Board of Health Meeting # 02-20

Public Health Sudbury & Districts

Wednesday, February 19, 2020

1:30 p.m.

Boardroom

1300 Paris Street

Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA – SECOND MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, SECOND FLOOR
WEDNESDAY, FEBRUARY 19, 2020 – 1:30 P.M.

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

- Order in Council Re: provincial appointment of Jacqueline Paquin effective February 22, 2020
- Letter from the Board Chair to the Minister of Health dated January 31, 2020, supporting provincial reappointments
- Thank you letter from the Board Chair to Janet Bradley dated February 10, 2020

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION/PRESENTATION

i) 2019 Year-In Review

- Dr. Ariella Zbar, Associate Medical Officer of Health
- Stacey Laforest, Director, Health Protection Division
- Sandra Laclé, Director, Health Promotion Division
- Renée St Onge, Director, Knowledge and Strategic Services Division

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. First Meeting – January 16, 2020

ii) Business Arising From Minutes

iii) Report of Standing Committees

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

a. MOH/CEO Report, February 2020

v) Correspondence

a. Healthy Smiles Ontario Funding

- Letter from the Board of Health Chair and the Chief Executive Officer, Windsor-Essex County Health Unit to the Minister of Health and Deputy Premier, dated January 17, 2020

b. Children Count Pilot Project

- Letter from the Board of Health Chair and the Chief Executive Officer, Windsor-Essex County Health Unit to the Minister of Health and Deputy Premier, dated January 17, 2020

c. E-Cigarettes and Aerosolized Products

- Letter from the Board of Health Chair, Porcupine Health Unit, to the Federal and Provincial Ministers of Health, dated January 9, 2020
- Letter from the Board of Health Chair, Peterborough Public Health, to the Minister of Health, dated January 22, 2020, supporting Board of Health for Public Health Sudbury & Districts motion 48-19

d. Public Health Modernization

- Letter and motion to the Premier of Ontario from the Chair of Manitoulin-Sudbury DSB dated January 24, 2020
- alPHa response to the Ministry of Health Modernization Discussion Paper
- Letter to the Premier from the Leader of the Official Opposition, Andrea Horwath, dated February 5, 2020
- Letter and Public Health Modernization Submission of Public Health Sudbury & Districts to the Ministry of Health dated February 10, 2020

e. Measurement of Food Insecurities

- Letter to the Federal Minister of Health the Board Chair, Kingston, Frontenac and Lennox & Addington Public Health, dated January 28, 2020

f. Off Road Vehicles and Bills 107 and 132

- Letter from the Board of Health Chair, Peterborough Public Health, to the Minister of Transportation dated January 29, 2020

vi) Items of Information

a. alPHa Information Break	January 22, 2020 February 3, 2020
b. Globe and Mail Opinion *A forgotten lesson of SARS: The need for public health specialists and expertise*	February 3, 2020
c. *Opportunities for Health for All: A Focus on Income* Report	February 2020
d. Public Health Sudbury & Districts *2019 Highlights* Santé publique Sudbury & Districts *2019 Faits saillants en chiffres*	

APPROVAL OF CONSENT AGENDA

MOTION:

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

6. NEW BUSINESS

i) Novel Coronavirus 2019

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated February 12, 2020

ii) Infrastructure Modernization

- Briefing note from the Medical Officer of Health and Chief Executive Officer dated February 12, 2020

iii) alPHa Board of Health North East Representative

NOMINATION TO THE ALPHA BOARD OF DIRECTORS FOR THE NORTH EAST REGION

WHEREAS there is currently a vacancy for a North East representative on the alPHa Board of Directors for a two-year term;

THAT the Board of Health for Public Health Sudbury & Districts supports the nomination of René Lapierre, Board Chair, as a candidate for election to the alPHa Board of Directors and for the Boards of Health Section Executive Committee seat from the North East region.

7. ADDENDUM

ADDENDUM

MOTION:

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

8. ANNOUNCEMENTS / ENQUIRIES

- Please complete the February Board of Health meeting evaluation in BoardEffect following the Board meeting.

9. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: ____

Ontario

Executive Council of Ontario
Order in Council

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

Conseil exécutif de l'Ontario
Décret

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

PURSUANT TO subsections 49(3) and 51(1) of the *Health Protection and Promotion Act*, **Jacqueline Paquin** of Sudbury be appointed as a part-time member of the Board of Health for the Sudbury and District Health Unit to serve at the pleasure of the Lieutenant Governor in Council for a period not exceeding one year, effective February 22, 2020.

EN VERTU DES paragraphes 49 (3) et 51 (1) de la *Loi sur la protection et la promotion de la santé*, **Jacqueline Paquin** de Sudbury, est nommée au poste de membre à temps partiel du conseil de santé de la circonscription sanitaire de Sudbury et du district pour exercer son mandat à titre amovible à la discrétion du lieutenant-gouverneur en conseil, pour une période maximale d'un an à compter du 22 février 2020.

Christine Elliott

Recommended: Minister of Health
Recommandé par : La ministre de la Santé

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

Approved and Ordered: JAN 3 1 2020
Approuvé et décrété le :

Elizabeth Dowdeswell

Lieutenant Governor
La lieutenante-gouverneure

O.C. | Décret : 174/2020

Public Health
Santé publique
SUDBURY & DISTRICTS

January 31, 2020

Minister Christine Elliott
Ministry of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister:

The purpose of the letter is to notify the Ministry of public appointees on the Board of Health for Public Health Sudbury & Districts whose terms of appointment will be expiring.

Nicole Sykes and James Crispo have served a three year term as provincial appointees on the Board of Health since May 31, 2017. Nicole Sykes and James Crispo, whose terms are ending May 30, 2020, have confirmed their interest in seeking reappointment. The Board of Health supports their request for a reappointment to the Board of Health. The Public Appointment Secretariat (PAS) Reappointment Information Forms are attached.

Also, Janet Bradley, provincial appointee, has been an effective Board of Health member since 2011. We have been informed from PAS that her appointment expiring February 21, 2020, will not be renewed. Should there be an opportunity for reappointment, Janet has indicated an interest in remaining on the Board and the Board of Health would unequivocally support her reappointment.

The Board recognizes the valuable contributions both public appointees have made to the Board of Health over the course of their terms.

Sincerely,

Original signed by

René Lapierre
Chair, Board of Health

Encls.

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St.-Charles ON P0M 2W0
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Espanola
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phsd.ca

Public Health
Santé publique
SUDBURY & DISTRICTS

February 10, 2020

Ms. Janet Bradley
Provincial Appointment
Board of Health
Public Health Sudbury & Districts

Dear Ms. Bradley:

Re: Public Health Sudbury & Districts Board of Health End of Term

Public Health Sudbury & Districts has been informed by Public Appointments that your term will be ending on February 21, 2020. On behalf of the Board of Health and Public Health Sudbury & Districts, I extend my sincere gratitude to you for your longstanding service as a committed member of our Board.

You have been a valued and respected longstanding Board of Health member. Your understanding of the Board's governance functions and insightful knowledge of upstream determinants of health, combined with your very effective communication and interpersonal leadership skills, have made you a remarkable asset to our Board. Your contributions to the Board of Health will be missed but we know we have a passionate public health ambassador in our community.

On behalf of the entire Board of Health, please accept my gratitude for your contributions and my well wishes for the future.

Sincerely,

Original signed by

René Lapierre, Chair
Board of Health

cc: Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer
Board of Health, Public Health Sudbury & Districts
Public Appointments, Agency Coordination & Corporate Initiatives Unit, Ministry of Health

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MINUTES – FIRST MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
PUBLIC HEALTH SUDBURY & DISTRICTS, BOARDROOM, SECOND FLOOR
THURSDAY, JANUARY 16, 2020 – 1:30 P.M.

BOARD MEMBERS PRESENT

Janet Bradley
James Crispo
Randy Hazlett
Robert Kirwan
René Lapierre
Bill Leduc
Paul Myre
Ken Noland
Mark Signoretti
Nicole Sykes
Carolyn Thain

BOARD MEMBERS REGRETS

Jeffery Huska
Glenda Massicotte

STAFF MEMBERS PRESENT

Sandra Laclé
Stacey Laforest
Jamie Lamothe
Rachel Quesnel
France Quirion
Dr. Penny Sutcliffe
Renée St. Onge
Dr. Ariella Zbar

MEDIA PRESENT

Media

R. QUESNEL PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

The meeting was called to order at 1:30 p.m.

i) Resignation from Board of Health member, Rita Pilon

- Thank you letter from the Board of Health Chair, Public Health Sudbury & Districts, to Rita Pilon, Board of Health member, dated December 18, 2019
- Email from Rita Pilon, Board of Health Member, representing the Township of Chapleau, to the Board of Health Chair and Dr. Sutcliffe, dated December 5, 2019

ii) Thank You Letter - Provincial Appointment – End of Term

- Thank you letter to Janet Bradley, Provincial Appointee, from the Deputy Premier and Minister of Health dated December 20, 2019

R. Pilon and J. Bradley were thanked for their longstanding contributions on the Board of Health.

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

There were no declarations of conflict of interest.

4. ELECTION OF OFFICERS

Following a call for nominations for the position of Chair of the Board of Health, R. Lapierre was nominated. There being no further nominations, the nomination for the Board of Health Chair for Public Health Sudbury & Districts for 2020 was closed. R. Lapierre accepted his nomination and the following was announced:

THAT the Board of Health appoints R. Lapierre as Chair of the Board for the year 2020.

R LAPIERRE PRESIDING

APPOINTMENT OF VICE-CHAIR OF THE BOARD

Following a call for nominations for the position of Vice-Chair of the Board of Health, Jeff Huska and Randy Hazlett were nominated.

There being no further nominations, the nomination for Vice-Chair for the Board of Health for 2020 was closed. R. Lapierre noted that J. Huska has indicated via email that he would accept a nomination to the Vice-Chair position. Randy Hazlett also accepted his nomination and a paper vote was conducted. The Chair announced:

THAT the Board of Health appoints Jeff Huska as Vice-Chair of the Board for the year 2020.

APPOINTMENTS TO THE BOARD EXECUTIVE COMMITTEE

Following a call for nominations for three positions of Board Member at Large to the Board Executive Committee, James Crispo, Ken Noland, Randy Hazlett, Nicole Sykes, and Carolyn Thain were nominated.

There being no further nominations, the nominations for the Board Executive Committee for the year 2020 was closed. All nominees accepted their nominations and a ballot vote was conducted. The Chair announced:

THAT the Board of Health appoints the following individuals to the Board Executive Committee for the year 2020:

1. ***James Crispo, Board Member at Large***
2. ***Nicole Sykes, Board Member at Large***
3. ***Ken Noland, Board Member at Large***
4. ***René Lapierre, Chair***
5. ***Jeff Huska, Vice-Chair***
6. ***Medical Officer of Health/Chief Executive Officer***
7. ***Director, Corporate Services***
8. ***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, Mark Signoretti, Randy Hazlett, and Carolyn Thain were nominated.

There being no further nominations, the nominations for the Finance Standing Committee of the Board of Health for the year 2020 was closed. All accepted their nominations and the Chair announced:

THAT the Board of Health appoints the following individuals to the Finance Standing Committee of the Board of Health for the year 2020:

1. ***Mark Signoretti, Board Member at Large***
2. ***Randy Hazlett, Board Member at Large***
3. ***Carolyn Thain, Board Member at Large***
4. ***René Lapierre, Board Chair***
5. ***Medical Officer of Health/Chief Executive Officer***
6. ***Director, Corporate Services***
7. ***Secretary Board of Health***

5. DELEGATION/PRESENTATION

i) Workforce Development at Public Health Sudbury & Districts

- David Groulx, Manager, Professional Practice and Development, Knowledge and Strategic Services Division
- Troy Haslehurst, Manager, Human Resources, Corporate Services Division

D. Groulx and T. Haslehurst began by noting that the primary aim of workforce development is to facilitate and sustain the development in the Public Health Sudbury & Districts' workforce.

A workforce development framework, developed to assist in and support the planning of workforce development strategies/activities, includes these key domains:

1. workforce planning
2. workforce capacity building
3. human resources management

Workforce development also supports ongoing capacity to meet Public Health Sudbury & Districts' strategic plan priorities. Due to investments in workforce development over the years, such as staff development, the Public Health Sudbury & Districts' workforce is competent, resilient, qualified, and well positioned to respond to community needs and emergency situations. The framework continuously guides efforts to ensure the right people are hired with the right skills and knowledge, in the right roles, at the right time.

Questions and comments related to hiring of students and recruitment of staff that are a good fit with the organizational culture and values. Further to an inquiry regarding succession planning, Dr. Sutcliffe noted that this is a high/red risk in the Risk Management Plan. She added that Public Health Sudbury & Districts undertook a formal process to develop a succession plan; however, the project scope had to be adjusted due to the Ministry of Health's Public Health modernization.

