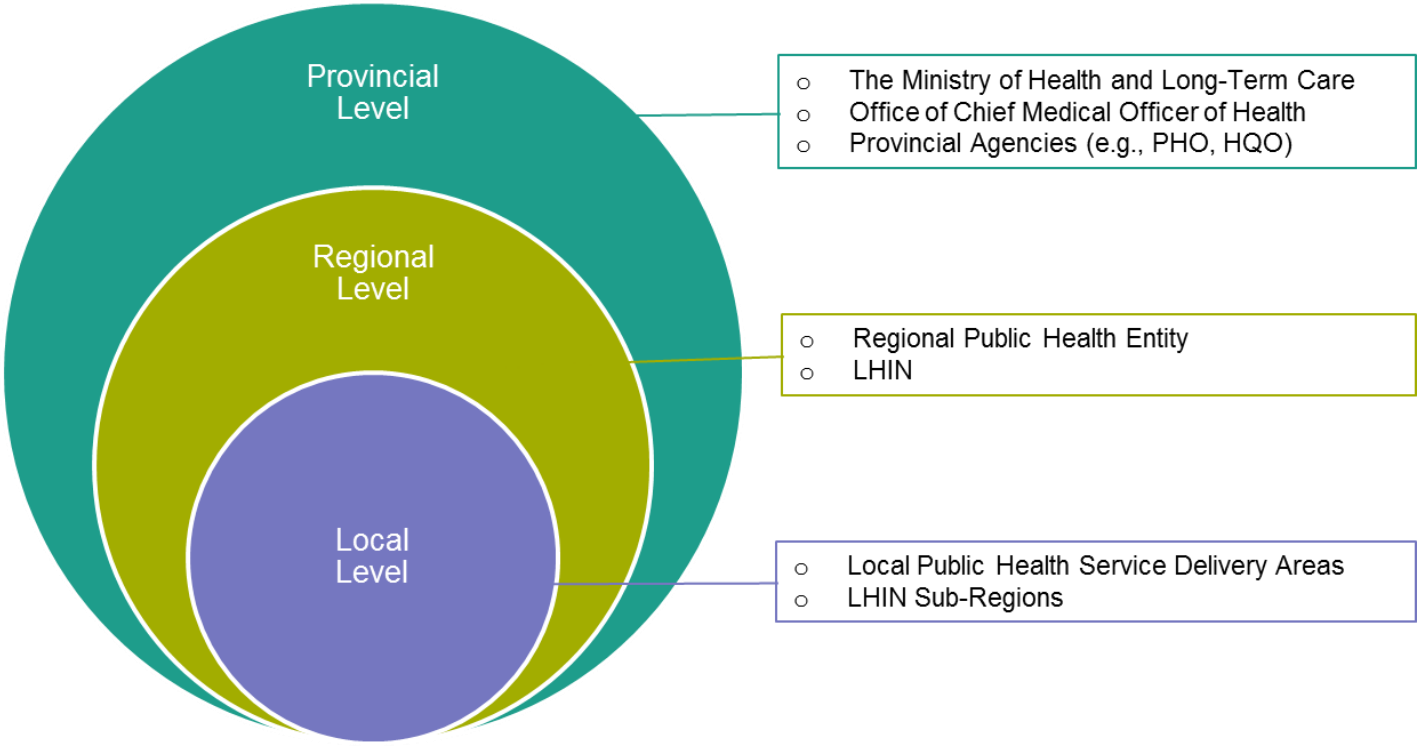


Table 1: Public Health Responsibilities and Functions

Category	Function	Regional	Local	Provincial	LHIN
Corporate Services	**Funding and Accountability**	• Accountability agreements with province • Performance management approach • Accountability for local public health entities	• Continuous quality improvement • Performance management initiatives	• Transfer payments • Overall provincial accountability with 14 regions	
	Human Resource Management	• Workforce strategy • Human resource policies and procedures	• Local oversight • Staff development	• 100% funded positions (e.g., social determinants of health nurses) • Medical Officer of Health/ Associate compensation	
	Administrative	• Risk management • Procurement • Service level agreements • Facilities planning and administration	• Local facilities management and input		
	Communications	• Strategic communication planning • Guidelines for use of relationships with media channels • Guidelines for public reporting	• Local issues management and correspondence with the media • Strategies for educating community partners and the public		
	Information tech-nology	• Corporate IT			

Table 1: Public Health Responsibilities and Functions (continued)

Category	Function	Regional	Local	Provincial	LHIN
Performance, Quality, and Analytics	**Surveillance and Monitoring**	• Collect and consolidate pertinent health-related data • Detect and notify of health events • Appropriate reporting of data to province, local offices, LHINs, etc.	• Apply surveillance data to guide public health policy and strategies • Document impact of an intervention or progress towards specified public health targets/goals • Investigation and confirmation of cases or outbreaks • Coordination and sharing of information with LHIN sub-regions	• Ongoing, systematic collection, analysis and interpretation of health-related data	• Receive surveillance information and assist with dissemination
	Information Management	• Responsible for common regional systems • Decision making • Data governance	• Systems designed to address local needs	• Centralized data systems • Data governance	• Potential integrated databases
	Performance and Evaluation	• Regional metrics and dashboards • Data repository • Inform /contribute to LHIN planning	• Local data collection and insights • Application of data in local planning and delivery • Program accountability • Quality of practice	• Provincial dashboards • Provincial level data • Coordination of data sharing with other jurisdictions and First Nations	• Coordination/ bridging work with public / population health data
	Research	• Set research priorities • Lead and/or participate in regional research projects • Review and incorporate research and evaluation findings into planning	• Conduct research projects • Help inform research proprieties • Partner with other organizations undertaking research • Stay up to date on latest studies • Ongoing program review and evaluation	• Set research priorities • Research grants	• Interpretation of population health research to inform planning

Table 1: Public Health Responsibilities and Functions (continued)

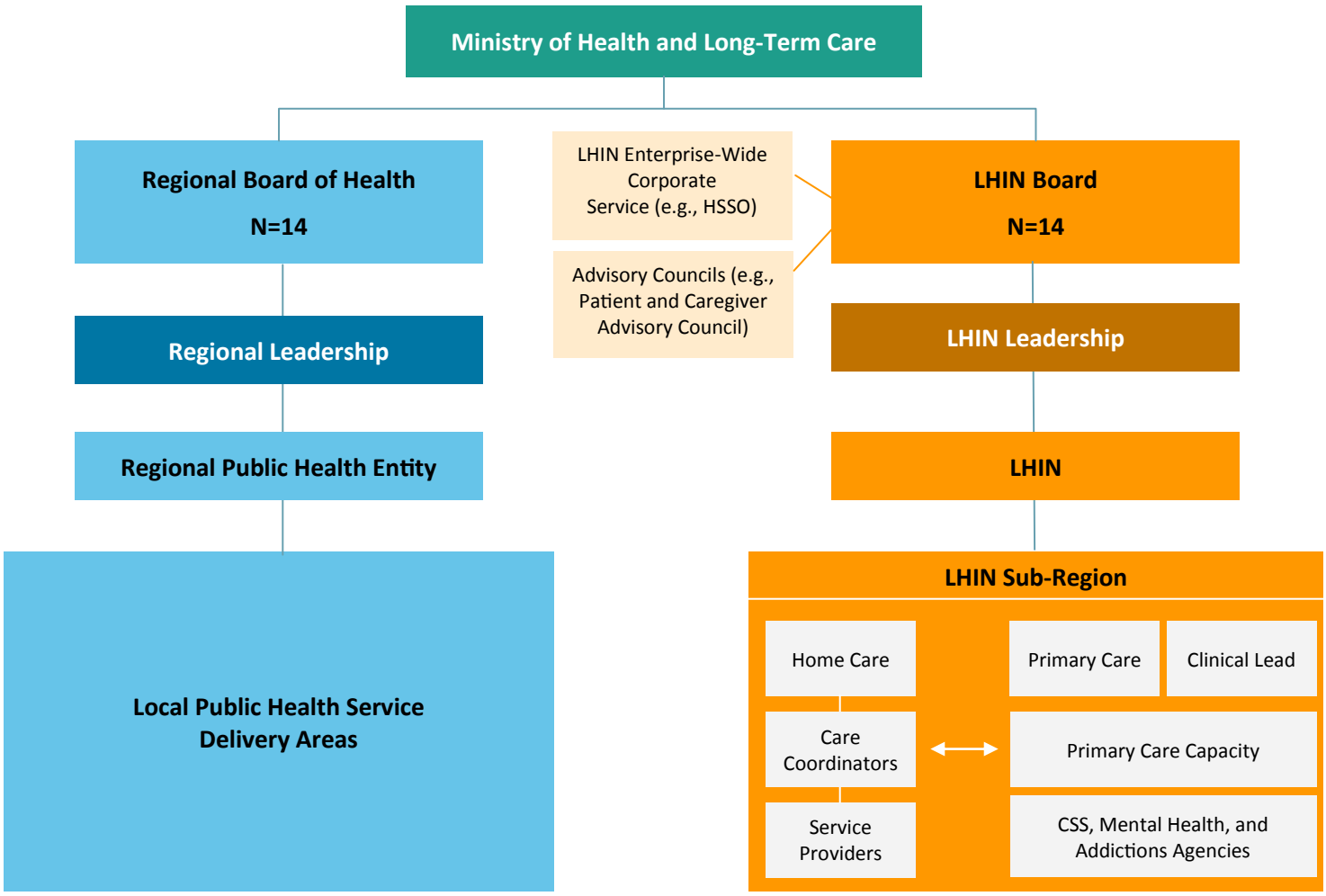
Category	Function	Regional	Local	Provincial	LHIN
Public Health Practice (Programs and Services)	**Planning**	• Annual service plan • Strategic plan • Health equity lens • Corporate planning • Resource allocation planning	• Operational plans • Implementation plans • Provide context, data, and costing inputs • Local perspective and considerations (including First Nations)	• Review and approve annual service plan • Mandate letters • Program and policy planning	• Regional input and alignment with other health services • Service planning
	Delivery	• Management of after-hours on-call system	• Implementation • Ongoing program and service delivery • Coordination of after-hours on-call system	• Provincial program implementation and oversight	• Coordinated delivery / optimization of services
	Coordination	• Work with leadership at all levels of government, throughout the public health organization, the 13 other regional MOHs, the LHIN, and across sectors • Functional integration and consistency with LHIN business plan	• Work with local leadership to execute public health services and delivery • Participation on local committees and in community meetings	• Chair provincial public health table with MOHs • Provide guidance and leadership on public health topics and issues	• Functional integration and consistency with public health business plan

