Board of Health for Public Health Sudbury & Districts

Second Meeting

Thursday, February 15, 2018

Boardroom, Public Health Sudbury & Districts

1300 Paris Street

Board of Health for Public Health Sudbury & Districts Meeting - February 15, 2018

Board of Health for Public Health Sudbury & Districts Meeting #02-18

1.0 CALL TO ORDER

2.0 ROLL CALL

3.0 REVIEW OF AGENDA / DECLARATIONS OF CONFLICT OF INTEREST

Agenda - February 15, 2018 Page 5

4.0 DELEGATION / PRESENTATION

i) 2017 Year-In Review
Dr. Ariella Zbar, Director, Clinical Services Division
Stacey Laforest, Director, Environmental Health Division
Sandra Laclé, Director, Health Promotion Division
Renée St Onge, Director, Resources, Research, Evaluation and Development Division

5.0 CONSENT AGENDA

i) Minutes of Previous Meeting

a. First Meeting, January 18, 2018 Page 10

ii) Business Arising From Minutes

iii) Report of Standing Committees

a. Joint Board/Staff Performance Monitoring Working Group Unapproved Minutes dated January 23, 2018 Page 18

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

MOH/CEO Report, February 2018 Page 20

v) Correspondence

a. Nutritious Food Basket (Advocacy for increasing social assistance rates)
Board of Health for Public Health Sudbury & Districts' Motion 48-17

Letter from the Township of Nairn and Hyman to the Premier of Ontario dated January 25, 2018, Page 37

b. Needle Exchange Program Initiative Additional Base Funding and One Time Funding for 2017-18 Funding Year

Letter from the Minister to the Board Chair dated January 24, 2018 Page 38

c. Income Security: A Roadmap for Change

Letter and Motion from the Northwestern Health Unit Board of Health dated January 5, 2018 Page 39

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Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA – SECOND MEETING
BOARD OF HEALTH FOR PUBLIC HEALTH SUDBURY & DISTRICTS
PUBLIC HEALTH SUDBURY & DISTRICTS, BOARDROOM, SECOND FLOOR
THURSDAY, FEBRUARY 15, 2018 – 1:30 P.M.

1. CALL TO ORDER

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION/PRESENTATION

i) 2017 Year-In Review

- Dr. Ariella Zbar, Director, Clinical Services Division
- Stacey Laforest, Director, Environmental Health Division
- Sandra Laclé, Director, Health Promotion Division
- Renée St Onge, Director, Resources, Research, Evaluation and Development Division

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a. MOH/CEO Report, February 2018

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b. Needle Exchange Program Initiative Additional Base Funding and One-Time Funding for 2017-18 Funding Year

- Letter from the Minister to the Board Chair dated January 24, 2018

c. Income Security: A Roadmap for Change
- Letter and Motion from the Northwestern Health Unit Board of Health dated January 5, 2018

d. Ontario Public Health Standards
- Memo from the Assistant Deputy Minister dated December 29, 2017

e. Support for Maintaining Local Surveillance and Monitoring of Food Costing by Public Health Units within the Modernized Standards for Public Health Programs and Services
- Letter from the Middlesex-London Health Unit to Boards of Health dated February 5, 2018

vi) Items of Information

a. Bicycle Friendly Community Award	January 10, 2018
b. Public Health Agency of Canada News Release: Government of Canada Supports Program that Promotes Smoke-Free Lifestyle	January 26, 2018
c. Statement from Chief Public Health Officer of Canada	January 18, 2018
d. The Globe and Mail article: "Canada must rethink health spending strategy"	January 22, 2018
e. The Globe and Mail article: "Fighting the flu: We need a new kind of intelligence"	January 22, 2018
f. Canadian Public Health Association, *Erosion of public health* capacity *should be a matter of concern for all Canadians*	Vol. 108, NO. 5-6
g. Email from alPHa Re: February 23 alPHa Board of Health Section Meeting and Updated Agenda	February 8, 2018

APPROVAL OF CONSENT AGENDA

MOTION:

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

6. NEW BUSINESS

i) Northern Network for Health Equity
- Briefing Note from the Medical Officer of Health/Chief Executive Officer to the Board Chair dated February 8, 2018

NORTHERN NETWORK FOR HEALTH EQUITY

MOTION:

WHEREAS Public Health Sudbury & Districts supported the development of a Ministry-funded Northern Ontario Health Equity Strategy in partnership with Health Quality Ontario and other northern stakeholders; and

WHEREAS health equity is a longstanding priority of the Board of Health, is a strategic priority in the 2018-2022 Strategic Plan, and is a Foundational Standard within the Ontario Public Health Standards, 2018;

THEREFORE BE IT RESOLVED that the Board of Health for Public Health Sudbury & Districts endorse in principle the establishment of a Northern Network for Health Equity, the Strategy's key recommendation; and

FURTHER THAT the Board directs the Medical Officer of Health to ensure appropriate organizational participation in the Northern Network for Health Equity.

ii) Tobacco and Smoke-Free Campuses

- Briefing Note from the Medical Officer of Health and Chief Executive Officer to the Board Chair dated February 8, 2018

TOBACCO AND SMOKE-FREE CAMPUSES

MOTION:

WHEREAS on January 1, 2018, McMaster University became the first post-secondary institution in Ontario to establish a 100% tobacco and smoke-free campus; and

WHEREAS the presence of tobacco use on campus further normalizes tobacco use, undermining provincial and local tobacco prevention and cessation efforts; and

WHEREAS an Environmental Scan of Ontario College and University Tobacco Control Policies 2016-2017, indicates that while the three post-secondary campuses in Sudbury have policies exceeding the current Smoke Free Ontario Act (SFOA), they maintain on-campus Designated Smoking Areas (DSA's);

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts congratulate area post-secondary institutions for their tobacco-related health protective policies surpassing current provincial legislation; and

FURTHER that the Board strongly urge and support area post-secondary institutions to enhance existing policies to achieve 100% tobacco and smoke-free campuses within an accelerated timeframe; and

FURTHERMORE that the Board share this motion with area post-secondary leadership, alPHa, the Chief Medical Officer of Health, Minister of Health and Long-Term Care, Ministry of Colleges and Universities and local MPPs.

iii) Part VIII – Ontario Building Code Fee Increases

- Revised Board Manual G-I-50 By-Law 01-98

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

MOTION:

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

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

WHEREAS the fee increases approved by the Board of Health in 2017 were phase 1 of a proposed 2 phase increase, where the second phase was scheduled to be implemented in 2018; and

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

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

FURTHERMORE THAT this fee schedule shall immediately come into effect.

iv) 2013 – 2017 Performance Monitoring Plan and Annual Performance Monitoring Report

- 2017 Performance Monitoring Report, February 2018

7. ADDENDUM

ADDENDUM

MOTION:

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

8. IN CAMERA

IN CAMERA

MOTION:

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

- Labour relations or employee negotiations

9. RISE AND REPORT

RISE AND REPORT

MOTION:

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

10. ANNOUNCEMENTS / ENQUIRIES

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

11. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time:

MINUTES – FIRST MEETING
SUDBURY & DISTRICT BOARD OF HEALTH
BOARDROOM, SECOND FLOOR, SUDBURY & DISTRICT HEALTH UNIT
THURSDAY, JANUARY 18, 2018, AT 9:30 A.M.

BOARD MEMBERS PRESENT

Maigan Bailey	Janet Bradley	James Crispo
Jeffery Huska	Robert Kirwan	Monica Loftus
Thoma Miedema	Paul Myre	Rita Pilon
Mark Signoretti	Nicole Sykes	Carolyn Thain

BOARD MEMBERS REGRETS

René Lapierre	Ken Noland

STAFF MEMBERS PRESENT

Rachel Quesnel	France Quirion	Renée St Onge
Dr. P. Sutcliffe	Dr. A. Zbar	

Media

RACHEL QUESNEL PRESIDING

1. CALL TO ORDER

The meeting was called to order at 9:30 a.m.

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

There were no declarations of conflict of interest.

4. ELECTION OF OFFICERS

APPOINTMENT OF CHAIR OF THE BOARD

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

There being no further nominations, the nomination for the Sudbury & District Board of Health Chair for 2018 was closed. René Lapierre had confirmed via email that he would accept a nomination. The following was announced:

THAT the Sudbury & District Board of Health appoints René Lapierre as Chair of the Board for the year 2018.

APPOINTMENT OF VICE-CHAIR OF THE BOARD

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

There being no further nominations, the nomination for the Sudbury & District Board of Health Vice-Chair for 2018 was closed. Jeff Huska accepted his nomination. The following was announced:

THAT the Sudbury & District Board of Health appoints Jeff Huska as Vice-Chair of the Board for the year 2018.

JEFFERY HUSKA PRESIDING

APPOINTMENTS TO THE BOARD EXECUTIVE COMMITTEE

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

There being no further nominations, the nominations for the Board Executive Committee for the year 2018 was closed. Mark Signoretti declined his nomination. The three other nominees accepted their nominations. The Chair announced:

THAT the Sudbury & District Board of Health appoints the following individuals to the Board Executive Committee for the year 2018:

Paul Myre, Board Member at Large
Nicole Sykes, Board Member at Large
Ken Noland, Board Member at Large
René Lapierre, Chair
Jeffery Huska, Vice-Chair
Medical Officer of Health/Chief Executive Officer
Director, Corporate Services
Secretary Board of Health (ex-officio)

APPOINTMENTS TO THE FINANCE STANDING COMMITTEE OF THE BOARD

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

There being no further nominations, the nominations for the Finance Standing Committee of the Board for the year 2018 was closed. Nicole Sykes declined her nomination. The three other nominees accepted their nominations. The Chair announced:

THAT the Sudbury & District Board of Health appoints the following individuals to the Finance Standing Committee of the Board for the year 2018:

Carolyn Thain, Board Member at Large
Paul Myre, Board Member at Large
Mark Signoretti, Board Member at Large
René Lapierre, Board Chair
Medical Officer of Health/Chief Executive Officer
Director, Corporate Services
Manager, Account Services
Secretary Board of Health

5. DELEGATION/PRESENTATION

None.

6. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Eighth Meeting – November 23, 2017

ii) Business Arising From Minutes

iii) Report of Standing Committees

a. Board Executive Committee – November 30, 2017
b. Board Finance Standing Committee – January 10, 2018

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

a. MOH/CEO Report, January 2018

v) Correspondence

a. Smoke-Free Ontario Strategy Modernization

– Letter from the Board of Health for Peterborough Public Health to the Minister of Health and Long-Term Care dated November 23, 2017

b. Income Security

– Letter from alPHa and OPHA to the Minister of Community and Social Services dated January 5, 2018

vi) Items of Information

a. alPHa Information Break — December 13, 2017

b. 2017 Financial Controls Checklist

c. 2017 Annual Report of the Office of the Auditor General (OAG)

- Office of the Auditor General of Ontario Media Release — December 6, 2017
- MOHLTC Media Release *Statement by the Minister of Health and Long-Term Care* — December 6, 2017
- 2017 Annual Report, Chapter 3, Section 3.10, Public Health: Chronic Disease Prevention

d. 2017 Winter Clothing Drive Campaign — November 27, 2017

e. SDHU awarded WSIB Public Sector Category Gold Award at the 2017 Canada's Safest Employer Awards — November 27, 2017

f. alPHa Boards of Health Section Winter 2018 Meeting — February 23, 2018

Information has not yet been received from the Association of Local Public Health Agencies regarding change management webinars.

The Board congratulated staff and management on receiving the WSIB Public Sector Category Gold Award.

01-18 APPROVAL OF CONSENT AGENDA

MOVED BY SYKES – THAIN: ***THAT the Board of Health approve the consent agenda as distributed.***

CARRIED

7. NEW BUSINESS

i) Board Survey Results from Monthly Board Meeting Evaluations

– 2017 Evaluation Summary Results

A summary compiling results and comments from the regular Board meetings is shared annually with the Board every January. The 2017 results are shared for information and discussion as required. There were no questions or comments.

ii) Sudbury & District Board of Health Meeting Attendance

- Board Meeting Attendance Summary – 2017

Every January, the Board receives a summary of attendance at regular Board meetings for the year prior. The 2017 summary is shared for information. There were no questions or comments.

iii) 2018 – 2022 Strategic Plan

- Presentation by the MOH/CEO and 2017 Board Executive Committee Chair

J. Huska, 2017 Board EC Chair, reminded Board members that work has been underway over the last year to collect feedback for the next iteration of the plan as the 2013-2017 Strategic Plan expired at the end of December 2017. The 2018-2022 Strategic Plan was developed based on key findings from engagement activities with members of the public, community partners, frontline staff, and consultations with Senior Management and the Board of Health. As part of this process, the need to review our visual identity was identified to make sure it was current and clearly reinforced our public health identity.

The Board's role in steering the strategic plan development was acknowledged as well as their input and guidance through the consultation session, online survey and workshops. Board EC members, J. Bradley, R. Lapierre, P. Myre, and K. Noland were acknowledged for their participation and guidance in multiple consultation meetings in 2017.

Dr. Sutcliffe reviewed the thorough engagement and consultation process to develop strategic directions, including an environmental scan and situational assessment, engagement activities, and an analysis of the key findings. Details from each of these steps were reviewed along with an overview of key findings.

The 2018-2022 Strategic Plan was presented to the Board. It was clarified that our vision and mission statements remain the same to continue building on our work and to strive to create optimal conditions for health for all.

The three values, Humility, Trust, and Respect were described as well as the four strategic priorities:

1. Equitable Opportunities
2. Meaningful Relationships
3. Practice Excellence
4. Organizational Commitment

Dr. Sutcliffe recapped feedback received during the engagement processes to consider how we could refresh our identity and accentuate public health, including in our agency name. The 2018-2022 Strategic Plan and Visual Identify and Name refresh were unveiled.

Bilingual pamphlets were provided to the Board members that summarize the recommended 2018-2022 Strategic Plan along with a report that outlines the development process.

Questions and comments were entertained. Following an inquiry regarding next steps to drive the priorities forward and the operationalization of the plan, Dr. Sutcliffe noted that the proposed motion speaks to development of a monitoring process for the Board.

Dr. Sutcliffe, R. St Onge, Committee members and staff were congratulated on the engagement and development process for the 2018-2022 Strategic Plan and Visual Identity refresh.

02-18 2018 – 2022 STRATEGIC PLAN

MOVED BY PILON – MIEDEMA: ***WHEREAS the Organizational Requirements of the Ontario Public Health Standards, 2018, stipulate that the board of health shall have a strategic plan that establishes strategic priorities over 3 to 5 years, includes input from staff, clients, and community partners, and is reviewed at least every other year; and***

WHEREAS the Sudbury & District Board of Health has engaged in a thorough review and engagement process to develop a new strategic plan following its 2013-2017 cycle; and

WHEREAS the Board concurrently reviewed its 2003 Visual Identity and Brand Guidelines;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health endorse the 2018 – 2022 Strategic Plan and Visual Identity as presented; and

FURTHER THAT the Board direct the Medical Officer of Health to operationalize the Strategic Plan and develop a monitoring process for the Board's approval.

CARRIED

iv) Incremental Costs to Implement the Ontario Public Health Standards, 2018

- Briefing Note and attachments from the Medical Officer of Health to the Board dated January 11, 2018
- Renfrew County and District Board of Health Resolution

C. Thain, Chair of the Board Finance Standing Committee, reported that the Committee held a special meeting on January 10, 2018, to review the incremental cost estimates for the implementation of the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability (OPHS)*. The Board was advised in November 2017 when the 2018 cost-shared budget was tabled, that the timing of the release of the Standards were such that incremental costs associated with the implementation of the Standards had not been incorporated in the budget but would be coming forward for the Board's consideration. Management has since analyzed the new requirements and identified related staffing requirements to meet the OPHS. The detailed analysis was reviewed at the January 10, 2018, Finance Standing Committee meeting and is recommended today for the Board's consideration.

The briefing note and attachments outline the additional requirements and resource implications by Standard and by Program, representing 28 FTEs and a total of $2.54 M.

C. Thain clarified that this is a request for provincial base funding only. Although there are current provincial fiscal constraints and the likelihood of a significant infusion of funding is low, it remains important to inform the ministry of the anticipated incremental costs associated with implementing the new standards. C. Thain concluded that the Finance Standing Committee recommends to the Board the approval of the incremental costs for implementation of the Ontario Public Health Standards.

Questions were entertained. Dr. Sutcliffe recapped comments and messaging from the Public Health Summit. Although there is no collective submission to the Ministry, it is understood that implementation of the new Standards will place significant pressures on local public health.

03-18 INCREMENTAL COSTS TO IMPLEMENT THE ONTARIO PUBLIC HEALTH STANDARDS, 2018

MOVED BY MYRE – KIRWAN: ***WHEREAS at its meeting of November 23, 2017, the Sudbury & District Board of Health approved the 2018 budget for cost-shared programs and services that did not incorporate incremental costs associated with implementing the newly released Ontario Public Health Standards; and***

WHEREAS the Board Finance Standing Committee has reviewed these cost estimates and recommends them to the Board for approval;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health request an additional $2.54M in base funding from the Ministry of Health and Long-Term Care to offset incremental costs associated with implementing the Ontario Public Health Standards: Requirements for programs, services and accountability, 2018

CARRIED

8. ADDENDUM

None

9. ANNOUNCEMENTS / ENQUIRIES

Board members were reminded to complete the Board evaluation following the Board meeting.

Board members were informed of and invited to a joint initiative between Laurentian University and Public Health Sudbury & Districts: Dr. Dan Andreae Distinguished Presidential Lecture Series on Living in Healthy Communities which will be presented on January 25, 2018, at 7:30 p.m. at the Universities' Fraser Auditorium. This year's lecture topic is Mind Matters that will include a panel discussion on Alzheimer's.

Board members were invited to attend the launch of the 2018-22 Strategic Plan at 11:15 a.m. in the Ramsey Room.

Date of the next Board meeting is Thursday, February 15, 2018, at 1:30 p.m. in the Boardroom.

10. ADJOURNMENT

04-18 ADJOURNMENT

MOVED BY KIRWAN – MIEDEMA: ***THAT we do now adjourn. Time: 10:20 a.m.***

CARRIED

_____ _____

(Chair) (Secretary)

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

Recorder: Rachel Quesnel, Executive Assistant and Board Secretary

Members: David Groulx, Nastassia McNair, Rita Pilon *, Renée St Onge, Carolyn Thain *

Regrets: Janet Bradley

* via teleconference

#	Item	Decisions, Assignments, Required Follow-up
1.0	**CALL TO ORDER / WELCOME**	The meeting was called to order at 10:30 a.m.
2.0	**PURPOSE**	The main purpose of today's meeting is to review the draft 2017 Performance Monitoring Report. It is also an opportunity to recognize the valuable feedback of the Joint Board/Staff Performance Monitoring Working Group members and thank members for their contributions since the first Working Group meeting in September 2013.
3.0	**REVIEW AND APPROVAL OF THE AGENDA**	The agenda was reviewed and approved.
4.0	**NEW BUSINESS**	
4.1	Meeting Notes – October 3, 2017	The Joint Board/Staff Performance Monitoring Working Group meeting notes dated October 3, 2017, were approved.
4.2	Draft 2017 Performance Monitoring Report	R. St Onge walked through the draft report which rolls up our performance in the following areas: • Strategic Priorities - Narrative Report • SDHU-Specific Performance Monitoring Indicators Report • Ontario Public Health Organizational Standards Report • Public Health Accountability Agreement Indicators Report There were no questions regarding the summary of the narrative topics that were presented in 2017. R. St Onge noted that data in *Table 1: SDHU-Specific Performance Monitoring Indicator Trends* displays values from 2013 to 2017. The shift to lower numbers for the website indicates improved efficiency in access to information on our new website. This is further explained in the Notes section. Also described in the Notes is the Board of Health Commitment Index which reflects vacancies and turnover in the 2017 Board membership. Notes for *Worker Engagement Index* and *SharePoint Deployment* are outlined under Organizational Excellence and provide status updates. Questions and comments were entertained. The Ontario Public Health Organizational Standards Report section shows our compliance with each Organizational Standard by either meeting or exceeding the Standard. The Notes highlight key projects and milestones that occurred throughout 2017. Questions and comments were entertained. It was reiterated that on the go forward, the Ontario Public Health Organizational Standards will be part of the Ontario Public Health Standards.