6. CONSENT AGENDA

i) Minutes of Previous Meeting

a. Seventh Meeting – November 21, 2019

ii) Business Arising From Minutes

iii) Report of Standing Committees

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

a. MOH/CEO Report, January 2020

v) Correspondence

a. E-Cigarettes and Aerosolized Products

- Letter from the Township of Nairn and Hyman to the Minister of Health dated January 3, 2020, in support of the Public Health Sudbury & Districts' Motion 48-19
- Email from Shelley Martel, NDP Stakeholder Relations, to Dr. Sutcliffe, dated December 17, 2019
- Letter from the Board of Health Chair, Leeds, Grenville & Lanark District Health Unit, to the Minister of Health, dated December 2, 2019
- Letter from the Board of Health Chair, Peterborough Public Health, to the Federal Minister of Health, dated November 29, 2019

- Letter from the Mayor, City of Hamilton, to the Federal Minister of Health, dated November 27, 2019
- Letter from the Mayor, City of Hamilton, to the Provincial Minister of Health, dated November 27, 2019
- Letter from the Board of Health Chair, Haliburton, Kawartha, Pine Ridge District Health Unit, to the federal and provincial Ministers of Health, dated November 21, 2019
- Report from the Medical Officer of Health, Middlesex-London Health Unit, to the Ontario Boards of Health, dated October 17, 2019

b. Opioid Overdose Emergency Resolution

- Letter from the Mayor, City of Hamilton, to the federal and provincial Ministers of Health, dated November 27, 2019

c. Local Health Care Services

- Letter and motion from the Municipality of Killarney, to the Town of Kingsville, dated November 27, 2019
- Letter from the Corporation of the Town of Espanola, to the Premier of Ontario, in support of the Town of Kingsville, dated November 12, 2019

d. Request for Weekly Data Reports on Vaping Cases

- Letter from the Board of Health Chair, Peterborough Public Health, to the Minister of Health, dated January 2, 2020
- Letter from the Mayor, City of Hamilton, to the Minister of Health, dated October 30, 2019

e. Opposition to Co-Payment for Dentures under the New Ontario Seniors Dental Care Program

- Letter from the Mayor, City of Hamilton, to the Minister of Health, dated October 30, 2019

f. Support for a Seamless Provincial Immunization Registry

- Letter from the Mayor, City of Hamilton, to the Minister of Health and the Chief Medical Officer of Health, dated October 30, 2019

g. National Universal Pharmacare Program

- Letter from the Board of Health Chair, Leeds, Grenville & Lanark District Health Unit, to the Federal Minister of Health, dated December 18, 2019

vi) Items of Information

a.	alPHa Information Break	December 13, 2019
b.	News Release re: Huron County Health Unit and Perth District Health Unit Merger	December 19, 2019
c.	alPHa 2020 Winter Symposium Save the Date Flyer	February 20 & 21, 2020

d. CBC: *Huron County becomes third municipality to pay living wage* December 20, 2019

01-20 APPROVAL OF CONSENT AGENDA

MOVED BY HAZLETT– LEDUC: THAT the Board of Health approve the consent agenda as distributed.

CARRIED

Kudos were extended to the Public Health Sudbury & Districts' team for its response to the recent hepatitis A incident. Dr. Sutcliffe responded to a question related to vaping.

7. NEW BUSINESS

i) Survey Results from Regular Board of Health Meeting Evaluations

- Board of Health Meeting Evaluations Summary – 2019

Evaluation results from regular Board of Health meetings have been summarized for the Board's information. It was clarified that where Board members selected *Not Applicable*, the response was excluded from the calculation and the number of N/A respondents for the question was noted below the relevant graph.

ii) Board of Health, Public Health Sudbury & Districts Meeting Attendance

- Board of Health Meeting Attendance Summary – 2019

A summary of individual Board of Health member attendance at regular Board of Health meetings for 2019 is shared for information. The yearly summary is tabled annually.

iii) Fully Funded Universal Healthy School Food Program

- Briefing Note from the Medical Officer of Health dated January 9, 2020

Dr. Sutcliffe highlighted that in Ontario, the school or student nutrition program aims to support students' learning and healthy development through additional nourishment. The school nutrition program funding model is unsustainable and is negatively impacting its effectiveness. It was shared that only 19% of Sudbury & District youth (ages 12-19) reported meeting the recommended intake of fruit and vegetables. Today's motion seeks support from the federal Minister of Health to develop a universal publicly funded school food program that aligns with Canada's Dietary Guidelines.

Questions and comments were entertained. It was suggested that the goals of the program be clearly articulated. In response to concerns of imposing a national program requiring participation of every school and concerns about parent choice and respecting cultural differences, it was clarified that the recommended motion advocates for a program that is based on the principles of the Canada Food Guide and would be open to all children thus reducing the potential for stigmatization. Food insecurity is a concern

across Canada. It was noted that the impacts of workload and food waste should be considered. It was also recognized that cost is the not the only barrier to accessing nutritious foods. It was suggested that we further advocate to the provincial government; therefore, a friendly amendment the motion to include the Ontario Minister of Health in the operative clause was supported.

The following motion was entertained and it was noted that the work and advocacy from other jurisdictions on this topic will be referenced when the motion is shared.

02-20 FULLY FUNDED UNIVERSAL HEALTHY SCHOOL FOOD PROGRAM

MOVED BY SYKES – NOLAND: WHEREAS a universal publicly funded healthy school food program in Canada enables all students to have the opportunity to eat healthy meals at school every day, and no child is left out due to their family's ability to pay, fundraise, or volunteer with the program; and

WHEREAS only 19% of Sudbury & District youth (ages 12-19) reported meeting the recommended intake of fruit and vegetables, an indicator of nutrition status and a risk factor for the development of nutrition-related chronic diseases;

THEREFORE BE IT RESOLVED THAT That the Board of Health for Public Health Sudbury & Districts support resolutions by the Federation of Canadian Municipalities, and Boards of Health for Grey Bruce Health Unit, Toronto Public Health, Peterborough Public Health and Windsor-Essex County Health Unit for a universal publicly funded healthy school food program.

FURTHER THAT the Board calls on Canada's Minister of Health and Ontario's Minister of Health to work in consultation with ~~the~~ all provinces, territories, Indigenous leadership, and other interest groups to collaboratively develop a universal publicly funded school food program that is aligned with Canada's Dietary Guidelines.

CARRIED WITH FRIENDLY AMENDMENTS

iv) Provincial Public Health Modernization Consultation

- Ministry of Health email invitation re: January 14, 2020, consultation session
- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated January 9, 2020
- Draft Preliminary Key Considerations: Public Health Modernization Discussion Paper Response

Through a slide presentation, Dr. Sutcliffe reviewed the process to seek the Board's input into the development of a Public Health Sudbury & Districts submission to the Ministry of Health on the Ministry's Discussion Paper on Public Health Modernization.

The Board's feedback was sought on the content of the draft *Preliminary Key Considerations* document and appendices and motion seeking support to give authority to the Board Chair to finalize our paper based on today's feedback in order to meet the February 10, 2020 submission deadline.

It was recapped that the Ministry launched the much-anticipated public health modernization consultation and released the Discussion Paper at a webinar on November 18. The Ministry also advised at that time that stakeholders would have an opportunity to complete a survey.

Public Health Sudbury & Districts, Algoma Public Health and North Bay Parry Sound District Health Unit attended the Ministry's consultation session in North Bay on January 14, 2020. Public Health Sudbury & Districts senior managers and Board members attended the consultation in person as well as by teleconference. The Ministry will present updates at the January 20, 2020, ROMA conference that will be attended by the Special Advisor. R. Lapierre will be attending the ROMA conference on behalf of the Board of Health.

The Board collectively reviewed the *Preliminary Key Considerations* document, appendices, prepared by management and the MOH and reflected on what was heard at the January 14 consultation session. Questions prompting discussions included what's missing, what needs further work, anything I cannot live with, and other considerations.

The Ministry has indicated that it is "pressing reset" from its original communication to dissolve 35 boards and create 10 regional public health entities, effective April 1, 2020, noting that this is no longer the intention. In response to an inquiry, Dr. Sutcliffe clarified that the Ministry change in funding policy to up to 70% for both cost-shared programs and previously-100%-funded programs is still in effect as of January 1, 2020.

Feedback provided at the consultation session was summarized and included concerns relating to the change in funding formula and financial impacts on municipalities. Challenges per the Ministry of Health Discussion Paper were reviewed and the five overarching messages to be included in the Public Health Sudbury & Districts submission discussed.

It was clarified that a model or structure has purposely not been recommended; however, principles that would be adhered to are clearly articulated. In response to an inquiry, Dr. Sutcliffe indicated that once the government signaled a change in direction,

the NEPHTI committees did not see a need to continue to meet. The four models proposed to the Ministry at the consultation session by North Bay Parry Sound District Health Unit, which did not include any input from NEPHTI, were summarized.

Board members were thanked for their input to be incorporated into the final document which will be shared with all members via email when it is submitted to the Ministry. The Ministry staff have indicated that it is not necessary to have multiple survey responses in addition to a document submitted on behalf of a group. It was suggested that our submission be shared with local partners.

In addition to the Board of Health's submission, the Public Health Sudbury & Districts management team will complete individual surveys highlighting Public Health Sudbury & Districts submission points.

03-20 PUBLIC HEALTH MODERNIZATION DISCUSSION PAPER RESPONSE

MOVED BY SIGNORETTI – HAZLETT: WHEREAS the Board of Health for Public Health Sudbury & Districts, having reviewed and discussed edits to the Preliminary Key Considerations: Public Health Modernization Discussion Paper Response, authorizes the Board of Health Chair to so finalize the document for submission on the Board of Health's behalf to the Ministry of Health and the Special Advisor by the February 10, 2020, deadline.

CARRIED

v) Board of Health Meeting Date

Due to the alPHa winter symposium scheduled for February 20, 2020, it is recommended that the regular Board of Health meeting date be changed.

04-20 BOARD OF HEALTH MEETING DATE

MOVED BY HAZLETT – SIGNORETTI: WHEREAS the Board of Health regularly meets on the third Thursday of the month; and

WHEREAS By-Law 04-88 in the Board of Health Manual stipulates that the Board may, by resolution, alter the time, day or place of any meeting;

THEREFORE BE IT RESOLVED THAT this Board of Health agrees that the regular Board of Health meeting scheduled for 1:30 pm Thursday, February 20, 2020, be moved to 1:30 pm on Wednesday, February 19, 2020.

CARRIED

8. ADDENDUM

None.

9. ANNOUNCEMENTS / ENQUIRIES

Board members are encouraged to complete the survey for today's Board of Health meeting as well as to complete two declaration forms in paper or electronic format.

10. ADJOURNMENT

O5-20 ADJOURNMENT

MOVED BY NOLAND – SIGNORETTI: THAT we do now adjourn. Time: 3:45 p.m.

CARRIED

_____ _____

(Chair) (Secretary)

Medical Officer of Health/Chief Executive Officer

Board of Health Report, February 2020

Words for thought

Better health and social policy would save more lives than sophisticated drugs.

Earlier this month, the American Cancer Society announced its latest figures on cancer incidence and mortality (R. L. Siegel. *et al. CA Cancer J. Clin.* **70**, 7–30; 2020). These included the largest drop ever observed in national cancer statistics, which several media outlets seized on. Cancer death rates in the United States peaked in 1990, and in 2008–17 fell by about 1.5% per year. Between 2016 and 2017, the drop was slightly larger: 2.2%. This is undeniably good news.

But our optimism must be tempered by other measures of population health — particularly declining life expectancy.

The reason behind the large drop is a decrease in mortality for lung cancer — without lung cancer, the rate is still about 1.5%. Several reactions to the Cancer Society's news heralded advances in precision treatments. Yet much of the continued reduction in mortality is due to the lower incidence of lung cancer, or a reduction in new cases per year. And new drugs cannot cause that. The two major therapeutic advances for treating this cancer — genome-targeted therapies and immunotherapy — are currently approved for the worst-off individuals: those with advanced or metastatic disease.

Exciting technologies that uncover genetic drivers of cancer and unleash the immune system against it make headlines, but I think we must be careful not to give customized treatments too much credit, and I have been outspoken about my work to pin down the impact of these therapies. We would do better to focus on public-health strategies that are less glamorous.

My colleagues and I have estimated that, as of 2018, 8.33% of the US population with advanced cancer was eligible for genome-targeted therapy, up from 5.09% in 2006 (J. Marquart *et al. JAMA Oncol.* **4**, 1093–1098; 2018). Another work found that people whose lung cancers are eligible for genome-targeted treatments and who receive them live, overall, about 30 weeks longer than those who are eligible and are not treated (G. Singal *et al. J. Am. Med. Assoc.* **321**, 1391–1399; 2019). That benefit is real, but is unlikely to have altered mortality rates markedly across a population.

Similarly, immunotherapy — which expanded into the market in 2015 — might have had only limited effects on the drop in overall cancer mortality. The benefits for melanoma and for advanced and metastatic lung cancer are impressive, but so far affect relatively few people.

Much bigger drops in US cancer mortality would come from a fairer society. The American Cancer Society estimates that, in 2014, 59% of lung-cancer deaths observed in people aged 25–74 could have been averted by eliminating socio-economic disparities (R. L. Siegel *et al. CA Cancer J. Clin.* **68**, 329–339; 2018).

> "The data do make it clear that the majority of our most effective solutions will be outside the cabinet of cutting-edge medicines."

What's more, US life expectancy has fallen for three straight years. The cause is largely diseases of despair: drug overdose, suicide and alcohol-related liver disease. And these kinds of risk factor cluster. People who die from using opiates are more likely to smoke, for instance. The American Cancer Society uses age-standardized populations to address concerns that a rise in untimely deaths could mask what would have been future cancer deaths and thus spuriously improve cancer death statistics, but it is hard to know exactly how factors behind declining life expectancy play into cancer mortality.

The data do make it clear that the majority of our most effective solutions will be found outside the cabinet of cutting-edge medicines. If we want to do all that we can to reduce the burden of cancer and to improve life expectancy, we must harness the tools of population statistics.

That means we need to create strategies to treat hypertension, end the use of tobacco products, dismantle policies that promote obesity and use of environmental carcinogens, encourage physical activity and reduce levels of carcinogens in the environment. In my cancer clinic, I often wish I had more effective drugs for the person in front of me. I, too, want sophisticated treatments that work. But what I really wish is that the person I'm treating did not have cancer at all.

Our public policy is a series of self-inflicted wounds. The current US administration has allowed loopholes that let the known carcinogen asbestos remain in use. It has failed to improve standards for airborne particulate pollution, clearly linked to higher rates of diseases and death. It reversed a decision to ban a pesticide, chlorpyrifos, associated with impaired childhood brain development, and atrazine, linked to leukaemia.

My deep frustration is this: it is hard to escape the conclusion that we, as a society, are not doing what it takes to maximize our health. We are prioritizing medications that cost US$100,000 a year or more, and at the same time are loosening restrictions on environmental pollution. These policies have one thing in common: they enhance corporate profits. It will take a realignment of public policy to make sure that we pursue systems that instead prioritize health.