Table 1: Public Health Responsibilities and Functions (continued)

Category	Function	Regional	Local	Provincial	LHIN
Strategic Engagement	**Health System**	• LHIN (cross-linkages) • Health regulatory colleges	• LHIN sub-regions (when applicable) • Primary care • Hospitals	• Public health accountability and reporting to province • Receive information/ direction/ mandates from province (when applicable)	• Information sharing • Inform planning at a LHIN and LHIN sub-region level • Consultation through LHIN committees (when applicable) • Routine collaboration between public health and LHIN leadership (at both regional and local/ LHIN sub-region levels) • Other health service providers e.g., hospitals, Community Health Centres and Family Health Teams
	Public Health System	• Chief Medical Officer of Health • Other MOHs and CNOs • Academic / research institutions • Public Health Ontario • Associations	• Regional public health • Other public health units • Academic / research institutions	• Regional MOHs (e.g., standing meetings)	• MOHs
	Governments	• Province	• Municipality	• Federal government • First Nations • Agencies	• Province
	Cross-Sector	• Leadership from all social deter-minants of health disciplines (e.g., environment, transportation, housing, children and youth services)	• Local community and social services • Education, transportation, housing, settlement, etc.	• Health in all policies approach	• Social services • Community and home care • Family services • Community and recreation services

Figure 2: Proposed End State — Public Health within an Integrated Health System

The Expert Panel recommends that Ontario establish 14 regional public health entities .



The proposed structure of 14 regional public health entities will allow public health to:

Centralize administrative and specialized public health functions at the regional level

Be Accountable for public health standards set provincially

Collaborate with LHINs and other partners to plan and tailor health services in their regions

Establish local public health service delivery areas within regions, based on population and geography

Locate public health programs and services in local communities to maintain local engagement

The Expert Panel believes that having fewer regional public health entities will result in more frequent and effective interactions among regional medical officers of health and between regional medical officers of health and the province. At the same time, maintaining local public health delivery areas will ensure a strong local presence and effective relationships with municipalities.

For the proposed structure to succeed, it will be essential to establish strong working relationships, develop effective communication mechanisms and undertake shared projects and activities:

- within each regional public health entity
- between the regional public health entity and the municipalities in the region
- between the regional public health entity and the LHIN
- among the regional public health entities
- with the province.

2. Optimal Geographic Boundaries

Background

Ontario's existing 36 public health units are organized based mainly on municipal boundaries. The current configuration of health unit areas make it difficult to operate as a unified system with LHINs and other health system partners following LHIN boundaries.

The current organization of public health units has a negative impact on the capacity of smaller health units. Boundary changes are necessary to enhance public health capacity and effectiveness, and to help public health be more integrated with the rest of the health system. At the same time, it is important to maintain the strengths associated with public health's close relationship with municipalities.

Criteria

To determine the number of regional public health entities and their recommended geographic boundaries, the Expert Panel used the following criteria:

- create regional public health entities that would serve a large enough population to achieve critical mass to be able to operate efficiently and effectively and attract skilled staff
- support effective linkages with LHINs by aligning with LHIN boundaries
- respect municipal boundaries and relationships as much as possible
- whenever feasible, move existing health units in their entirety into the same regional health entity catchment area
- when it is not feasible to move entire existing health units together, divide health units based on municipal boundaries

Proposed Geographic Boundaries

The Expert Panel recommends that Ontario establish catchment areas for the 14 regional public health entities that are consistent with LHIN boundaries and respect existing municipal boundaries.

Figure 3: Proposed Boundaries Mapped Against Current Public Health Unit Boundaries

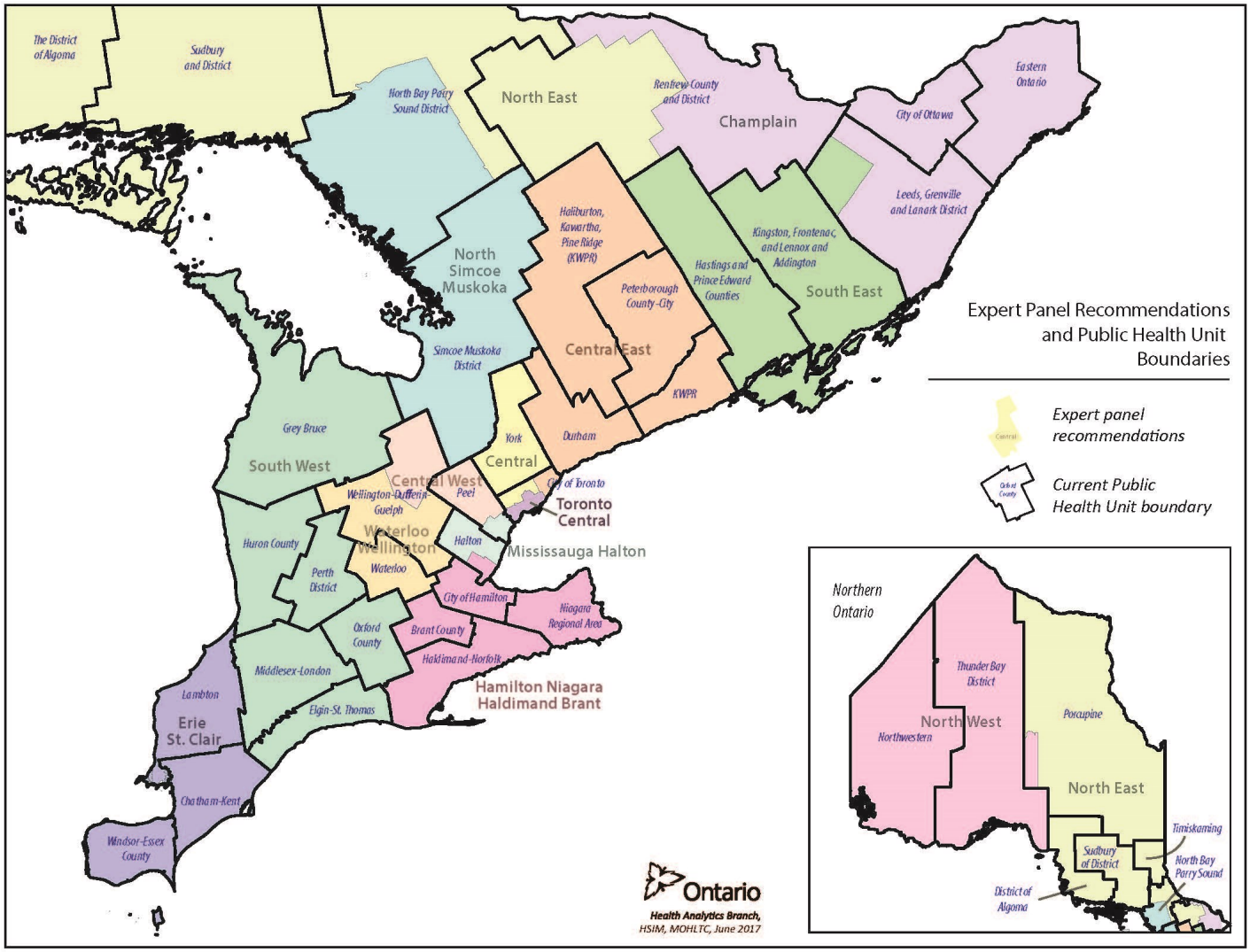
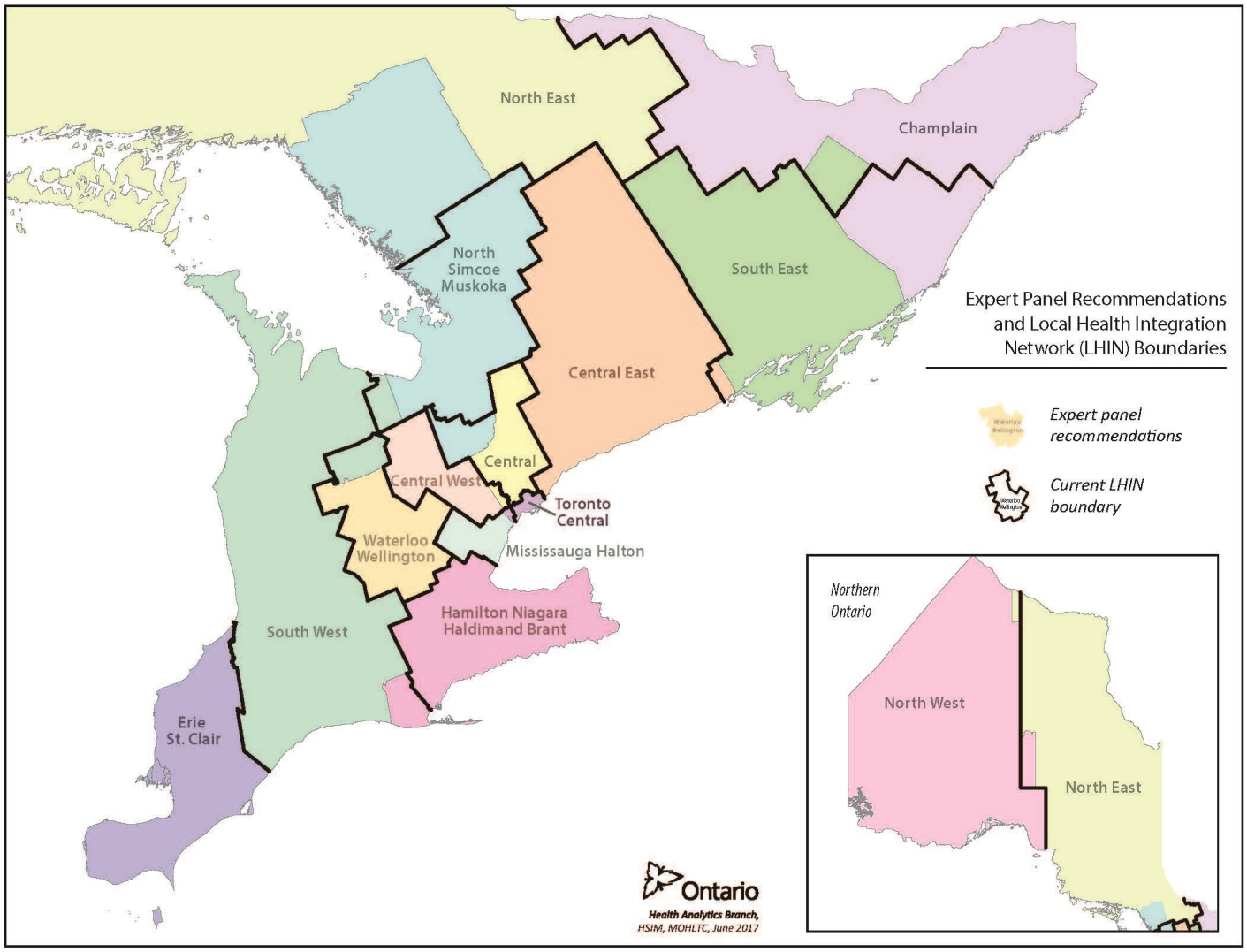