#	Item	Decisions, Assignments, Required Follow-up
		The Public Health Accountability Agreement (AA) Indicators Report have changed over the last five years. The Notes explain that as of June 2017, the Ministry of Health and Long-Term Care discontinued measuring the AA indicators; therefore, there is no data for 2017. Dr. Sutcliffe shared that there have been no changes in our internal processes and performances. The 2017 Performance Monitoring Report will be updated with our new name and refreshed logo before it goes to the Board as this is an opportunity to further promote our new identity. R. Pilon will present the report at the February 15, 2018, Board meeting.
4.3	Next Steps	Dr. Sutcliffe indicated that the 2017 Performance Monitoring Report is the last iteration of the 2013-2017 Performance Monitoring Plan, sunsetting the work of the Joint Board/Staff Performance Monitoring Working Group. Board motion 02-18 directed the Medical Officer of Health to operationalize the Strategic Plan and develop a monitoring process for the Board's approval. The MOH will also be taking into consideration other reporting responsibilities. All members were thanked for their contributions on the 2013–2017 performance monitoring groundwork in capturing all reporting requirements.
5.0	**NEXT MEETING DATE/TIME**	None – Working Group sunsetted.
6.0	**ADJOURNMENT**	The meeting was adjourned at 10:52 a.m.

Public Health
Santé publique
SUDBURY & DISTRICTS

Medical Officer of Health/Chief Executive Officer

Board of Health Report, February 2018

Words for thought

Canada must rethink health spending strategy

If we want a healthier Canada, we should spend less on health care.

That's the counterintuitive conclusion of a new study.

But, of course, there's a catch: To reap the benefits, we need to spend the savings on social programs such as income assistance, subsidized housing, early childhood education and affordable child care.

In other words, we don't need to spend less on health, we need to do a better job of allocating our health dollars.

To start, we must redefine "health spending."

The vast majority of our health dollars go to providing care after people fall ill – principally for hospitals, physician services and drugs. Only about 5 per cent of health dollars go to prevention and health promotion.

But that's only part of the story. We spend about three times as much on sickness care as we do on social programs. This is a rough estimate, of course: While we track our sickness care obsessively – a large institution, the Canadian Institute for Health Information, was created solely for this purpose – no one is really tracking how much Ottawa, the provinces and territories invest collectively in social welfare.

That's where the new study, published in Monday's edition of the Canadian Medical Association Journal, comes in…

They found that average per capita spending for health was $2,900, almost three times the $930 per capita spending for social services…

Dr. Dutton's research team also looked at the impact of spending choices on health outcomes – specifically avoidable mortality, infant mortality and life expectancy. With some fancy math, they showed that if governments had spent one more cent on social services for every dollar spent on health, life expectancy in this country could have increased by another 5 per cent and avoidable mortality could have dropped an additional 3 per cent. (In their calculations there was no appreciable effect on child mortality.)…

In democratic, just societies, we tackle these inequities with laws, political actions and social programs designed to redistribute wealth.

The new research reminds us that when we fail to do so, we pay the price in lost lives and life expectancy.

Yet, at the end of the day, we always pour money into sickness care and wind up shortchanging social programs that would result in people being healthier 10, 20 and 30 years down the road.

It is an approach best illustrated by a parable: One day, a group sitting by a river sees a baby in the water. One of them dives in to save her. Soon, more babies appear, and the bystanders all jump in to save the children. But one person has the presence of mind to go upstream and figure out how to stop babies from falling into the river in the first place.

In our public policies we need more of that upstream thinking, beginning with a sounder redistribution of health and sickness care spending.

Source: Excerpted from Picard, A. January 22, 2018. Globe and Mail. https://www.theglobeandmail.com/opinion/new-study-says-canada-must-rethink-health-spending-strategy/article37679063/ Accessed on February 5, 2018

Chair and Members of the Board,

Welcome to the February meeting of the Board of Health for Public Health Sudbury & Districts.

The research article referred to in André Picard's column cited above reinforces the perspective and role of public health. In our work to support population health, public health seeks to leverage the health enhancing potential of diverse sectors, including social services, so that collectively our efforts increase opportunities for health for all.

The contention that increased spending in health care is not the answer to improved population health informs our public health actions. Local examples include Public Health Sudbury & Districts' work with schools to increase students' resiliency; municipalities to improve walkability; and social services to address housing and mental health. Also noteworthy is our yearlong leadership and engagement with many sectors to develop a strategy for health equity across the north. This work culminates in the recommendation that the Board endorse a Northern Network for Health Equity as presented in today's agenda. There is much untapped health potential in broader public policies that could better "redistribute health and sickness care spending" to more fundamental determinants of health.

February marks the reporting to the Board on the previous year's work "by the numbers".

My report this month provides a snapshot of the scope and volume of our work in addition to key governance updates.

General Report

1. Board Updates

The winter alPHa Board of Health Section meeting will be held on February 23, in Toronto.

alPHa's 2018 Annual Conference and General Meeting will be held on June 10 to June 12 in Toronto. Board members interested in attending are asked to pencil these dates in their calendars. A motion will be included on the April Board agenda relating to Board attendance and delegation for the alPHa AGM.

2. Finance

The required forms for the new 2018 Annual Service Plan and Budget Submission are being prepared for the March 1, 2018, deadline. The new forms incorporate the Board of Health approved cost-shared operating budget as well as the additional ongoing costs related to the implementation of the new Ontario Public Health Standards. The Ministry of Health and Long-Term Care continues to advise Boards of health to plan for no growth funding for 2018.

Our auditors, KPMG, will return to Public Health Sudbury & Districts for the 2017 audit. On-site audit work will commence March 5, 2018, and conclude by March 9, 2018. The current due date for submission of the audited financial statements and annual reconciliation report to the

Ministry is April 30, 2018. As has been the case in previous years, we expect Health Units to request an extension to this deadline in order to provide for Board of Health approval given the various meeting dates. The Ministry has always approved the extension.

3. Strategic planning

Following the Board of Health's approval of the 2018–2022 Strategic Plan and refreshed visual identity on January 18, 2018, Public Health Sudbury & Districts hosted a public launch event. The event was attended by approximately 40 people, including members of local media, Board of Health members, community partners, and councillors. Public Health Sudbury & Districts staff members were also invited to celebrate the launch of the new Strategic Plan and visual identity on the same day. The Strategic Plan Committee is now working to socialize and operationalize the plan.

4. Performance Monitoring Plan

The Joint Board/Staff Performance Monitoring Working Group met on January 23, 2018, to review the draft 2017 Performance Monitoring Report. Board representation on this working group include C. Thain, R. Pilon and J. Bradley. The final report is included in today's Board meeting agenda package.

Members of Senior Management have also begun the process for development of a 2018–2022 Performance Monitoring Plan, which will include monitoring of the strategic priorities, ministry requirements, and key organization-specific indicators. Once finalized, the draft performance monitoring plan and process will be recommended to the Board of Health.

5. Regulatory Health Protection Reporting

Control of Infectious Diseases

During the month of January, three sporadic enteric cases and two infection control complaints were investigated. Five enteric outbreaks were declared in institutions.

Food Safety

Public health inspectors issued one charge to one food premise for infractions identified under the Food Premises Regulation.

Health Hazard

In January, 37 health hazard complaints were received and investigated. Four of these complaints involved marginalized populations.

Rabies Prevention and Control

Seventeen rabies-related investigations were carried out in the month of January. One specimen was submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis, and was subsequently reported as negative.

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

Safe Water

One drinking water order was issued in the month of January.

Tobacco Enforcement

In January, tobacco enforcement officers charged one individual for smoking in an enclosed workplace, and one retail employee for selling tobacco to a person who is less than 19 years of age.

I am pleased to commend to you the following sections of my report which provide the statistical highlights in public health programming and services for the 2017 year per division.

Clinical Services Division

Control of Infectious Diseases

Universal Influenza Immunization Program (UIIP)

37 382 doses of seasonal influenza vaccine distributed to health care providers

2 223 doses of vaccine administered by Public Health Sudbury & Districts at community and office-based clinics

2 community clinics were provided in areas identified and requested assistance (Dowling – 175 flu vaccines given and Harm Reduction Home at the Off The Street Shelter 4 flu vaccines) given to members of the community

50 pharmacies took part in UIIP

Respiratory Outbreaks

28 outbreaks in long-term care homes/retirement homes and acute care (Institutions) (Influenza A, Influenza B, RSV, Coronavirus and unknown)

School Immunization Program

1 261 Grade 7 students completed the hepatitis B series

1 940 Grade 7 students received meningococcal vaccine

1 039 eligible female and male (included Grade 8 girls and the updated inclusion of Grade 7 girls and Grade 7 boys) students completed the HPV vaccine series

TB Control Program

2 072 TB tests performed

2 030 TB reading and follow ups

Publically and Non-publicly Funded Vaccines

11 898 vaccines administered (includes district office sites)

Nurse On Call – CID

3 280 calls on topics such as school vaccine, travel related, immunization, infection control, and reportable diseases

Growing Family Health Clinic

973 client appointments

139 prenatal and postnatal appointments

470 appointments for children aged 0–6 years

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

5 833 client visits at the Rainbow Centre office

3 266 sexual health calls includes inquiries on a variety of sexual health and sexually transmitted infection topics and follow up. Does not include calls made for service coordination.

1 124 nominal HIV tests completed

112 anonymous HIV tests completed

1 236 total HIV tests/people

344 point-of-care HIV tests completed

334 client visits in Sudbury schools and agency outreach

519 client visits in district offices and school outreach

136 online tests (program discontinued in August 2017)

Sexual Health Promotion

2 000 pamphlets and promotional items distributed

54 presentations and 6 interactive displays to **2 153** participants

4 media campaigns

Healthy Babies Healthy Children (HBHC) Program

1 919 live births in the Sudbury and Manitoulin districts in 2017

89% of new moms were screened to identify those who would benefit from further services

305 families supported with ongoing home visiting

1 212 women attended breastfeeding clinics at the Sudbury and Val Caron clinic sites

28% of pregnant women are screened prenatally to determine if they would benefit from HBHC services

HBHC Information Line

2 056 total number of calls with over 49% of those being in the area of breastfeeding

- **132** calls related to car seat safety which is an increase of 154% over last year
- **47** calls related to a lack of a primary care physician which is a decrease of 51% over last year
- **74** walk-ins requesting information/assistance which is an increase of 54% over last year

Oral Health

1 438 calls received for assistance, emergency care, and general information

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

11 111 children screened during school screening clinics

577 children referred for urgent care

318 children participated in school-based preventive services

377 children participated in Public Health Sudbury & Districts-based preventive care

341 children enrolled for emergency assistance

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

Academic Detailing – Low Milk Supply

232 clinicians were sent a personal invitation letter by mail

57 clinicians participated in an AD session

Needle Exchange Program

17 779 client visits

1 210 563 needles given out

761 812 needles taken in

63% needle return rate to the Needle Exchange Program

8 602 inhalation kits were distributed

31 930 condoms were distributed

Corporate Services Division

Volunteer Resources

61 active volunteers

9 new volunteers

379 volunteer hours of services provided

1 new volunteer role

Environmental Health Division

Food Safety

3 435 inspections of food premises

235 complaint investigations

14 charges: **3** closure orders issued

50 food handler training courses

691 food handlers certified

14 food recalls: **1 966** recall inspections

652 special events food service permits

294 consultations and inquiries

Chronic Disease Prevention

227 Healthy Menu Choices Act inspections

Safe Water

Drinking Water

29 boil water orders

2 boil water advisories

11 drinking water advisories

1 drinking water order

11 blue-green algae advisories

1 049 adverse drinking water reports investigated

287 bacteriological samples taken

276 consultations and inquiries

23 complaint investigations and **20** for blue-green algae

89 Small Drinking Water System (SDWS) risk assessments completed

89 SDWS directives completed

83 SDWS inspections conducted

Recreational Water

35 beaches inspected weekly

456 beach inspections

2 718 bacteriological samples taken

15 beaches temporarily posted

7 blue-green algae beach advisories

170 pool inspections

54 spa inspections

23 splash/spray pad inspections

7 pool or spa closure orders issued

133 bacteriological samples taken

Chronic Disease Prevention – Comprehensive Tobacco Control

Smoke-Free Ontario Act and Electronic Cigarettes Act Enforcement

452 youth access inspections

12 sales or supply charges issued

1 warning letter issued to retailers/vendors

270 display and promotion inspections

170 school compliance inspections/checks

19 charges: smoking on school property

38 charges: smoking on hospital property

39 charges: smoking in the workplace

1 charge smoking in a public place

4 charges: CGS smoking bylaw

102 complaints investigated

27 consultations and inquiries

Health Hazard

535 complaint investigations

- **118** mould complaints
- **119** insects, cockroaches, birds
- **33** marginalized population/housing
- **30** housing complaints
- **66** rodents, vermin
- **30** discarded syringes
- **6** sewage backup, spills
- **15** heating complaints
- **11** garbage and waste
- **107** miscellaneous complaints

2 orders issued

325 consultations and inquiries

50 arena air quality inspections

1 088 calls to the after-hours line (24/7)

Control of Infectious Diseases

56 enteric outbreaks investigated

1 210 people ill

108 sporadic enteric cases investigated

47 consultations and inquiries

Rabies

334 animal exposure incidents investigated

15 animal specimens submitted

No positive cases of rabies

14 individuals received post-exposure prophylaxis

36 consultations and inquiries

Infection Control

7 institutional infection control meetings

308 inspections in institutional settings

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

92 consultations and inquiries

33 complaint investigations

Vector-borne Diseases

298 mosquito traps set

31 323 mosquitoes trapped

14 490 mosquitoes speciated

531 mosquito pools tested:

- **18** for Eastern Equine Encephalitis
- **513** for West Nile virus

No positive mosquito pools for WNv/EEE

2 human cases of WNv

38 ticks submitted: **1** positive for bacteria causing Lyme disease

Environmental Health Policy

Extreme Weather Alerts

1 heat warning issued

Built Environment

5 plans and proposals reviewed

Emergency Response

62 staff received respirator fit testing

Participated in **5** municipal emergency exercises

Part 8 – Land Control

2 334 inspection activities

322 sewage system permits issued

33 consent applications processed

171 renovation applications processed

57 mandatory maintenance inspections completed

38 private sewage complaints investigated

5 orders issued

2 charges issued

599 consultations and inquiries

66 file search requests

87 copy of record requests

Health Promotion Division

Chronic Disease Prevention – Comprehensive Tobacco Control

657 inquiries to the Tobacco Information Line

229 appointments to the Quit Smoking Clinic

250 nicotine replacement therapy (NRT) vouchers (valued at $20 each) distributed to clients

211 NRT vouchers redeemed by clients at participating pharmacies

85 participants attended six STOP on the Road sessions accessing NRT from Centre for Mental Health and Addictions (CAMH)

1 080 participants attended 7 group cessation information sessions/event, inclusive of workplaces, post-secondary educational institutions, and partner agencies

28 health care providers gained Minimal Contact Intervention (MCI) training

15 health care providers provided with MCI information, and an additional **64** post-secondary learners (Nursing/NOSM)

5 NE Cessation Network (CoP) teleconference meeting for 45 members, offering 4 partner presentations

Exposure to Ultraviolet Radiation and Early Detection of Cancer

12 communications activities related to the early detection of cancer delivered in Greater Sudbury and in **2** district office areas

104 people screened by a Dermatologist at the annual skin cancer screening clinic. Skin cancer was diagnosed in **7** individuals and over **40** pre-cancerous actinic keratoses were identified.

100 youth junior summer camp counsellors educated on the importance of sun safety

Healthy Eating

300 people attended the launch of healthy options at the Northeastern Manitoulin and the Islands (NEMI) recreation centre canteen

47 people participated in train-the-trainer sessions on Adventures in Cooking

6 food skills sessions with a reach of **21** people

10 youth from a pre-employment program pilot provided with food handler training

15 CBC radio interviews on a variety of nutrition related topics

160+ people attended the launch of the City of Greater Sudbury Food Strategy

24 Pop-Up Vegetable and Fruit Markets offered in **2** neighbourhoods by the Sudbury and District Good Food Box program

Healthy Weights

6 knowledge exchange sessions on the topics of weight-bias and body-image with a reach of **105** pre-service health professionals and community partners

Diabetes Prevention Program

7 consultations with local organizations

Collaborative planning meetings held with **3** First Nations Communities on Manitoulin Island

Physical Activity, Sedentary Behaviours and Sleep

56 local service providers and post-secondary students participated in **2** physical literacy workshops

58 local physicians, medical and post-secondary students attended the Physical Activity Counseling and Exercise

Prescription in Health Care Workshop, hosted in collaboration with NOSM and **2** post-secondary institutions

115 delegates attended the Moving and Learning Together conference, organized by Active Sudbury

66 children received bicycles through the bike exchange partnership, **75** Bicycles were collected to use in future events

503 individuals within the Sudbury, Espanola, Mindemoya, and Sudbury East service areas received pairs of skates through the skate exchange partnership

- **314** pairs were collected in addition to **21** boxes of skates from Value Village

63 people attended presentations related to sleep hygiene

1 295 people participated in our Community Sleep Survey

Prevention of Injury and Substance Misuse

5 Neonatal Intensive Care Unit (NICU) in-services for general car seat safety for nursing staff

5 car seat technician trainings, **2** technicians recertified, **29** new car seat technicians trained, **4** instructors trained (Sudbury, Porcupine, Temiscaming and Algoma)

195 car seats evaluated, **59** car seat inspection clinics held

59 hockey helmets and **53** bike helmets provided to youth and adults in need

128 lawn signs and **4** digital billboards to address vulnerable road users safety

100 youth counsellors received a presentation on concussion prior to the summer

200 Manitoulin Island Secondary School students educated about the danger of texting and driving

80 texting and driving radio messages in Manitoulin

210 students educated on bicycle helmet safety in Sudbury East. **12** helmets and **50** vouchers distributed

150 students educated on bicycle helmet safety in Manitoulin and **150** helmets distributed

15 helmet vouchers distributed in Espanola

1 100 ATV resources were distributed in Sudbury East

Falls Prevention in Older Adults

64 community partners engaged in Stay on Your Feet (SOYF) Sudbury-Manitoulin Falls Prevention Coalition meetings

5 Northeast public health units and the NELHIN engaged in regional planning

3 SOYF regional working groups (physical activity, medication management, evaluation)

45 134 SOYF educational resources distributed

3 710 Exercise booklets outlining exercise programs in Sudbury for older adults distributed

10 community events with Stay On Your Feet information and resources shared with **608** attendees including males, French, and Indigenous populations

38 Stand-Up exercise programs supported throughout Sudbury and Districts (includes programs in French and Indigenous populations)

14 facilitators received STAND UP! refresher training

76 CTV spots across the North East reaching **215 910** with **456** views on Facebook and **125** views on YouTube – medication management commercial (phase one of regional fall prevention campaign)

10 older adult video testimonials on physical activity developed (phase 2 of campaign)

38 Assistive Devices Program clinics supported in the community (Parkside Centre for Older Adults)

13 Sudbury Rising Star community performances on fall prevention messaging to **484** attendees

3 Age-friendly communities being supported

Alcohol Misuse Prevention

1 provincial wide campaign – Rethink Your Drinking "Size Matters" (RYD)

1 promotional video for RYD campaign

25 000 views for the RYD video shown at Imagine Cinemas over 3 month period (December 2016 – March 2017)

14 397 guests viewed the RYD video played at SilverCity Cinemas for 1 week during campaign

721 visits to RYD website for the RYD campaign

2 telephone interviews with Radio Canada and Manitoulin Expositor

47 students reached through 2 information booths and pour challenges to promote Canada's Low-Risk Alcohol Drinking Guidelines (LRADG)

53 students reached via training presentation on LRADG to Residence Assistance staff at Laurentian University

2 events in the community (held by Action Sudbury – Chain of Life Event for Grade 12 students and Red Ribbon Campaign) attended and supported

48 162 total users reached on our Alcohol; Let's Get Real Facebook page

School Health

807 total activities provided reaching **20 040** school community members (school administration, school staff, parents, students and community partners)

- **299** chronic disease prevention (CDP) activities in elementary and secondary schools, and post-secondary institutions – Healthy eating (**136**), tobacco prevention (**74**), sexual health (**37**), physical activity (**23**), child health (**13**), substance use (**10**), and healthy weights (**6**) – reaching **3 554** school community members
- **337** resilient school communities activities, reaching **9 504** school community members
- **154** mental health promotion activities reaching **6 771** school community members
- **18** activities reaching **565** post-secondary students and faculty members. The topics addressed included physical activity, resiliency,

healthy eating, mental health promotion, and substance use.
- **22** sessions held in alternative schools reaching **162** staff and students. These sessions included workshops/presentations on mental health promotion, resiliency, and mindfulness.
- **316** workshops/presentations delivered on topics including resiliency, healthy eating, healthy weights, sexual health, mental health promotion and substance use that reached **16 257** school community members
- **41** training sessions and workshops/presentations reached a total of **957** adults in school communities
- **13** youth group meetings were held with Indigenous youth as part of the This is My Tobacco project

4 schools participated in a 15 week mindfulness pilot project

17 686 students in **82** elementary schools received fruits and vegetables weekly for **10** weeks as part of the Northern Fruit and Vegetable Program

Workplace Health

4 workplace health presentations delivered to **110** people

24 consults on workplace health initiatives

8 requests for presentations and workshops on workplace health topics

20 individuals representing **16** workplaces attended the workplace health network meetings

168 pedometers borrowed by a total of **5** workplaces

393 copies of workplace health newsletters distributed to **332** workplaces in the Sudbury and district area and **111** members of the Workplace Health E-Network

2 promotional radio ads to promote Canada's Healthy Workplace Month on KISS 105.3 and KICX 91.7 reaching **40 000** residents 12 years old and over

3 442 followers on Facebook would have seen our weekly messages for Canada's Healthy Workplace Month

2 490 followers on the Twitter Account would have seen our weekly tweets for Canada's Healthy *Workplace Month*

Smoke-Free Ontario (TCAN)

All **7** TCANs and **10** NGO partners participated in Freeze the Industry – Plain and Standardized Packaging, reaching **104 159** people through social media, and over **8 000** participants through various initiatives (events, presentations, leadership activities)

32 participants attended the Engaging Indigenous Young People Summit (Walking the Good Life) in the spring of 2017

38 participants attended the Engaging Indigenous Young People Summit (Planning) in the fall of 2017

Over 232 500 people reached through social media for Smoke-Free Movies and over **20 800** people took action (petition signatures)

Multi regional/Leave the Pack Behind public education cinema ad campaign promoting

the Would You Rather Contest (WUR) targeting young adults to quit, reduce or never start smoking

21 TCAN members participated in a tobacco cessation knowledge exchange session on increasing quit attempts using testimonials in the northeast region

20 TCAN members (tobacco enforcement officers and tobacco control coordinators) participated in a tobacco protection/enforcement knowledge exchange session for the northeast region

Promoted Fire Prevention Week October 8 through 14, 2017, with message of smoke-free housing/multi-unit housing via social media ads

Public education media campaign promoting smoke-free multi-unit housing/housing using regional television ads ran October through December 2017 targeting **742 000** people

589 northeast region tobacco vendors referred to SFOA-Training.com for tobacco vendor education (e.g. sales to minors)

85 TV ads with a reach of **249 500** weekly were created and aired regionally to promote the youth access component of the Electronic Cigarette Act (ECA)

705 French and English posters and **1 125** bilingual postcards were distributed throughout the northeast region to educate youth on ECA youth access legislation

Family Health

Healthy Growth and Development

1 poster presentation highlighting Baby Friendly designation

37 breastfeeding mothers attended the face to face support group implemented in Greater Sudbury

20 mothers and their children attended the Breastfeeding Challenge 2017. In partnership with Rainbow Routes and Jubilee Heritage Hub with support of the Sudbury BFI workgroup members, Rainbow Routes led a walk through Mallards Landing followed by the Breastfeeding Challenge at the South End Hub.