Public-health policies are not personalized to any individual, but can promote longevity for all of us, even if it will not make for feel-good stories about scientific breakthroughs or miraculous drugs. In this exciting age of precision medicine, we will reap the biggest gains by celebrating better health for everyone.

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The author declares competing interests; see go.nature.com/2tuseqb for details.

AUDREY TRAN

Source: V. Prasad. Our best weapons against cancer are not magic bullets. Nature; 577; January 23, 2020(451).

Chair and Members of the Board,

This month's *Words for thought* speak to the longstanding tension between clinical medicine's focus on individuals and public health's focus on populations. With the advancement of "precision medicine", (e.g. personalized genome-targeted therapy and immunotherapy), there is concern about distraction from the goal of producing healthier populations with fewer health inequities. Without minimizing the gains to clinical care of (expensive) investments in individualized therapies, research demonstrates that it is the persistent social and economic realities of people's lives that matter most to population health. This goal is best achieved by public health policies that are not personalized to an individual and that create opportunities for health for all. This of course is the focus of Public Health Sudbury & Districts and of the public health system overall.

February marks the annual reporting to the Board of the volume of 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 of Health Updates

Membership

We await confirmation from the Township of Chapleau regarding a replacement for Rita Pilon who tendered her resignation in December 2019.

The term of Board member, Janet Bradley, provincial appointee, concludes on February 21, 2020. Members and provincial appointees Nicole Sykes and James Crispo have applied for reappointments as their terms are slated to end on May 30, 2020.

Conferences

The alPHa winter 2020 Symposium and Board of Health Section meeting taking place February 20 and 21 in Toronto will be attended by Dr. Sutcliffe, Dr. Zbar and Board Chair, René Lapierre.

alPHa's Annual Conference and General Meeting will be held on June 7 to June 9, 2020.
A motion will be included on the April Board agenda relating to Board attendance and voting delegation for the alPHa AGM.

Board orientation / training

A general orientation session will be scheduled once new Board members are in place. Although the general orientation session is for new Board of Health members, all Board members are invited to attend as a refresher. Please stay tuned for further details. Also, per the Ontario Public Health Standards requirements of good governance and management practices, governance training is being explored for this spring for all Board of Health members.

Mask Fit Testing Board Executive Committee

As part of Public Health Sudbury & Districts emergency preparedness planning, Board of Health Executive Committee members have been offered qualitative mask fit testing.

2. Health Equity

Local data has been used to inform a new report, *Opportunities for Health for All: A Focus on Income*. This report demonstrates how income influences physical health, mental health, and our own perceptions of health. The local data is aligned with Board of Health motion 53-10, endorsing the principles of living wage employment and recognizing the serious health and societal costs of inadequate income. The findings from this report will be used to inform our further work in health equity.

3. Red Dress Campaign

Our agency participates in the February 14, 2020, Red Dress Campaign, raising awareness about missing and murdered Indigenous women and girls throughout Canada. The campaign encourages red dresses to be displayed in public places to bring attention to the violence against Indigenous women and girls, thus creating space for dialogue and reflection on the issue. Red dresses will be displayed throughout the office building at 1300 Paris St., including the main lobby and outside the boardroom. Felt red dress pins will be made available for staff to wear, and a video about the issue will be shared with staff members. In addition, our agency will acknowledge the campaign via social media posts.

4. Finance

The 2020 Annual Service Plan and Budget Submission are being prepared for the March 1, 2020, deadline.

Our auditors, KPMG, will return to Public Health Sudbury & Districts for the 2019 audit. On-site audit work will commence March 9, 2020, and conclude by March 13, 2020. The current due date for submission of the audited financial statements and annual reconciliation report to the ministry is April 30, 2020. As our audited financial statements are usually presented to the Board of Health at its May meeting, we will request an extension to the ministry deadline and expect other boards of health to do the same. The ministry has historically approved the extension.

5. Regulatory Health Protection Reporting

Control of Infectious Diseases (CID): During the month of January, six sporadic enteric cases, and four infection control complaints were investigated. Six enteric outbreaks, and two respiratory outbreaks were declared in institutions.

Food Safety: Public health inspectors issued one charge to one food premises for an infraction identified under the *Food Premises Regulation*.

Health Hazard: In January, 29 health hazard complaints were received and investigated.

Rabies Prevention and Control: Twenty-eight rabies-related investigations were carried out in the month of January. Two specimens were submitted to the Canadian Food Inspection Agency Rabies Laboratory for analysis and were subsequently reported as negative.

One order to produce an animal for observation was issued.

Safe Water: During the month of January, one public spa was closed due to adverse water sample results. The order has since been rescinded and the premises allowed to re-open.

Smoke-Free Ontario Act, 2017 Enforcement: In January, 20 individuals were charged for smoking or vaping on school property.

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 2019 year per division.

Clinical Services Division

Control of Infectious Diseases

Infectious Diseases and Vaccine Preventable Diseases Programs

12 205 publicly and non-publicly funded vaccines administered by public health nurses (excludes influenza and school-based)

10 215 on-site vaccination appointments completed

40 848 doses of seasonal influenza vaccine distributed to health care providers*

3 109 doses of seasonal influenza vaccine administered by public health nurses*

2 599 doses of hepatitis B vaccine administered in schools**

1 526 doses of meningococcal vaccine administered in schools**

2 719 doses of HPV vaccine administered in schools**

1 463 tuberculin skin tests performed by Public Health Nurses

143 positive tuberculin skin tests reported to Public Health and for whom follow-up was provided

4 538 immunization records submitted electronically by the public

2 700 immunization records retrieved electronically by the public

3 480 calls responded on topics such as immunization, infection control, and reportable diseases

4 presentations and events with community partners on topics such as immunization, infection control, and reportable diseases.

*Sept. 1/19 to Dec. 31/2019

**During the 2018/19 school year

Respiratory Outbreaks

28 respiratory outbreaks were declared in institutions

- 19 long-term care homes
- 4 licensed child care settings
- 4 hospitals
- 1 retirement home

11 institutions were placed on enhanced respiratory surveillance

Child Care and Early Years Act

69 licensed child care settings requiring immunization record review of enrolled children

2 326 enrolled children receiving immunization records review

Immunization of School Pupils Act (2018/19 school year)

26 250 school student immunization records reviewed

3 186 letters sent to parents or students who had incomplete immunization records

930 school students had suspensions applied

Growing Family Health Clinic

1 001 client appointments

125 prenatal and postnatal appointments

423 appointments for children aged 0–6 years

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

5 439 client visits at the Rainbow Centre office

2 953 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.

1 110 nominal HIV tests completed

73 anonymous HIV tests completed

1 325 total HIV tests

215 point-of-care HIV tests completed

167 client visits in Sudbury schools and agency outreach

452 client visits in district offices and school outreach

Sexual Health Promotion

2 000 pamphlets and promotional items distributed

53 presentations and **4** interactive displays to **1 751** participants

4 media campaigns

Oral Health

1 110 calls or walk-ins seeking assistance for emergency care, completion of paperwork, or general information

11 389 children screened during school screening clinics

836 children referred for urgent care

457 children participated in school-based preventive services

429 children participated in Public Health preventive care

301 children enrolled for emergency assistance

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

118 inquiries related to the new Ontario Seniors Dental Care Program

Vision Health

1 760 senior kindergarten level children participated in the vision screening program

555 children screened were referred to their optometrist for follow up

82 schools participated in the screening program

Harm Reduction Supplies and Services

27 900 client visits

1 495 919 needles given out

935 576 needles taken in

63% needle return rate to Public Health

11 710 inhalation kits were distributed

57 885 condoms were distributed

Corporate Services Division

Volunteer Resources

59 active volunteers

28 new volunteers

1 251 volunteer hours of services provided

Environmental Health Division

Food Safety

3 745 inspections of food premises

295 complaint investigations

14 charges: **3** closure orders issued

87 food handler training courses

1 458 food handlers certified

10 food recalls: **699** recall inspections

596 special events food service permits

254 consultations and inquiries

239 requests for service

Chronic Disease Prevention

40 *Healthy Menu Choices Act* inspections

Safe Water

Drinking Water

43 boil water orders

1 drinking water advisory

12 drinking water orders

9 blue-green algae advisories

1 health information notice

806 adverse drinking water reports investigated

339 bacteriological samples taken

193 consultations and inquiries

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

109 Small Drinking Water System (SDWS) risk assessments completed

105 SDWS directives completed

116 SDWS inspections conducted

Recreational Water

33 beaches inspected weekly

235 beach inspections

1 365 bacteriological samples taken

4 beaches temporarily posted

1 blue-green algae beach advisory

158 pool inspections

30 spa inspections

36 splash/spray pad inspections

113 bacteriological samples taken

6 pool and spa closure orders issued

7 charges issued

Chronic Disease Prevention – Comprehensive Tobacco Control

Smoke-Free Ontario Act and Electronic Cigarettes Act Enforcement

455 youth access inspections

295 display and promotion inspections

175 school compliance inspections or checks

21 sales or supply charges issued

6 warnings issued to retailers or vendors

138 charges: smoking or vaping on school property

9 charges: smoking or vaping on hospital property

32 charges: smoking or vaping in the workplace

4 charges: smoking or vaping in a public place

4 charges: City of Greater Sudbury smoking or vaping by-law

264 complaints investigated

47 consultations and inquiries

218 requests for service

Health Hazard

524 complaint investigations

- **133** mould complaints
- **121** insects, cockroaches, birds
- **12** marginalized population or housing
- **61** housing complaints
- **64** rodents, vermin
- **20** odours or animal excrement
- **17** indoor air quality
- **7** sewage backups, spills
- **28** heating complaints
- **4** garbage and waste
- **57** miscellaneous complaints

260 consultations and inquiries

4 orders issued

51 arena air quality inspections

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

Control of Infectious Diseases

Response to hepatitis A food handler case

51 enteric outbreaks investigated

588 people ill

113 sporadic enteric cases investigated

66 consultations and inquiries

1 charge issued

Rabies

464 animal exposure incidents investigated

15 animal specimens submitted

No positive cases of rabies

2 charges issued

32 individuals received post-exposure prophylaxis

53 consultations and inquiries

Infection Control

6 institutional infection control meetings

64 inspections in institutional settings

219 inspections in licensed child care centres

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

79 consultations and inquiries

33 complaint investigations

1 charge issued

Vector-borne Diseases

137 mosquito traps set

13 843 mosquitoes trapped

4 726 mosquitoes speciated

165 mosquito pools tested

- **8** for eastern equine encephalitis
- **157** for West Nile virus

0 positive mosquito pools for WNv/EEE

0 human cases of WNv/EEE

2 horses positive for EEE

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

No human cases of Lyme disease reported

64 complaints

81 consultations or inquiries

Environmental Health Policy

Extreme Weather Alerts

5 heat warnings issued

Built Environment

3 plans and proposals reviewed

Emergency Response

81 staff received respirator fit testing

Participated in **3** municipal emergency exercises

Part 8 – Land Control

1 777 inspection activities

263 sewage system permits issued

40 consent applications processed

174 renovation applications processed

36 mandatory maintenance inspections completed

33 private sewage complaints investigated

4 orders issued

630 consultations and inquiries

26 file search requests

103 copy of record requests

98 requests for service

Health Promotion Division

Chronic Disease Prevention

Comprehensive Tobacco Control

677 calls or drop-in visits for the Tobacco Information Line

317 appointments at the Quit Smoking Clinic in Sudbury

20 appointments at the new Quit Smoking Clinic in Sudbury East

263 nicotine replacement therapy (NRT) vouchers distributed to clients

984 NRT products distributed to clients who attended the Quit Smoking Clinics

36 participants attended one of **6** STOP on the Road sessions accessing 6 weeks of NRT products

2 presentations to **53** dental hygiene students on comprehensive tobacco control

2 campuses supported in their efforts to implement smoke-free campus policies

254 post-secondary students participated in One Day Stand activities for smoke-free campuses

190 post-secondary students participated in interactive Nico-bar activities co-hosted by the Canadian Cancer Society learning about the impacts of smoking and strategies for cessation

1 multi-unit housing complex supported with smoke-free housing policy implementation

5 consultation and advocacy letters submitted on proposed tobacco and electronic cigarette regulation

6 municipalities (St. Charles, French River, Markstay/Warren, Killarney, Gore Bay, and Espanola) supported in review of their smoke-free policies and by-laws

1 promotional campaign to promote Proud to be Vape Free

Exposure to Ultraviolet Radiation and Early Detection of Cancer

85 people were screened by a dermatologist at the Skin Cancer Screening Clinic

6 079 people reached by sun safety-related social media posts

Healthy Eating

12 media interviews supporting healthy eating behaviours and healthy food environments

15 capacity building workshops promoting healthy eating behaviours and healthy food environments for **188** health, community, and early years service providers

14 presentations for **184** community members on making informed healthy eating choices

40 Good Food Markets offered in **7** neighbourhoods by the Sudbury Good Food Project

1 Four Minute Foodie event, **1** film screening, and **1** infographic promoting the importance of sustainable food systems with **120** people

1 Food Strategy Outreach Coordinator hired in collaboration with community partners

Health and Well-Being Approach to Weight

1 knowledge exchange session on normalizing body diversity with **100** playground staff

1 presentation on public health approach to the promotion of healthy weights to **35** nursing students

3 consultation sessions with provincial partners and health professionals on normalizing body diversity and reducing weigh bias for the development of a new initiative – Eating Disorders Promotion, Prevention, and Early Intervention

Physical Activity, Sedentary Behaviours, and Sleep

123 pairs of skates were collected and **108** were donated through **4** skate exchange events

11 workshops and presentations hosted in the community setting to increase physical literacy capacity, with a total of **191** participants

48 delegates attended the Active Sudbury conference

9 bike events supported

1 CTV interview about back to school and the importance of regular sleep routines

3 325 people reached by sleep-related social media posts

Road & Off-road Safety

4 car seat technician trainings and **18** new car seat technicians trained across the service area

208 car seats inspected, **10** car seat clinics held, and **1** baby ride blitz hosted within service area

2 partner agencies implementing community car seat clinics with our support

8 car seat instructional videos created to provide public education, **1** training module developed for professionals on car seat safety