Figure 4: Proposed Boundaries Mapped Against Current LHIN Boundaries



With the recommended boundaries, the populations served by the regional public health agencies would range from about 0.25 million to 1.8 million.

3. Optimal Leadership Structure

Background

The proposed regional public health entities will be complex multi-million dollar organizations with staff spread across multiple local sites. The leadership structure and the quality and competence of public health leaders will be critical to the success of the proposed organizational structure.

Public health units of the future will require leaders with broad-based skills that encompass strong demonstrated organizational and business management, relationship management, strategic planning and performance management skills as well as extensive public health experience.

The literature indicates that, for large health organizations, a single leader as opposed to a joint leadership model is more effective – when the leader has the right mix of experience and competencies. It also indicates that it is essential for that single leader to have both content expertise – in this case, public health knowledge – and management expertise.

Criteria

The Expert Panel's goal was to propose a leadership structure that would:

- Reflect best practices in the leadership of health organizations
- Reinforce and capitalize on strong public health/clinical skills
- Be able to support geographically distributed programs and staff
- Maintain strong expertise and skills at both the regional and local levels
- Capture all the roles and functions of current leaders
- Operate efficiently and effectively

Proposed Leadership Structure

Figure 5: Proposed Leadership Considerations

Regional Public Health Entity	
CEO	• Direct report to the Board of Health
Regional Medical Officer of Health	• Public health physician • Ability to report directly to the Board of Health on matters of public health and safety
Senior Public Health Leadership	• E.g., nursing (Chief Nursing Officer), associate medical officers of health, other content-specific leaders, corporate management (e.g., Chief Administrative Officer, Chief Operating Officer, Chief Information Officer, etc.)

Local Public Health Service Delivery Areas	
Local Medical Officer of Health	• Local public health physician • Report to regional Medical Officer of Health • Number—variable, e.g., based on population and geography
Local Public Health Program and Service Management	• E.g., nursing leadership, public health inspection management, etc. • Program managers • Multi-disciplinary teams

Regional Public Health Entity—Functional Departments

Corporate Services

- Funding & Accountability
- Human Resource Management
- Administrative Services
- Communications
- Information Technology

Public Health Practice (Programs and Services)

- Planning
- Delivery
- Coordination

Performance, Quality, and Analytics

- Surveillance and Monitoring
- Information Management
- Performance and Evaluation
- Research

Strategic Engagement

- Strategic Planning and Integration

Engagement:

- LHINs
- Health System
- Public Health System
- Governments
- Cross-Sector
- Community

4. An Optimal Approach to Governance

Background

All public health units are governed by a board of health. While the *Health Protection and Promotion Act (HPPA)* requires that all health units be governed by a board of health, the legislation does not set out a specific model of governance. Currently, public health governance models vary considerably across the province (i.e., some are autonomous boards, others are part of the structure of the municipal or regional government). While variation is not necessarily a problem in and of itself, it can result in inequities.

A number of reviews and reports have highlighted challenges with current public health governance, including the wide variety of governance models, gaps in skills on some boards and challenges with both provincial and municipal appointments to the boards. Over time, this may affect public health's ability to work effectively with the LHIN boards, which have a consistent governance model.

Although the HPPA sets out a process for appointing members of the boards of health that reflect both the municipal and provincial responsibility for public health (i.e., some members are appointed by the municipalities and some by the Ministry of Health and Long-Term Care through orders in council), there are no specific requirements related to the skills or experience that board members should have. As a result, there are significant skill gaps on some boards of health.

In terms of appointing board members, boards of health experience high vacancy rates among provincial appointees. Vacant seats can make it difficult for boards to optimally function. Furthermore, there can be gaps in appointment of elected municipal officials as a result of elections.

Criteria

The Expert Panel's goal was to recommend a public health governance structure that would:

- Ensure greater consistency in governance of public health
- Maintain public health autonomy and independence
- Maintain a strong municipal voice and representation
- Relate effectively to LHIN boards
- Reflect best practices in governance
- Address issues related to board vacancies
- Reinforce the roles and responsibilities of board members
- Ensure accountability and effective oversight

Proposed Governance Model

The Expert Panel recommends that Ontario establish a consistent governance structure for regional boards of health in Ontario with the following features:

	Board of Health Governance Characteristics
Governance	Free-standing autonomous board
	Consideration for appropriate secretariat support for board operations
Appointees	Municipal members (formula for representation to be defined in Regulations – e.g., by population, by upper tier etc.)
	Provincial appointees (including OIC appointments for specific position(s) such as board chair, vice chair, finance – to be nominated by the board)
	Citizen members (municipal appointees)
	Other representatives (e.g., education, LHIN, social sector, etc.)
Size	Varied: 12-15 members
Indigenous Representation	Meaningful opportunity for representation to ensure Indigenous partners have an active voice (based on population demographics)
Francophone Representation	Representation for the Francophone community (based on population demographics)
Diversity and Inclusion	Boards should reflect the communities which they serve, including but not limited to inclusion of: • Gender and sexual orientation • Visible minorities • Lived experience • Diverse ages
Qualifications	Skills-based
	Experience
Appointment Process	Flexibility for combination of provincial and local appointments (for non-specific positions) to address varying capacity across province
Board Compensation	Apply consistent approach for board member compensation
	Consideration of equitable compensation across public boards (e.g., public health, LHINs, agencies, etc.)
Committees	Establishment of standing committees (e.g., good governance and nomination committees, finance and audit, HR, etc.) to be defined in Regulations
	Committees are responsive to community needs
Succession Planning and Implementation	Staggered transition/appointments for new board structures
	Tenure
	Targeted recruitment

Considerations for Proposed Regional Board of Health

The regional board of health should be small enough to be efficient but large enough to support strong standing committees (i.e., governance, finance/audit, quality). The literature shows that doing certain work in standing committees is more functional and effective than doing it as an entire board.

The goal is to attract highly skilled and competent individuals who will speak for the interests of public health to serve on the board. It is critical that:

- the board have the right mix of skills, competencies, and diverse perspectives
- all board members understand and accept their role
- the boards have a process to manage attendance and to remove people from the board who are not fulfilling their responsibilities.

Furthermore, when recruiting members to the regional board of health, the governance committee should look specifically for people who want to work on a team and share a commitment to improving the health of the population.

Because of past challenges with timing Order in Council (OIC) appointments, the Expert Panel recommends a smaller number of provincial appointees; however, to ensure accountability to the provincial government, those seats should be key positions (e.g., chair, vice-chair, chair of the finance/ audit committee). The governance committee should recommend the candidates for OIC appointments, and those candidates should be able to include elected municipal officials.

To address continuity of service challenges with municipal officials, the Expert Panel recommends that when an elected official appointed to the board of health is not re-elected, he or she continue to serve on the board of health until the municipality makes a new appointment. Municipalities should also be encouraged to appoint a mix of elected officials and members of the community to ensure diversity and continuity, and to reduce the challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health.

IV. Implementation Considerations

The Expert Panel recognizes that if implemented, the recommendations will mean large organizational change for the sector. The Expert Panel was not asked to make specific recommendations about implementation, however, they have identified elements that should be considered in developing an implementation plan.

Legislation

The proposed health unit boundary changes and implementation of regional public health entities will have implications for public health and other related legislation. A detailed analysis will be required to determine how much of the proposed structure and governance model will require legislative amendments.

Funding

While public health funding was not within the scope of the Expert Panel's mandate, they have flagged that the current public health funding model may be a barrier to implementing the proposed structure.

Under the HPPA, municipalities have legislated authority for public health and provincial funding for public health is discretionary. Public health units receive an annual grant from the Ministry of Health and Long-Term Care– and the amount the province contributes has varied over the years.