4 new volunteers were trained for “A Breastfeeding Companion” program

482 hand expression kits were distributed to HSN and the public

645 prenatal packages delivered to health care provider offices

240 pregnant women and their support persons attended prenatal classes

105 pregnant women registered for online prenatal

100 people participated in an FASD awareness event. We promoted alcohol-free drinks during pregnancy. Partners included Laurentian University with an affiliation with CANFasd. Laurentian University provided mocktails in the Atrium to students and staff.

118 parents participated in Triple P Program interventions

3 staff from the FHT attended Reaching In and Reaching Out three day intensive training. A resiliency program for adults working with children 0-8 years.

9 presentations were completed regarding resiliency with approximately **89** people throughout community agencies such as

Our Children Our Future, Children's Aid Society, and the City of Greater Sudbury staff

156 community phone calls fielded by family health (e.g. Triple P, breastfeeding, safe sleep, healthy eating and child safety, and injury prevention)

3 primary health care stakeholders engaged and used an Electronic Medical Record (EMR) based NutriSTEP questionnaire to provide nutrition education and follow-up services to patients

2 internal programs were engaged and used the NutriSTEP questionnaire to provide nutrition education and follow-up services to patients

128 toddlers were screened using the NutriSTEP questionnaire

96 preschoolers were screened using the NutriSTEP questionnaire

1 Program for the Education and Enrichment of Relationship Skills (PEERS) research project with Health Sciences North

Community Drug Strategy

1 takeactionsudbury.ca website integrated into the Public Health Sudbury & Districts website

5 Community Drug Strategy Steering Committee meetings

3 Community Drug Strategy Executive Committee

2 drug alerts were released to prevent overdoses in the community

1 media interview on Cannabis use with the new C 45 Cannabis Act

1 presentation at the N'Swakamok Native Friendship Centre

262 residents responses to the Manitoulin Drug Strategy Drug and Alcohol Use and Misuse Survey

Mental Health and Addictions

Mental Health Promotion

1 mental health literature review and 1 environmental scan of Public Health Sudbury & Districts' catchment area conducted

20 community partners recruited for the Mental Health and Addictions Systems Planning Action Table across **6** sectors (health, child, education, police, justice and municipalities)

5 staff received Mental Health First Aid Training

5 staff participated in a tour of Northern Initiative for Social Action, a new partner agency in Mental Health Promotion

5 public health units consulted on mental health and addictions programming

11 meetings with external stakeholders

Harm Reduction – Naloxone

16 naloxone telephone inquiries

35 naloxone email inquiries

4 in person consultations about naloxone program

Resources, Research, Evaluation and Development (RRED) Division

Population Health Assessment and Surveillance

SDHU Population Health Profile

Completed sections on Infectious and Communicable Diseases and Injuries and Poisonings with most currently available data.

1 Population Health Assessment and Surveillance team-Indicator Report for internal use on more than 8 indicators

49 internal and external data requests, and **27** consultations on topics such as communicable diseases, demographics, determinants of health, maternal health, chronic disease, mental health, etc.

1 930 Public Health Sudbury & Districts area residents surveyed by Rapid Risk Factor Surveillance System (RRFSS)—1 130 as part of the regular Public Health Sudbury & Districts cycles and an additional 800 surveys to provide information at each district office area level

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

Research, Evaluation, and Needs Assessments

18 research and evaluation projects where RRED acts in a lead or consultation role, including: Relationship building with First Nations and public health: Exploring principles and practices for engagement to improve community health

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

15 new proposals reviewed by the Research Ethics Review Committee

1 needs assessment

54 web surveys

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

Knowledge Exchange

2 Knowledge Exchange Symposiums

4 Knowledge exchange sessions

43 conference or external meeting presentations and workshops

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

Contribution to 26 rapid reviews of evidence or reviews of literature

Professional Practice and Development

Academic Affiliations

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

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

Student Placements

95 students from **10** post-secondary institutions representing **14** disciplines

8 956 hours of student placement experience

16 undergraduate medical students from NOSM

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

2 NOSM dietetic interns

3 Masters in Public Health students

8 new online orientation modules developed for students as part of their orientation

1 preceptor appreciation event

76 staff and **10** teams in preceptor roles

Staff Development

5 lunch and learn sessions (hosted by Nutrition Working Group, Workplace Wellness Committee, and Clinic and Family Services Division, Manager Professional Practice and Development)

10 management development sessions (5 in person and **5** externally hosted webinars)

34 cross-divisional development opportunities (**9** in person and **25** via webinar)

16 division specific development webinars offered

25 externally hosted staff development webinars/teleconferences offered to staff

Strategic Planning

Promotion of the 2013–2017 Strategic Plan continued through internal activities (use of the whiteboards, Inside Edition, ceiling decals)

300 Strategic Plan engagement surveys were completed by the public, partners, staff, and Board of Health members to inform the 2018–2022 strategic planning process

1 poster presentation was delivered at the Ontario Public Health Association Fall Forum about the 2018–2022 planning process

Performance Monitoring

1 *SDHU Annual Performance Monitoring Report* presented to the Board of Health (part of the 2013–2017 Performance Monitoring Plan)

1 *SDHU 2016 Annual Report – Connections* presented to the Board of Health as outlined within the Ontario Public Health Organizational Standards

3 *Strategic Priorities Narrative Reports* presented to the Board of Health and shared with external community partners

Monitoring of indicators to measure the SDHU's performance as an organization and to further demonstrate our commitment to excellence and accountability

Collection of performance monitoring data for 2017

Compliance with the Ontario Public Health Organizational Standards

Reporting of the Public Health Accountability Agreement Indicators

Committee Work and Partnerships

Participation on:

4 national committees, **16** provincial committees, and **20** local or regional committees, e.g. City of Greater Sudbury Community Safety and Well-being Planning Committee, Sudbury Data Consortium, Public Health Ontario's Ethics Review Board

Health Equity Team

Planning and delivery of three linked programs to support local poverty reduction featuring intersectoral partnerships and collaboration:

11 partner agency external steering committee established; **10** engagement sessions, **9** steering committee meetings; Indigenous and Francophone advisory committees established

23 Bridges out of Poverty workshops; **442** participants representing **68** organizations

19 Circles Leader Training Sessions; **23** participants

Circles planning and program development; **2** public information sessions

External

58 presentations (including 19 Bridges out of Poverty and 19 Leader Training), **17** requests for health equity resources, **26** consultations, **11** partner support instances (e.g. grant writing, evaluation support, community events), **4** requests for the adaptation of Public Health Sudbury & Districts health equity resources

Internal

24 instances of staff support, **24** consultations, **5** presentations (including 4 Bridges out of Poverty), and **9** resources provided or created

Strategic Engagement Unit (SEU)

Communications Support and Consultations

252 resource review and approval requests

86 media releases issued

145 media requests processed by SEU staff

Electronic and Social Media Reach

806 988 Facebook users reached

296 400 Twitter impressions

430 Requests for information received through the Health Unit's website www.sdhu.com

1 Public Health Champion, Dr. McElhaney, was recognized for her work in older adult influenza vaccinations and her collaborative and compassionate approach to Indigenous health equity

Respectfully submitted,

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

TOWNSHIP OF NAIRN AND HYMAN

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

January 25, 2018

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

RE: Food Insecurity / Nutritious Food Basket Costing

Dear Premier Wynne:

Please be advised that our Council adopted the following resolution at their meeting of January 8, 2018:

SUPPORT RESOLUTION RE SOCIAL ASSISTANCE RATE INCREASE
RESOLUTION #2018-1-9
MOVED BY: Riet Wigzell
SECONDED BY: Katherine Bourrier
RESOLVED: that Council supports resolution number 48-17 adopted by the Sudbury and District Board Health on November 23, 2017 requesting that social assistance rates be increased immediately to reflect the cost of the Nutritious Food Basket and local housing costs.

CARRIED

Sincerely Yours,

Robert Deschene,
CAO-Clerk-Treasurer
RD/lc
cc: Sudbury & District Health Unit
Michael Mantha, MPP, Algoma-Manitoulin
Carol Hughes, MP, Algoma-Manitoulin-Kapuskasing
Association of Municipalities of Ontario
Federation of Northern Ontario Municipalities

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

JAN 2 4 2018

iApprove-2017-01523

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 $16,000 in additional base funding and up to $40,554 in one-time funding for the 2017-18 funding year to support the enhanced provision of Needle Exchange Program Initiative in your community.

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

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

Yours sincerely,

Dr. Eric Hoskins
Minister

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

January 5, 2018

Sent via email to: incomesecurity@ontario.ca; mcssinfo.css@ontario.ca

Ministry of Community and Social Services
80 Grosvenor St - Hepburn Block - 6th Floor
Toronto ON M7A 1E9

Dear Minister Jaczek,

I am writing as the Medical Officer of Health of Northwestern Health Unit to provide feedback on the recently released report called “Income Security: A Roadmap for Change”. As the Medical Officer of Health, I lead the local public health agency in Northwestern Ontario that covers part of the Kenora District and the Rainy River District, and includes 19 municipalities and 40 First Nation communities[1]. Local public health agencies implement programs and services that promote health, prevent illness and protect from disease.

Research has established the strong relationship between income and health. With increasing income, there are improvements in a wide scope of health outcomes including life expectancy, mortality and morbidity of cancers, heart disease, lung disease, mental health, addictions and substance misuse, and infectious diseases[2]. For the population of Northwestern Ontario, there are high rates of mental health, addictions, chronic diseases such as cancer and lung disease, and life threatening infectious diseases such as hepatitis C and invasive group A streptococcus[3]. Poverty/low income is a significant contributor to the high rates of these diseases.

Poverty and low-income intersect and impact other social determinants of health including housing, education, early childhood development, access to affordable and healthy foods (food security) and social inclusion[2]. Inequities in health brought about by these social factors can be challenging to change. Poverty/low-income is a core issue that must be addressed in order to improve food insecurity, early childhood vulnerability, housing inadequacy and overall health.

I applaud the work that has been carried out in to produce “Roadmap for Change”. The recommendations of the report can have substantial population health improvements for the individual, the family, the community, and future generations.

1. Northwestern Health Unit 2. The Canadian Facts 3. Health Statistics - Northwestern Health Unit 4. Cost of Eating in Northwestern Ontario

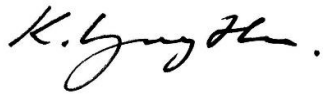
Northwestern Health Unit
www.nwhu.on.ca

In particular, I stress the importance of the following:

1. ***Income adequacy*** to ensure affordable housing and food security. Northwestern Health Unit often has the highest cost of food in Ontario with remote First Nation communities being particularly affected. Northwestern Ontario statistics indicate that current social assistance rates are distressingly inadequate considering the cost of food and housing[4].
2. Income as it relates to ***early childhood development***. Early childhood experiences are affected by family income[2]. Poverty/low-income contributes to family stress, food insecurity, social exclusion, and decreased opportunities which can have detrimental effects on the critical period of the early years. Early childhood development has lifelong impacts on health outcomes, high school completion rates, educational attainment, employment success and subsequent demands on the social service and criminal justice system. I strongly support the recommendations under *Income Supports for Children*
3. Income as it relates to ***housing***. Safe, stable and affordable housing is necessary for addressing health concerns and maintaining good health[2]. Northwestern Ontario is plagued with high rates of mental health and addictions. Recovery from such illnesses would be challenging for anyone and is particularly difficult without stable housing. I strongly support the recommendations under *Ontario Housing Benefit.*

As a public health and preventive medicine specialist and a Medical Officer of Health, I fully support the recommendations of “Roadmap to Change”. Moving forward with the recommendations of this report will be **investing in human health and wellbeing**, will lead to the improvements in population health, and will decrease future demands on the health care system, social service system and justice/enforcement system.

Sincerely,



Dr. Kit Young Hoon, Medical Officer of Health
Northwestern Health Unit

Copy: Hon. Kathleen Wynne, Premier of Ontario
Hon. Peter Milczyn, Minister Responsible for the Poverty Reduction Strategy
Hon. Eric Hoskins, Minister of Health and Long-term Care
Hon. Michael Coteau, Minister of Child and Youth Services
Sarah Campbell, MPP, Kenora – Rainy River
Dr. David Williams, Chief Medical Officer of Health, Ontario
Board of Health, Northwestern Health Unit

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT

BOARD OF HEALTH

MOTION/RESOLUTION

No. 10-2018

Moved by Alan Smith

Seconded by Enid Board

THAT 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, it is well documented that household income influences housing, food security, education, early childhood development and the ability to participate in society; and

WHEREAS, evidence confirms that people with lower incomes have inadequate nutrition, poorer physical and mental health and higher rates of mortality, and;

WHEREAS, low-income individuals and families are more likely to be challenged with covering basic needs and 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 those experiencing poverty/low income 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, for the population of Northwestern Ontario, poverty/low income is a significant contributor to the high rates of mental illness, addictions, chronic diseases such as cancer and lung disease, and life threatening infectious diseases such as hepatitis C and invasive group A streptococcus; 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, proceeding with the recommendations of *Income Security: A Roadmap for Change*, will lead to substantial population health improvements for individuals, families, communities and future generations; and

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT

BOARD OF HEALTH

MOTION/RESOLUTION

WHEREAS, the Roadmap will decrease future demands on the health care system, social service system and justice/enforcement system;

THEREFORE BE IT RESOLVED that the Northwestern Health Unit Board of Health commend the work done in producing the "Roadmap for Change", as an effort to make a better life for those experiencing poverty/low income; and

FURTHER BE IT RESOLVED THAT the Board of Health fully support the recommendations made in this report as an investment in human health and wellbeing; 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.

	Yea	Nay	Abstained	Disclosure of Interest
C. Baron				
D. Brown				
Y. Kirlew				
L. MacDonald				
J. Ruete				
P. Ryan				
T. Sachowski				
S. Smith				
D. Squires				
B. Thompson				

CARRIED ✓ Date: January 19, 2018

Chair Paul Ryan

Ministry of Health and Long-Term Care

Assistant Deputy Minister's Office

Population and Public Health Division
777 Bay Street, 19th Floor
Toronto ON M7A 1S5

Telephone: (416) 212-8119
Facsimile: (416) 212-2200

Ministère de la Santé et des Soins de longue durée

Bureau du sous-ministre adjoint

Division de la santé de la population et de la santé publique
777, rue Bay, 19e étage
Toronto ON M7A 1S5

Téléphone: (416) 212-8119
Télécopieur: (416) 212-2200

December 29, 2017

MEMORANDUM

TO: Medical Officers of Health, CEOs, and Board Chairs

RE: Ontario Public Health Standards: Requirements for Programs, Services, and Accountability

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Dear Colleagues,

In follow up to the November 16th Public Health Summit, please find attached the official Ontario Public Health Standards: Requirements for Programs, Services and Accountability (Standards), which come into effect January 1st, 2018. The Standards are published by the Minister of Health and Long-Term Care under the authority of section 7 of the *Health Protection and Promotion Act* (HPPA) to specify the mandatory health programs and services provided by boards of health.

Appendix 1 includes a summary of the changes to the Standards in comparison to the version that was released at the November 16th summit, as well as a summary of changes to the provincial case definition for Hepatitis C.

The following protocols and guidelines are included as part of the official release and are also in effect as of January 1st, 2018:

- Board of Health and Local Health Integration Network Engagement Guideline, 2018
- Electronic Cigarettes Protocol, 2018
- Menu Labelling Protocol, 2018
- Population Health Assessment and Surveillance Protocol, 2018
- Tanning Beds Protocol, 2018
- Tobacco Protocol, 2018
- Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018
- Substance Use Prevention and Harm Reduction Guideline, 2018
- Vaccine Storage and Handling Protocol, 2018

The remaining incorporated protocols and guidelines will be released at a later date and will come into effect on the date of release. Please see Appendix 2 for more details. It is

…/2

expected that boards of health will continue to operate business as usual until the new protocols and guidelines have been released. Finally please note that the Healthy Babies Healthy Children Protocol, 2018 will be released by the Ministry of Children and Youth Services shortly.

As previously communicated, the implementation of the Standards begins on January 1st 2018, and will continue throughout the year. The ministry will continue to work with all our health unit partners to support you during this transition. We will provide an update early in the New Year on the proposed Standards Implementation Work Plan, which will include the development of tools, training, and other supports.

However, an important update we are sharing at this time is the establishment of an Indicator Implementation Task Force in early 2018 to support the implementation of the Public Health Indicator Framework for Program Outcomes and Contributions to Population Health Outcomes. In response to the consultations, the indicator implementation task force will include activities such as: the identification of the indicators within the framework that can be reported on by the end of 2018, identification of data source gaps, establishment of definitions and data sources as needed, and identification of where data collection can be centralized. There could be other activities as well - these are a reflection of what we heard during consultations.

All the documents circulated today will also be available on the Ministry's website in English and French in January, and we will provide the web link as soon as it is ready.

Thank you all for your continued support and collaboration. If you have any questions, please do not hesitate to contact the ministry by e-mail at PHTransformation@ontario.ca.

Sincerely,

Original signed by

Roselle Martino
Assistant Deputy Minister
Population and Public Health Division

c: Dr. David Williams, Chief Medical Officer of Health
Darryl Sturtevant, ADM, Ministry of Children and Youth Services (MCYS)
Stacey Weber, Director, Early Child Development Branch (MCYS)
Jackie Wood, Director, Planning and Performance Branch
Nina Arron, Director, Disease Prevention Policy and Programs Branch
Liz Walker, Director, Accountability and Liaison Branch
Laura Pisko, Director, Health Protection Policy and Programs Branch
Dianne Alexander, Director, Healthy Living Policy and Programs Branch
Clint Shingler, Director, Health System Emergency Management Branch

Appendix 1: Summary of Changes to the Standards Document and Provincial Case Definition for Hepatitis C

Document	Summary of Changes
Standards Document	Healthy Environments Standard: Addition of reference to the Healthy Environments and Climate Change Guideline, 2018 in requirements 3, 4, and 7 of the standard.
	Infectious and Communicable Diseases Prevention and Control Standard : Replacement of the term “reportable diseases” with “diseases of public health significance”. Addition of a program outcome and requirements related to the control of avian chlamydiosis, avian influenza, novel influenza and Echinococcus multilocularis infection. Addition of the following 5 new guidelines: Management of Potential Rabies Exposures Guideline, 2018; Tuberculosis Program Guideline, 2018; Management of Avian Chlamydiosis in Birds Guideline, 2018; Management of Avian Influenza or Novel Influenza in Birds or Animals Guideline, 2018; and Management of Echinococcus Multilocularis Infections in Animals Guideline, 2018.
	School Health Standard: Addition of a new School Health Guideline.
	Substance Use and Injury Prevention Standard: Addition of “substance use” to the list of topics for consideration.
	Public Health Indicator Framework for Program Outcomes and Contributions to Population Health Outcomes: Removal of the indicators related to the Healthy Environments Standard (added to the list of standards where indicators will be locally determined). Addition of an indicator under the Immunization Standard related to adverse events following immunization (AEFI).
Provincial Case Definition for Hepatitis C	The Provincial Case Definition for Hepatitis C has been revised to reflect changes to Regulation 569 under the HPPA. It is outlined in Appendix B of the Infectious Diseases Protocol and will come into effect on January 1, 2018. The updates to this document will allow public health units to classify cases based on whether they are newly acquired versus previously acquired/unspecified, and infectious versus non-infectious. Resources to support public health units in the implementation of the new case definition will be provided by Public Health Ontario. Updates to the Disease-Specific Chapter for Hepatitis C will come into force at a later date and the document will be released at the time.