4 200 car seat fact sheets and promotional resources distributed throughout the community

350 students, parents and teachers participated in Sudbury East helmet, bicycle, and Road Safety Blitz

490 Grade 11 and 12 students of three high schools in Sudbury educated on the dangers of risky driving behaviours during National Teen Drivers Safety week

168 community members received training on bicycle and helmet safety in Chapleau

53 individuals learned about the rules of the road and helmet safety at bike rodeos in Espanola

10 “Watch for Us” road safety signs put up in Township of Baldwin

Falls Prevention in Older Adults

76 community partners engaged in Sudbury-Manitoulin Falls Prevention Coalition meetings

5 Northeast health units and the North East Local Health Integration Network engaged in regional planning

114 calls received on the Stay on Your Feet (SOYF) telephone line

19 962 SOYF educational resources distributed

3 new resources created in partnership on winter safety, healthy eating, and physical activity

52 participants attended the falls prevention month celebration at Parkside Centre for Older Adults

31 health care providers attended the Registered Nurses’ Association of Ontario falls prevention best practice champion workshop hosted by SOYF and Public Health Sudbury & Districts

70 individuals attended a health fair which focused on falls prevention and indigenous populations

40 Stand Up! Falls Prevention exercise programs supported and delivered by partners throughout Sudbury and districts and **462** older adults reached

12 new Stand Up! facilitators were trained and **14** Stand Up! facilitators provided a refresher

34 media spots on CTV to promote healthy eating and **669 700** individuals reached across Northern Ontario and **9 601** people reached on social media

1 Move4Life social media campaign developed to encourage physical activity among older adults

19 Assistive Devices Program clinics supported and **80** older adults screened in partnership with Parkside Centre for Older Adults

1 Additional Good Food Market location added in partnership with Sudbury Housing

758 individuals attended **64** older adult skits on falls prevention performed by the Sudbury Rising Stars

Substance Use (Alcohol & Cannabis)

7 community presentations delivered on the health impacts of alcohol and cannabis use and how to reduce risks across the service area

152 post-secondary students learned about risks associated with alcohol and cannabis use and developed skills on how to pour standard drink sizes

22 residence advisors from Cambrian College built skills on how to recognize standard drink sizes and reduce harms associated with alcohol and cannabis use

1 provincial conference, Arrive Alive DRIVE SOBER, hosted in Greater Sudbury; **25** youth participated in a workshop; **90** adults provided with information about reducing risks of alcohol and cannabis impaired driving

1 Festive RIDE event sponsored to reduce impaired driving; **501** vehicles checked

2 media interviews conducted (on Canada's Low-Risk Alcohol Drinking Guidelines and re-thinking drinking).

1 Advisory Article published on the Canada's Lower-Risk Cannabis Use Guidelines

1 consultation response submitted to Health Canada in partnership with the Ontario Public Health Collaboration on Cannabis to inform the potential market for cannabis health products

1 consultation response submitted to the Ministry of the Attorney General of Ontario on the proposed extension of hours of sale and service in licensed establishments in certain airports in Ontario

8 Facebook posts on Low-Risk Alcohol Drinking Guidelines

2 educational campaigns on cannabis harm reduction

Be Cannabis Wise and Lock it Up ("Kids can't tell the difference") messages were shared on **4** lobby posters, **11** digital TV ads (French and English), **8** billboards ads, **6** newspaper or newsletter ads, **3** bus backs

and **3** bus shelter ads, **55** interior bus panel posters, and **1765** educational postcards

9 radio stations ran advertisements on planning ahead for a safe night out to reduce impaired driving and responsible consumption during the holiday season

115 individuals from across the service area participated in Be Cannabis Wise campaign intercept interviews to inform campaign development and program planning

275 Grade 5 and 6 students participated in R.A.C.E. Against Drugs events on Manitoulin Island

39 public service announcements encouraging Manitoulin Island residents to plan for a safe ride home on long weekends

School Health

94 presentations, workshops or skill building opportunities, and consultations were delivered to school community members on the following topics: mental health promotion, healthy eating behaviours, healthy sexuality, substance use and harm reduction, healthy growth and development, physical activity and sedentary behaviour, ultraviolet exposure, and injury prevention

23 training sessions, workshops, and presentations were delivered to adult influencers, reaching **835** adults in school communities on mental health promotion, healthy eating behaviours, substance use and harm reduction and physical activity and sedentary behaviour

4 school board mental health leads were consulted and collaborated in the development and implementation of school-based programs (health and wellness, health equity, and access to services)

700 students from **14** schools took part in physical literacy assessments with Active Sudbury

75 school and school board staff, including principals, superintendents, leaders and decision-makers, and teachers, were trained to administer naloxone

450 students from **6** schools participated in the Inhale, Exhale school mindfulness program, for students in Grades 7–8

56 activities delivered to post-secondary students, faculty members and decision-makers on comprehensive tobacco control, substance use prevention, physical activity and sedentary behaviour, healthy eating behaviours, injury prevention, mental health promotion and healthy growth and development, and preconception health

3 schools participated in the PEERS® school pilot project, reaching **80** students (in Grades 7–8)

60 adult influencers from **3** school communities participated in the Reaching In Reaching Out/Bounce Back and Thrive (RIRO/BBT) school pilot project

250 secondary school students from **4** schools participated in Safe Grad (Right Kind of Memorable)

21 students from **2** secondary schools participated in youth engagement groups on e-cigarette use

4 schools from **3** school boards participated in the Food Literacy pilot project, reaching **100** students

Northern Fruit and Vegetable Program

19 570 students received fruits and vegetables weekly for **20** weeks as part of the Northern Fruit and Vegetable Program; **93** elementary schools from Sudbury and each district office participated in the program, including First Nations schools

Workplace Health

12 individuals representing **11** workplaces attended **2** workplace health network meetings

2 workplace health presentations delivered to **75** individuals from different workplaces

2 editions of the workplace health newsletter published and distributed to **885** people; **313** copies shared throughout the community

391 workplace wellness resources distributed throughout the community

2 promotional radio ads promoting Canada's Healthy Workplace Month reached **78 800** listeners

6 050 individuals reached with social media messages during Canada's Healthy Workplace Month

Smoke-Free Ontario (TCAN)

30 North East Tobacco Control Area Network (NE TCAN) members participated in education on vaping and tobacco control enforcement

15 participants attended the NE TCAN Youth Tobacco and Vaping Summit

6 smoke-free campuses social media posts reached **42 234** individuals

1 smoke-free multi-unit housing campaign reached **38 904** individuals through social media posts

702 301 individuals were reached through regional CTV television ads

10 cessation testimonial videos reached **139 841** people on social media and **702 301** by television

Over **1.4 million** social media impressions for smoke-free movies advocacy initiatives

Healthy Babies Healthy Children (HBHC) Program

There were **1 660** live births in the Sudbury and Manitoulin districts in 2019. Of those:

- **1 454** mothers were screened to identify those who would benefit from further services
- **1 253** 48-hour infant feeding calls were made
- **195** new families registered to be supported with ongoing home visiting from the Healthy Babies Healthy Children Program in 2019
- **95** families declined HBHC support services
- **144** with risk* HBHC screens were done prenatally (*score of 2+)
- **2 002** Family Home Visitor visits were completed and **1 538** public health nurse visits were completed for a total of **3 540** visits
- **1 159** breastfeeding clinic appointments were provided to breastfeeding women at the Sudbury and Val Caron offices

HBHC Information Line

2 336 total number of calls

Of those calls:

- **174** calls were related to health during pregnancy
- **754** calls were related to breastfeeding
- **41** calls were related to formula feeding
- **28** calls were related to infant feeding
- **72** calls were related to infant care
- **53** calls were general health questions for children under the age of 12 years
- **70** calls were related to family health
- **96** calls related to car seat safety
- **27** calls related to a lack of a primary care physician
- **53** walk-ins occurred requesting information/assistance

With regards to the topic above:

- **316** actions were taken by the caller
- **865** required education relating to physical health
- **641** required education related to materials and other supports
- **420** calls were related to listening and support
- **2** calls were related to perinatal mood disorder
- **10** calls were related to drug abuse
- **5** calls were related to vaccine and immunization

Family Health

Healthy Growth and Development

21 breastfeeding mothers attended weekly face-to-face support group in Greater Sudbury

31 mothers and their children attended the Breastfeeding Challenge 2019

800 hand expression kits were distributed to Health Sciences North and the public

800 prenatal packages delivered to health care provider offices

158 pregnant women and their support persons attended prenatal classes

226 people registered for the new online prenatal course

200 people participated in a fetal alcohol spectrum disorder (FASD) awareness event. Partners included Laurentian University with an affiliation with CanFASD

600+ purple toques for infants were donated to HSN and distributed to all new families to promote the Period of Purple Crying programming and create awareness regarding shaken baby syndrome. The hats were knit by volunteers in the community

75 professionals attended a session focused on the latest research around adverse childhood experiences, what it means to be trauma informed, and practitioner burnout with Dr. Sheri Madigan and on cultural competence with Dr. Michele Manocchi

Completed **1** new www.parentingforme.com website in

partnership with child health sector partners (OCOF, BBBF, CCN, CTC, Compass, Jubilee Heritage centre, Early On centres, School Boards) to centralize registration for all parenting related services across the Sudbury and Manitoulin districts

Established **1** new Partner Service Advisory Committee (PSAC) with multiple child health agencies to coordinate services and prevent duplication of programming

233 parents registered for Triple P interventions across the Sudbury and districts (Positive Parenting Program)

30 online access codes for the Triple P program were distributed to parents

1 level-4 group Triple P teen session was delivered by two public health nurses with **4** parents in attendance

49 professionals received Reaching In Reaching Out (RIRO), a resiliency program for adults working with children 0–8 year at **6** different half-day workshops

2 Bounce Back and Thrive courses (10 sessions each) were held with approximately **25** parents completing this parenting resiliency program

Through partnership with Our Children Our Future (OCOF), approximately **146** parents received information and skill building on topics such as healthy eating, label reading, the new Food Guide, prenatal nutrition, introduction to solids, and positive parenting through delivery of the eight-session Bounce Back and Thrive program

45 people attended the Multiple Births Conference and received a presentation on resiliency, positive parenting, and social and emotional development

3 "Welcome to Sudbury Events" were hosted by Public Health for newcomers to Sudbury in partnership with the City of Greater Sudbury, school boards, and child health sector partners

Approximately **11** refugee families were provided information health and safety of children, how to access health services, transportation, Canadian laws (for example, car seats are required for infants and children), healthy eating on a budget, and how to register for essential services

81 early childhood educators, concurrent education students, Girl Guide leaders, child and youth workers, Carrefour Francophone young adults' counsellors received the Brain Architecture game to learn how adverse childhood experiences can impact growth and development

1 500 preconception health promotion pins provided to Laurentian and College Boréal for frosh kits

2 primary health care stakeholders engaged and used an electronic medical record 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

87 toddlers were screened using the NutriSTEP questionnaire

45 preschoolers were screened using the NutriSTEP questionnaire

2 radio interviews on new Canada's Food Guide

1 radio interview on the Vegan Parents Project, supported by the Louise Picard Public Health Research Grant

3 social media contests were created with prizes awarded to the public for participation (for example, Breastfeeding Photo Challenge, Early Connections Matter)

Community Drug Strategy

1 opioid surveillance dashboard launched

5 Community Drug Strategy Steering Committee meetings

3 Community Drug Strategy Executive Committee meetings

4 drug alerts were released to prevent overdoses in the community

2 drug warnings were released in the community

22 community drug strategy and opioid presentations to approximately **712** community

35 community drug strategies and opioids media spots completed

1 presentation in collaboration with Noojmowin Teg Health Centre to the Espanola Municipal Council

207 resident responses to the Sudbury East Drug Strategy Drug and Alcohol Use Survey

109 resident responses to the Lacloche Foothills Drug Strategy Drug and Alcohol Use Survey

3 campaigns launched (We are Jeff, Everyone Can Reduce Harms, and Those People are Us)

1 Opioid Poisonings Response Plan completed in collaboration with partners

Mental Health and Addictions

Mental Health Promotion

1 Public Mental Health Action Framework developed

1 mental health literacy survey with public health staff

4 Mental Health and Addictions System Priority Table meetings

24 mental health promotion presentations to approximately **484** community members

1 suicide prevention presentation to community members

1 event hosted with Carol Hopkins, Thunderbird Partnership Foundation and 45 adult influencers

Harm Reduction – Naloxone

14 naloxone train-the-trainer sessions completed

3 naloxone presentations to **102** persons

2 224 individuals trained to administer nasal spray naloxone

2 276 naloxone kits distributed to individuals by eligible agencies

Knowledge and Strategic Services

Population Health Assessment and Surveillance

11 mental health indicators added to the existing online Public Health Sudbury and Districts Population Health Profile. When data is available, these are presented by geographic area, sex, age, income, education, and first official language spoken

16 Population Health Assessment and Surveillance Team-Indicator Reports for internal use on nearly 50 indicators – **10** reports (28 indicators) using Rapid Risk Factor Surveillance System and **6** reports (20 indicators) using the Canadian Community Health Survey

52 internal and external data requests, and **47** consultations on topics such as communicable diseases, demographics, determinants of health, maternal health, chronic disease, mental health

1 750 residents were surveyed by Rapid Risk Factor Surveillance System (RRFSS) — to provide program needs and planning information for Public Health Sudbury & Districts service area and additional surveys to provide information at each district office area level

1 opioid surveillance dashboard including monthly including monthly naloxone distribution, paramedic services, emergency room overdose, and opioid-specific visits and death data

Seasonal bi-weekly or weekly Acute Care Enhanced Surveillance (ACES) reports and daily school absenteeism reports

Research, Evaluation, and Needs Assessments

23 research and evaluation projects where Knowledge and Strategic Services acts in a lead or consultation role

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

13 new proposals reviewed by the Research Ethics Review Committee

1 needs assessment

71 online surveys on a variety of topics

22 consults on development of methodology or approach for research, evaluation, or needs assessments