The Ministry of Health and Long-Term Care provides funding for:

- up to 75% of ministry approved allocations

- 100% of certain programs, such as Healthy Smiles Ontario, the Infectious Disease Control Initiative, nursing initiatives and the Smoke-Free Ontario Strategy

- 100% of services in unorganized territories (i.e., areas without municipal organizations)

Municipalities provide funding for:

- at least 25% of ministry approved allocations (many provide more)

- other public health programs and services– beyond those provincially mandated

The ministry's contribution recognizes the challenges many municipalities – particularly smaller ones – face in funding public health services.

The proposed shift from local health units, whose costs are shared by local municipalities, to a regional public health entity will likely raise questions about the funding obligations of each municipality in the region.

As part of implementation planning, the ministry will need to re-visit funding constructs in order to implement the recommendations.

Transition Planning/Change Management

The proposed structure will have a significant impact on the 36 existing health units and boards of health. Although the transition may be more straightforward for the public health units that move in their entirety into a regional health entity than for those divided across two or more regional agencies, all will require assistance with change management. Given the complex nature of municipal government (i.e., upper tier, lower tier, independent), it may be helpful to engage consultants with a strong track record in change management to help with transition planning.

The transition from the current 36 local boards of health to a smaller number of regional boards of health will have particular implications for municipalities and municipal members. It is important that the new board structure recognize and protect municipal interests, while recognizing the potential for competition for municipal seats.

To ensure greater consistency across the province, it may be helpful to work with the Association of Ontario Municipalities to develop the criteria for municipal representation on the new regional boards.

Effective Linkages with LHINs and the Health System

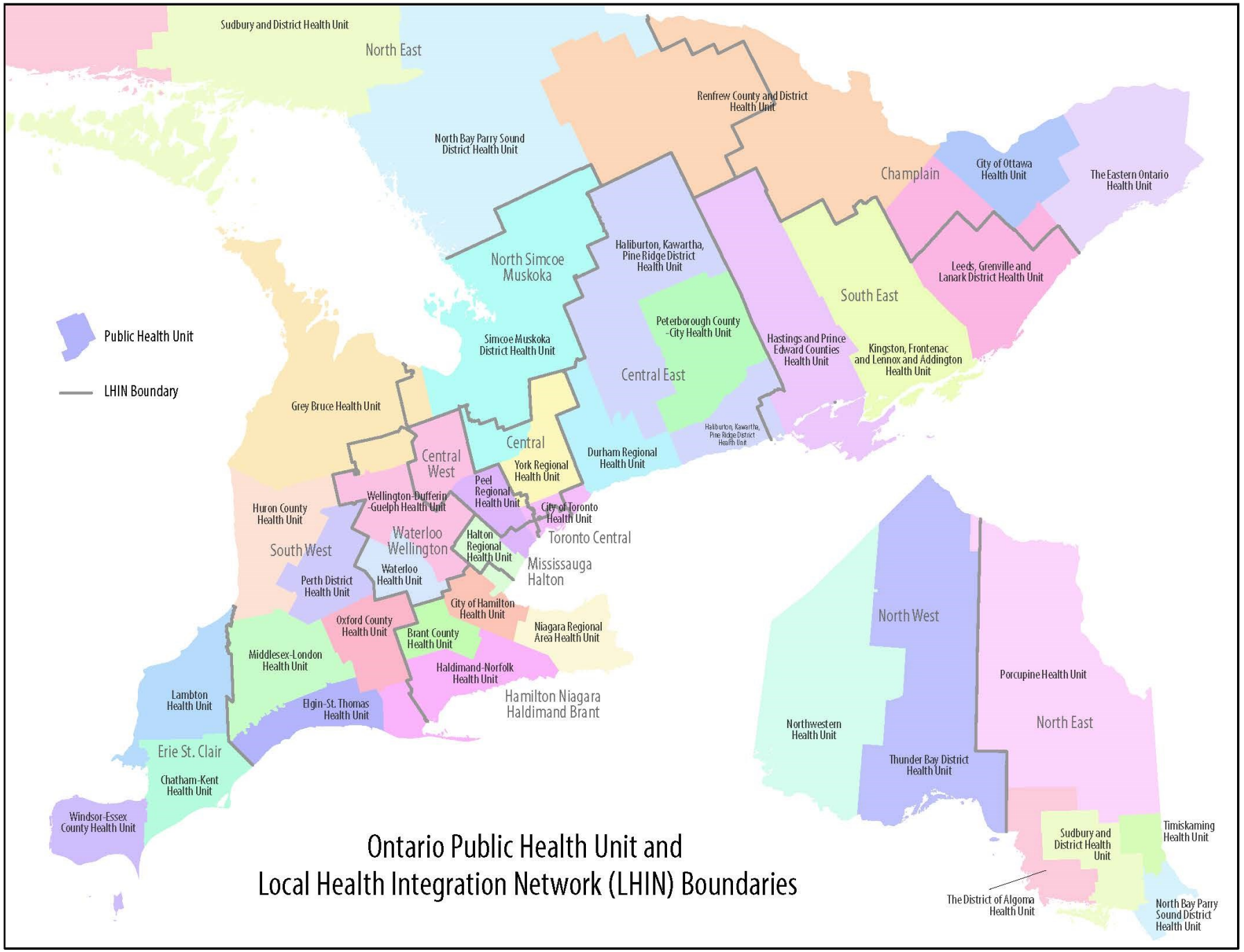
During its deliberations, the Expert Panel identified a number of strategies that, in its view, could enhance linkages with LHINs, such as:

- potential cross appointments (or ex-officio) to the regional Board of Health and the LHIN board
- regular meetings between the Regional Board of Health chair and the LHIN board chair
- regular meetings between public health and LHIN leadership as well as shared projects and activities.

Structured relationships will also be necessary with all health system partners including primary care, hospitals, and home and community care to develop stronger linkages between disease prevention, health promotion and care, maximize system efficiencies and support a fully integrated health system.

Appendix

Appendix A: Current LHIN and PHU Boundaries



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July 20, 2017

Minister's Expert Panel Report on Public Health Released

Today the Minister of Health and Long-Term Care, the Honourable Dr. Eric Hoskins, released the Report of the Minister's Expert Panel on Public Health entitled "Public Health within an Integrated Health System".

The MOHLTC Bulletin, that accompanied the Expert Panel Report, said that the report recommends strengthening public health's relationships with primary care, community care and other partners, so that all health care services are more responsive to community needs. The report has been released without provincial comments or indication as to whether the report's recommendations will be accepted, however, the bulletin states, "that the Ministry is now reviewing the recommendations provided by the panel, and exploring options for further engagement in order to achieve our government's plan to deliver a stronger and more integrated health care system for the people of Ontario".

The key recommendation proposes an end state for Public Health within an Integrated Health System that would have Ontario establish 14 regional public health entities—that are consistent with the LHIN boundaries except for a new Toronto Central LHIN/Regional Public Health entity.

Other Expert Panel Report recommendations include:

- Proposed Leadership Structure consisting of:
    - Regional public health entity with a CEO that reports to the Board and a Regional Medical Officer of Health (MOH) who reports to the Board on matters of public health and safety.
        - Under each regional entity would be a Local Public Health Service Delivery Area with a Local Medical Officer of Health (reporting to the Regional MOH), local public health programs and services.
- Proposed Board of Health Governance would be freestanding autonomous boards:
    - appointees would be municipal members (with formula defined by regulation), provincial appointees, citizen members (municipal appointees), and other representatives (e.g. education, LHIN, social sector, etc.)
    - varied member numbers of 12 - 15
    - diversity and inclusion – board should reflect the communities they serve

    - qualifications – skills-based and experience
    - Board to have the right mix of skills, competencies, and diverse populations
    - "Municipalities should also be encouraged to appoint a mix of elected officials and members of the community to ensure diversity and continuity and to reduce challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health".

The Expert Panel was not asked to make specific recommendations on implementation; however, they did identify elements that should be considered in developing an implementation plan. These elements include:

- Legislation
- Funding – it was noted that "as part of implementation planning the Ministry will need to revisit funding constructs in order to implement the recommendations"
- Transition planning/change management- with wording that says:
    - "The transition from the current 36 local boards of health to a smaller number of regional boards of health will have particular implications for municipalities and municipal members. It is important that the new board structure recognizes and protects municipal interests, while recognizing the potential for competition for municipal seats."
    - "To ensure greater consistency across the province, it may be helpful to work with the Association of Ontario Municipalities to develop the criteria for municipal representation on the new regional boards."
- Effective Linkages with LHINs and the Health System.

Although engagement details are pending, we do understand that there will likely be a reasonable amount of time for review and discussion. AMO will be convening its Health Task Force in early September to fully consider this report and assist the development of the AMO Board's response at the September Board meeting. At the upcoming AMO Conference, there will be a concurrent session on the future of public health on Tuesday, August 15th.

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alPHa Summary
Public Health within an Integrated Health System:
Report of the Minister's Expert Panel on Public Health

On July 20 2017, the Minister of Health and Long-Term Care released the Expert Panel on Public Health report, Public Health within an Integrated Health System. This report is the product of deliberations that began in January of this year as part of the Government's efforts to increase integration of public health and health care services to achieve the Patients First vision of a transformed and integrated health system that improves access to care and actively promotes health and reduces health disparities.

The first step in this process was the passage of the Patients First Act (alPHa Summary here), which formalized linkages between LHINs and public health units.

The establishment of the Expert Panel was then announced by the Minister on January 18 2017, with the mandate of providing advice on structural and organizational factors required to "improve the integration of population and public health into the health system, deepen the partnerships between local boards of health and LHINs, and improve public health capacity and delivery within a transformed and integrated health system". alPHa provided key messages to the Panel in the early part of its mandate (attached).