Appendix 2: Summary of Remaining Protocols and Guidelines and Anticipated Release Dates

Document	Anticipated Release Date
Food Safety Protocol, 2018	January
Operational Approaches for Food Safety Guideline, 2018	January
Recreational Water Protocol, 2018	January
Operational Approaches for Recreational Water Guideline, 2018	January
Safe Drinking Water and Fluoride Monitoring Protocol, 2018	January
Small Drinking Water Systems Risk Assessment Guideline, 2018	January
Health Hazard Response Protocol, 2018	January
Healthy Environments and Climate Change Guideline, 2018	January
Infectious Diseases Protocol, 2018	January
Infection Prevention and Control Complaint Protocol, 2018	January
Infection Prevention and Control Disclosure Protocol, 2018	January
Infection Prevention and Control Protocol, 2018	January
Institutional/Facility Outbreak Management Protocol, 2018	January
Management of Potential Rabies Exposures Guideline, 2018	January
Rabies Prevention and Control Protocol, 2018	January
Tuberculosis Prevention and Control Protocol, 2018	January
Tuberculosis Program Guideline, 2018	January
Management of Avian Chlamydiosis in Birds Guideline, 2018	January
Management of Avian Influenza or Novel Influenza in Birds or Animals Guideline, 2018	January
Management of Echinococcus Multilocularis Infections in Animals Guideline, 2018	January

Document	Anticipated Release Date
Health Equity Guideline, 2018	January
Relationship with Indigenous Communities Guideline, 2018	February
Chronic Disease Prevention Guideline, 2018	January
Injury Prevention Guideline, 2018	January
Mental Health Promotion Guideline, 2018	January
Healthy Growth and Development Guideline, 2018	January
Child Visual Health and Vision Screening Protocol, 2018	January
Oral Health Protocol, 2018	January
Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018	January
Qualifications for Public Health Professionals Protocol, 2018	January
School Health Guideline, 2018	February
Guidelines for Emergency Management	TBD

From: Info [mailto:info@alphaweb.org]
Sent: Monday, February 5, 2018 3:12 PM
To: All Health Units <AllHealthUnits@lists.alphaweb.org>
Cc: Lynn Guy <lynn.guy@mlhu.on.ca>
Subject: Support for maintaining local surveillance and monitoring of food costing by public health units within the modernized Standards for Public Health Programs and Services (SPHPS);

Attention Boards of Health

At the November 16th, 2017 meeting of the Middlesex-London Board of Health, report No. 060-017 (attached) was reviewed and it was recommended that the Board of Health:

1. ***Write to the Minister of Health and Long-Term Care supporting maintaining local surveillance and monitoring of food costing by public health units within the modernized Standards for Public Health Programs and Services (SPHPS);***
2. ***Submit a letter to the Associate Deputy Minister of Health System Information Management and CIO of the Ministry of Health and Long-Term Care, and the Director General of the Office of Nutrition Policy and Promotion at Health Canada, advocating for the Household Food Security Survey Module to be made a core module of the Canadian Community Health Survey; and,***
3. ***Forward Report No. 060-17 re: "2017 Nutritious Food Basket Survey Results and Implications for Government Public Policy" and Appendix A to Ontario Boards of Health, the City of London, Middlesex County, and appropriate community agencies.***

Regards

Lynn

Lynn Guy
Executive Assistant to the Medical Officer of Health and CEO
Middlesex London Health Unit | 50 King St., London, ON N6A 5L7
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Share the Road Announces Bicycle Friendly Community Awards

40 Communities in Ontario now recognized as Bicycle Friendly

Ottawa, Ontario (January 10, 2018) – The Share the Road Cycling Coalition (Share the Road) announced today the latest Bicycle Friendly Community (BFC) awards for Ontario.

The most recent application round saw the City of Greater Sudbury earn a Bronze Bicycle Friendly Communities Award, making it Ontario's 40th Bicycle Friendly Community. The Town of Ajax also received a Silver Award, which is an upgrade from the Town's previous Bronze designation (2011). In addition to the new awards, The City of Thorold renewed its Bronze designation and the City of Ottawa renewed its Gold status as one of Ontario's leading bicycle friendly communities. The Town of Lincoln and the Town of Saugeen Shores both received Honourable Mentions for their applications.

"The new & renewing award recipients in this round illustrate how cycling is growing and evolving across the Province of Ontario," said Jamie Stuckless, Executive Director of Share the Road. "Municipalities of all shapes and sizes are recognizing that when their communities bike, their communities benefit, be it through improved road safety, decreased congestion, increased support for the local economy or improved health and well-being."

The City of Greater Sudbury joins Thunder Bay and Temiskaming Shores as Bronze level BFCs in the Ontario's North, demonstrating the growing demand for cycling in all areas of the province. "Greater Sudbury is an example of how the work and support of community groups can help to foster a culture of cycling," noted Stuckless. "Local organizations like Rainbow Routes and the Sudbury Cyclists' Union have been working for years to educate people about the benefits and opportunities for cycling in Greater Sudbury, laying the foundation for a more bicycle friendly community. Greater Sudbury has now invested in staff resources and made budgetary commitments to improve their cycling network. They are also receiving more than $1.1 Million from the Ontario Municipal Commuter Cycling Program, giving them the opportunity to develop a connected network of safe cycling infrastructure in the near future."

Ajax is a community that has been a part of the BFC network since the program began, providing information, leadership and inspiration for many other communities in Ontario as they strive to become more Bicycle Friendly. Ajax was one of the first communities to submit a BFC Application when the program was launched in Ontario in 2010, and was part of the inaugural group of BFCs announced in 2011. Since then, the Town has made improvements in their infrastructure, building a well-connected network of off-road trails while also making improvements to their on-road cycling infrastructure. "Ajax has long been a leader in Durham Region when it comes to active transportation," said Stuckless. "They were one of the first municipalities in Ontario to adopt a Complete Streets Policy, and they continue their innovative work with their #GetAjaxMoving social marketing campaign. It's very exciting to see them continuing to make progress and advance through the BFC rankings."

Stuckless noted that 2017 was a great year for cycling in Ontario, with the announcement of $93 Million for municipal cycling infrastructure. "We anticipate that many of our BFC partners will be making substantial improvements in the 'Engineering' sections of their applications thanks to that funding," she said. "Ajax, Greater Sudbury and the City of Ottawa have all set an example of the importance of the other 4 Es of the BFC Program – Education, Encouragement, Enforcement and Evaluation & Planning, and we encourage all municipalities to learn from their successes as they go about building new cycling infrastructure and programs to support cycling. As we see communities set their sights on Platinum and, eventually, Diamond BFC certifications, an integrated approach to building not just cycling infrastructure, but a cycling community is going to be required – so it's best to lay those foundations now."

About the Bicycle Friendly Community Awards and Share the Road

The Bicycle Friendly Communities (BFC) Program, an initiative of the Washington-based League of American Bicyclists, was launched in Ontario in 2010 by Share the Road with support from the Canadian Automobile Association (CAA) South Central Ontario. The program provides incentives, hands-on assistance and award-recognition for communities that actively support bicycling. Municipalities are judged in five categories often referred to as the Five "E's" of being bicycle friendly: Engineering, Education, Enforcement, Encouragement and Evaluation & Planning. A community must demonstrate achievements in each of the five categories in order to be considered for an award. **The Award categories are: Bronze, Silver, Gold, Platinum and Diamond.**

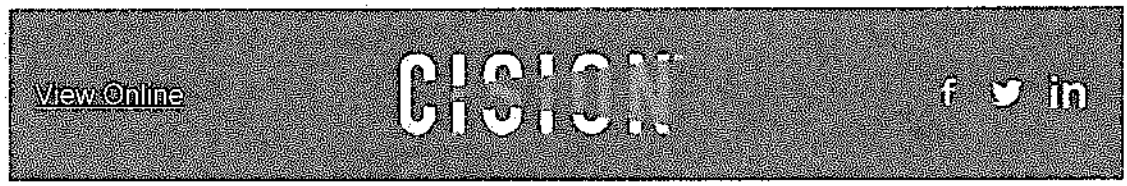
Share the Road is a provincial non-profit organization working to build a bicycle friendly Ontario. We work in partnership with municipal, provincial and federal governments, the business community, road safety organizations and other non-profits to:

- Enhance access for bicyclists on roads and trails
- Improve safety for all bicyclists
- Educate citizens on the value and important of safe bicycling for healthy lifestyles and healthy communities.

For information: Jamie Stuckless, Executive Director (905) 233-2273 ext. 100 jamie@sharetheroad.ca

Justin Jones, Bicycle Friendly Community Program Coordinator (905) 233-2273 ext. 110 justin@sharetheroad.ca

From: my CNW subscription <noreply@newswire.ca>
Date: January 26, 2018 at 12:19:45 PM EST
To: Portfolio E-Mail <noreply@newswire.ca>
Subject: Government of Canada Supports Program that Promotes Smoke-free Lifestyle



News by Public Health Agency of Canada
Transmitted by Cision on January 26, 2018 12:13 ET

Government of Canada Supports Program that Promotes Smoke-free Lifestyle

Picking Up the PACE program addresses risk factors for chronic disease related to smoking

TORONTO, Jan. 26, 2018 /CNW/ - Tobacco use is the leading preventable cause of disease and premature death in Canada. One Canadian dies from a smoking-related illness every 12 minutes, and smoking-related illnesses claim the lives of more than 45,000 Canadians per year. That's why the Government of Canada is committed to reducing tobacco use in Canada to less than 5% by 2035.

Today, during National Non-Smoking Week, on behalf of the Honourable Ginette Petitpas Taylor, Minister of Health, Robert Oliphant, Member of Parliament, announced funding for *Picking Up the PACE* (Promoting and Accelerating Change through Empowerment) – a smoking cessation resource program for health practitioners provided through the Centre for Addiction and Mental Health (CAMH).

The program provides online courses for health practitioners as well as tools they can use with patients to help address multiple risk factors for smoking, such as excess alcohol consumption, physical inactivity, poor nutrition, stress and poor sleep. The program builds on CAMH's *Training Enhancement in Applied Cessation Counselling and Health Project,* which trains health practitioners on how to promote healthy living habits that can help Canadians decrease tobacco use. PACE is also supported by the Medical Psychiatry Alliance, a unique Canadian health care partnership between CAMH, The Hospital for Sick Children, Trillium Health Partners and the University of Toronto.

Quotes

"Our Government is pleased to provide funding towards the Centre for Addiction and Mental Health's work to promote smoke-free lifestyles. Promoting healthy living

habits goes hand-in-hand with decreasing the number of Canadians using tobacco and will help us achieve our goal of reducing tobacco use in Canada to less than 5% by 2035."

The Honourable Ginette Petitpas Taylor
Minister of Health

"The Government of Canada is proud to support programs like *Picking Up the PACE* that help reduce tobacco use and addiction, and contribute to improved health for Canadians. Through this project, we are helping health practitioners who support Canadians in improving their overall health, well-being and quality of life."

Robert Oliphant
Member of Parliament for Don Valley West

"Tobacco use alone is harmful enough but when combined with poor nutrition, physical inactivity, stress, poor sleep and or excessive drinking, the risk for chronic disease and dying early increase immensely. Our patients need expert treatment paying attention to root causes to improve these behaviours. I am very grateful to PHAC and for the additional support from the Medical Psychiatry Alliance to enable us to develop better programs to help patients lead healthier lives."

Dr. Peter Selby, Director of Medical Education
Centre for Addiction and Mental Health

"A healthy, smoke-free lifestyle can help reduce Canadians' risk for a number of chronic diseases. We often don't consider the multiple risk factors that can contribute to tobacco use, from poor nutrition and lack of physical activity to our ability to cope with stress. The Centre for Addiction and Mental Health's *Picking Up the PACE* program aims to address these factors by promoting healthy living habits that can support chronic disease prevention and decrease tobacco use by Canadians."

Dr. Theresa Tam
Canada's Chief Public Health Officer

Quick Facts

- Tobacco use plays a role in causing more than 40 diseases and other serious health outcomes, including cancer, respiratory ailments and heart disease.
- The Public Health Agency of Canada is investing $703,904 over five years through its *Multi-sectoral Partnerships Approach to Promote Healthy Living and Prevent Chronic Disease* to support CAMH's *Picking Up the PACE* program.
- CAMH is Canada's largest mental health and addiction teaching hospital and one of the world's leading research facilities in the field.

- A recent report released by the Conference Board of Canada and funded by Health Canada offered more evidence that tobacco use is a significant burden on all Canadians, costing society $16.2 billion in 2012 – $466 for every Canadian. This includes costs associated with direct health care, fire, policing, research and prevention as well as lost productivity due to disability and premature death.
- The Medical Psychiatry Alliance (MPA), which also supports the PACE program, is a collaborative partnership with CAMH, The Hospital for Sick Children, Trillium Health Partners and the University of Toronto, in conjunction with Ontario's Ministry of Health and Long-Term Care, focused on transforming care for people living with both mental and physical illness. MPA resources and evidence-based materials will assist with content development of PACE.

Associated Links:
Smoking and tobacco
Training Enhancement in Applied Cessation Counselling and Health

SOURCE Public Health Agency of Canada

For further information: Thierry Bélair, Office of Ginette Petitpas Taylor, Minister of Health, 613-957-0200; Media Relations: Public Health Agency of Canada, 613-957-2983; Public Inquiries: 613-957-2991, 1-866 225-0709

View Online

Government of Canada / Gouvernement du Canada

Statement from Dr. Theresa Tam, Chief Public Health Officer of Canada

Statements

From Public Health Agency of Canada

January 18, 2018

As Canada's Chief Public Health Officer, I am frequently asked to outline my priorities and plans for promoting and improving the overall health of Canadians.

My overarching role is to provide the Minister of Health and the Public Health Agency of Canada with evidence-based public health advice to improve and protect the health and safety of Canadians.

Over the course of my mandate, I will champion the reduction of health disparities in key populations in Canada. All Canadians deserve a chance to achieve optimal health so that they can fully participate in, and contribute to, society. A healthy Canada requires us to level the playing field, so that the poorest and most marginalized among us have a chance to lead healthy lives, both physically and mentally.

In so doing, I am committed to working with all of our partners, to support science and research to provide the best evidence to inform our actions, and to engage with Canadians, especially those with lived experience. I will continue to work collaboratively with the Public Health Network Council, the Council of Chief Medical Officers of Health, and with other federal ministries who, through their mandates and programming, can help effect change in the inequity landscape.

The Government of Canada has made a commitment to working closely with Indigenous Peoples to close socio-economic gaps and collaborate on shared priorities. This commitment will be at the forefront as I advance my priorities and contribute to broader efforts to improve the health and well-being of Indigenous Peoples of Canada.

Beyond the Public Health Agency of Canada's important role in disease prevention, health promotion, emergency preparedness and response, and scientific activities, I intend to have a particular focus on the following key areas:

- problematic substance use, with a focus on opioids and alcohol, and supporting pan-Canadian public education efforts on cannabis use and its potential health impacts for children and youth;
- reducing tuberculosis in Indigenous Peoples and immigrant populations;
- promoting childhood health with a focus on obesity, mental health, immunizations and breastfeeding;
- reducing sexually transmitted and blood-borne infections in at-risk populations;
- promoting the sound use of antibiotics and raising awareness of the risk of antimicrobial resistance; and
- raising awareness, as highlighted in my annual report, on how the built environment contributes to widening or reducing health inequities.

To deliver on these priorities, a collaborative and comprehensive approach is required because the public health community does not have all of the levers necessary to tackle these complex challenges. To be successful, we need a wide variety of partners from many different sectors of society from public health to primary care, to social services and economic development, and linking the not-for-profit sector with private sector partners. We must work together to address the underlying factors that prevent people from achieving optimal health, such as poverty, lack of safe and affordable housing, the accessibility to nutritious and affordable food, family violence, and physical and social environments.

A healthy Canada is a prosperous Canada. I will do my part in helping achieve this common goal.

Dr. Theresa Tam
Chief Public Health Officer

Search for related information by keyword: Health | Health impact | Health promotion | Public Health Agency of Canada | Canada | Health | Aboriginal peoples | general public | government | media | non-governmental organizations | statements

Date modified:
2018-01-18

OPINION

Canada must rethink health spending strategy

ANDRÉ PICARD ›
PUBLISHED JANUARY 22, 2018

If we want a healthier Canada, we should spend less on health care.

That's the counterintuitive conclusion of a new study.

But, of course, there's a catch: To reap the benefits, we need to spend the savings on social programs such as income assistance, subsidized housing, early childhood education and affordable child care.

In other words, we don't need to spend less on health, we need to do a better job of allocating our health dollars.

To start, we must redefine "health spending."

The vast majority of our health dollars go to providing care after people fall ill – principally for hospitals, physician services and drugs. Only about 5 per cent of health dollars go to prevention and health promotion.

But that's only part of the story. We spend about three times as much on sickness care as we do on social programs. This is a rough estimate, of course: While we track our sickness care obsessively – a large institution, the Canadian Institute for Health Information, was created solely for this purpose – no one is really tracking how much Ottawa, the provinces and territories invest collectively in social welfare.

That's where the new study, published in Monday's edition of the Canadian Medical Association Journal, comes in.

A team led by Dr. Daniel Dutton of the School of Public Policy at the University of Calgary compared funding for health care (read: sickness care) and social services from 1981 to 2011.

They found that average per capita spending for health was $2,900, almost three times the $930 per capita spending for social services.

More striking still is that health spending increased much more quickly than social-welfare spending over those three decades.

"Real" health spending (minus the impact of inflation) per capita doubled to $4,000 from $2,000 in that period. Meanwhile, real social spending rose to just $970 per capita from $770.

If you prefer the more traditional budgetary numbers, we spent $136-billion on health care in 2011, compared with $49-billion in 1981. By comparison, $33-billion went to social programs in 2011, up from $19.7-billion. (Again, these are constant dollars.)

Dr. Dutton's research team also looked at the impact of spending choices on health outcomes – specifically avoidable mortality, infant mortality and life expectancy. With some fancy math, they showed that if governments had spent one more cent on social services for every dollar spent on health, life expectancy in this country could have increased by another 5 per cent and avoidable mortality could have dropped an additional 3 per cent. (In their calculations there was no appreciable effect on child mortality.)

In a related commentary, Dr. Paul Kershaw of the School of Population and Public Health at the University of British Columbia said "these results add to evidence that should impel governments to seek better balance between medical and social expenditures."

That spending on social programs provides far more bang for the health buck than spending on sickness care is not news. We've long known that the conditions in which people grow, work, live and age (what academics call the social determinants of health) matter a lot more to the health of individuals and society than medicine does. Having a decent income, an education, housing, food security, a sound physical environment and a sense of belonging is what allows you to be healthy. People's health can also be adversely affected by racism, sexism, homophobia and other circumstances that interfere with those basic needs.

In democratic, just societies, we tackle these inequities with laws, political actions and social programs designed to redistribute wealth.

The new research reminds us that when we fail to do so, we pay the price in lost lives and life expectancy.

Yet, at the end of the day, we always pour money into sickness care and wind up shortchanging social programs that would result in people being healthier 10, 20 and 30 years down the road.

It is an approach best illustrated by a parable: One day, a group sitting by a river sees a baby in the water. One of them dives in to save her. Soon, more babies appear, and the bystanders all jump in to save the children. But one person has the presence of mind to go upstream and figure out how to stop babies from falling into the river in the first place.

In our public policies we need more of that upstream thinking, beginning with a sounder redistribution of health and sickness care spending.