Knowledge Exchange

2 Knowledge Exchange Symposiums

4 Knowledge Exchange Sessions

23 conferences or external meeting presentations, poster presentations, or workshops

7 publications (research and evaluation reports, journal, or newsletter articles)

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 Public Health Sudbury & Districts

Student Placements

99 students from **7** post-secondary institutions representing **11** disciplines

10 170 hours of student placement experience

6 undergraduate medical students from NOSM

2 NOSM dietetic interns

3 postgraduate medical students from the NOSM Public Health and Preventive Medicine program

5 Master of Public Health students

1 preceptor appreciation event

39 staff and **2** teams in preceptor roles

Staff Development

33 staff completed staff orientation

16 in-person management development session and **24** externally hosted webinars or workshops for managers and leaders

126 cross-divisional development opportunities (**29** in person and **97** offered via webinar)

10 division-specific development opportunities offered

Strategic Planning

Numerous activities related to the implementation of the 2018–2022 Strategic Plan and ways in which it can be put into action (internal and external)

Accountability Monitoring

1 Accountability Monitoring Report presented to the Board of Health in April 2019

2 Strategic Priorities Narrative Reports presented to the Board of Health in May 2019 and October 2019

Committee Work and Partnerships

Participation on:

2 national committees, **15** provincial committees, and **15** local or regional committees

Health Equity Team

Poverty Reduction

Partners to End Poverty Steering Committee

- **17** partner agencies committed to the Circles initiative including Indigenous and Francophone advisories

Circles Leader Training program

- **4** Leader Training programs offered to **17** community members living in low income; **3** community partner host sites

Circles Program

- **24** Circles meetings, and **1** Circles Volunteer Ally session at **2** community partner host sites
- **27** Circles Leaders (participants) recruited into the program with their **33** children; 56 Circles Allies (volunteers) recruited into the program
- **1** Circles video launched in May 2019: **1 997** combined views

Circles Photovoice Project

- **6** individuals living in poverty participated in the development and the implementation of the project

Bridges out of Poverty

- **200** participants attended **12** Bridges out of Poverty sessions (3- and 6-hour formats)

Living Wage Advocacy

- Invited panelist on public Living Wage Forum during Greater Sudbury's Living Wage Week hosted by the Sudbury Workers Education and Advocacy Centre featuring the impact of income on health
- Development of **1** motion [#53-19] approved by the Board of Health for Public Health Sudbury & Districts formally endorsing principle of living wage and directing Medical Officer of Health to pursue formal living wage certification

Engagement with Ontario Living Wage Network to prepare application for living wage certification

Indigenous Engagement

Continued advancement of agency strategy, "Finding our Path Together – Maamowi Mkamang Gdoo-miikaansminaa – Kahkinaw e mikskamahk ki meskanaw".

Key focus on strategic direction three, "*Strengthen our capacity for a culturally competent workforce",* including:

- **4** staff roundtables seeking input on capacity building needs and opportunities: **2** in Sudbury, **1** in Mindemoya, and **1** in Espanola
- Development and approval of **1** agency-wide Indigenous Engagement policy including **4** protocols (Indigenous Language Translation, Guide for Offering Semaa (tobacco) to Elders, Guide for Working Respectfully With Elders, Territorial Acknowledgment
- **2** agency workshops on implementing the Indigenous Engagement policy and protocols
- **5** division-wide one-hour staff development sessions on the history of the colonization of Canada and the impact on Indigenous peoples attended by all staff
- **4** half-day Indigenous cultural mindfulness training sessions attended by **147** staff members
- **1** full-day Indigenous cultural competency training session attended by **26** staff members

Racial Equity

- Collaborative development of **1** racial equity action framework from agency-wide racial equity task group with endorsement from the Board of Health
- Full-day racial equity workshop training offered to staff and partners
- Two-day training on anti-black racism and oppression offered to staff and partners
- Development of allyship workshop materials and pilot of materials with key staff and partners
- Submission of **2** successful grants to support community-based work to advance racial equity including:
    - Anti-black racism project to empower young people and provide allyship training to community partners ($200,000

from federal Department of Canadian Heritage)

Exploration of race relations among young people ($5,000 from Louise Picard Public Health Research Grant)

Requests to the Health Equity (HE) Team

External HE requests:

180 instances of external support including:

60 presentations or workshops; **53** meetings; **27** external supports or collaborative work; **4** media requests; **12** resources provided; **10** consultations; **4** research-related activities, **6** referrals; and **2** other requests

Internal HE requests:

***51** instances of staff support including:*

***19** internal supports or collaborations, **8** consultations, **12** presentations or workshops, **3** instances of training, **4** instances of campaign work, and **3** other requests*

Communications

544 resource review and approval requests

75 media releases issued

204 media requests processed

1 595 982 Facebook users reached (Eng./Fr. combined)

421 711 Twitter impressions (Eng./Fr. combined)

455 requests for information received through phsd.ca

8 Public Health Heroes from the community were recognized for their efforts to put public health into action and make tangible, positive differences in their communities

Respectfully submitted,

Original signed by

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

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

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January 17, 2020

The Honorable Christine Elliott
Minister of Health and Deputy Premier
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

On December 18, 2019, the Windsor-Essex County Board of Health passed the following Resolution regarding **Healthy Smiles Ontario Funding. WECHU's resolution as outlined below recognizes the growing need, and increase in dental decay, among vulnerable children in Windsor-Essex and existing barriers to access to care. The WECHU recommends that HSO retain its current funding and structure as 100% funded, merging it with the Ontario Seniors Dental Care Program to be a comprehensive dental care program for vulnerable children and seniors in Ontario:**

Windsor-Essex County Board of Health

RECOMMENDATION/RESOLUTION REPORT – Healthy Smiles Ontario Funding

December 19, 2019

ISSUE

Healthy Smiles Ontario (HSO) is a publically funded dental care program for children and youth 17 years old and under from low-income households. The Ministry of Health introduced HSO in 2010 as a 100% provincially funded mandatory program for local health units, providing $1,529,700 in funding for children in Windsor-Essex (2019). HSO covers regular visits to a licensed dental provider within the community or through public health units.

In April 2019, the provincial government introduced its 2019 Budget Protecting What Matters Most (Minister of Finance, 2019). Following the release of the provincial budget, the Ministry of Health introduced changes to the funding models for health units effective January 2020. The changes in funding for local health units include a change from a 25% municipal share, 75% provincial cost-shared budget for mandatory programs to 30% and 70% respectively. In addition, the Ministry notified health units that formerly 100% provincially funded mandatory programs such as HSO would now share these costs with municipalities at the rate of 30%, a download of approximately $458,910.00 to local municipalities.

BACKGROUND

Oral health is vital to our general health and overall well-being at every stage of life. Most oral health conditions are largely preventable and share common risk factors with other chronic diseases, as well as the social determinants of health, such as income, employment and education, whereby those in the lowest income categories have the poorest oral health outcomes. Approximately 26% of children (0-5 yrs) and 22.6% of children and youth (0-17yrs) in Windsor-

Essex County live in low-income households, compared to 19.8% and 18.4% in Ontario (Windsor-Essex County Health Unit, 2019). Tooth decay is one of the most prevalent and preventable chronic disease, particularly among children. In Windsor-Essex from 2011 to 2016, the number of children screened in school with decay and/or urgent dental needs increased by 51%. Tooth decay is also the leading cause of day surgeries for children ages one to five. The rate of day surgeries in Windsor-Essex in 2016 was 300.6/100K compared to 104.0/100K for Ontario, representing a significant cost and burden to the healthcare system (WECHU Oral Health Report, 2018). For children, untreated oral health issues can lead to trouble eating and sleeping, affect healthy growth and development, speech and contribute to school absenteeism.

In 2016, the MOHLTC integrated six publicly funding dental programs into one 100% funded program, providing a simplified enrolment process and making it easier for eligible children to get the care they need. The HSO program was part of Ontario's Poverty Reduction Strategy commitment to build community capacity to deliver oral health prevention and treatment services to children and youth from low-income families in Ontario. Windsor-Essex Health Unit operates two dental clinics, one in Windsor and one clinic in Leamington. The WECHU provides preventative and restorative services with a team of registered dental hygienists, general dentists and a pediatric dentist. There is about a six-month wait list for services in our current clinics. The number of preventative oral health services provided through the WECHU dental clinics has increased year over year from 1,931 in 2011 to 7,973 in 2017 (WECHU Oral Health Report, 2018).

Community dentists are not required to take patients under the Healthy Smiles Ontario program which can create barriers to accessing services. Changes to the funding model for HSO will not affect the services provided by local dentists and is only applied to local health units. Mixed model funding for public health units and private fee-for-service dental providers, poses a risk to the delivery of the HSO program in Ontario. Based on the data and analysis in the 2018 Oral Health report, the Windsor-Essex County Health Unit proposed recommendations to improve the oral health status in Windsor-Essex including: Improve access to oral health services within Windsor-Essex and advocate for improved funding for oral health services and expansion of public dental programs such as Healthy Smiles Ontario to priority populations. Given the growing urgent need and increase in dental decay among vulnerable children in Windsor-Essex and recognizing the existing barriers to access to care, the WECHU recommends that HSO retain its current funding and structure as 100% funded, merging it with the Ontario Seniors Dental Care Program to be a comprehensive dental care program for vulnerable children and seniors in Ontario.

PROPOSED MOTION

Whereas the WECHU operates a dental clinic in Leamington and Windsor for HSO eligible children with wait times for services exceeding 6 months, and

Whereas one in four children under five years (26.0%), one in five children under 17 years (22.6%), and one in ten seniors (11.4%) in Windsor and Essex County live in poverty, and

Whereas inadequate access and cost remain barriers to dental care for Windsor and Essex County residents, 23.7% report that they lack dental insurance that covered all or part of the cost of seeing a dental professional, and

Whereas indicators show an overall trend of declining oral health status among children in Windsor and Essex County compared to Ontario, and

Whereas the rate of oral health day surgeries for children in Windsor and Essex County (300.6/100K) far exceeds that of Ontario (100.4/100K), and

Whereas there is an increased difficulty in obtaining operating room time for dental procedures in Windsor-Essex with wait times exceeding 1 year for children in need of treatment, and

Whereas there is a chronic underfunding of the Healthy Smiles Ontario program creating barriers to accessing services among local dentists, and

Now therefore be it resolved that the Windsor-Essex County Board of Health recognizes the critical importance of oral health for vulnerable children and youth, and

FURTHER THAT, urges the Ministry of Health to reconsider its decision to download 30% of the funding of the Healthy Smiles Ontario Program to local municipalities, and

FURTHER THAT this resolution be shared with the Ontario Minister of Health, the Chief Medical Officer of Health, the Association of Municipalities of Ontario, local MPP's, the Association of Public Health Agencies, Ontario Boards of Health, the Essex County Dental Society, the Ontario Association of Public Health Dentistry, the Ontario Dental Association and local municipalities and stakeholders .

References:

Windsor-Essex County Health Unit. (2019). Community Needs Assessment 2019 Update. Windsor, Ontario
Windsor-Essex County Health Unit. (2018). Oral Health Report, 2018 Update. Windsor, Ontario

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Doug Ford, Premier of Ontario
Hon. Patty Hadju, Minister of Health
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Local Public Health Agencies – Loretta Ryan
Association of Municipalities of Ontario
Essex County Dental Society
Ontario Association of Public Health Dentistry
Ontario Dental Association
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Irek Kusmeirczyk, Chris Lewis, Dave Epp

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

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Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

January 17, 2020

The Honorable Christine Elliott
Minister of Health and Deputy Premier
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

On January 16, 2020, the Windsor-Essex County Board of Health passed the following Resolution regarding the **Children Count Pilot Project. WECHU's resolution as outlined below recognizes that the Children Count Pilot Study Project, Healthy Living Module, is a feasible approach to fulfil local, regional and provincial population health data gaps for children and youth:**

Windsor-Essex County Board of Health

RECOMMENDATION/RESOLUTION REPORT – Children Count Pilot Project

January 16, 2020

ISSUE

The behaviours initiated in youth create a foundation for health through the life course (Toronto Public Health, 2015). Supporting student achievement and improving overall quality of life for children and youth is a priority shared across multiple sectors, including health and education. Both the Ministry of Health and the Ministry of Education have identified the importance of this stage of development through the Ontario Public Health Standards (OPHS) and the Ontario Curriculum (2019), and the interrelationship between health, well-being and educational outcomes. Collecting, analyzing and reporting data at the local level is essential for the planning, delivery and evaluation of effective and efficient services that meet the unique needs of students and ensure the responsible public stewardship of the resources allocated to these services (Windsor-Essex, 2017). The lack of a coordinated provincial system for the assessment and monitoring of child and youth health that meets local needs has been the focus of many reports, including the 2017 Annual Report of the Ontario Auditor General. The Auditor General's report identified that children are a public health priority population and that epidemiological data on children are not readily available to public health units for planning and measuring effective programming (Office of the Auditor General of Ontario, 2017).

In the initial report, Children Count: Assessing Child and Youth Surveillance Gaps for Ontario Public Health Units (Populations Health Assessment LDCP Team, 2017), public health units and school boards identified a need for local data related to mental health, physical activity and healthy eating for school-aged children and youth. In 2017, the Children Count Locally Driven Collaborative Projects (LDCP) Team convened a Task Force of leaders in education, public health, research, government and non-governmental organizations to explore solutions and make recommendations for improving assessment and monitoring of child and youth health. The Task Force recommendations have been endorsed by many organizations including the Council of Directors of Education (CODE) and Council of Medical Officers of Health (COMOH). In their report, the Children Count Task Force (Children Count Task Force, 2019) recommended building on existing infrastructure by using the Ministry of Education's mandated school climate survey (SCS). The SCS provides population level data for children and youth grades 4 to 12 and represents a significant opportunity to understand local health needs of students.