The proposed structural, organizational, and governance changes for Ontario's public health sector contained in the report appear to be significant and their implications could be far-reaching. **alPHa strongly encourages its members to read the report carefully and in full** to understand the proposals and the effects that they could have. It is included in this package for your convenience.

It is important to note however that these are recommendations made by the Panel and not decisions that have been made by Government. alPHa has already started work on developing processes to gather feedback from our members to ensure that concerns are articulated and that a complete and thoughtful analysis of the proposals is undertaken during the promised consultation (no information has been made available about format or timing of this).

alPHa is pleased to provide its members with this summary of the Expert Panel report and will keep members informed of new developments and opportunities for input.

Included following the report summary are the following materials:

- alPHa response to the release of the Report, August 1 2017
- alPHa Submission to the Expert Panel, March 15 2017
- The full Expert Panel Report.

We hope you find this information useful.

PUBLIC HEALTH WITHIN AN INTEGRATED HEALTH SYSTEM: REPORT OF THE MINISTER'S EXPERT PANEL ON PUBLIC HEALTH

I. ABOUT THE EXPERT PANEL

The Expert Panel was asked to consider the optimal organizational structure for public health in Ontario to:

- ensure accountability, transparency and quality of population and public health programs and services
- improve capacity and equity in public health units across Ontario
- support integration with the broader health system and the Local Health Integration Networks (LHINs) – the organizations responsible for planning health services
- leverage public health's expertise and leadership in population health-based planning, decision-making and resource allocation, as well as in addressing health equity and the social determinants of health.

Desired Outcome: A Strong Public Health Sector within an Integrated Health System

- Ontario will benefit from a highly skilled and highly visible public health sector at the community level
- Public health will maintain relationships with municipal governments and other local organizations to positively influence the social determinants of health and healthy environments.
- Public Health work will be overseen by boards that reflect the perspectives and diversity of local communities and municipalities. The work will be supported by province-wide efforts to collect and analyze data on health status
- Public health will continue to focus on identifying at-risk populations and Indigenous communities will have an active voice.
- Public health will use Its understanding of local health needs to help identify health system priorities and shape health policy and services.

Principles Guiding the Panel's Work

- The strong independent public health voice and core public health functions will be preserved and leveraged to help reorient the health system.
- The local strengths of public health – including relationships with municipal and other community partners – will be maintained and enhanced to support integrated planning and service delivery.
- Ontario's public health sector has a responsibility to protect and promote Indigenous health and to ensure Indigenous partners have an active voice.
- Being part of an integrated health system will create opportunities to enhance capacity and improve efficiency– some services may be delivered more effectively by or through other parts of the system.
- Structural changes will be based on a clear understanding of the public health sector's role in an integrated health system.

- The organization and distribution of public health expertise, resources and services will reflect local needs and priorities.
- Boundary changes will be necessary to align public health with LHINs, and to support systems planning.

II THE OPPORTUNITY

Public Health is now seen as part of an integrated health system whose component parts will work together to enhance Ontarians' health and well-being at all ages and stages of life.

A stronger relationship between public health and LHINs is expected to integrate a population health approach into local planning and service delivery, so that health services are responsive to population health needs and contribute to promoting health and achieving health equity.

Preparing Public Health for its role in an Integrated Health System

Three public health transformation initiatives that were undertaken in parallel with Patients First are briefly outlined:

- The modernization of the Ontario public health standards
- The Public Health Work Stream, which is a collaboration between public health and LHINs to provide guidance on formal engagement parameters. A report from this group is expected in the early part of the fall.
- The Expert Panel on Public Health

The Impact of Public Health within an Integrated System

- Public health is expected to continue using its relationships outside the health system (municipal governments, community organizations, schools, etc.) to protect and promote health and apply them to broker relationships between health care, social services, municipal governments, and other sectors to create healthier communities.
- Public health is expected to bring a greater focus on the social determinants of health and health equity by embedding a population health approach into health service planning and delivery
- Public health can identify high risk communities and assist in developing comprehensive targeted health interventions to prevent chronic diseases by addressing identifiable risk factors
- Public health can help the health system develop care pathways for patients that incorporate social factors (e.g. food insecurity, precarious housing) that affect health outcomes.
- Public health will enjoy greater public recognition and the importance of investing in health protection and promotion across the life course, and its role in the sustainability of the universal health care system will be more fully understood.

III A STRONG PUBLIC HEALTH SYSTEM IN AN INTEGRATED SYSTEM

The Expert Panel identifies criteria for an optimal structure and governance model for public health to align with the vision of Patients First as well as support more efficient and effective operations of public health within its own mandate. It also agrees with the findings of previous reviews that have concluded that Ontario's public health system would be stronger if there were fewer health units with greater capacity, a consistent governance model and better connections to other parts of the health system. The Panel recommends a new model for public health that would:

- Maintain a strong independent public health sector within an integrated health system
- Relate effectively with the LHINs to influence health system planning
- Enhance public health's strong local presence and effective relationships with municipalities
- Ensure Ontarians continue to have access to public health programs and services in their communities
- Create public health organizations large enough to achieve critical mass and retain public health personnel and resources to efficiently operate services in all parts of the province
- Allow for clear definition of public health functions and roles at the provincial, regional and local levels, to make more effective use of public health expertise and resources
- Enhance public health practice and ensure more consistent implementation of the public health standards across the province
- Foster collaboration/coordination within the public health sector and with the rest of the health system.

A more detailed description of existing public health responsibilities and functions at provincial, regional and local levels is provided in a set of tables and figures on pages 11-15. These are presented with suggestions that they could be redistributed following the implementation of the "proposed end-state", which is presented as an organizational chart on page 16.

Optimal Geographic Boundaries

The Expert Panel has proposed geographic boundaries 14 regions that ensure critical mass by creating larger regional public health entities while supporting effective linkages with LHINs and respecting municipal boundaries and relationships as much as possible. They are therefore not completely aligned with existing LHIN or PHU boundaries. They are mapped against current PHU and LHIN boundaries on pages 18 and 19.

Proposed regions are largely amalgamations of existing Public Health Units, there are exceptions. Parts of the existing catchment areas of Halton, Wellington-Dufferin-Guelph, Toronto, Leeds-Grenville-Lanark, Renfrew, North Bay Parry Sound and Porcupine would be in different regions.

Proposed Model / Leadership Structure

14 REGIONAL BOARDS OF HEALTH / PUBLIC HEALTH ENTITIES, each with a CEO who reports to the Board of Health and a Regional Medical Officer of Health, who may report to Board of Health on matters of public health and safety. Senior public health leadership such as the Chief Nursing Officer, AMOHs, CAOs, CIOs etc. would also be housed here.

LOCAL PUBLIC HEALTH SERVICE DELIVERY AREAS (number TBD), subdivisions of the Regional Entities**,** each with a local MOH who reports to the Regional MOH. Local Program and Service Management staff would be hosed here.

An Optimal Approach to Governance

Following an outline of the current challenges inherent in the current system of variable models, gaps in skills and different appointment processes for Ontario's boards of health, the Expert panel recommends a governance structure that would ensure consistency, maintain autonomy and independence, and maintain a strong municipal voice and representation and ensure the effective performance of the core functions of board governance. A proposed model is presented in a table on page 23.

Key characteristics include autonomy, inclusivity, skills and experience as qualifications and stronger links to the Province and municipalities via their respective appointees.

IV IMPLEMENTATION AND CONSIDERATIONS

The Expert Panel does not make recommendations for implementation, but briefly outlines the required considerations:

- **Legislation**: a detailed analysis will be required to determine how much of the proposed structure and governance model will require legislative amendments.
- **Funding**: the current public health funding model may be a barrier to implementing the proposed structure. The ministry will need to re-visit funding constructs in order to implement the recommendations.
- **Transition Planning/Change Management:** all of the existing 36 public health units will require assistance with change management and the Ministry will need to recognize the complex nature of municipal government and take measures to protect municipal interests. Engaging with consultants to assist with transition and working with the Association of Ontario Municipalities to develop the criteria for municipal representation on the new regional boards.
- **Effective Linkages with LHINs and the Health System:** strategies to enhance linkages could include LHIN / Regional BOH cross appointments, regular meetings between the Chairs of each, and regular meetings between public health and LHIN leadership as well as shared projects and activities.

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

August 2 2017

Dear Minister Hoskins,

Re: Public Health within an Integrated Health System: Report of the Minister's Expert Panel on Public Health

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 thank you for sharing the Expert Panel on Public Health Report with us so that we can review the recommendations and begin to assess their potential implications.

We understand that the report provides a framework for the government to consider for changes to Ontario's public health system to enhance its effectiveness within its own mandate while augmenting its contributions within the transformed health system as envisioned in the Patients First Strategy.

We remain strongly supportive of bringing our leadership and expertise in health promotion and disease prevention into other areas of the broader health system to ensure a stronger focus on the causes of poor health.

We also remain committed to ensuring that Ontario continues to benefit from a robust, locally relevant and collaborative public health system that maintains its essential relationships with non-health system sectors that have such an important influence on health outcomes.

A careful and considerate analysis of the governance, organizational and structural changes proposed by the Expert Panel will be required to determine their suitability for achieving the stated desired outcome of a strong public health sector within an integrated health system.

We appreciate that no decisions have yet been made and we are already developing processes to gather feedback from our members on the proposals so that we can provide fully-informed and comprehensive advice during the promised consultation process.

We look forward to working with you to ensure that promoting health and reducing health disparities remain central to the Patients First vision.