FOLLOW ANDRÉ PICARD ON TWITTER @PICARDONHEALTH

OPINION

Fighting the flu: We need a new kind of intelligence

ALAN BERNSTEIN AND STEVEN HOFFMAN
CONTRIBUTED TO THE GLOBE AND MAIL
PUBLISHED JANUARY 22, 2018

Alan Bernstein is the president and CEO of the Canadian Institute of Advanced Research. Steven J. Hoffman is the scientific director of the Canadian Institutes of Health Research's Institute of Population & Public Health and a professor of Global Health, Law and Politics at York University.

Chances are this winter you've already had the aches, fever and exhaustion that typically accompany the flu, or at least you know people who have. As this becomes one of the worst flu seasons on record, public-health agencies around the world are working to monitor and track the spread of the virus. But it's a difficult process.

Artificial intelligence will soon help us undertake this task better, faster and cheaper. Canadian researchers are developing AI systems that monitor social media, calls to health lines, emergency-room visits and other real-time data sources, so that computer algorithms can identify flu outbreaks much earlier. The goal is to help public-health agencies accurately identify the start and spread of infectious diseases so that we can all react more effectively. For example, real-time analysis of huge quantities of data – enabled by AI – could allow authorities to create systems of mobile notifications, arm clinicians with relevant information, and rapidly evaluate the effectiveness of their efforts.

This is just one way in which AI is already starting to improve public health. However, solving problems like these is easier said than done.

With the amount of available data increasing exponentially, combined with increasing computer power and artificial intelligence techniques, it is now possible to make much more accurate predictions about everything – from the weather to traffic collisions to the next disease outbreak. The applications of AI are endless.

AI is particularly helpful for medicine, with applications ranging from the detection of genetic mutations in our DNA to improvements in medical diagnostics, image recognition, pharmaceuticals and personalized medicine, among others. The great promise of AI for medicine explains why the Senate's standing committee on social affairs, science and technology is working on recommendations to further integrate AI into Canada's health-care system.

But so far AI approaches have not been widely used to tackle public-health challenges, such as infectious disease outbreaks or efforts to promote healthy behaviours and prevent chronic disease. This is a missed opportunity – one that makes us all less healthy than we could be.

Public health poses an interesting challenge: It primarily deals with disease prevention. It is hard to demonstrate the value of public-health interventions when the desired outcome is the absence of disease. Consider the polio vaccine. Before it was introduced in 1955, thousands of Canadian children were affected by the disease. Today, we have largely forgotten about this victory.

Public health also deals with the underlying determinants of health – poverty, relationships, education and environments – as well as the growing health inequities among different populations. These are all social challenges that, when addressed, have great benefits for both society and individuals.

AI could be a powerful tool for public health because it can predict future events based on past data. This makes it possible to answer many questions of great social significance. Where will the next pandemic occur? How should we design our cities to reduce chronic diseases? At what scale should screening programs be implemented? Answering these questions will help to improve everyone's health.

The challenges and opportunities for applying AI to public health requires a concerted effort to make it happen. To enable researchers to explore these issues, the Canadian Institutes of Health Research's Institute of Population & Public Health (CIHR-IPPH) and the Canadian Institute for Advanced Research

(CIFAR) are working collaboratively under the Government of Canada's broader Pan-Canadian Artificial Intelligence Strategy. For the most part, researchers in these fields – public health and AI – have worked independently of each other. We need these communities to discuss common issues and learn from each other to spark the innovation necessary to address social challenges related to public health. Last week CIHR-IPPH and CIFAR hosted a workshop in Toronto to get those sparks flying.

By bringing these two fields together, we hope Canada will be positioned to take a leadership role in utilizing AI tools to solve public-health challenges that affect us all. Our goal is to ensure that AI benefits all Canadians. The workshop is important because public health affects us all, and with the advancements AI can provide, we'll all be a lot healthier.

In a few years, our collective efforts could even be the reason you don't get the flu.

Erosion of public health capacity should be a matter of concern for all Canadians

Public health matters for society, and the benefits of prevention have been clearly demonstrated:[1] a healthy population is a social good. Not having a disease or injury in the first place avoids much pain and suffering among patients and their families, as well as premature death. On top of this, there are significant economic benefits from prevention, both in avoided health care costs and in avoided loss of production, income, and tax revenue.[2,3] Moreover, arguably, quality health care is not possible without a strong public health sector,[4] which contributes in a significant way to all three goals of the "Triple Aim", a widely-used set of overall goals for the health care system: improved population health, improved patient experience of care, and reduced per capita cost of health care.[5,6]

The Editorial Board of the Canadian Journal of Public Health is thus alarmed by the ongoing erosion of public health capacity in Canada. Those concerns have been expressed in these pages several times in recent years. Public health has been characterized as "under siege"[7] and "under attack".[8] It has been argued that its weakening – characterized by downgrading the status of public health within governments and health authorities; eroding the independence of Medical Officers of Health; limiting the scope of public health by combining it with primary care; and decreasing funding – is a threat to both the health of the population and the sustainability of the health care system.[9]

Moreover, given public health's work on the most basic determinants of health and its commitment to social equity, the erosion of capacity will likely disproportionately impact populations already experiencing unacceptable health disparities – for example, Indigenous populations, who continue to experience health inequities that are rooted in unaddressed basic public health challenges and shame Canada on the international stage.[10,11]

Public health continues to face challenges. Several further actions that erode public health capacity have occurred in just the few short months since our last editorial.[9] At a national level, the Public Health Agency of Canada has backed away from one of the key reasons it was established – to address concerns about public health capacity in Canada[12] – by eliminating both the Skills Online program[13] and the practicum awards for MPH students established in 2013. This award had "provided over $1.8 M of funding to 17 institutions across Canada".[14]

At the provincial level, the most serious attack on public health has occurred recently in New Brunswick, where the government fired the former Chief Public Health Officer (CPHO) last year for no discernible reason and has moved some 70 of the 110 staff out of the Ministry of Health, spreading them across three different ministries,[15] thus disrupting the cohesiveness of the public health department and undermining its ability to address important public health issues.

The reaction has been strong, with critical comments from public health professionals from across Canada in the local print media, on radio programs, and in open letters from the Canadian Network of Public Health Associations[16] and the Public Health Physicians of Canada.[17] Dr. Wayne McDonald, a former CPHO for New Brunswick,

L'érosion des capacités en santé publique devrait préoccuper tous les Canadiens

La santé publique importe pour la société, et les avantages de la prévention sont clairement démontrés[1] : une population en bonne santé est un bien social. En prévenant les maladies et les blessures, on évite beaucoup de souffrance et de douleur (celles des patients et de leurs familles), ainsi que les décès prématurés. La prévention présente aussi d'importants avantages économiques : coûts de soins de santé évités, pertes de production évitées, revenus et recettes fiscales[2,3]. Sans compter qu'il est probablement impossible d'offrir des soins de santé de qualité en l'absence d'un secteur de la santé publique vigoureux[4], car celui-ci contribue beaucoup aux trois branches du « triple objectif » (un ensemble d'objectifs globaux très utilisé dans le système de soins de santé) : une meilleure santé des populations et une meilleure expérience des services de santé à un meilleur coût par habitant[5,6].

Le comité éditorial de la *Revue canadienne de santé publique* est donc alarmé par l'érosion constante des capacités en santé publique au Canada. Cette inquiétude a été exprimée plusieurs fois en ces pages ces dernières années. La santé publique a été caractérisée comme étant « en état de siège[7] » et « en butte à des attaques[8] ». Il a été soutenu que son affaiblissement – marqué par son déclassement au sein des gouvernements et des autorités sanitaires; par l'érosion de l'indépendance des directeurs de la santé publique/médecins-hygiénistes; par la limitation de la portée de la santé publique en la combinant avec les soins primaires; et par la réduction de son financement – menace à la fois la santé de la population et la durabilité du système de soins de santé[9].

De plus, comme la santé publique s'attache aux déterminants les plus fondamentaux de la santé et qu'elle adhère à l'équité sociale, l'érosion de ses capacités aura sans doute un impact démesuré sur les populations déjà sujettes à des disparités d'état de santé inacceptables – les populations autochtones, par exemple, subissent encore des inégalités de santé ancrées dans des problèmes de santé publique de base non résolus qui font honte au Canada sur la scène internationale[10,11].

La santé publique a encore des défis à relever. Plusieurs mesures qui érodent encore ses capacités ont été prises quelques mois à peine depuis notre dernier éditorial[9]. À l'échelle nationale, l'Agence de la santé publique du Canada a renoncé à l'une des principales raisons pour lesquelles elle a été créée (soit de répondre aux préoccupations concernant la capacité du Canada en matière de santé publique[12]) en supprimant à la fois le programme Compétences en ligne[13] et les bourses de stage qui étaient octroyées aux étudiants de maîtrise en santé publique depuis 2013. Par ces bourses, plus de 1,8 million de dollars de fonds ont été consentis à 17 établissements canadiens[14].

À l'échelle provinciale, l'attaque la plus grave contre la santé publique a été perpétrée récemment au Nouveau-Brunswick, où le gouvernement a congédié la médecin-hygiéniste en chef l'an dernier sans raison apparente et déplacé 70 des 110 membres du personnel hors du ministère de la Santé en les répartissant entre trois autres ministères[15], ce qui a perturbé la cohésion du Service de santé publique et miné sa capacité de résoudre d'importants problèmes de santé publique.

Les réactions ont été vives; des professionnels de la santé publique de tout le Canada ont exprimé leur opposition dans la presse écrite locale, à la radio et dans les lettres ouvertes du Réseau canadien des associations de santé publique[16] et des Médecins de santé publique du Canada[17]. Dr Wayne McDonald, ancien médecin-hygiéniste en chef du Nouveau-Brunswick, a qualifié ces

has labeled the changes "a recipe for disaster",[18] while Dr. Jim Talbot, a former CPHO of Alberta, has written that it "makes no sense" and "displays a profound ignorance of what public health is and what it does".[19] Despite these strong expressions of concern, the government of New Brunswick has gone ahead with its changes.

Public health capacity is being undermined in Ontario too, the last bastion of municipal public health in Canada. The recent *Report of the Minister's Expert Panel on Public Health* (Government of Ontario, 2017)[20] proposes a much closer relationship between public health and the health care system and an erosion of its links to local government. These proposals are problematic because most of what determines our health lies outside of the scope of the health care system. The Council of Medical Officers of Health, the Association of Municipalities of Ontario, the Association of Local Public Health Agencies, and the Ontario Public Health Association have all rejected or raised serious objections to the recommendations of this report.[21–24]

Even Canada's provincial and territorial CPHOs, not known for speaking out critically on government policy, have recently raised the alarm. Pointing to the 2010 Federal, Provincial, and Territorial Ministers' *Declaration on Prevention and Promotion*,[25] the CPHOs state: "Reviving a national prevention agenda is key to sustainability of health care in Canada" and they "implore health ministers to reaffirm commitment to the principles outlined in the declaration",[26] which include making prevention a priority, recognizing that it is the first step in disease management and a hallmark of a quality health system.

At a time when public health is under an unrelenting attack on its capacity to carry out its central functions, it is vital that the entire public health community – all our many professional/disciplinary and academic organizations – come together and form a united front to defend and strengthen public health's capacity to promote and protect the health of Canadians in all provinces and territories.

It is equally important that groups and organizations in society that are concerned with the sustainability of the health care system rally round and support public health. They should insist that Canada's Ministers of Health honour their 2010 commitment that "the promotion of health and the prevention of disease, disability and injury are a priority and necessary to the sustainability of the health system" and that "a better balance between prevention and treatment must be achieved".[25]

Finally, all those in Canada concerned with the health of the population and the sustainability of the health care system need to demand that their provincial, territorial, and federal governments cease undermining and instead commit to strengthening public health. The continued erosion of public health capacity in Canada must be reversed, and instead must be reinforced, both to improve the health of the population and to reduce the burden of disease that threatens the sustainability of the health care system. Failure to do so puts at risk both of these highly valued social benefits.

Trevor Hancock, CJPH Senior Editor, On behalf of the Editorial Board of the Canadian Journal of Public Health

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mesures de « recette désastreuse[18] », et D[r] Jim Talbot, ancien médecin-hygiéniste en chef de l'Alberta, a renchéri en écrivant qu'elles n'avaient « aucun sens » et qu'elles étaient la preuve d'une profonde ignorance de la nature et du mandat de la santé publique[19]. Malgré ces vives inquiétudes, le gouvernement du Nouveau-Brunswick a mis ses changements en œuvre.

Les capacités en santé publique sont également minées en Ontario, le dernier bastion de la santé publique municipale au Canada. Le récent *Rapport du comité ministériel d'experts sur la santé publique* (gouvernement de l'Ontario, 2017)[20] propose de resserrer les liens de la santé publique avec le système de soins de santé et de relâcher ses liens avec les administrations locales. Ces propositions posent problème, car la plupart des facteurs déterminants pour notre santé ne relèvent pas du champ d'application du système de soins de santé. Le conseil des médecins-hygiénistes de la province, l'association des municipalités, l'association des organismes de santé publique locaux et l'Association pour la santé publique de l'Ontario ont tous rejeté les recommandations du rapport ou y ont opposé de sérieuses réserves[21–24].

Même les médecins-hygiénistes en chef (MHC) des provinces et des territoires du Canada, qui ne sont pourtant pas connus pour leurs critiques à l'endroit des politiques gouvernementales, ont sonné l'alarme dernièrement. Invoquant la *Déclaration sur la prévention et la promotion*[25] des ministres fédéraux, provinciaux et territoriaux publiée en 2010, les MHC écrivent qu'il est essentiel à la durabilité des soins de santé au Canada de relancer un plan d'action national sur la prévention et implorent les ministres de la Santé de réaffirmer leur engagement envers les principes directeurs de la Déclaration[26], c'est-à-dire de faire de la prévention une priorité, de reconnaître qu'elle est la première étape de la gestion des problèmes de santé et de reconnaître qu'elle est une caractéristique distinctive d'un réseau de la santé de qualité.

À l'heure où les capacités de la santé publique de s'acquitter de ses fonctions centrales font l'objet d'attaques incessantes, il faut absolument que toute notre communauté – nos nombreuses associations professionnelles, disciplinaires et universitaires – forment un front uni pour défendre et renforcer les capacités en santé publique, pour que celle-ci puisse promouvoir et protéger la santé des Canadiens dans l'ensemble des provinces et des territoires.

Il est tout aussi important que les groupes et les organisations de la société qui ont à cœur la durabilité du système de soins de santé se rallient pour soutenir la santé publique. Ils devraient insister pour que les ministres de la Santé du Canada respectent leur engagement de 2010, à savoir que « la promotion de la santé et la prévention des maladies, des incapacités et des blessures sont prioritaires et nécessaires à la viabilité du système de santé » et que « nous devons atteindre un meilleur équilibre entre la prévention et le traitement[25] ».

Enfin, les citoyens qui ont le souci de la santé de la population et de la durabilité du système de soins de santé doivent exiger de leur gouvernement provincial ou territorial et du gouvernement fédéral qu'ils cessent de miner la santé publique et s'engagent plutôt à la renforcer. L'érosion continue des capacités en santé publique au Canada doit être inversée; il faut que ces capacités soient renforcées, à la fois pour améliorer la santé de la population et pour réduire la charge de morbidité qui menace la durabilité du système de soins de santé. Sinon, ces deux biens sociaux très appréciés risquent de disparaître.

Trevor Hancock, rédacteur, Au nom du comité éditorial de la Revue canadienne de santé publique

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From: Susan Lee [mailto:susan@alphaweb.org]
Sent: Thursday, February 8, 2018 11:08 AM
To: All Health Units <AllHealthUnits@lists.alphaweb.org>
Subject: alPHa BOH Section Chair Announces New Speakers for Feb. 23 alPHa Boards of Health Meeting

PLEASE ROUTE TO:

All Board of Health Members / Members of Health & Social Service Committees
Staff in Public Health Units
alPHa Affiliates
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Hello!

We are just a little over two weeks away from the alPHa Boards of Health Section meeting and I am pleased to let you know that the program for February 23rd just got even better! **Councillor Joe Mihevc**, Chair of the City of Toronto's Board of Health, will now join us to give welcoming remarks. The line-up of panelists for the morning session on alPHa's Election Policy Priorities has also been finalized with **speakers who will discuss important public health issues** for the upcoming provincial election. In addition, we have been able to book a special luncheon speaker who is a leadership and teambuilding expert. **Tim Arnold** helps leaders get unstuck by providing steps to allow them to unite their team, spark change and live their values in both their professional and personal lives. You won't want to miss hearing him speak. Flyer on Lunch and Learn Session on The Power of Healthy Tension

Here's what else you can expect from the exciting line-up of sessions and speakers:

- Explore key learnings, new resources and tools in public health.
- Hear from our **legal expert James LeNoury** on suggested changes and sample policies to implement.
- Give alPHa your input on new Strategic Directions for the association. We want to hear what you are thinking.
- Get the latest updates from **Ontario's Chief Medical Officer of Health** and the Ministry of Health and Long-Term Care.
- Draw prizes – Yes, we have prizes but you need to be in the room to win!

We have more in store. Check out the Updated Feb. 23rd BOH Section Meeting agenda. This is a great opportunity to connect, network and find out what alPHa is doing for you. You won't want to miss it!

There is still time to sign up. Register for the BOH meeting here. Please be sure to reserve your hotel guestrooms. Click here to learn more.

Don't hibernate! Take this opportunity to reinvigorate!

I look forward to seeing you all at the alPHa winter meeting on the 23rd.

Best regards,

Trudy Sachowski, alPHa BOH Section Chair
alPHa North West Representative

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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Providing leadership in public health management

To All Members of Ontario Boards of Health

AGENDA

(DRAFT as of February 7th)

Boards of Health Section Meeting

Friday, February 23, 2018 ● 8:30 AM – 3 PM
Hotel Novotel Toronto - Champagne Ballroom, 2nd Floor
45 The Esplanade, Toronto, ON M5E 1W2

CHAIR: Trudy Sachowski, North West Region

7:30 **Registration and Continental Breakfast**
Located in foyer of Champagne Ballroom, 2nd Floor

8:30 **Welcome, Introductions and Welcoming Remarks**
Councillor Joe Mihevc, Chair, Board of Health, City of Toronto

Attendee's Draw (must be present)
Generously donated by Board of Health for the Northwestern Health Unit

9:00 **Cannabis, Opioids, Oral Health, Universal Pharmacare and Tobacco Endgame - Provincial Election and Local Public Health Issues**

alPHa's Election Task Force developed areas of policy focus to influence party platforms for the 2018 Provincial Election. alPHa is asking candidates to endorse these priority actions and to work towards their implementation during the new provincial term and to invest in the health of the population, while also reducing the significant costs associated with the burden of illness.

Come and learn more about why these local public health issues are important to you, what alPHa is doing, and join in on the discussion!

Moderator:
Trudy Sachowski, Member of alPHa Executive, Chair, BOH Section and BOH Representative for the North West, alPHa Executive Member

Panelists:
Maureen Cava, Past OPHNL Representative, past alPHa Board Member
Dr. Howard Shapiro, COMOH Representative, Toronto, alPHa Board Member
Paul Sharma, OAPHD President, alPHa Executive Member

10:00 **BREAK**

10:30 **Section Business**
Approval of Minutes from November 3, 2017 BOH Section Meeting

Faster, Higher, Stronger – It Isn't Just an Olympic Motto!
Glen Paskiw, Managing Director, Enterprise Inc.

A quick look at alPHa's upcoming series of Change Management Webinars that will focus on delivering better, faster and less-expensive change. Building on previous alPHa presentations highlighting change/transformation theory and evidence, the Webinars will feature practical information, tools and techniques to create and support better on-the-ground change in your organization whether it's delivering on your strategic plan or moving forward with other new and better ways of doing business, the primary objective of the alPHa Change Management Webinars is to enhance your organization's potential for change success.

Other alPHa activities, including the new Risk Management e-Learning Module and the upcoming alPHa Conference June 10th-12th
Loretta Ryan, alPHa Executive Director

MOHLTC Update
Update on Ministry activities by the Ministry staff (invited)

11:30 **Dr. David Williams, Ontario Chief Medical Officer of Health, Update**

12:00 **LUNCH and Learn – with a Buffet**
The Power of Healthy Tension – Tim Arnold

Tim Arnold is a leadership and teambuilding expert who helps leaders get unstuck by providing steps to allow them to unite their team, spark change and live their values in both their professional and personal lives. Why is Healthy Tension important? It helps you and your team to be relevant and timely, His keynote will address how to unite your team, spark change, and get unstuck, relevant and timely, practical and actionable, and let's not forget, that healthy tension can also help to make things interactive and, maybe even fun.

1:00 **Strategic Directions**
Glen Paskiw, Managing Director, Enterprise Inc.

alPHa wants your input on Strategic Directions for the association. alPHa is working for you! Join in on this interactive consultation session.

2:00 **Boards of Health Constitution**
James LeNoury

Join in as we discuss the legal changes required to BOH constitutions to align with the new Ontario Public Health Standards (OPHS). Session includes suggested changes and sample policies to implement such as "Electronic Meeting", Ontario Municipal Act (2017). These changes are important ones that you can share, take back with you and implement with your Board.