BACKGROUND

In follow up to this previous work, the Children Count LDCP Team, with a renewal grant from Public Health Ontario (PHO), embarked upon The Children Count Pilot Study Project. The Children Count Pilot Study began in December 2017 with the goal to explore the feasibility of coordinated monitoring and assessment of child and youth health, utilizing the SCS, to address local health data gaps. This provincial project included six school board and public health unit pairings who developed and piloted a Healthy Living Module (HLM) as part of the school board's SCS. The HLM covered the topics previously prioritized of mental health, healthy eating, and physical activity.

The objectives of the Pilot Study were:

1. To work collaboratively to develop a HLM for the SCS;

2. To pilot test and evaluate the applicability and feasibility of the partnership between public health units and school boards in coordinated monitoring and assessment utilizing the SCS; and

3. To develop a toolkit for implementation of coordinated monitoring and assessment for health service planning using the SCS for child and youth health in Ontario.

Using a Participatory Action Research (PAR) model, the steering committee (comprised of school board and public health leadership), worked together to build the HLM. The HLM was successfully integrated into the SCS led by participating school boards. Collaboratively school boards and local public health units analyzed and interpreted the results for knowledge sharing and planning.

The HLM enriched each school boards' SCS and identified areas for further work to support student health and well-being. The process of piloting the HLM with multiple and diverse school boards using different methods demonstrated that the overall process of coordinating a HLM into the SCS is feasible and adaptable to suit local needs while still enabling consistency in data across regions. The Children Count Pilot Project captured the process and lessons learned in their final report (December 2019) as well as developed the *Children Count Pilot Study Project: Healthy Living Module Toolkit* as a guide for school boards and health units across the province.

PROPOSED MOTION

Whereas, boards of health are required under the Ontario Public Health Standards (OPHS) to collect and analyze health data for children and youth to monitor trends over time, and

Whereas, boards of health require local population health data for planning evidence-informed, culturally and locally appropriate health services and programs, and

Whereas, addressing child and youth health and well-being is a priority across multiple sectors, including education and health, and

Whereas, Ontario lacks a single coordinated system for the monitoring and assessment of child and youth health and well-being, and

Whereas, there is insufficient data on child and youth health and well-being at the local, regional and provincial level, and

Whereas, the Children Count Pilot Study Project, Healthy Living Module is a feasible approach to fulfill local, regional and provincial population health data gaps for children and youth, and

Now therefore be it resolved that the Windsor-Essex County Board of Health receives and endorses the Healthy Living Module, and

FURTHER THAT, the Windsor-Essex County Board of Health encourage the Ministry of Health and the Ministry of Education to adopt the Healthy Living Module as part of the Ontario Public Health Standards and the Ontario School Climate Survey.

References

Children Count Task Force. (2019). Children Count: Task Force Recommendations. Windsor, ON: Windsor-Essex County Health Unit.

Office of the Auditor General (2017). Annual Report 2017. Toronto: Queen's Printer for Ontario.

Ministry of Education. (2019). The Ontario Curriculum, Grades 1-8: Health and Physical Education.

Ministry of Health and Long-Term Care. (2018). Ontario Public Health Standards: Requirements for Programs, Services, and Accountability. Toronto: Queen's Printer for Ontario.

Population Health Assessment LDCP Team (2017). Children Count: Assessing Child and youth Surveillance Gaps for Ontario Public Health Units. Windsor, ON: Windsor-Essex County Health Unit.

Toronto Public Health. (2015). Healthy Futures: 2014 Toronto Public Health Student Survey. Toronto: Toronto Public Health

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Stephen Lecce, Minister of Education
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Local Public Health Agencies – Loretta Ryan
Association of Municipalities of Ontario
Greater Essex County District School Board – Erin Kelly
Windsor Essex Catholic District School Board – Terry Lyons
CSC Providence (French Catholic) – Joseph Picard
Conseil Scolaire Viamonde (French Public) – Martin Bertrand
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Irek Kusmeirczyk, Chris Lewis, Dave Epp

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..\..\2020 BOARD MEETINGS\01-JANUARY 16-20\RESOLUTION\Children Count Pilot Study Toolkit ENG 2019.pdf

January 9, 2020

Honourable Patty Hajdu
Minister of Health, Canada
House of Commons
Ottawa, ON K1A 0A6
Sent via email: patty.hajdu@parl.gc.ca

Honourable Christine Elliott, Deputy Premier
Minister of Health, Ontario
Hepburn Block 10th Floor 80 Grosvenor Street
Toronto, ON M7A 1E9
Sent via email: christine.elliott@pc.ola.org

Dear Minister Hajdu and Minister Elliot,

The Board of Health for the Porcupine Health Unit would like to take this opportunity to support the correspondence forwarded by the Board of Health Chair of the Simcoe Muskoka District Health Unit dated September 18th, 2019. This requested stronger provincial legislation to restrict the display and promotion of vaping products and ban flavoured vaping products to address the youth vaping crisis. Accordingly, the concerns identified in the document reflect those of our Board of Health and community partners.

We would like to commend your leadership in making the decision to prohibit the promotion of vaping products in convenience stores and gas stations effective January 1, 2020. This measure is a critical first step towards preventing youth access and initiation. Nevertheless, the Board of Health for the Porcupine Health Unit (PHU) remains uncertain that banning the promotion of vaping products in retail settings will be enough to reduce youth uptake and related harms. With increasing numbers of youth seen vaping across PHU communities, and an already higher than provincial average tobacco use rate we remain extremely concerned. Evidence supports that e-cigarette companies are appealing to young people through the promotion of flavours. As such, banning flavoured e-cigarette products would be a great step towards curbing the current youth vaping epidemic.

The Board of Health for the Porcupine Health Unit supports Private Members Bill 151 which was brought forward in the Ontario Legislature by the Ontario NDP Health Critic France Gélinas on November 27, 2019. The Smoke-Free Ontario Amendment Act (*Vaping is not for Kids*) bill includes measures concerning e-cigarettes, such as banning flavours unless exempted by regulation; banning sales except in adult-only specialty vape stores; and requiring specialty vape stores to be approved by local Board of Health. The bill would prohibit the promotion of vaping products, regulate the availability of flavours, set a maximum amount of nicotine per milliliter of e-fluid, restrict sales to specialty shops, require Ontario Health to prepare an annual report on vaping usage and health effects as well as prioritize research by setting tax money aside. We urge the Ministry of Health to support this bill so that we not only protect our youth but can mutually reach our goal of achieving a smoking rate of less than 5% by 2035.

... 2

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

Our concern that current measures will not be enough to adequately address the crisis of youth vaping continue to be supported. Decades of experience with youth smoking demonstrate the need for comprehensive protective measures. As such, the recommendations forwarded on December 19, 2019, by the *Physicians for a Smoke-Free Canada* should also be considered in the development of new regulations.

Thank you for your attention to this very important matter for the protection of the health of our youth.

Sincerely,

Sue Perras
Chair, Board of Health for the Porcupine Health Unit

cc: Ontario Boards of Health
Association of Local Public Health Agencies
Ontario Public Health Association
Porcupine Health Unit - Member Municipalities

Peterborough Public Health

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

January 22, 2020

The Honourable Christine Elliott
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Sent via e-mail: ***Christine.elliott@pc.ola.org***

Dear Minister Elliott:

At its meeting on December 11, 2019, the Board of Health for Peterborough Public Health received correspondence from Public Health Sudbury & Districts (enclosed) regarding e-cigarette and aerosolized product prevention and cessation.

Foremost, we wish to congratulate the Ministry for the recently announced changes to the *Smoke-Free Ontario Act* that, effective January 2020, ban the promotion of e-cigarettes/vapour products in corner stores and gas stations. The Board of Health for Peterborough Public Health also urges **the adoption of an expert-informed comprehensive tobacco and e-cigarette strategy to address flavoured e-juice, online sales to minors, treatment program of youth cessation and public education.**

The previous Smoke-Free Ontario Strategy, released in May 2018, provided an updated framework for tobacco control, guiding direction across the province on tobacco prevention, cessation, protection and enforcement. Considering the increase in use of vapour products and the ongoing prevalence of tobacco use impacting the lives of Ontarians, it is a critical in this time of public health modernization for the Ministry of Health to develop a new comprehensive tobacco and e-cigarette strategy.

A greater proportion of the Peterborough population 12 years and older are currently smoking (2013/2014) compared to both the province and the Peer Group, at 27.0%, 17.3%, and 20.6% respectively.[1] These rates have the potential to increase with 24.1% of Peterborough area students in grades 9 to 12 trying electronic cigarettes.[2] Further to this, Professor David Hammond of the University of Waterloo, found that among Ontario youth 16-19 years old, vaping increased by a stunning 74% from 2017 to 2018, from 8.4% to 14.6%.[3]

The recent rise in youth addiction to vaping products seen in local secondary schools and requests for prevention supports in elementary schools, speak to the current situation and the need for a coordinated and comprehensive tobacco and e-cigarette strategy to improve the health of Ontarians and stay on course for achieving the lowest smoking prevalence rates in Canada.

We look forward to working with the Ministry and local partners to develop and implement a comprehensive tobacco and e-cigarette strategy that will ultimately protect the health of all Ontarians.

Respectfully,

Original signed by

Mayor Andy Mitchell
Chair, Board of Health

/ag
Encl.

cc: Hon. Doug Ford, Premier of Ontario
Dr. David Williams, Ontario, Ontario Chief Medical Officer of Health
Local MPPs
Hon. Doug Downey, Attorney General of Ontario
France Gélinas, MPP, Health Critic
Association of Local Public Health Agencies
Ontario Boards of Health

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[1] Peterborough County-City Health Unit (2016). Tobacco Use in Peterborough: Priorities for Action Peterborough, ON: Beecroft, K., Kurc, AR.

[2] During the 2014/2015 school year, the Peterborough County City Health Unit (PCCHU) collected data on 1,358 students at six (out of nine) different secondary schools across Peterborough with support from the Propel Centre for Population Health Impact at the University of Waterloo. This represents approximately 15% of the population 15 through 19 according to Statistics Canada's 2011 Census. Source: University of Waterloo. Canadian Student Tobacco, Alcohol, and Drugs Survey. Available: https://uwaterloo.ca/canadian-student-tobacco-alcohol-drugs-survey/about

[3] Hammond, D., Reid, J., Rynard, V., Fong, G., Cummings, K.M., McNeill, A., Hitchman, S., Thrasher, J., Goneiwicz, M., Bansal-Travers, M., O'Connor, R., Levy, D., Borland, R., White, C. (2019) Prevalence of vaping and smoking among adolescents in Canada, England, and the United States: repeat national cross sectional surveys. *British Medical Journal* 365:l2219.

Conseil des Services du District de
Manitoulin-Sudbury
District Services Board

210 boul Mead Blvd
Espanola, ON P5E 1R9
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Fax/Télécopieur: (705) 862-7805
http://www.msdsb.net

January 24, 2020

Premier Doug Ford
Room 281
Legislative Building, Queens Park
Toronto ON
M7A 1A1

SENT VIA EMAIL: premier@ontario.ca

Dear Premier Ford,

The purpose of this letter is to bring to your attention that, at its regular monthly meeting of January 23, 2020, the Manitoulin-Sudbury District Services Board adopted Resolution # 20 – 08 in support of Resolution 19-374 passed by the Municipality of Killarney.

A duly authorized copy of the Manitoulin-Sudbury DSB Resolution # 20 – 08 is attached calling upon the Ontario government to halt the closures of, mergers of, and cuts to our local health care services including Public Health Units, Paramedic Services, hospitals and long-term care homes.

We look forward to working with the government in addressing these important issues.

Sincerely,

Les Gamble
Chair of Manitoulin-Sudbury DSB

cc: AMO
FONOM
Public Health Sudbury & Districts
Carole Hughes, MP
Mike Mantha, MPP
Marc Serré, MP
Paul Lefebvre, MP

Conseil des Services du District de
Manitoulin-Sudbury
District Services Board

RESOLUTION 20-08

DATE: January 23, 2020

MOVED BY: Jim Rook SECONDED BY: Paul Schoppmann

WHEREAS the Manitoulin-Sudbury DSB supports Resolution 19-374 passed by the Municipality of Killarney at their November 26, 2019 meeting regarding Local Health Care Services;

THEREFORE BE IT RESOLVED THAT the Manitoulin-Sudbury DSB calls upon the Ontario government to halt the closures of, mergers of, and cuts to our local health care services including Public Health Units, Paramedic Services, hospitals and long-term care homes.

FURTHER BE IT RESOLVED THAT this resolution be forwarded to Premier Doug Ford, AMO, FONOM, Public Health Sudbury & Districts and all local MPP's.

Carried

Leslie Gamble

CHAIR

MEMBER	YEAS	NAYS	MEMBER	YEAS	NAYS
BEER, JILL			LEVESQUE, MICHAEL		
GAMBLE, LESLIE			SCHOPPMANN, PAUL		
GORHAM, VERN			ROOK, JIM		
HAM, DAVID			SANTI, DAVID		
HAYDEN, ARTHUR			STEPHENS, RICHARD		
KILLAH, BRUCE			VAN ALSTINE, MAUREEN		
LEONARD, DAVID			WHYNOTT, NED		

Public Health Modernization Discussion Paper Response Submitted to the Public Health Modernization Team

The Association of Local Public Health Agencies (alPHa) is pleased to present the following response to the Public Health Modernization Discussion Paper. We invited our members to provide answers to the questions that are posed in the paper to help us identify themes common to the local public health sector throughout the province. This feedback has been synthesized and presented within the framework of themes and questions laid out in the consultation survey.

alPHa's response is intended to be complementary to the individual responses of its members, not a summary or a substitute. alPHa urges the Public Health Modernization team to take the unique local circumstances and perspectives presented in its members' and partners' direct feedback to the survey and in-person consultations into careful consideration as it formulates its advice to the Minister.

PREAMBLE and PRINCIPLES

alPHa agrees with the Ministry's vision of a "coordinated public health sector that is nimble, resilient, efficient and responsive to the province's evolving health priorities". alPHa also agrees with improving consistency where it makes sense to do so and improving clarity and alignment of the related roles and responsibilities of the province, Public Health Ontario (PHO), and local public health. alPHa certainly agrees that enhanced investment in health promotion and prevention will be critical to the success of Ontario's plan to end hallway health care.