Yours sincerely,

Carmen McGregor
alPHa President

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

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March 15, 2017

Public Health Expert Panel Members
c/o
Dr. David Williams, Chair
Roselle Martino, Executive Sponsor

Dear Panel Members,

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

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

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

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

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

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

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

1. PROVINCIAL RELATIONSHIP

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

2. MUNICIPAL RELATIONSHIP

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

3. NUMBERS OF BOARDS OF HEALTH

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

4. ALIGNING LOCALLY TO PROMOTE HEALTH

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

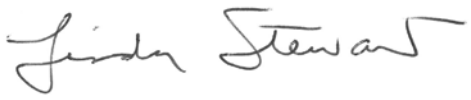
5. LOCAL PUBLIC HEALTH CAPACITY CONSIDERATIONS

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

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

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

Yours sincerely,



Linda Stewart
Executive Director

Helene Leroux

From: Maria Cook <Maria.Cook@porcupinehu.on.ca>
Sent: August 31, 2017 3:30 PM
To: Carmen Kidd (Temiskaming); Lee Mason (Algoma); Rachel Quesnel; Nancy Jacko (nhjacko@icloud.com)
Cc: Gilles Chartrand; Don West
Subject: Request to NE BOH Chairs for Feedback on Public Health Expert Panel Report

Importance: High

Please note subject line in previous email was incorrect.

Dear Board of Health Chair,

As you are well aware, the Minister of Health and Long-Term Care has released the report of the Expert Panel on Public Health, *Public Health within an Integrated Health System*, which makes recommendations on how to increase public health's integration within the rest of Ontario's health care system. (Click here to view the report.) The Ministry has invited responses to the recommendations in the report by October 31, 2017. They are also working on a process to engage with stakeholders in the public health sector in September.

The alPHa Board of Directors will be meeting on September 29 to discuss alPHa's response. As your regional board of health representative on the alPHa Board, I would like to get your feedback as BOH Chair on the questions below. Please email your response to me at girard_chartrand@hotmail.com with a copy to maria.cook@porcupinehu.on.ca by **Monday, September 18** so that there is enough time to collate and channel feedback back to the alPHa Board before its meeting on the 29th.

QUESTIONS FOR FEEDBACK:

1. **What questions do you have about the Expert Panel report and its recommendations?**
2. **What in the report and its recommendations is helpful for Ontario's public health sector? Why?**
3. **What concerns you in the report and its recommendations? Why?**
4. **What do you believe is absolutely essential for alPHa to be communicating to the government regarding the report of the Expert Panel on Public Health? Why?**

Thank you for your assistance on this important engagement.

Maria Cook

for

Gilles Chartrand
Board of Health Chair, Porcupine Health Unit
girard_chartrand@hotmail.com

Maria Cook
Executive Assistant to the Chief Administrative Officer, and
Secretary to the Board of Health

Porcupine Health Unit
Postal Bag 2012, 169 Pine St. So.
Timmins, ON P4N 8B7
Phone: 705-267-1181, Ext. 2361
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maria.cook@porcupinehu.on.ca

Helene Leroux

From: Sims, Kevin (MOHLTC) <Kevin.Sims@ontario.ca> on behalf of Martino, Roselle (MOHLTC) <Roselle.Martino@ontario.ca>
Sent: August 31, 2017 5:02 PM
To: PH Transformation (MOHLTC)
Subject: Invitation: An Information Session on the Report of the Minister's Expert Panel on Public Health
Attachments: Minister Letter July 20 2017.pdf

Public Health Within an Integrated Health System:
Report of the Minister's Expert Panel on Public Health

Dear Colleagues,

The Ministry of Health and Long Term Care ("the ministry") recently released the Report of the Minister's Expert Panel on Public Health to the public and stakeholders. The Expert Panel provided advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system.

The ministry invited stakeholders to submit feedback and comments to PHTransformation@ontario.ca. This account will be active until October 31st, 2017.

At this time, the ministry would like to invite all Board of Health Chairs and CEOs **(who do not share the role of Medical Officer of Health)**, to an in-person information session on the report.

A meeting has been scheduled for:

Date: September 29, 2017

Time: 9:30am – 11:00am

Location: DoubleTree by Hilton Hotel Toronto Downtown

Address: 108 Chestnut Street, Toronto, Ontario, M5G1R3, Canada

Please confirm your attendance by emailing PHTransformation@ontario.ca. Your response is requested by **September 15, 2017, at 5:00pm**.

We look forward to meeting with you.

Roselle Martino,
Assistant Deputy Minister
Population and Public Health Division
Ministry of Health and Long-Term Care

From: Sims, Kevin (MOHLTC) [mailto:Kevin.Sims@ontario.ca] **On Behalf Of** Martino, Roselle (MOHLTC)
Sent: Thursday, August 31, 2017 5:26 PM
To: PH Transformation (MOHLTC) <PHTransformation@ontario.ca>
Subject: Invitation: An Information Session on the Report of the Minister's Expert Panel on Public Health

Public Health Within an Integrated Health System:

Report of the Minister's Expert Panel on Public Health

Dear Colleagues,

The Ministry of Health and Long Term Care ("the ministry") recently released the Report of the Minister's Expert Panel on Public Health to the public and stakeholders. The Expert Panel provided advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system.

The ministry invited stakeholders to submit feedback and comments to PHTransformation@ontario.ca. This account will be active until October 31st, 2017.

At this time, I would like to invite the Council of Ontario Medical Officers of Health (all Medical Officers of Health and Associate Medical Officers of Health) to an in-person information session on the report.

A meeting has been scheduled for:

Date: September 15, 2017

Time: 9:30am – 11:00am

Location: DoubleTree by Hilton Hotel Toronto Downtown

Address: 108 Chestnut Street, Toronto, Ontario, M5G1R3, Canada

Please confirm your attendance by emailing PHTransformation@ontario.ca. Your response is requested by **September 8, 2017, at 5:00pm**.

We look forward to meeting with you.

Roselle Martino,
Assistant Deputy Minister
Population and Public Health Division
Ministry of Health and Long-Term Care

Provincial panel recommends replacing 36 health units with 14 larger bureaucracies

By Jonathan Sher, Postmedia

Tuesday, September 12, 2017 1:03:17 EDT PM

Ontario has quietly proposed sweeping changes to public health units that could make them less nimble in responding to emergencies such as SARS, an expert and opposition health critic warn.

An expert panel convened by Ontario's Liberal government has recommended scrapping the province's 36 health units and replacing them with 14 much larger bureaucracies that replicate the geographic boundaries local health integration networks (LHINs).

In northeastern Ontario alone, that would mean replacing the North Bay Parry Sound District, Timiskaming, Sudbury and District, and Porcupine health units with a single entity to cover the region.

"(The proposals) are a leap of faith. (The panel) didn't provide any evidence," said Joseph Lyons, director of the local government program at Western University.

It's true that there could be better integration between public health and health services generally, Lyons said. It's also true some of Ontario's smallest health units have struggled because of a lack of resources, he said, but that is not a good reason to scrap the entire system.

"Smaller health units can be fixed without turning whole systems on their heads," he said this week.

The group released its report in the summer without much public notice but its recommendations alarm Progressive Conservative health critic Jeff Yurek. Giant health units "would delay a timely response," to health crisis, the Elgin-Middlesex-London MPP said Tuesday.

Lyons and Yurek highlighted a number of concerns about the proposals:

• While health units now have board members from the communities they serve, many communities would have to go without representatives on LHIN-sized health units.

• The expert panel assumes larger bureaucracies will be more effective and efficient but history has proven otherwise: The amalgamation of communities and hospitals in Ontario in the past did not produce savings and may have added to costs.

• Public health needs in downtown Sudbury are nothing like needs in rural Timiskaming, but a proposed, massive health unit for the region would have to manage both.

• Under the proposed changes, local medical officers of health would have to answer to a CEO, adding another level of bureaucracy.

The science behind public health is driven by evidence but the proposals of the expert panel lack that vigor, Lyons said. “These are pretty sweeping (changes). I’m not sure I’d be comfortable accepting the claims of the expert panel on face value,” he said.

After public health crisis with SARS and an outbreak of E.coli in Walkerton’s drinking water, some recommended that public health units have more autonomy, not less, Lyons said.

The proposal to the province would take us down the opposite path, Yurek said. “We will see centralization. If anything goes wrong, there will be less accountability and less local oversight,” he said.

Ontario now has 36 public health units, with the smallest serving only 34,246 people dispersed over a geographic area as large as France, and the largest serving 2,771,770 people within 630 square kilometres.

EXPERT PANEL CONSULTATION

MOTION:

THAT the Sudbury & District Board of Health receive for information the Medical Officer of Health's briefing note concerning the Expert Panel Report and consultation process; and

THAT the Board of Health authorize the Chair of the Board of Health to work with the Medical Officer of Health on a submission for the alPHa Board; and

THAT the Board of Health authorize the Chair of the Board of Health to work with the Medical Officer of Health on a draft submission for the Province of Ontario for the Board's approval at its October 2017 meeting.

The Board of Health members are asked to complete the 2017 Board self-evaluation questionnaire in BoardEffect (under the *Sudbury & District Board of Health* workroom – *Collaborate* – *Surveys*) by Tuesday, October 24, 2017.