3:00 **Adjournment**
Attendee's Draw (must be present)
Generously donated by Board of Health for the Northwestern Health Unit

APPROVAL OF CONSENT AGENDA

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

Briefing Note

To: René Lapierre, Chair, Board of Health for Public Health Sudbury & District

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

Date: February 8, 2018

Re: Northern Network for Health Equity

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:
People living in Northern Ontario experience poorer health outcomes and greater health inequities on many indicators compared with the rest of the province and subpopulations within the North face substantial inequities. In response to these challenges, and at the request of the Ontario Government, *Health Quality Ontario* (HQO) led the creation of a strategy that is aligned with the goal and vision that all northerners have equal opportunities for health, including access to social and economic resources, as well as to high-quality health care, regardless of where they live, what they have or who they are. Public Health Sudbury & Districts welcomed the opportunity to engage with HQO over the past year to develop this strategy, including co-chairing the Steering Committee and participating in secondments to research, consult and ultimately draft the final report.

Recommended Action:
WHEREAS Public Health Sudbury & Districts supported the development of a Ministry-funded Northern Ontario Health Equity Strategy in partnership with Health Quality Ontario and other northern stakeholders; and

WHEREAS health equity is a longstanding priority of the Board of Health, is a strategic priority in the 2018-2022 Strategic Plan, and is a Foundational Standard within the Ontario Public Health Standards, 2018;

THEREFORE BE IT RESOLVED that the Board of Health for Public Health Sudbury & Districts endorse in principle the establishment of a Northern Network for Health Equity, the Strategy's key recommendation; and

FURTHER THAT the Board directs the Medical Officer of Health to ensure appropriate organizational participation in the Northern Network for Health Equity.

Background:

Process

To address health inequities in the north, in 2016 Health Quality Ontario began a Ministry-funded initiative in partnership with Public Health Sudbury & Districts to engage communities across the North to identify northern needs and to develop a strategy to address health inequities. This work has been directed by a steering committee represented by both the North East and North West LHIN, the Northwestern Health Unit, Public Health Sudbury & Districts, CMHA Sudbury/Manitoulin, Laurentian University, the Ministry of Health and Long-Term Care, Northern Ontario School of Medicine, Sioux Lookout First Nations Health Authority, Réseau du mieux-être francophone du Nord de l'Ontario, and lived experience advisors. This process and the members of the steering committee are outlined in the *Northern Ontario Health Equity Strategy* which will be publicly released in March 2018.

Through extensive engagement with more than 300 individuals representing over 150 organizations across the North it was identified that while there is a wide range of organizations, tables, and initiatives aiming to address health equity in the north, gaps exist across sectors and an intersectoral approach is needed to address the upstream causes of poor health. Based on these engagement findings, a review of evidence on health equity initiatives and strategies, the steering committee is proposing the development of a Northern Network for Health Equity.

The Steering Committee has supported Health Quality Ontario in the development of a business case seeking support for the Network from the Ministry of Health and Long-Term Care, which would support dedicated Network staff, community engagement, and initial project funding.

Key health equity priorities identified by Northerners

The Network would focus on health equity broadly, and will bring together network partners and key stakeholders to work on key Northern health equity priorities. The Network partners would have the opportunity to identify these priorities, which would include issues identified through broad consultation and which have disproportionate impacts on vulnerable populations such as mental health and addictions; diabetes; and parental and child health. These types of enduring health challenges require a coordinated, intersectoral approach to develop long-term solutions. The Network will support partnership development, governance and accountability, advocacy, and monitoring and evaluation to advance health equity in Northern Ontario.

To achieve the Network's vision of equitable opportunities for health for all Northerners, the Network will focus on four Foundations for Action identified through the engagement process. These are:

1. Addressing the social determinants of health
2. Equitable access to high-quality and appropriate health services
3. Indigenous health, healing and well-being
4. Evidence availability for equity decision-making

Network Objectives

Preliminary objectives of the proposed Network were developed through consultation with northern stakeholders and solidified through an environmental scan. The objectives are far-reaching and ambitious; however, advances in health equity rely on taking bold action and moving forward together for meaningful change. The objectives range from working across sectors to develop solutions to alleviate poverty and improve access to food and education; to working to support health care providers in the provision of equitable, timely access to health care; to moving forward the Truth and Reconciliation Commission of Canada's Calls to Action; to supporting local engagement in research and the use of evidence. Francophones have also been identified as a priority population particularly with respect to access to health services. There are specific recommended actions aimed at improving access to French language health services, for example training providers on the Active Offer of French Language Services.

These proposed objectives and options are not a final mandate for the Network, but reflect the important contributions of participants in the development of the *Strategy* and give tangible meaning to the potential for a northern-led Network. The Network would implement a planning process to further consider these objectives and options for action.

Led by a pan-Northern steering committee

The Network will be directed by a steering committee that provides direction and establishes priorities for achieving the objectives of the Network. The steering committee will be supported and advised by working groups, with participation from the Northeast and the Northwest. The committee members would be individuals with expertise relevant to their group domain, with representation from partnering agencies and sectors including sectors outside of health. To be effective in driving policy change and developing health equity initiatives, the Network will require resources with dedicated staff who would provide leadership and coordination to the collaborative efforts of the Steering Committee and its working groups.

Through these collaborations, the combined strength of all partners will create the potential to improve the health of all people residing in northern Ontario through education, policy development, and evidence-informed action. Networks of this type are increasingly recognized as the essential structures needed to align organizations, governments, communities, and healthcare providers to bring lasting systemic change in complex systems and have yielded impressive results in other jurisdictions. As England's Health Development Agency stated:

> The arena of health inequalities demands recognition of the complex nature of the system, and the interdependence of factors operating to influence health and efforts to improve health. There needs to be a better balance between the top-down style of policy making and a local, bottom-up approach based more on lateral partnerships and networks.[1]

With strong intersectoral enthusiasm and support, the Network will be well-positioned to build on existing work within communities.

[1] Hunter, D and Killoran D. (2004). Tackling health inequalities: Turning policy into practice? NHS Health Development Agency. http://www.who.int/rpc/meetings/en/Hunter_Killoran_Report.pdf

Analysis
As a member of the Network's Steering Committee, PHSD would work to ensure the activities of the Network's equity objectives are aligned with its our own equity strategic priority.

The Network will drive change by creating the infrastructure to develop, seek funding for, and support intersectoral projects across the north. It would leverage existing projects and develop effective integrated responses to promote lasting change to address the challenges of inequitable health outcomes facing Northerners. The Network's intermediate deliverables would be process-oriented. Within three years, it will achieve the structures for intersectoral collaboration and each partner organization will commit to Network equity outcomes in their strategic plans. Also within three years it will achieve internal equity capacity building outcomes. In the longer term, the Network will undergo a formal evaluation after five years to evaluate progress on achieving health system equity outcomes.
At ten years, the Network is expected to demonstrate progress on population health indicators.

Strategic Priority:
1-4

NORTHERN NETWORK FOR HEALTH EQUITY

MOTION:

WHEREAS Public Health Sudbury & Districts supported the development of a Ministry-funded Northern Ontario Health Equity Strategy in partnership with Health Quality Ontario and other northern stakeholders; and

WHEREAS health equity is a longstanding priority of the Board of Health, is a strategic priority in the 2018-2022 Strategic Plan, and is a Foundational Standard within the Ontario Public Health Standards, 2018;

THEREFORE BE IT RESOLVED that the Board of Health for Public Health Sudbury & Districts endorse in principle the establishment of a Northern Network for Health Equity, the Strategy's key recommendation; and

FURTHER THAT the Board directs the Medical Officer of Health to ensure appropriate organizational participation in the Northern Network for Health Equity.

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: René Lapierre, Chair, Board of Health for Public Health Sudbury & Districts

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

Date: February 8, 2018

Re: Tobacco and Smoke-Free Campuses

☒ For Information ☒ For Discussion ☒ For a Decision

Issue:
Smoke-free environments promote health and wellness, denormalize tobacco use and deminish exposure to smoke and tobacco. Smoking rates among young Canadians remain higher than any other age group and post-secondary campuses are in an ideal position to implement protective policies for which this age group would specifically benefit. In recognition of its commitment to advance health and societal well-being, McMaster University on January 1, 2018, became the first Ontario post-secondary institution to make its campus entirely tobacco and smoke-free.

An Environmental Scan of Ontario College and University Tobacco Control Policies 2016-2017, completed by Leave The Pack Behind (Brock University) indicates that there are three post-secondary campuses in Sudbury that have policies exceeding the current Smoke Free Ontario Act (SFOA), however each has Designated Smoking Areas (DSA's).

Recommended Action:

1. Recognize area post-secondary institutions for their establishment of tobacco-related health protective policies surpassing current provincial legislation; and
2. Strongly urge and support area post-secondary institutions to enhance existing policies to achieve 100 % tobacco and smoke-free campuses within an accelerated timeframe.

Background:
Public Health Sudbury & Districts Board of Health has a longstanding history of proactive and effective action to prevent tobacco use and promote tobacco use cessation (e.g. resolutions #03-17, #21-16, #55-15, #62-14, #57-14, #23-14, #32-05, #44-04, #25-03, #93A-98).

Although Canada has had much success in decreasing smoking rates, smoking among young adults between the ages of 25 and 29 still remains higher than any other age group at 22.8%. [Canadian Community Health Survey 2014)] The smoking rate of 17.3% among 20 to 24 year olds is another cause for concern. [Canadian Community Health Survey 2014)] Among 20 to 29 year old current or former smokers, the most common age reported for smoking initiation is between 16 and 19 years old. [Canadian Community Health Survey (2013)]

Post-secondary campuses offer a unique opportunity to intervene and support large numbers of young adults to not start – or quit – smoking, and to protect them, as well as staff, faculty, administration, and visitors, from

exposure to second-hand smoke through a tobacco-free campus policy. The presence of tobacco use on campus encourages and facilitates further tobacco use, undermining tobacco prevention and cessation efforts.

Scientific evidence indicates that commercial tobacco products are harmful to one's health and to the health of others through exposure to second-hand smoke. Commercial tobacco use, can cause many illnesses such as cardiovascular and respiratory diseases and cancer. Cigarette smoking is the leading cause of preventable death and disability in Canada. Non-users exposed to second-hand tobacco smoke can also incur illnesses such as asthma, bronchitis, cancer, chronic pulmonary and cardiovascular diseases.

Financial Implications:
Costs within budget associated with Public Health Sudbury and Districts staff time to support post-secondary policy development and implementation of prevention campaigns.

Strategic Priorities:
Equitable Opportunities
Meaningful Relationships
Practice Excellence
Organizational Commitment

Contact:
Sandra Laclé, Director, Health Promotion Division and Chief Nursing Officer

TOBACCO AND SMOKE-FREE CAMPUSES

MOTION:

WHEREAS on January 1, 2018, McMaster University became the first post-secondary institution in Ontario to establish a 100% tobacco and smoke-free campus; and

WHEREAS the presence of tobacco use on campus further normalizes tobacco use, undermining provincial and local tobacco prevention and cessation efforts; and

WHEREAS an Environmental Scan of Ontario College and University Tobacco Control Policies 2016-2017, indicates that while the three post-secondary campuses in Sudbury have policies exceeding the current Smoke Free Ontario Act (SFOA), they maintain on-campus Designated Smoking Areas (DSA's);

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts congratulate area post-secondary institutions for their tobacco-related health protective policies surpassing current provincial legislation; and

FURTHER that the Board strongly urge and support area post-secondary institutions to enhance existing policies to achieve 100% tobacco and smoke-free campuses within an accelerated timeframe; and

FURTHERMORE that the Board share this motion with area post-secondary leadership, alPHa, the Chief Medical Officer of Health, Minister of Health and Long-Term Care, Ministry of Colleges and Universities and local MPPs.

Information

Category: Board of Health By-Laws

Section By-laws

Subject: By-law 01-98

Number: G-I-50

Approved By: Board of Health

Original Date March 26, 1998

Revised Date: February 15, 2017~~78~~~~June 18, 2015~~

Information

Being a By-law of the Board of Health for~~of~~ Public Health Sudbury & Districts~~the Sudbury & District Health Unit~~ RR~~e~~specting Construction, Demolition, Change of Use Permits, Inspections and Fees Related to Sewage Systems.

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

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

NOW THEREFORE the Board of Health ~~of~~for Public Health Sudbury & Districts~~ the Sudbury & District Health Unit~~ hereby enacts as follows:

Short Title

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

Definitions

In this By-law,

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

b) "applicant" means the owner of a building or property who applies for a permit or land use planning report or any person authorized in writing by the owner to apply on the owner's behalf, or any person or corporation empowered by statute to cause the demolition of a building or buildings and anyone acting under the authority of such person or corporation.

c) "as constructed plans" means as constructed plans as defined in the Building Code.

d) "Board of Health" means the Board of Health ~~of~~for Public Health Sudbury & Districts~~the Sudbury & District Health Unit~~.

e) "building(s)" means a building as defined in Section 1(1) of the Building Code.

f) "Building Code" means the regulations made under Section 34 of the Act.

g) "Notice of Substantial Completion" relates to the day on which a sewage system has been completed and is ready for a final inspection before backfilling.

h) "sewage system inspector" means an inspector appointed by the Board of Health under Section 3(2) of the Act.

i) "permit" means written permission or written authorization from the Chief Building Officer to perform work regulated by the Act, this By-law, and the Building Code.

j) "permit holder" means the person to whom the permit has been issued and who assumes the primary responsibility for complying with the Act, the Building Code and this By-law.

k) "plumbing" means plumbing as defined in Section 1(1) of the Act.

l) "renovation" means the extension, alteration or repair of an existing building or sewage system or the change in use or part of the use of an existing building or sewage system.

m) "repair requiring permit" means the replacement of a treatment unit or the replacement or alteration of materials in a leaching bed or any component contained therein.

n) "sewage system" means sewage system as defined in Section 1(1) of the Act.

o) "sewage system permit" means a building permit as defined in Section 8(1) of the Act for the purposes of this By-law.

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

Classes of Permits

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

Permit Applications

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

1) Where application is made for a sewage system permit under subsection 8(1) of the Act, the application shall:

   a) identify and describe in detail the work, use and occupancy to be covered by the permit for which application is made;

   b) identify and describe in detail the existing use(s) and the proposed use(s) for which the premises are intended;

   c) include complete plans and specifications as described in this By-law for the work to be covered by the permit and show the occupancy of all parts of the building;

   d) include the legal description, municipal address and where appropriate the unit number of the land on which the work is to be done;

   e) be accompanied by the required fees as calculated with Schedule "A";

   f) state the name, address and telephone number of the owner, and if the owner is not the applicant, the applicant's name, address and telephone number and the signed statement of the owner consenting to the application;

   g) where applicable, state the name, address and telephone number of the architect, engineer or other designer, and the constructor or person hired to carry out the construction or demolition;

   h) where any person named in clause (g) requires a license under the Act or Building Code, include the number and date of issuance of the license and the name of the qualified person supervising the work to be covered by the permit;

   i) when Section 2.3 of the Building Code applies, be accompanied by a signed acknowledgement of the owner that an architect or professional engineer, or both, have been retained to carry out the general review of the construction or demolition of the sewage system;

   j) when Section 2.3 of the Building Code applies, be accompanied by a signed statement of the architect or professional engineer, or both, undertaking to provide a general review of the construction or demolition of the sewage system;

k) include the applicant's registration number where the applicant is a builder or vendor as defined in the Ontario New Home Warranties Plan Act;

l) include, as the Chief Building Inspector deems necessary, proof of the zoning and permitted uses applicable to the land on which the work is to be done; and

m) be signed by the applicant who shall certify as to the truth of the contents of the application.

2) Where application is made for the demolition of a sewage system under subsection 8(1) of the Act, the application shall:

a) contain the information and other requirements provided in subsection 4(1), and;

b) be accompanied by satisfactory proof that arrangements have been made with the proper authorities for the termination and capping of the appropriate utilities and for the removal and disposal of the sewage system components.

3) Where application is made for a renovation to an existing building under the Act and Building Code, the application shall:

a) contain the information and other requirements provided in subsection 4(1), and;

b) include plans and specifications which show the current and proposed occupancy of all parts of the building, and which contain sufficient information to establish compliance with the requirements of the Building Code, including floor plans, and detailed information respecting the existing sewage disposal system and prior permits.

4) Inspections will be carried out on properties that are identified under the mandatory maintenance inspection program according to section 1.10.2 of Division C, Part 1 of the Ontario Building Code and a fee will be charged as noted in Schedule "A".

5) Where compliance with all the requirements for a permit application is unnecessary or unreasonable, the Chief Building Inspector may, in cases where he or she deems appropriate, authorize deletion of one or more of the requirements provided the intent and purpose of this By-law is maintained.

6) Where an application for a permit remains incomplete or inactive for six (6) months after it is made, the application may be deemed by the Chief Building Inspector to have been abandoned and notice thereof shall be given to the applicant.

Plans, Specifications, Documents and Information

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

a) zoning approval from the applicable Planning Authority;

b) plans that are legible and drawn to scale on paper, cloth or other suitable and durable material;

c) documents submitted that are legible;

d) if applicable, Conservation Authority or Ministry of Natural Resources approval.

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

Site Plans shall show:

a) lot size and dimensions of the property;

b) setbacks from existing and proposed buildings to the property boundaries and to each other;

c) setbacks from existing and proposed wells, including wells on adjacent properties;

d) setbacks from property boundaries, lakes, rivers, streams, reservoirs, ponds and water drainage courses;

e) the location of any unsuitable, disturbed or compacted areas;

f) proposed access routes for system maintenance and proposed parking areas;

g) culverts, drainage patterns and swales;

h) existing and proposed utility corridors, whether above or below grade;

i) existing right-of-ways, easements and crown reserves;

j) the legal description of the property, and if available, the municipal address.

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

a) depth of existing soils to bedrock;

b) depth of soils to groundwater table;

c) soil properties including soil percolation test results and/or soil permeability as determined by a grain size analysis utilizing the Unified Soil Classification System;

d) soil conditions, including the potential for flooding;

e) soil profiles as determined by test pits excavated in the area of the proposed leaching bed;

f) where the applicant is proposing a raised or partially raised leaching bed, specifications on the amount of fill required, the dimensions of the area to be filled and the soil properties as noted in subsection 3(c);

g) detailed specifications on the type of sewage system proposed, the size of the sewage system proposed and detailed design drawings;

h) where deemed necessary by the Chief Building Inspector, a site plan shall include contour mapping, existing and finished ground elevations;

i) an application for a Class 5 system shall be accompanied by evidence that confirms that the proposal is in compliance with the Building Code.

Equivalents

1) Where an application for a permit or for authorization to make a material change to a plan, specifications, document or other information on the basis of which a permit was issued, contains an equivalent material, system or system design for which authorization under Section 9 of the Act is requested, the following information shall be provided:

   a) a description of the proposed material, system or system design for which authorization is requested;

   b) any applicable provisions of the Building Code, and;

   c) evidence that the proposed material, system or system design will provide the level of performance required by the Building Code.

   d) the Chief Building Inspector reserves the right to have any application requiring authorization under Section 9 of the Act referred to the Building Materials Evaluation Commission for review.

Revisions to Permit

1) After the issuance of a permit under the Act, notice of any material change to a plan, specification, document or other information on the basis of which the permit was issued, must be given in writing to the Chief Building Inspector together with the details of such change which is not to be made without his or her written authorization;

2) The fees for revising a permit, reviewing new plans and repeating inspections shall be set out in Schedule “A” of this By-law.

Notice Requirements

1) Notices required by Section 10.2 (1) of the Building Code shall be given by the permit holder to the Director at least 5 business days in advance of the stages of construction specified therein.

2) A notice pursuant to clause (1) of this By-law is not effective until written or oral notice is actually received by the Chief Building Inspector, the sewage system inspector or designate.

3) Notice required upon completion of the sewage system Section 11 (4)a of the Building Code shall be in writing in a form designated by the Chief Building Inspector. The completion form shall be given to the Chief Building Inspector at least 10 days in advance of the intended use of the sewage system.

4) Where the applicant files a completion form with the Chief Building Inspector, the form shall:

   a) indicate that the sewage system was backfilled, graded and seeded or sodded in accordance with the Building Code;

   b) indicate the date on which the work was completed;

   c) where the applicant has retained an architect or professional engineer, or both, to carry out the general review of the construction of the sewage system, contain the written opinion of the architect or engineer that the completed work conforms to the Building Code;

   d) be signed by the applicant who shall certify the truth of the contents of the information contained within the completion form;

   e) where information is received by the Chief Building Inspector as required by this section, the Chief Building Inspector may, upon the signed recommendations of a sewage system inspector, deem that the requirements of the Building Code have been satisfied, without having an inspection conducted to verify the information;

   f) the Chief Building Inspector may require that a set of as constructed plans of the sewage system or any part of the sewage system be submitted by the applicant.