In November of 2019, alPHa transmitted its Statement of Principles for Public Health Modernization to the Minister and the Public Health Modernization Team and these remain the foundation of alPHa's present response. These principles are incorporated into the responses to the survey questions as appropriate and the full document is attached.

The foundational principle is that any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services. Public health unit (PHU) realignments, identification of efficiencies, clarification of roles and strengthening of institutional relationships must all have that central aim as their starting point.

It must be recognized that Ontario already has an enviable public health system, based on a network of 34 PHUs with expert staff, strong partnerships and a clear and authoritative mandate to protect and promote health within their local communities. These are supported by the central research and evidence functions of PHO and the oversight of the Chief Medical Officer of Health (CMOH) within the Ministry. Building on the Ontario system's existing strengths must be the strategic foundation for any proposed changes.

Theme: Insufficient Capacity

What is currently working well in the public health sector?

- Actions taken in response to the Walkerton and SARS crises in the early 2000s (e.g., increased provincial responsibility for funding, strengthened role of the Chief Medical Officer of Health (CMOH), creation of PHO) have led to measurable improvements to the Ontario public health sector's capacity to detect and respond to emerging threats. The swift collective and thorough response to the developing Novel Coronavirus (2019-nCoV) epidemic is a clear application by Ontario's public health sector of the lessons learned from the 2003 SARS outbreak.

- Ontario's public health sector is already an effective network of 34 local public health units (PHUs)with a strong and detailed mandate to identify and meet the health protection and promotion needs of their communities. That mandate is clearly spelled out in the Health Protection and Promotion Act (HPPA) and the Ontario Public Health Standards (OPHS), with explicit flexibility built in to ensure that programs and services can be adapted according to local circumstances.

- Within each of the existing PHUs' boundaries, strong partnerships have been forged with local municipalities, social services, school boards and health care providers among others to support this work.

- The sector benefits from the collaborative work of province-wide professional (e.g., alPHa, COMOH, ASPHIO, ODPH, OPHNL, APHEO) and topic-specific (e.g. TCAN, LDCP) groups. These groups provide ongoing opportunities for collaboration and information exchange across PHU boundaries throughout Ontario.

- There is clear public and political recognition of the critical importance of investments in health protection and promotion to improving population health and ensuring the sustainability of the health care system.

- There is an invaluable range of professional, political and technical expertise resident in the public health sector (public health physicians, elected officials, epidemiologists, nurses, public health inspectors, health promoters, policy analysts, dentists, dietitians, business administrators, lawyers and highly skilled support staff).

- Local representation on boards of health (in a variety of models that includes elected municipal officials in all cases, with provincial appointees and citizen representatives serving in many) reflects community characteristics and values within the PHU boundary and provides direct accountability.

- Collaboration among PHUs including the development of consistency of practice (e.g., HIV case management, immunization enforcement in schools and child care centres, infection prevention and control inspections in the health care sector, electronic medical record use, records retention policies), mutual aid agreements, cross-coverage, outbreak management, and voluntary mergers (Southwestern and Huron-Perth).

- PHO is a unique and invaluable resource within the sector that has strong roles in research, professional development, ethics review, knowledge translation and response to emerging threats.

- The cost-sharing model provides the framework to ensure a stable and predictable source of adequate funding for public health programs and services while ensuring accountability at both the provincial and municipal levels.

- PHUs with large populations have budgets that allow them to deliver services efficiently and cost-effectively while also ensuring surge capacity.

- PHUs that are integrated with Regions (e.g., Halton, Durham) and cities (e.g., Toronto, Ottawa) benefit from support services (e.g. administrative, IT) embedded within those structures. This integration also facilitates coordination among public health, social services, emergency health services and public works.

What are some changes that could be considered to address the variability in capacity in the current public health sector?

- Formal mechanisms and commitment at both the provincial and municipal levels to ensure that the total annual public health funding envelope is stable, predictable, protected and sufficient to cover all costs for the full delivery of all public health programs and services in all PHUs whether they are mandated by the province or developed to serve unique local needs as authorized by Section 9 of the HPPA.

- Provincial support for voluntary mergers of PHUs with complementary characteristics where it can be demonstrated that functional capacity will be improved. Any realignments of present PHU boundaries must be considered only to ensure critical mass to efficiently and equitably deliver public health programs and services. As a general rule, existing PHUs should be left intact, particularly with regard to municipal boundaries, and complementary geographic, demographic and organizational characteristics should be key factors in deciding which mergers should be considered. Evidence about the relationship between critical population mass and the effective allocation of public health resources should also be examined.

- Enhance centralized provincial supports, to increase efficiency and the capacity of all public PHUs to deliver the full scope of the OPHS. PHO already has important research and evidence roles but is also well-positioned to coordinate the strengths of different PHUs. Provincial-level strategic and topic-specific advisory tables that include PHO, the CMOH and local public health leadership have also proven very useful in the past.

- In partnership with local public health, educational institutions and other relevant organizations, develop a provincial public health human resources strategy to build on the successful recruitment and retention of a skilled and competent public health workforce. Maintaining the visibility of the public health sector, demonstrating its stability and importance, presenting the wide range of opportunities within it, providing incentives to work in remote areas and keeping salaries competitive will be vital components.

- Increase decision-making flexibility at the local level to develop their own models for the provision of mandated services according to local circumstances and resources, as well as to develop more formal arrangements to share resources if surge capacity is needed (e.g. epidemiology, analysis, evaluation).

What changes to the structure and organization of public health should be considered to address these challenges?

- alPHa does not believe that systemic structural and organizational changes are necessary to address capacity challenges. As we have demonstrated in our answers to the other discussion questions, any capacity issues can be appropriately addressed within the existing framework by building on its strengths.

- Capacity for most PHUs has been steadily eroding over the years largely due to the Ministry putting caps (often 0%) on annual budget increases that are necessary to cover the costs of delivery of new programs, annual Consumer Price Index (CPI) increases and honouring collective agreements. This erosion will be significantly magnified by the Province's decision to shift 5% of the cost-shared and 30% of previously 100% provincially funded public health programs to municipalities. More details on this were presented by alPHa to the Standing Committee on Finance and Economic Affairs on January 17, 2020 as part of its pre-budget consultation. Speaking notes and the transcript of this presentation are linked above and attached below.

- The autonomy of each local board of health (BOH) must be maintained and stronger mechanisms should be considered to reinforce their sole focus on and local decision-making authority over public health matters as well as to protect them from intrusive policies (e.g., municipal hiring freezes, vacancies on local boards and Associate Medical Officer of Health (AMOH) positions due to inappropriate delays in the provincial appointment and approval processes).

- Several organizational considerations are outlined in the attached alPHa Statement of Principles.

Theme: Misalignment of Health, Social, and Other Services

What has been successful in the current system to foster collaboration among public health, the health sector and social services?

- alPHa respectfully observes that the use of the term "misalignment" in the wording of this theme is misleading, as it creates the false impression that misalignments are a significant systemic problem. On the contrary, PHUs are very well aligned with municipalities, social services, school boards and other community-based services and partners. Previous proposals to align PHU boundaries with those of the health sector (i.e., LHINs) has threatened these existing local relationships without demonstrating the necessity for doing so. If misalignments in certain areas are identified, they must be measured against and prioritized in context of existing alignments in others.

- The reciprocal mandate between the local MOH and LHIN CEO became an important enabler for public health's relationship with the health care sector and this is being expanded upon with most PHUs having direct involvement in the new Ontario Health Teams (OHTs).

- Our members provided us with many specific examples of successful local collaborations with the health care sector related to such topics as injury prevention, substance use, perinatal health, infectious disease prevention and health equity in program design. These will surely be presented in more detail in their individual submissions to the present survey.

- Our members provided us with many specific examples to demonstrate the strength of local collaboration with social services, boards of education and community agencies. The existing geographical alignments of these different groups was cited as critically important. Where public health is integrated within a municipal or regional government, links to their social services

departments are particularly strong. In other cases, formal service agreements and partnerships are highly dependent on shared community boundaries and characteristics.

- The OPHS are explicit in their requirement of all boards of health to carry out their mandated obligations in partnership with local stakeholders. Public health is in turn seen as a credible broker within the local community that can support multi-stakeholder engagement and community mobilization for healthy public policy.

How could a modernized public health system become more connected to the health care system or social services?

- Strengthen the health and social services sectors' focus on prevention and the social determinants of health. Explore the implementation of a "health in all policies" approach with parallel mandates, clear role expectations and accountability for protecting population health across related provincial government ministries and government-funded agencies.

- The Ministry of Health (Ministry) could provide a reciprocal and clearly defined mandate for PHUs and OHTs to utilize public health's surveillance and analysis expertise to conduct population-based needs assessments to inform the effective local allocation of primary health care resources and build capacity among health service providers to offer evidence-based health promotion and prevention interventions.

- Improvements to information technology to support interoperability and data standards to accelerate the appropriate inclusion of public health information into electronic health records and facilitate public health's receipt of vital information from primary care and the broader health care system. This collaboration would support disease prevention and health promotion at the individual to population-level to end hallway health care. More details on digital modernization will be provided in a separate submission by the COMOH Digital Health Committee.

What are some examples of effective collaborations among public health, health services and social services?

- Our members provided us with many specific examples of successful local collaborations among public health, health services and social services. These will surely be presented in more detail in their individual submissions to the present survey.

- The mandated reciprocal relationship between the local Medical Officer of Health (MOH) and Local Health Integration Network (LHIN) CEO was cited as instrumental in promoting a better understanding of public health's mandate, focus and functions to the health care conversation. Direct involvement of public health in local OHTs is expected to increase the momentum.

- The partnership between the Council of Ontario Directors of Education and COMOH (CODE-COMOH) is expected to contribute to the well-being of Ontario's children and students through enhancing PHU and school board partnerships in order to achieve optimal delivery of services and ongoing supports for children and students.

Theme: Duplication of Effort

As with the previous theme, alPHa would argue that the use of the term "Duplication of Effort" suggests that it is a systemic problem that underlies widespread inefficiencies. While we agree that

there are public health functions that could in fact be carried out jointly, regionally or centrally, the local nature of public health requires certain programs and services with similar aims to be developed and implemented in different ways to meet unique local needs.

Care must therefore be taken in defining the term and in identifying and eliminating duplication that is in fact redundant. Care must also be taken when examining alleged duplication of effort between sectors. Public health has a unique set of roles and responsibilities and it would be a mistake to assume that they are transferrable. For example, health promotion in public health differs fundamentally from health promotion in primary care. Only public health focuses on upstream population-level approaches to prevent injuries and illnesses before they occur, and success often depends on strong existing relationships with community partners.

What functions of public health units should be local and why?

- The health protection functions of public health are local by definition. Health hazard investigation and response, infection prevention and control, communicable disease outbreak management, water quality and food safety are examples of areas where local public health has clearly prescribed and detailed roles and responsibilities under the HPPA and OPHS. Carrying these out relies heavily on interaction with individuals, institutions, businesses and service providers throughout the local community. Timeliness and efficiency are supported by preexisting positive relationships.

- Health promotion work is also informed in large part by understanding the local population's characteristics, identifying local priorities and strategically developing approaches for policy development and program and service delivery that will be most responsive to local population health needs. Ongoing population health assessment and surveillance ensures that local data are at the root of program planning as well as healthy public policy development through public health's relationship with municipalities.

- Some public health services (e.g. harm reduction, screening programs, prenatal education, Healthy Babies Healthy Children, neighbourhood groups) focus on individuals and families with high needs. Public health's knowledge of the community and partnerships are a valuable resource for connecting clients with necessary services, which are also primarily local.

What population health assessments, data and analytics are helpful to drive local improvements?

- The epidemiological capacity to collect and access data to conduct detailed local population health assessments within local contexts must be enhanced. Public health programs and services benefit from solid data at the sub-health unit level (e.g., priority neighbourhoods, planning zones, ER admissions). Local epidemiologists have a keen understanding of the local context and are well positioned to collaborate with stakeholders to gather data, conduct analysis and inform recommendations for action and priority setting.

- The CMOH's 2017 Annual Report recommended a provincial population health survey to collect data at the local community and neighbourhood levels to contribute to a better understanding of community wellness. The survey would need to be flexible and nimble, with the ability to customize questions to local needs.

- The Rapid Risk Factor Surveillance System is an ongoing local health telephone survey conducted collaboratively since 2001 by numerous PHUs and the Institute for Social Research at York

University. Information is gathered using questionnaires on a wide variety of health topics to inform service planning for the broad range of public health programs that are required by the OPHS, to advocate for healthy public policy development and to improve community awareness of health risks.

- Strategies to identify and address gaps in data and information must be considered. The Children Count Locally Driven Collaborative Project is an important current example of a strategy to improve available data and interventions to improve child and youth health in Ontario.

What changes should the government consider to strengthen research capacity, knowledge exchange and shared priority setting for public health in the province?

- alPHa believes that the most important development in this regard was the establishment of the Ontario Agency for Health Protection and Promotion, a.k.a. PHO. PHO has been instrumental in supporting our health protection activities with excellent standards of practice developed in communicable disease control, vaccination, and infection prevention and control. We believe that there is an important opportunity to reinforce PHO's capacity to strengthen similar work in the areas of environmental health and non-communicable diseases (which account for over 70% of ill health in Ontario) by focusing on evidence, translating it into recommended practice, and setting common implementation standards. PHO is the key agency for scientific expertise, research and knowledge exchange and is one of the Ontario public health sector's strongest assets. This is one of the strengths that needs to be built upon as the Ministry seeks to achieve the outcomes outlined in this discussion paper.

What are public health functions, programs or services that could be strengthened if coordinated or provided at the provincial level? Or by Public Health Ontario?

- As noted above, the existing roles and responsibilities of PHO should be reinforced and expanded.