Sudbury & District Health Unit
Board of Health Manual

Information

Category: Board of Health By-Laws

Section By-laws

Subject: By-law 04-88

Number: G-I-30

Approved By: Board of Health

Original Date June 23, 1988

Revised Date: ~~June 15, 2017~~September 21, 2017

Information

To Regulate the Proceedings of the Board of Health

The Board of Health for the Sudbury & District Health Unit enacts as follows:

Interpretation

1. In this By-law:

   a) "Act" means the *Health Protection and Promotion Act*. S.O. Ontario, Chapter 10 as amended;

   b) "Board" means the Board of Health for the Sudbury & District Health Unit

   c) "Chair" means the person presiding at the meeting of the Board;

   d) "Chair of the Board" means the chair elected under the Act, which reads:

   At the first meeting of a board of health in each year, the members of the board shall elect one of the members to be chair and one to be vice-chair of the board for the year.

   g) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

   h) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

i) “Council” means the Council of any constituent municipality;

j) “Meeting” means a meeting of the Board;

k) “Member” means a member of the Board;

l) “Quorum” means a majority of the members of the Board who are present at a Board meeting in person;

m) “Secretary” means the Secretary of the Board of Health.

n) "Absences" means a Board member who is not present at a Board meeting in person for the purpose of establishing quorum

General

As per section 49. (2) of the Health Protection and Promotion Act, the Board of Health for the Sudbury & District Health Unit shall have no fewer than three and no more than thirteen municipal members. R.S.O. 1990, c. H.7, s. 49 (2). In addition, the Lieutenant Governor in Council may appoint one or more persons as members of the board of health as long as the number of Lieutenant Governor in Council appointees are fewer in number that the municipal members of the board of health. R.S.O. 1990, c. H.7, s. 49 (3).~~The Board of Health for the Sudbury & District Health Unit shall consist of 13 members.~~

Where a vacancy occurs in a Board of Health by the death, disqualification, resignation or removal of a member, the person or body that appointed the member shall appoint a person forthwith to fill the vacancy for the remainder of the term of the member.

2. In all the proceedings at or taken by this Board, the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committee thereof.

3. Except as herein provided, the rules of order of the Parliament of Canada, Bourinot shall be followed for governing the proceedings of this Board and the conduct of its members.

4. A person who is not a member of the Board or who is not a member of the council shall not be allowed to address the Board except upon invitation of the Chair subject to written request to the Secretary at least two weeks prior to the scheduled meeting.

5. Persons who have not requested in writing to address the Board may address the Board provided two-thirds of the Board are in agreement.

6. No persons shall smoke in the health unit buildings or on health unit premises.

Convening a Regular Meeting

7. Regular monthly meetings shall be held at a date and time as determined by the Board which is normally the 3rd Thursday of the month at 1:30 p.m. with the exception of March, July, August and December when regular Board meetings are not scheduled.

It is expected that commitments to regularly scheduled Board meetings be honoured by the Board members.

The Board may, by resolution, alter the time, day or place of any meeting.

~~Subject to any conditions or limitations in the Health Protection and Promotion Act and/or the Municipal Act, a member who participates in a an open meeting through electronic means is deemed to not be present at the meeting including, , for purposes of establishing quorum; however, ifs quorum is established with those in attendance in person, members, full participating electronically have ation rights and full voting rights.~~

Board members are expected wherever possible to attend meetings in person. Subject to any conditions or limitations in the Health Protection and Promotion Act and/or the Municipal Act, a member who participates in a an open meeting through electronic means is deemed to ~~not~~ be absent (i.e. not present at the meeting for purposes of establishing quorum); however, if quorum is established with those in attendance in person, members participating electronically have full participation, including voting rights. ~~Electronic participation may be approved by the Board of Health Chair in special circumstances recognizing that someone participating electronically will not be counted for the purpose of establishing quorum as per the requirements set out in the Municipal Act.~~ Further, electronic participation shall not be permitted for a meeting which is closed to the public.

The electronic means will enable the member to hear and to be heard by the other meeting participants. Normal board of health meeting rules and procedures will apply with necessary modifications arising from electronic participation.

Convening a Special Board Meeting

8. A special meeting shall not be summoned for a time which conflicts with a regular meeting or a meeting previously called of (participating) council(s) or municipality(s).

A special meeting may be called by the Chair of the Board of Health.

The Secretary shall summon a special meeting upon receipt of a signed petition of the majority of Board members, constituting a quorum, for the purpose and at the time mentioned in the petition.

Notice of Meetings

9. The Secretary shall give notice of each regular and special meeting of the Board and of any Committee to the members thereof and to the heads of divisions concerned with such meeting.

The notice shall be accompanied by the agenda and any other matter, so far as is known, to be brought before such meeting.

The notice shall be provided to each member no later than one week prior to the day of the meeting.

Lack of receipt of the notice shall not affect the validity of holding the meeting or any action taken thereat.

The notice for calling a special meeting of the Board shall state the business to be considered at the special meeting and not business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

The public is made aware of regular board meetings or board committee meetings through the Sudbury & District Health Unit website as per the *Municipal Act*, 238 subsection 2.1

Preparation of the Agenda

10. The Secretary, in conjunction with the Medical Officer of Health/Chief Executive Officer, shall have prepared for the use of members at the regular meetings the agenda as follows:

- Call to Order
- Roll Call
- Declaration of Conflict of Interest
- Delegations/Presentation
- Consent agenda *which normally shall include*:
  - Minutes of Previous Meeting
  - Business Arising from Minutes
  - Report of Standing Committees
  - Report of the Medical Officer of Health/Chief Executive Officer
  - Correspondence
  - Items of Information
- New Business
- Addendum
- In-Camera
- Rise & Report
- Announcements/Enquiries
- Adjournment

11. For special meetings, the agenda shall be prepared when and as the Chair of the Board may direct or, in default of such direction, as provided in the last preceding section so far as is applicable.

12. The business of each meeting shall be taken up in the order in which it stands upon the agenda, unless otherwise decided by the Board.

Commencement of Meetings / Quorum

13. As soon as there is a quorum after the hour fixed for the meeting, the Chair of the Board, or Vice-Chair or person appointed to act in their place and stead, shall take the chair and call the members to order.

14. If the person who ought to preside at any meeting does not attend by the time a quorum is present, the Secretary shall call the members to order and a presiding officer shall be appointed by majority vote to preside during the meeting or until the arrival of the person who ought to preside.

15. If there is no quorum within 15 minutes after the time appointed for the meeting, the Secretary shall call the roll and take down the names of the members then present, and the meeting shall then adjourn until such time as quorum is available.

16. Upon any member directing the attention of the Chair to the fact that a quorum is not present, the Secretary, at the request of the Chair, shall within three minutes following such request, record the names of those members present and advise the Chair, if a quorum is, or is not, present.

Rules of Debate and Conduct of Members at the Board

17. The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on points of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

18. Each deputation will be allowed a maximum of one speaker for a maximum of 10 minutes, but a member of the Board may introduce a deputation in addition to the speaker or speakers. Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

    The Board shall render its decision in each case within seven days after deputations have been heard.

19. When a member finds it impossible to attend any meeting, the onus is upon the member to advise the Secretary prior to the holding of such meeting of his wishes with respect to items on the agenda or matters appearing therein in which he is vitally interested.

Three consecutive absences by a member of the Board of Health will be reviewed by the Chair, following which notification will be forwarded to the appropriate municipality or council.

Board members who are elected or appointed representatives of their municipalities shall be bound by the rules of attendance that apply to the councils of their respective municipalities. Failure to attend without prior notice at three consecutive Board meetings, or failure to attend a minimum of 50% of Board meetings in any one calendar year will result in notification of the appointing municipal council by the Board chair and may result in a request by the Board for the member to resign and/or a replacement be named.

Board members appointed by the Lieutenant Governor-in Council are answerable to the Board of Health for their attendance. Failure to provide sufficient notice of non-attendance at three consecutive meetings or failure to attend a minimum of 50% of Board meetings without just cause may result in a request by the Board for the member to resign.

20. If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall call on another member to fill his place until he resumes the Chair.

21. Every member, prior to speaking to any question or motion, shall respectfully address the Chair.

22. When two or more members ask to speak, the Chair shall name the member who, in his opinion, first asked to speak.

23. A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

    No member shall speak to the same question at any one time for longer than ten minutes except that the Board upon motion therefore, may grant extensions of time for speaking of up to five minutes for each time extended.

24. Subject to this section, no member may ask a question of the previous speaker except with the consent of such previous speaker and then only to clarify any part of the previous speaker's remarks and such question shall be stated concisely.

    When it is a member's turn to speak, before speaking he may ask questions of the Medical Officer of Health/Chief Executive Officer or Secretary, in order to obtain information relating to the report or clause in question and, with the consent of the speaker, other members of the Board may ask a question of the same official.

    A member's question shall not be ironical, rhetorical, offensive, contain epithet, innuendo, satire or ridicule, be trivial, vague or meaningless, or contain questions and answers.

25. Any member may require the question or motion under discussion to be read at any time during the debate, but not so as to interrupt a member while speaking.

26. A member shall not:

- speak disrespectfully of the Reigning Sovereign, any member of the Royal Family, the Governor-General or a Lieutenant-Governor;
- use offensive words or unparliamentary language at the Board meetings;
- disobey the rules of the Board or decision of the Chair of the Board, on questions of order or practice or upon the interpretation of the rules of the Board;
- leave his seat or make any noise or disturbance while a vote is being taken and until the result is declared; or
- interrupt a member while speaking except to raise a point of order.

27. In case any member persists in a breach of the foregoing section after having been called to order by the Chair, the Chair shall without debate put the question, “Shall the member be ordered to leave his seat for the duration of the meeting?”

If the Board votes in the affirmative, the Chair shall order the member to leave his seat for the duration of the meeting.

If the member apologizes, the Chair, with the approval of the Board, may permit him to resume his seat.

Questions of Privilege and Points of Order

28. A member who desires to address the Board upon a matter which concerns the rights or privileges of the Board collectively, or of himself as a member thereof, shall be permitted to raise such matter of privilege. A breach of privilege is a wilful disregard by a member or any other person of the dignity and lawful authority of the Board. A matter of privilege shall take precedence over other matters. When a member raises a point of privilege, the Chair shall use the words “Mr./Mrs. _____ state your point of privilege”. While the Chair is ruling on the point of privilege, no one shall be considered to be in possession of the floor.

29. When a member desires to call attention to a violation of the rules of procedure, he shall ask leave of the Chair to raise a point of order and after leave is granted, he shall state the point of order with a concise explanation and then not speak until the Chair has decided the point of order.

Unless a member immediately appeals to the Board, the decisions of the Chair shall be final.

If the decision is appealed, the Board shall decide the question without debate and its decision shall be final.