Transfer of Permits

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

2) The fee for transferring a permit shall be set out in Schedule ”A”.

Refunds

1) No refund of fees shall be made once a site inspection for a permit or a land use evaluation has been carried out.

2) All requests for withdrawal of an application shall be in writing by the applicant.

Revocation

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

Fees

1) The payment of fees for a permit or maintenance inspection shall be set out in Schedule “A” and are due and payable upon submission of an application or completion of inspection.

2) No permit shall be issued until the fees therefore have been paid in full.

Forms

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

Offence/Penalty

1) Every person who contravenes any provision of this By-law is guilty of an offence.

2) Every person who is convicted of an offence is liable to a fine as provided for in the Provincial Offences Act, R.S.O. 1990, cP.33.

Policies and Procedures

1) The Board of Health ~~o~~for~~f~~ Public Health Sudbury & Districts~~the Sudbury & District Health Unit~~ shall from time to time establish policies and procedures related to sewage program activities as are appropriate.

Validity

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

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

Revised and passed by the Board of Health, Sudbury & District Health Unit this 27th day of May 1999.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 25th day of May 2000.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of February 2001.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 19th day of February 2004.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 17th day of June 2004.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of November 2007.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 14th day of May 2009.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 20th day of January 2011.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of February 2012.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 20th day of February 2014.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of February 2017.

SCHEDULE "A" TO BY-LAW 01-98

Cost Per Permit and Record

1) Sewage System Permits:

a)	Class 2 Sewage System (Leaching Pit)	**$~~350.00~~400.00**
b)	Class 2 Sewage System (more than 4 sites) (plus $100 for each lot over 4)	**$~~1400.00~~1600.00** **$100.00**
c)	Class 3 Sewage System (Cesspool)	**$~~350.00~~400.00**
d)	Class 4 Sewage System (Septic Tank and Leaching Bed)	**$~~825.00~~900.00**
e)	Class 4 Sewage System (Leaching Bed Only)	**$~~500.00~~550.00**
f)	Class 4 Sewage System (Tank Only)	**$~~325.00~~350.00**
g)	Class 5 Sewage System (Holding Tank)	**$~~825.00~~900.00**

2) Sewage System Permits: Re-Inspection **$250.00**

~~2)~~3) Renovation Permit **$300.00**

~~3)~~4) Demolition Permit **$~~250.00~~300.00**

~~4)~~5) Revisions to Permit (Inspection Required) **$~~350.00~~400.00**

~~5)~~6) Transfer of Permit to New Owner **$100.00**

~~6)~~7) Extraordinary Travel Costs by Air, Water, etc. **Full Cost Recovery**

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

Other Fees

Mandatory Maintenance Inspection	**$175.00**
File Search	**$~~225.00~~300.00**
Consent Applications	**$~~225.00~~250.00/lot**
Minor Variance Applications	**$~~225.00~~250.00**
Copy of Record	**$~~65.00~~80.00**
Other Government Agencies	**$~~225.00~~250.00**

SCHEDULE "B" TO BY-LAW 01-98

Forms for Sewage Systems

1) Sewage System Permits:

    a) Application Form for a Sewage System Permit
    b) Inspection Reports
    c) Form Letters and Orders
    d) Completion Notice Re: Readiness for Use of a Sewage System

2) Mandatory Maintenance Inspections

    a) Inspection Reports

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

MOTION:

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

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

WHEREAS the fee increases approved by the Board of Health in 2017 were phase 1 of a proposed 2 phase increase, where the second phase was scheduled to be implemented in 2018; and

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

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

FURTHERMORE THAT this fee schedule shall immediately come into effect.

2017 Performance Monitoring Report

Performance Monitoring Plan 2013 2017

February 2018

Public Health
Santé publique
SUDBURY & DISTRICTS

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

Strategic Priorities: Narrative Report

The 2013–2017 Strategic Plan includes five Strategic Priorities that steer the planning and delivery of public health programs and services, learning activities, and partnerships. Narrative Reports ensure ongoing monitoring and integration of the Strategic Priorities within Public Health programs or services to gauge progress on key areas.

Organization-Specific Performance Monitoring Indicators Report

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

Ontario Public Health Organizational Standards Report

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

Public Health Accountability Agreement Indicators Report

The Ministry of Health and Long-Term Care (MOHLTC) has set out indicators for boards of health to ensure accountability. In previous years, these indicators included a set of performance indicators and a set of monitoring indicators that were measured and monitored by the MOHLTC throughout accountability agreement periods. The indicators represented outcomes relating to the delivery of public health programs and services. In June 2017, the suite of indicators was revised and, for the time being, includes 15 monitoring indicators which are used to monitor progress.

Reporting Timelines

* Includes Strategic Priorities Narratives "roll-up", Ontario Public Health Organizational Standards Report, Public Health Accountability Agreement Indicators Report, and Public Health Sudbury & Districts' Organization-Specific Performance Monitoring Indicators Report

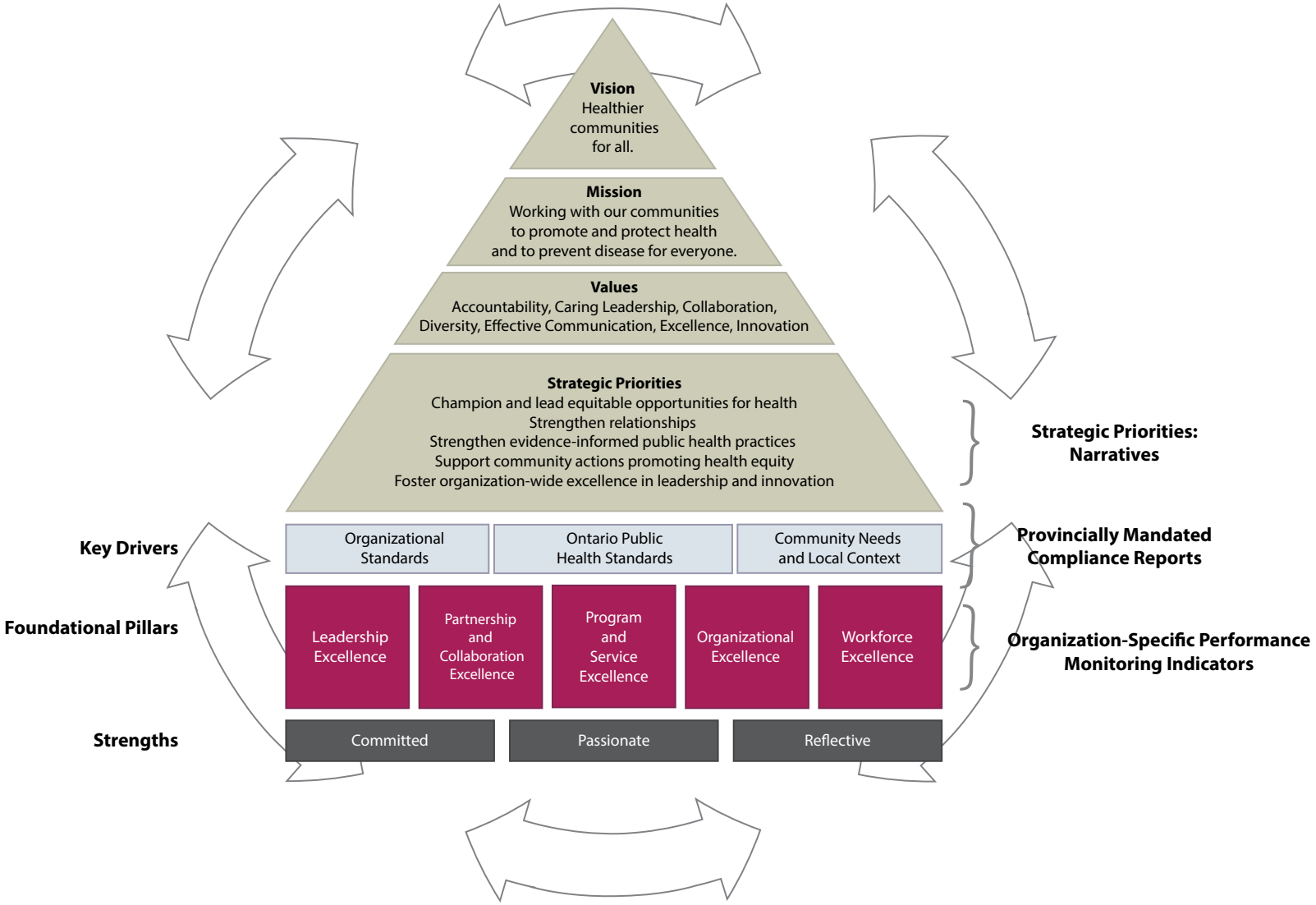
Executive Summary

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

Key Findings

- 15 Strategic Priorities Narratives that highlight descriptive stories of Public Health Sudbury & Districts' programs and/or services that demonstrate the 5 Strategic Priorities "in action"
- On track with meeting the 13 Public Health Sudbury & Districts' Organization-Specific Performance Monitoring Indicators
- Compliance with all 44 Ontario Public Health Organizational Standards
- Indicators monitored as outlined by the Public Health Accountability Agreement with the Ministry of Health and Long-Term Care

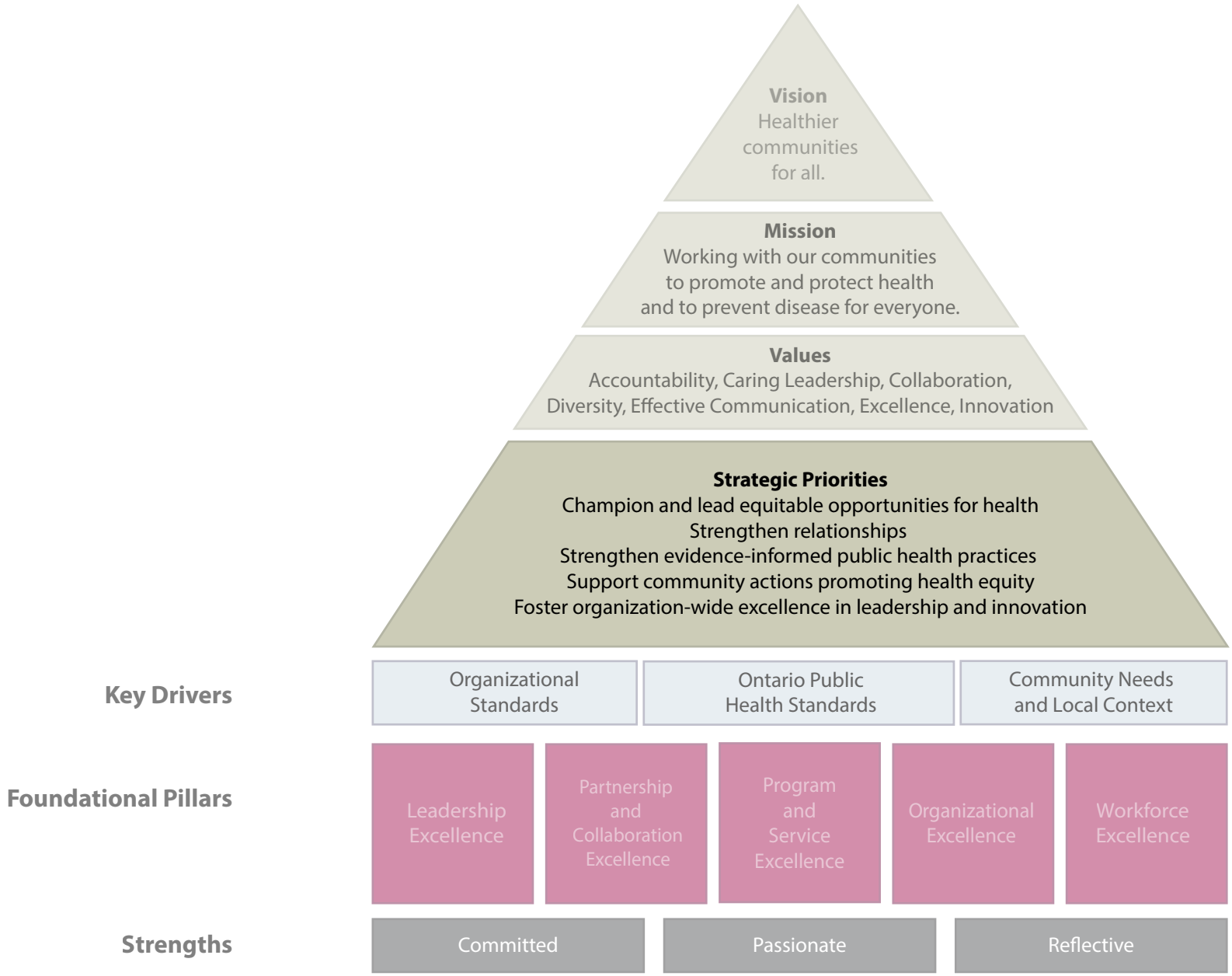
Figure 1: Sudbury & District Board of Health Strategy Map 2013–2017



Strategic Priorities: Narrative Report

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

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



2017 Strategic Priorities Narrative Topics

The following presents a summary of the Strategic Priorities Narrative topics that were presented in 2017.

Click on the narrative title below for more information.

Strategic Priority: Champion and lead equitable opportunities for health

Advocating for a Basic Income Guarantee to Promote Optimal Health for All

Pathways to Equity: Supporting Indigenous Partners to Address Factors that Impact Health

Raising Awareness and Inspiring Health Equity Action Through Bridges Out of Poverty Training

Strategic Priority: Strengthen relationships

SDHU's Baby-Friendly Initiative Journey

Partnering with Greater Sudbury Housing Corporation on Bedbug Education for Tenants

Strengthening Relationships with Indigenous Communities

Strategic Priority: Strengthen evidence-informed public health practice

Ridgecrest Playground Research Study – Utilizing Evidence to Promote Accessible Playgrounds

Sharing Our Research Knowledge

Sharing Knowledge to Advance Evidence-informed Public Health Practice

Strategic Priority: Support community actions promoting health equity

Youth in Crisis: Employability Partnership with the Sudbury Food Bank

Nourishing the Future of Our School Communities

Putting the Public in Public Health Planning

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

Risk Management @ SDHU

Building Opportunities for Student Placement in Rural Areas

Leading the Way to Organizational Excellence

Organization-Specific Performance Monitoring Indicators Report

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

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

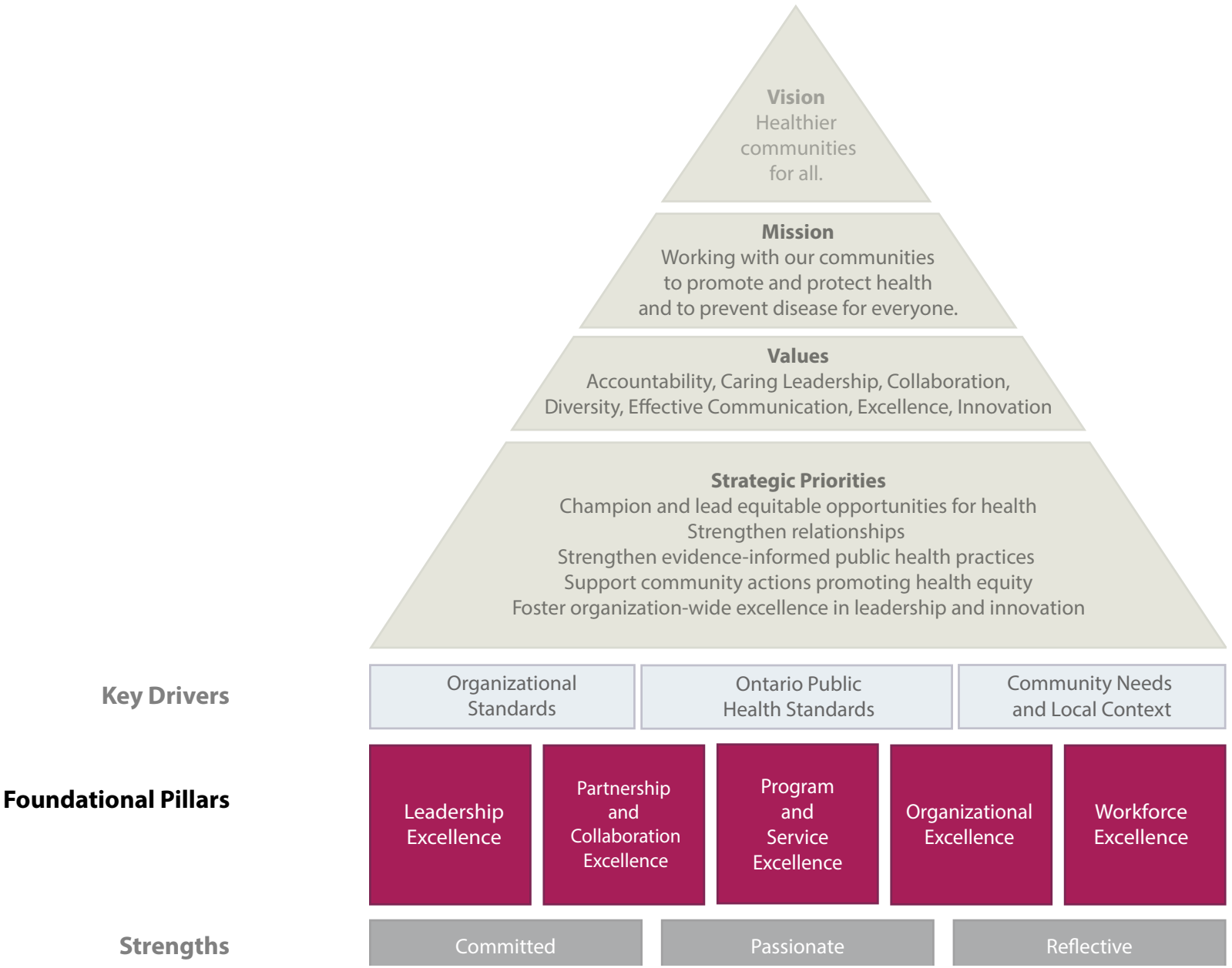


Table 1: Organization- Specific Performance Monitoring Indicator Trends 2013–2017

FOUNDATIONAL PILLAR	INDICATOR	2013	2014	2015	2016	2017
Leadership Excellence	Board of Health Commitment Index	95	89	85	86	83
	Number of Program-related Board of Health Motions Passed	9	8	9	12	10
	Board of Health Member's Satisfaction Index	96	100	95	96	95
Partnership and Collaboration Excellence	Percent of Partnerships That Are Intersectoral	61%	63%	66%	66%	63%
	Number of External Partnership Effectiveness Reviews Goal: 5	Under Development	5	5	5	5
	Website Usage Status Average web visits per day Average web page views per day	1 773 16 555	1 736 13 415	See Notes	373 1134	378 1109
Program and Service Excellence	Number of New Advanced Knowledge Products	106	97	152	180	112
	Number of Academic Research Projects	18	17	19	18	18
	Organization-wide Program or Service Evaluations Used by Senior Management Goal: 1	2	3	1	1	1
	Emergency Preparedness Index	99	99	100	98	99
Organizational Excellence	Worker Engagement Index	88	See Notes	90	92	94
	SharePoint Deployment Status	P1, P2, P3 In Progress	P1, P3–P5 In Progress; P2 Complete	P1, P3, P4, P5 In Progress; P2 Complete	P1, P3, P4, P5 In Progress; P2 Complete	P1, P3, P4, P5 In Progress; P2 Complete
Workforce Excellence	Workforce Development Status	P1, P2 In Progress	P1, P2 In Progress	P1, P2 In Progress; P3 Complete	P2, P4 In Progress; P1, P3 Complete	P2, P4, P5 In Progress; P1, P3 Complete

Notes

Public Health Sudbury & Districts' Organization-Specific Performance Monitoring Indicators measure our performance as an organization and further demonstrate its commitment to excellence and accountability.

LEADERSHIP EXCELLENCE

Board of Health (BoH) Commitment Index

- The Commitment Index score of 83% reflects vacancies and turnover in Board of Health membership throughout 2017.
- Quorum was met for all meetings and a total of 73% of BOH members completed the annual self-evaluation questionnaire.
- Throughout 2017, Board of Health Executive members attended additional meetings to guide the strategic planning process and, in September 2017, the majority of Board of Health members participated in a workshop to further inform the development of the Strategic Plan.

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

- The BOH continues to provide leadership for public health in our communities and in the province. A total of 10 program-related motions were passed in 2017.

PARTNERSHIP AND COLLABORATION EXCELLENCE

Percent of Partnerships That Are Intersectoral

- Intersectoral partnerships are partnerships where at least one member in the partnership represents a sector other than public health or health care (ex. education, childcare, etc.)
- Public Health Sudbury & Districts is currently involved in 301 partnerships; 188 of these are intersectoral.
- While the percentage of intersectoral partnerships has decreased since 2016, the total number of intersectoral partnerships remained the same (188 intersectoral partnerships). Some year-to-year fluctuation in partnerships can be expected depending on the current public health and community contexts and the dynamic nature of partnerships.