30. When the Chair calls a member to order, the member shall immediately cease speaking until the point of order is dealt with then he shall not speak again without the permission of the Chair unless to appeal the ruling of the Chair.

Motions and Order of Putting Questions

31. A motion for introducing a new matter shall not be presented without notice unless the Board, without debate, dispenses with such notice by a majority vote and no report requiring action of the Board shall be introduced to the Board unless a copy has been placed in the hands of the members at least one day prior to the meeting, except by a majority vote, taken without debate.

32. Every motion presented to the Board shall be written.

33. Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

34. When a matter is under debate, no motion shall be received other than a motion:

- to adopt,
- to amend,
- to defer action,
- to refer,
- to receive,
- to adjourn the meeting, or
- that the vote be now taken.

35. A motion to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.

A motion to refer shall require direction as to the body to which it is being referred and is not debatable.

A motion to defer must include a reason and a time period for the deferral and is not debatable.

36. When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and if carried by a majority vote of the members ~~present~~, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

A motion relating to a matter not within the jurisdiction of the Board shall not be in order.

37. Only one amendment at a time can be presented to the main motion and only one amendment can be presented to an amendment, but when the amendment to the

amendment to the amendment has been disposed of, another may be introduced, and when an amendment has been decided, another may be introduced.

The amendment to the amendment, if any, shall be voted on first, then if no other amendment to the amendment is presented, the amendment shall be voted on next, then if no other amendment is introduced, the main motion, or if any amendment has carried, the main motion as amended shall be put to a vote.

Nothing in this section shall prevent other proposed amendments being read for the information of the members.

38. When the question under consideration contains distinct propositions, upon the request of any member, the vote upon each proposition shall be taken separately.

39. After the Chair commences to take a vote, no member shall speak to or present another motion until the vote has been taken on such motion, amendment or sub-amendment.

40. Every member eligible to vote ~~present~~ at a meeting of the Board~~, whether in person or electronically,~~ when a vote is taken on a matter, shall vote therein unless prohibited by statute; and, if any member eligible to vote at a meeting~~present~~ persists in refusing to vote, he shall be deemed as voting in the negative.

~~40.~~41.

~~41.~~42. If a member disagrees with the announcement by the Chair of the result of any vote, he may object immediately to the Chair's declaration and require that the vote be retaken.

~~42.~~43. When a member eligible to vote at a meeting ~~present~~ requests a roll call vote, all members ~~present~~eligible to vote, unless prohibited by statute, shall vote in alphabetical order with a call for the Chair's vote to be the last taken. A roll call vote and the names of those who voted for and against the resolution shall be noted in the minutes unless the Board is in-camera. The Secretary shall announce the results of the vote.

~~43.~~44. Any member, including the Chair, may propose or second a motion and all members including the Chair shall vote on all motions except when disqualified by reasons of interest or otherwise; a tie vote shall be considered lost. When the Chair proposes a motion, he shall vacate the chair to the Vice-Chair during debate on the motion and reassume the chair following the vote.

~~44.~~45. After any matter has been decided, any member who voted therein with the majority may move for a reconsideration at the same meeting or may give notice of a motion for reconsideration of the matter for a subsequent meeting in the same year, but no discussion of the question that has been decided shall be allowed until the motion for reconsideration has carried, and no matter shall be reconsidered more than once in the same year. For the purposes of this section, the word "year" shall mean the period from January 1st to December 31st in the same year.

Adjournment

~~45.~~46. A motion to adjourn the Board meeting or adjourn the debate shall be in order, except:

- when a member is in possession of the floor;
- when it has been decided that the vote be now taken; or,
- during the taking of a vote;

but no second motion to the same effect shall be made until after some intermediate proceedings have taken place.

~~46.~~47. Every communication intended to be presented to the Board must be fairly written or printed and must not contain any impertinent or improper matter and shall be signed by at least one person.

~~47.~~48. Every such communication shall be delivered to the Secretary before the commencement of the meeting of the Board.

Secretary for the Board

~~48.~~49. It shall be the duty of the Secretary:

- to attend or cause an assistant to attend all meetings of the Board;
- to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of by-laws and resolutions passed by it; and
- to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same.

Appointment and Organization of Committees

~~49.~~50. At the first meeting in any year, the Board shall appoint the members required by the Board to standing committees.

~~50.~~51. The Board may appoint committees from time to time to consider such matters as specified by the Board.

Conduct of Business in Committees

~~51.~~52. The rules governing the procedure of the Board shall be observed in the Committees insofar as applicable.

~~52.~~53. It shall be the duty of the Committee:

- to report to the Board on all matters referred to them and to recommend such action as they deem necessary;
- to report to the Board the number of meetings called during a year, at which a quorum was present, and the number of meetings attended by each member of the Committee; and
- to forward to the incoming Committee for the following year any matter undisposed of.

~~53.~~54. The procedures of the Board with respect to:

- incurring of liabilities and paying of accounts;
- contacts and expenditures;
- petty cash;
- tenders and quotations;

shall be in accordance with By-law 01-88 and 01-93.

Corporate Seal

~~54.~~55. The corporate seal of the Board shall be in the form impressed herein and shall be kept by the Executive Officer or the Secretary of the Board.

Execution of Documents

~~55.~~56. The Board may at any time and from time to time, direct the manner in which and the person or persons who may sign on behalf of the board and affix the corporate seal to any particular contract, arrangement, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, conveyances, mortgages, obligations or documents.

Duties of Officers

Chair and Vice-Chair

At the first meeting of a board of health in each year, the members of the board shall elect one of the members to be chair and one to be vice-chair of the board for the year.

~~56.~~57. The Chair of the Board shall:

- preside at all meetings of the Board;
- represent the Board at public or official functions or designate another Board member to do so;
- be ex-officio a member of all Committees to which he has not been named a member;
- perform such other duties as may from time to time be determined by the Board.

~~57.~~58. The Vice-Chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of the Chair of the Board, together with such powers and duties, if any, as may be from time to time assigned by the Board.

When undertaking the duties outlined above, the Vice-Chair shall be paid, in lieu of his regular Board member per diem, a fee as stipulated in Board of Health policies.

~~58.~~59. The Vice-Chair shall preside during in-camera sessions.

~~59.~~60. When it is moved and carried that the Board recess and go in-camera, the Chair shall vacate the Chair and the Vice-Chair shall preside over the Board sitting as a Committee of the Whole

Board of Health in-camera matters shall be as per F-III-10 Freedom of Information.

The Vice-Chair shall report the proceeding to the Board and a motion of concurrence shall be voted upon.

Amendments

~~60.~~61. Any provision contained herein may be repealed, amended or varied, and additions may be made to this by-law by a majority vote to give effect to any recommendation contained in a Report to the Board and such Report has been transmitted to members of the Board prior to the meeting at which the Report is to be considered, but otherwise no motion for that purpose may be considered, unless notice thereof has been received by the Secretary two weeks before a Board meeting and such notice may not be waived and in any even no bill to amend this by-law shall be introduced at the same meeting as that at which such report or motion is considered.

Medical Officer of Health

~~61.~~62. The Board of Health may institute arrangements with the Medical Officer of Health to continue to provide medical officer of health services to the Sudbury & District Health Unit during periods of leave so as to ensure that the requirements of the governing legislation continue to be met, and such that no compensation above that provide in the existing employment agreement is paid to the Medical Officer of Health;

The Medical Officer of Health, wherever possible, will advise the Board of Health Chair if such arrangements constitute an absence or inability to act of the Medical Officer of Health as per Section 69(1) of the Health Protection and Promotion Act;

Activation of an Acting MOH appointment will be delegated to the MOH with the MOH providing notice of the Acting Appointment to the Board of Health Chair. In the event that the MOH is unable to activate an Acting MOH appointment the activation will be done by the Board of Health Chair. The Acting Medical Officer of Health must provide written consent to the appointment. In the event of Acting Medical Officer of Health appointments of six months or greater, the consent of the Minister and Chief Medical Officer of Health will be obtained in accordance with the HPPA;

Dismissal of Medical Officer(s) of Health

~~62.~~63. A decision by the Board of Health to dismiss a Medical Officer of Health or an Associate Medical Officer of Health from office is not effective unless:

- the decision is carried by the vote of two-thirds of the members of the Board; and
- the Minister consents in writing to the dismissal.

The Board of Health shall not vote on the dismissal of a Medical Officer of Health unless the Board has given to the Medical Officer of Health:

- reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;
- a written statement of the reason for the proposal to dismiss the Medical Officer of Health; and
- an opportunity to attend and to make representation to the Board at the meeting.

MOH/CEO Meeting Notice and Attendance

~~63.~~64. The MOH/CEO is entitled to notice of and to attend each meeting of the Board of Health and every committee of the board, but the Board may require the MOH/CEO withdraw from any part of a meeting at which the Board of a committee of the board intends to consider a matter related to the remuneration or the performance of the duties of the MOH/CEO.

General

~~64.~~65. In this by-law, words importing the singular number of the masculine gender only shall include more person, parties or things of the same kind than one and females as well as males and the converse.

Enacted and passed by the Board of Health, Sudbury & District Health Unit this 23rd day of June 1988.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 26th day of February 1990.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 23rd day of May 1991.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 29th day of June 1992.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of April 1993.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 28th day of April 1994.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 27th day of April 1995.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 23rd day of May 1996.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 28th day of May 1998.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of April 1999.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 25th day of May 2000.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of February 2001.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 17th day of October 2002.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 17th day of June 2004.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of November 2007.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 18th day of November 2010.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of February 2012.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 20th day of February 2014.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of October 2015.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of June 2016.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of June 2017.

BOARD OF HEALTH MANUAL

MOTION:

THAT the Board of Health, having reviewed the revised By-Law 04-88 approves the contents therein for inclusion in the Board of Health Manual.

ADDENDUM

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

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

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