Number of External Partnership Effectiveness Reviews (Goal: 5)

- This indicator highlights Public Health Sudbury & Districts' commitment to ensure that our contributions to external community partnerships meet our strategic and operational priorities.
- A total of 5 reviews were completed; 1 from the Resources Research Evaluation and Development Division, 1 from the Clinical Services Division, and 3 from the Health Promotion Division.

Website Usage Status

- Public Health Sudbury & Districts launched a new website in June 2015, and 2016 marked the first year of reporting usage data on the new website. The new website uses different website analytic software to monitor website traffic, therefore, data from 2016 and beyond should not be compared to data from previous years.
- The website usage status data represents average daily visits and page views to the organization's website from users who have their locations set as "Canada", and excludes staff activity.
- Analysis of the data shows that users are getting to the pages they wish to browse more quickly and that the usability of the website has increased with the new website. From January 1 to December 31 2017, each website visitor looked at approximately 3 pages and spent an average of 2 minutes on the website.

PROGRAM AND SERVICE EXCELLENCE

Number of New Advanced Knowledge Products

- This indicator captures the number of new internally developed or significantly altered products that require knowledgeable interpretation by an informed audience (reports, manuals, presentations).
- In 2017, there were 112 advanced knowledge products, which is less than in 2016, but is similar to the number of products reported in the previous years. Some year-to-year fluctuation can be expected.

Number of Academic Research Projects

- This indicator captures new and ongoing research projects conducted in collaboration with academic and research institutions, such as projects funded by the Louise Picard Public Health Research Grant, a joint Public Health Sudbury & Districts/Laurentian University research grant.
- Out of the 18 academic research projects; 5 are new in 2017, 2 were completed, and 11 are ongoing.
- Completed projects include the Northern Ontario Dietetic Internship Project - Using Food as a Reward - the Impact on Early Childhood development and Phase 1 of the Locally Drive Collaborative Project: Strengthening Continuous Quality Improvement (CQI) in Ontario's Public Health Units in collaboration with other health units.

Organization-wide Program or Service Evaluations Used by Senior Management

- This indicator denotes evaluations undertaken that inform organization-wide decisions.
- The target goal of one was met in 2017. The evaluation of the Compressed Work Week program took place in 2017 and the results informed the decision to discontinue the program in June 2018 and to pursue alternate flexible work arrangements for staff members.

Emergency Preparedness Index

- This indicator demonstrates Public Health Sudbury & Districts' ongoing preparedness for public health emergencies and presents the extent to which staff members have completed measures to ensure effective preparedness and response capabilities.
- Public Health Sudbury & Districts was on track with this indicator in 2017. All Public Health Inspectors and the majority of managers and directors have completed Basic Emergency Management Training. One manager, one director, and two new Board of Health members will be scheduled for training in 2018.

ORGANIZATIONAL EXCELLENCE

Worker Engagement Index

- Data for 2013, 2016, and 2017 were collected using the 5 worker engagement focused questions from the Guarding Minds @ Work (GM@W) survey.
- Data for 2015 were collected using a different measuring tool, that measured similar physical, cognitive, and emotional engagement concepts.
- Direct comparisons between results reported in 2013, 2016, and 2017 can be made; however, comparison of results from 2015 to other years should be made with caution.
- The staff engagement questions from the Guarding Minds at Work survey were distributed in fall 2017. A total of 128 out of 280 staff members completed the survey for a response rate of 45.7%.
- Based on the results, the Worker Engagement Score is 94/100.

SharePoint Deployment Status

- SharePoint is an internal, web-based, collaboration tool that supports document storage and records management, allows for content to be shared among staff, and helps users find the right people and the right information to make informed decisions.
- The deployment of SharePoint continues to progress as planned with some improvements to SharePoint features made in 2017. One out of five SharePoint deployment phases is complete; all other phases are being worked on simultaneously.
- File storage management has been deferred at this time.

WORKFORCE EXCELLENCE

Workforce Development Status

- The Workforce Development Framework outlines a structure to guide Public Health Sudbury & Districts in ensuring that its workforce has the knowledge, skills, and abilities needed to respond to and be aligned with current and future public health service demands.
- Phase 1 and 3 of the Workforce Development Plan were completed while Phases 2, 4, and 5 continue to progress as planned.
- Key Workforce Development milestones for 2017 include: the expansion of the mentorship program, the development of a Public Health Sudbury & Districts' Leadership Framework and Development Strategy, the development of 3 new student placement agreements, the development of succession planning policies and procedures, and the hiring of a Workforce Development Officer to assist in growing the work associated with the Workforce Development Framework.

Ontario Public Health Organizational Standards Report

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

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

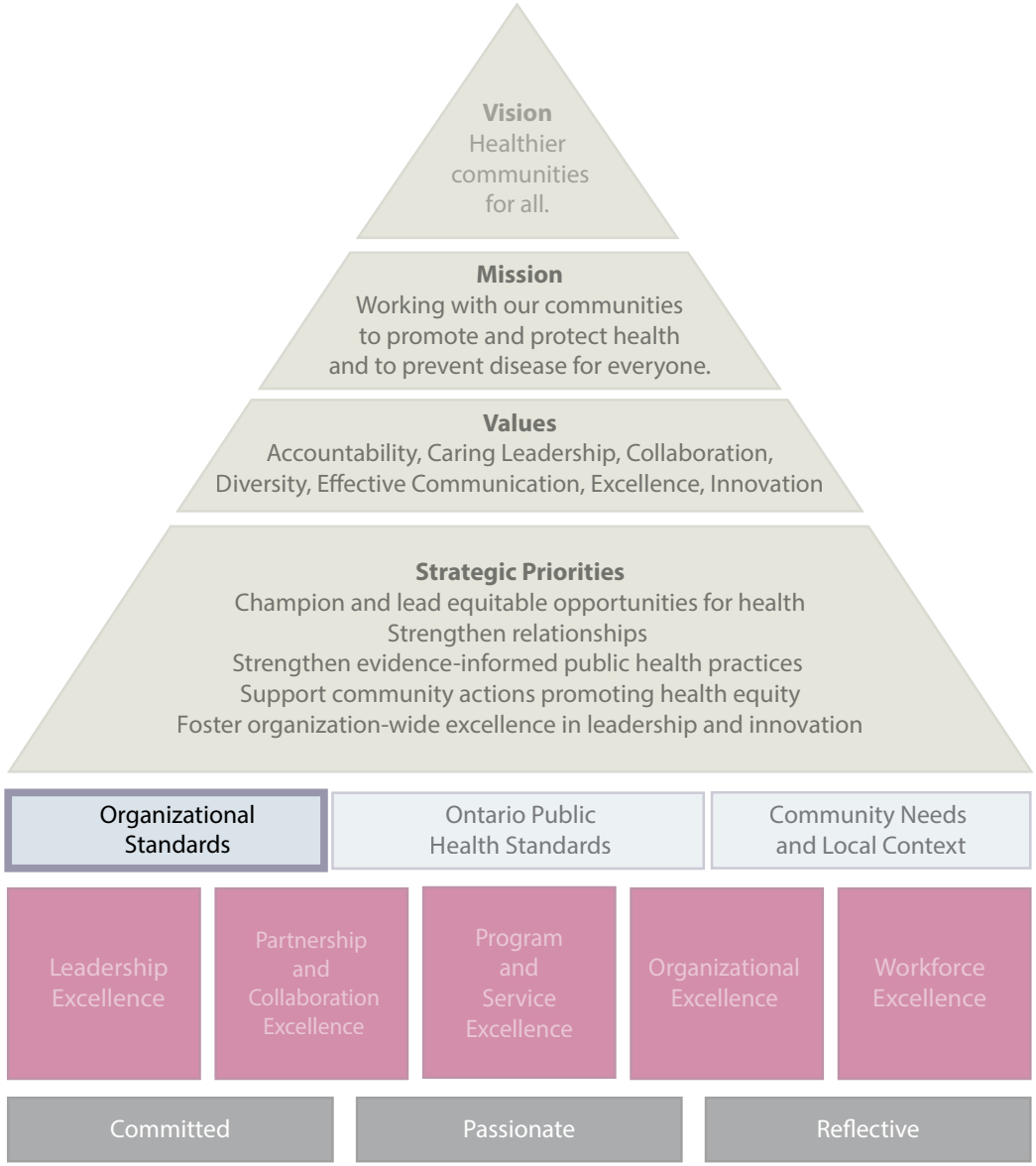


Table 2: Ontario Public Health Organizational Standards Compliance, 2013–2017

STANDARD	REQUIREMENT	2013	2014	2015	2016	2017
1. Board Structure	1.1 Definition of a board of health	-				
	1.2 Number of members on a board of health	-				
	1.3 Right to make provincial appointments	-				
	1.4 Board of health may provide public health services on reserve	-				
	1.5 Employees may not be board of health members	-				
	1.6 Corporations without share capital	-				
	1.7 Election of the board of health chair	-				
	1.8 Municipal membership	-				
2. Board Operations	2.1 Remuneration of board of health members	-				
	2.2 Informing municipalities of financial obligations	-				
	2.3 Quorum	-				
	2.4 Content of by-laws	-				
	2.5 Minutes, by-laws and policies and procedures	-				
	2.6 Appointment of a full-time Medical Officer of Health	-				
	2.7 Appointment of an acting Medical Officer of Health	-				
	2.8 Dismissal of a Medical Officer of Health	-				
	2.9 Reporting relationship of the Medical Officer of Health to the board of health	-				
	2.10 Board of health policies	-				

Met or exceeded standard Non-compliant with standard

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

STANDARD	REQUIREMENT	2013	2014	2015	2016	2017
3. Leadership	3.1 Board of health stewardship responsibilities	-				
	3.2 Strategic plan	-				
4. Trusteeship	4.1 Transparency and accountability	-				
	4.2 Board of health member orientation and training	-				
	4.3 Board of health self-evaluation	-				
5. Community Engagement and Responsiveness	5.1 Community engagement	-				
	5.2 Stakeholder engagement	-				
	5.3 Contribute to policy development	-				
	5.4 Public reporting	-				
	5.5 Client service standards	-				
6. Management Operations	6.1 Operational plan	-				
	6.2 Risk management	-				
	6.3 Medical Officer of Health provides direction to staff	-				
	6.4 Eligibility for appointment as a Medical Officer of Health	-				
	6.5 Educational requirements for public health professionals	-				
	6.6 Financial records	-				
	6.7 Financial policies and procedures	-				
	6.8 Procurement	-				

Met or exceeded standard Non-compliant with standard

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

STANDARD	REQUIREMENT	2013	2014	2015	2016	2017
6. Management Operations	6.9 Capital funding plan	-				
	6.10 Service level agreements (Public Health Sudbury & Districts has an autonomous Board not integrated with the municipality.)	-	N/A	N/A	N/A	N/A
	6.11 Communications strategy	-				
	6.12 Information management	-				
	6.13 Research ethics	-				
	6.14 Human resources strategy	-				
	6.15 Staff development	-				
	6.16 Professional practice support	-				

Met or exceeded standard Non-compliant with standard

Notes—Program Highlights

All Organizational Standards have been met or were exceeded. The following updates highlight key projects and milestones that occurred throughout 2017.

1.0 BOARD STRUCTURE

1.2 Number of members on a Board of Health (BoH)

- Board of Health by-laws and Board of Health membership policy illustrate that we are in compliance with legislative requirements. The number of provincial appointments increased from two to three which raised the Board of Health for Public Health Sudbury & Districts complement to 14 members.
- In 2017, two Board of Health members resigned and four new members were appointed.

1.4 Board of Health may provide public health services on reserve

- The Board of Health continues its work in this area with key activities including but not limited to the hiring of a full-time Manager, Indigenous Engagement and the establishment of an Indigenous Engagement Steering Committee.

2.0 BOARD OPERATIONS

2.6 Appointment of a full-time MOH

- A review of this policy is being undertaken due to correspondence received from the Ministry of Health and Long-Term Care in November 2017 regarding the Ministry Policy Guide for Medical Officer of Health, Associate Medical Officer of Health, and Acting Medical Officer of Health appointments.

3.0 LEADERSHIP

3.1 Board of health stewardship responsibilities

- In September 2017, Board of Health members participated in Bridges Out of Poverty training which aims to increase awareness about poverty and inspire compassion and a commitment to poverty reduction.

3.2 Strategic plan

- Since January 2017, the development for the next iteration of the Strategic Plan has been underway. The Strategic Plan engagement plan was implemented in early 2017. Engagement activities included: Have Your Say surveys for the general public, community partners, Board of Health members, and staff; a World Café session for staff; and consultation sessions and workshops with the Senior Management Executive Committee, Board of Health members, and key stakeholders such as Indigenous community members. The results of these sessions informed the drafting of the 2018–2022 Strategic Plan.

4.0 TRUSTEESHIP

4.2 Board of Health member orientation and training

- Orientation sessions were held July 12 and November 9, 2017 for new board members.

4.3 Board of Health self-evaluation

- Meeting-specific evaluations are conducted monthly and feedback is shared with the Chair of the Board of Health.

5.0 COMMUNITY ENGAGEMENT AND RESPONSIVENESS

5.1 Community engagement

- In comparison to past strategic planning practices, members of the general public and community partners were given more opportunity to provide feedback on future strategic directions.
- Community engagement is also built into the annual program planning cycle.

5.4 Public reporting

- Public Health Sudbury & Districts produced an annual financial report, performance report, and annual report that were shared with general public. This year's online version of the Annual Report incorporated a video message from the Medical Officer of Health.

5.5 Client service standard

- In March 2017, a number of factors prompted a review of the format, promotion, and scope of the Client Centred Care (CCC) Survey. As a result, a new organization-wide client satisfaction questionnaire has been approved. The launch of the new survey is anticipated in early 2018.

6.0 MANAGEMENT OPERATIONS

6.2 Risk management

- The first Organizational Risk Management Report (for 2016) was approved at the Board of Health Meeting in May 2017. The report included identified risks, risk prioritization, and progress notes on the management and mitigation of the top identified risks.
- In 2017, management teams and select teams within the agency also conducted risk assessments.

6.11 Communications Strategy

- Public Health Sudbury & Districts continues to leverage multiple internal and external communication vehicles and channels such as social media, web content, radio, and print materials to provide information and ensure accessibility.
- In 2017, Public Health Sudbury & Districts coordinated the development of an agency-wide social media strategy, to be implemented in 2018.

6.13 Research Ethics

- The internal Research Ethics Review Committee (RERC) continues to review proposed research projects, in accordance with the 2nd edition of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. In 2017, 15 proposals were reviewed and approved by the committee.

Public Health Accountability Agreement Indicators Report

The Ministry of Health and Long-Term Care (MOHLTC) has set out indicators for boards of health to ensure accountability. In previous years, these indicators included a set of performance indicators and a set of monitoring indicators that were measured and monitored by the MOHLTC throughout accountability agreement periods and represented outcomes relating to the delivery of public health programs and services. As of June 2017, the suite of indicators has been reduced to 15 monitoring indicators. Monitoring indicators do not have set targets and are used to ensure that high levels of achievement are sustained, to allow time for baseline levels of achievement to be confirmed, and to monitor risks related to program delivery.

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

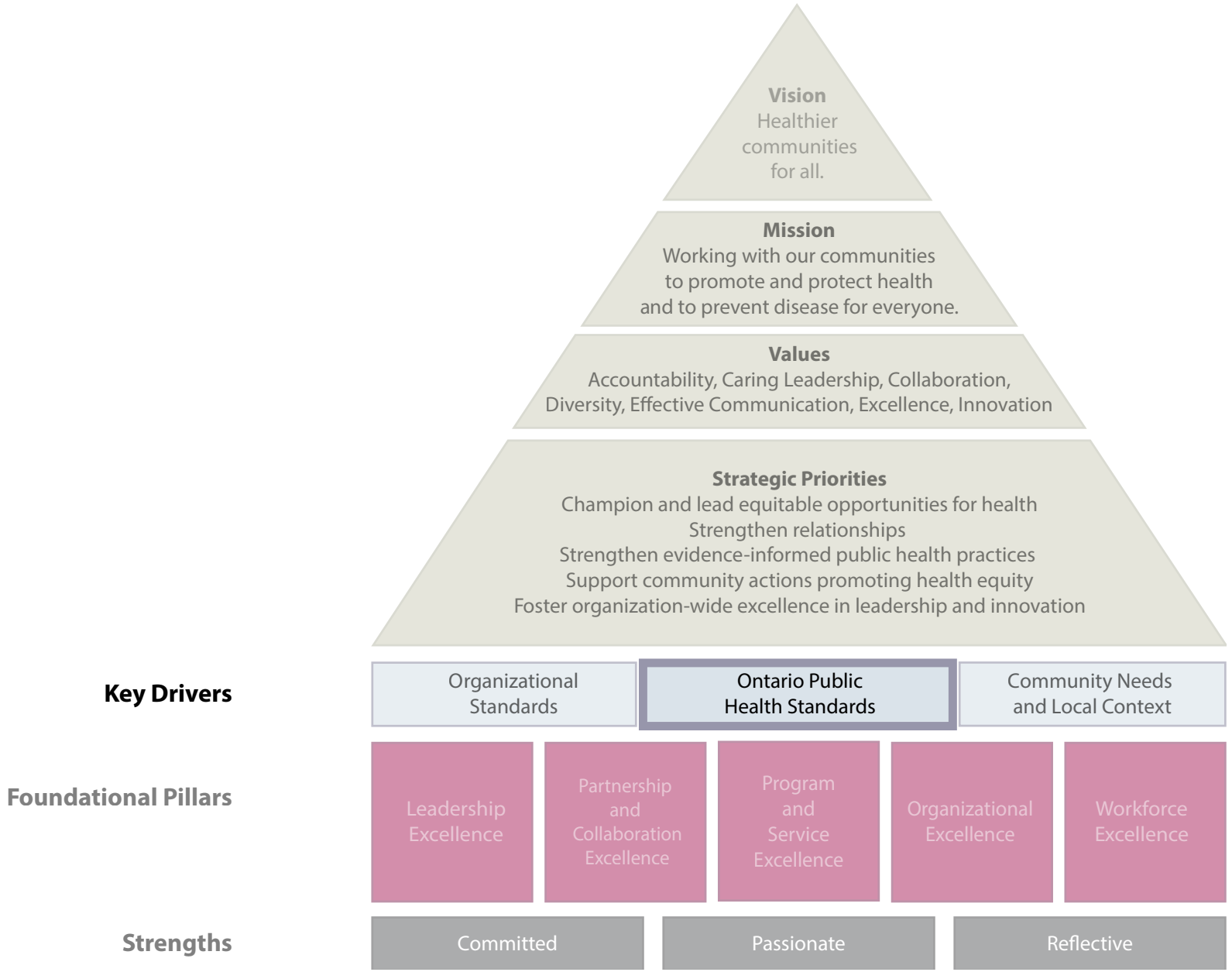


Table 3: Accountability Agreement Performance Indicators 2013–2017

DIVISION	PERFORMANCE INDICATOR	2013	2014	2015	2016	2017
Clinical Services	% of 7 or 8 year old students in compliance with ISPA					*
	% of 16 or 17 year old students in compliance with ISPA					*
	Oral health assessment and surveillance: % of JK, SK and Grade 2 students screened in publicly funded schools					*
	Implementation status of NutriSTEP®					*
	Baby-Friendly Initiative (BFI) status					*
	% of influenza vaccine wasted that is stored/administered by the public health unit					*
	% of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection					*

Table 3 continued: Accountability Agreement Performance Indicators 2013–2017

DIVISION	PERFORMANCE INDICATOR	2013	2014	2015	2016	2017
Environmental Health	% of tobacco vendors in compliance with youth access legislation at the time of last inspection					*
	% of secondary schools inspected once per year for compliance with section 10 of the Smoke Free Ontario Act (SFOA)					*
	% of tobacco retailers inspected for compliance with section 3 of the SFOA					*
	% of tobacco retailers inspected once per year for compliance with display, handling and promotion sections of the SFOA					*
	% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection					*
	% of suspected rabies exposures reported with investigations initiated within 1 day of public health unit (PHU) notification					*
	% of salmonellosis cases where one or more risk factor(s) other than "Unknown" was entered into integrated Public Health Information System (iPHIS)					*

Baseline Met or exceeded target Variance

Notes

- As per the June 2017 Accountability Agreement, the Ministry of Health and Long-Term Care (the Ministry) has discontinued measuring these indicators pending the review of the Ontario Public Health Standards (OPHS).

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ADDENDUM

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

IN CAMERA

MOTION: THAT this Board of Health goes in camera. Time:_____

RISE AND REPORT

MOTION: THAT this Board of Health rises and reports. Time: _____

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: _____