- Increased centralized supports, provided by PHO or the Ministry, have the potential to reduce duplication of effort, and contribute to increased consistency and improved delivery of public health programs and services. Examples include a provincial immunization registry, provincial electronic medical records, centralized digital supports including facilitation of data sharing, provincial health communication campaigns, continuing professional education opportunities, centralized reviews of evidence, bulk purchasing, access to data repositories, provincial advisory committees etc. Centralized supports must be designed to sustain the local capacity to develop and implement innovative and locally relevant campaigns.

- Developing provincial leadership on surveillance and population health assessment, technical direction (especially on emerging public health issues), emergency management, healthy policy development and chronic disease prevention coordination. Setting provincial population health goals with targets and cross-sectoral strategies would be a useful foundation upon which to carry out these functions.

- The Ministry, likely via the independent authority of the CMOH, needs to be more active in providing local public health with guidance and / or direction when asked to ensure consistent approaches where there is agreement that they are required. There have been instances (ISPA enforcement, IPAC investigations and HIV Case management for recent examples) where local public health asked for direction to address disparate and sometimes conflicting local practices. With none provided, local MOHs were compelled to work together to develop their

own recommendations for a collective approach.

Beyond what currently exists, are there other technology solutions that can help to improve public health programs and services and strengthen the public health system?

- The COMOH Digital Health Committee will be making a detailed submission to the Public Health Modernization consultation. It will call on the Province to develop a digital strategy for public health; provide sufficient resources to support aligned and necessary information systems and common applications; work with public health partners to facilitate the incorporation of public health information into a provincial electronic health record; centralized coordination and technical support for digital solution integration and Provincial leadership on data standards and interoperability.

- Other suggestions put forth by our members included bulk purchasing of information technology hardware and software, a centralized website with important public health information, a seamless provincial immunization registry, a centralized online inspection disclosure system, enhanced technology to reduce travel requirements (e.g., video calls for client interactions and videoconferencing for health unit staff in rural areas). Inequities in access to technology solutions and tech-mediated opportunities for collaboration were also raised. We expect that many other suggestions will be made in other submissions to the survey question.

Theme: Inconsistent Priority Setting

As with previous themes, alPHa would argue that the use of the term "Inconsistent Priority Setting" suggests a systemic problem that underlies widespread inefficiencies. The existence of different public health priorities in different parts of the province is a feature of the system, not a bug, and is one of its strengths. Local authority over priority setting must be preserved to ensure that the unique health needs of each community can be served. This should include the authority to adapt programs and services to address province-wide public health priorities according to the local context.

What processes and structures are currently in place that promote shared priority setting across public PHUs?

- PHUs are required, through the HPPA, to meet the requirements of the OPHS. These standards provide a framework to support consistent priority setting across Ontario and the related Accountability Agreements ensure provincial approval and awareness of each BOH's plan for the delivery of mandated programs and services each year.

- Ontario's 34 PHUs are connected to a wide range of networks that provide opportunities for sharing of information, priority setting and collective action. alPHa, including COMOH, BOHs and Affiliate Sections, is the most important of these at the systemic level as it brings the governance, medical and programmatic aspects of the entire system together at a single table, which in turn provides an ideal point of contact for government and other stakeholders.

- Profession-specific associations such as ASPHIO, OPHNL, APHEO, AOPHBA, OAPHD, ODPH and HPO provide similar opportunities for the collective identification of priorities within their purview. Each of these groups is represented at the alPHa table.

- Topic-specific collaboratives, spanning regions or the province, provide opportunities to share information and resources, and to collectively address common goals. For example, regional

TCANs allow for shared priority setting and planning related to reducing smoking behavior in regions spanning multiple PHUs. Similar collaborative groups have addressed cannabis, alcohol and opioids.

- Regional PHU groupings (South West, Central West, Central East, North East, North West, East) are networks that provide similar opportunities for neighbouring PHUs that share geographic and demographic characteristics.

- 100% provincially funded public health programs (e.g. Universal Influenza Immunization Program, Ontario Seniors Dental Care Program (OSDCP)) are a clear demonstration of priorities that are shared province wide.

What should the role of Public Health Ontario be in informing and coordinating provincial priorities?

- PHO's mandate is to provide a foundation of sound information, knowledge and evidence to support policy, action and decisions of government, public health practitioners, front-line health workers and researchers. Centralized and timely evidence reviews, provision of provincial and local data, guidance documents and best practices, research ethics, and coordination of tables to address significant province-wide needs (e.g., Healthy Human Development table, Provincial Infectious Disease Advisory Committee) are key functions that underlie evidence-based setting of priorities throughout the public health sector. Reinforcing PHO's capacity to perform these functions in the areas of health promotion and non-communicable disease prevention should be considered.

- PHO's "hub and spoke" model, which was the basis for the former Regional Infection Control Networks, could be used to establish collaborative regional tables in the various public health areas of focus to inform common priorities and joint projects. Such an approach would be valuable in setting province-wide priorities as common themes emerge.

- PHO would be instrumental in providing the evidentiary basis for the establishment of provincial population health goals as proposed above.

What models of leadership and governance can promote consistent priority setting?

- A model of leadership and governance to promote consistent priority setting is already in place. The HPPA provides a clear, detailed and specific framework for the organization and delivery of public health programs and services, including the composition, authority and duties of boards of health. The HPPA is in turn the enabling legislation for the OPHS, which set out clear, detailed and specific requirements for the delivery of public health programs and services in each of the province's 34 PHUs.

- The Office of the CMOH is responsible for ensuring that the OPHS continue to be relevant and based on evidence, and for supporting local public PHUs in meeting the requirements of the standards. Each BOH is required to submit annual business plans to the Ministry through this office as part of the budget and accountability processes.

- Leadership and governance principles are outlined in the attached alPHa Statement, including preserving the autonomy and authority of the local MOH and reinforcing local boards' autonomy, skill sets, effective governance and public health focus.

Theme: Indigenous and First Nation Communities

What has been successful in the current system to foster collaboration among public health and Indigenous communities and organizations?

- PHUs with significant indigenous populations long ago identified the importance of improving their access to public health programs and services, especially in First Nations communities. Many have independently entered into formal agreements with local bands under Section 50 of the HPPA for the provision of programs and services.

- The 2018 OPHS added a requirement for boards of health to engage with First Nations and Indigenous communities and organizations under the Health Equity Standard. The *Relationship with Indigenous Communities Guideline, 2018* was developed to support this work and a *Relationship with Indigenous Communities Toolkit* is said to be under development by the Ministry.

- The widespread acceptance of and commitment to the Truth and Reconciliation Calls to Action throughout the public health sector. Staff training in cultural awareness / competency /safety, the local involvement of Indigenous leaders in decision making, program planning and relationship development, and local partnerships and initiatives have sprung forth from that commitment in all of Ontario's PHUs.

Are there opportunities to strengthen Indigenous representation and decision- making within the public health sector?

- In its Statement of Principles, alPHa notes the necessity of special consideration being given to the effects of any proposed organizational change on Ontario's many Indigenous communities, especially those with a close relationship with the boards of health for the PHUs within which they are located. It is further notes that opportunities to formalize and improve these relationships must be explored as part of the modernization process. alPHa recommends that this exploration, including consideration of the above question, be conducted in full consultation with Indigenous communities and organizations as well as boards of health that have already demonstrated commitment to and experience with Indigenous engagement and service delivery to these populations.

- In its Statement of Principles, alPHa recommends that local BOHs be reflective of the communities that they serve. In areas with large indigenous populations and / or First Nations communities, consideration should be given to appointing one or more members of those communities to the BOH itself. This has already been done, for example, in Peterborough. This could be reinforced with the formation of local Indigenous health advisory committees with more widespread stakeholder involvement. These committees would be especially important for identifying and addressing the health needs of Indigenous people living off-reserve in a culturally sensitive way.

- Provincially, the Office of the CMOH should ensure that central resource and policy supports are in place to facilitate local engagement with Indigenous communities and reinforce pathways to increasing representation and decision-making. The Health Equity requirements of the OPHS that are specific to improving the health of First Nations, Métis, and Inuit people living in Ontario should be the foundation of these supports. The CMOH will also have an important role to play as a liaison with the Government of Canada (through the Public Health Agency of Canada) to ensure that it abides by its complementary obligation to contribute to the improvement of health care and health outcomes for these communities.

Theme: Francophone Communities

What has been successful in the current system in considering the needs of Francophone populations in planning, delivery and evaluation of public health programs and services?

- alPHa's members have extensive experience in providing programs and services aimed at different cultural and linguistic groups within their communities, including Ontario's significant Francophone population. PHUs with significant Francophone populations are best equipped to share what has been successful, identify the gaps and provide advice on how to address them. This is in fact a good example of the importance of ensuring that local boards of health retain decision-making authority over program planning and service delivery to best serve local needs.

What improvements could be made to public health service delivery in French to Francophone communities?

- The provision of a 100% provincially funded centralized translation service that is accessible to all boards of health was cited repeatedly in our members' feedback to this question, as was support for French-language training programs for health unit staff.

Theme: Learning from Past Reports

What improvements to the structure and organization of public health should be considered to address these challenges?

- Most past reports have recommended PHU mergers, and alPHa is not opposed to this in principle, as long as such mergers are of entities with complementary community characteristics and values, will lead to a demonstrable positive impact on capacity, are worth the extraordinary cost and disruption, and are favoured by all concerned parties. The Simcoe-Muskoka, North Bay-Parry Sound, Southwestern and Huron-Perth PHUs are the results of mergers that have taken place since 2005, and valuable insights on the process, including the identification of driving forces, key success factors and challenges, are readily available.

- As noted above, alPHa does not believe that structural and organizational changes are necessary to address capacity challenges. While we agree that health unit mergers as a means to finding efficiencies and reducing duplication of efforts are worth considering, we have not been presented with a clear and convincing argument that a wholesale restructuring of the Ontario's public health system – with its concomitant major costs and disruptions - is a prerequisite for making it nimble, resilient, efficient and responsive.

What about the current public health system should be retained as the sector is modernized?

From alPHa's Statement of Principles:

- Ontario's public health system must remain financially and administratively separate and distinct from the health care system.

- The strong, independent local authority for planning and delivery of public health programs and services must be preserved, including the authority to customize centralized public health programming or messaging according to local circumstances.

- Parts I-V and Parts VI.1 – IX of the HPPA should be retained as the statutory framework for the purpose of the Act, which is to "provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario".

- The OPHS should be retained as the foundational basis for local planning and budgeting for the delivery of public health programs and services.

- The leadership role of the local MOH as currently defined in the HPPA must be preserved with no degradation of independence, leadership or authority.

What else should be considered as the public health sector is modernized?

- Any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services.

- Achieving efficiencies must be defined in terms of improvements to service delivery and not cost savings. Each of the completed health unit mergers for example has had the former as their central aim but the merger process itself has always been costly.

- Provincial supports (financial, legal, administrative) must be provided to assist existing local PHUs in their transition to any new state without interruption to front-line services. Any costs associated with Public Health Modernization should be fully covered by the Ministry, including additional funding to address technology changes associated with any structure or governance changes.

- alPHa is very pleased with the format and process of the current consultation. That said, in the period between the initial 2019 budget announcement and the formal launch of this consultation (a period of over seven months), there was an unacceptable scarcity of information available to Ontario's considerable public health workforce. This has had a measurable and possibly irreversible negative impact on culture and morale within Ontario's public health workplaces. It has also put a considerable hindrance on the working relationship between local public health leadership and its partners within the Ministry. We hope that the transparency, comprehensiveness and reciprocity of this consultation will continue throughout the analysis and implementation phases to restore trust and demonstrate that the Government of Ontario values the public health professionals that are the foundational strength of the system.

ABBREVIATIONS

alPHa	Association of Local Public Health Agencies
AOPHBA	Association of Ontario Public Health Business Administrators
APHEO	Association of Public Health Epidemiologists in Ontario
ASPHIO	Association of Supervisors of Public Health Inspectors of Ontario
BOH	Board of Health
CMOH	Chief Medical Officer of Health
COMOH	Council of Ontario Medical Officers of Health
HPO	Health Promotion Ontario
HPPA	*Health Protection and Promotion Act*
HIV	Human Immunodeficiency Virus
IPAC	Infection Prevention and Control
ISPA	*Immunization of School Pupils Act*
LDCP	Locally Driven Collaborative Project
OAPHD	Ontario Association of Public Health Dentistry
OPHNL	Ontario Association of Public Health Nursing Leaders
ODPH	Ontario Dietitians in Public Health
OPHS	Ontario Public Health Standards
PHO	Public Health Ontario
PHU	Public Health Unit
TCAN	Tobacco Control Area Network

Enclosures:

alPHa Statement of Principles (November 2019), also attached.
alPHa Deputation, Standing Committee on Finance and Economic Affairs (January 17, 2020), also attached

Statement of Principles
Public Health Modernization
November 2019

BACKGROUND

On April 11, 2019 the Minister of Finance announced the 2019 Ontario Budget, which included a pledge to modernize "the way public health units are organized, allowing for a focus on Ontario's residents, broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention to improve public health promotion and prevention".

Plans announced for this initiative included regionalization and governance changes to achieve economies of scale, streamlined back-office functions and better-coordinated action by public health units, adjustments to the provincial-municipal cost-sharing of public health funding and an emphasis on digitizing and streamlining processes.

On November 6, 2019, further details were presented as part of the government's Fall Economic Statement, which reiterates the Province's consideration of "how to best deliver public health in a way that is coordinated, resilient, efficient and nimble, and meets the evolving health needs and priorities of communities". To this end, the government is renewing consultations with municipal governments and the public health sector under the leadership of Special Advisor Jim Pine, who is also the Chief Administrative Officer of the County of Hastings. The aim of the consultation is to ensure:

- Better consistency and equity of service delivery across the province;
- Improved clarity and alignment of roles and responsibilities between the Province, Public Health Ontario and local public health;
- Better and deeper relationships with primary care and the broader health care system to support the goal of ending hallway health care through improved health promotion and prevention;
- Unlocking and promoting leading innovative practices and key strengths from across the province; and
- Improved public health delivery and the sustainability of the system.

In preparation for these consultations and with the intent of actively supporting positive systemic change, the alPHa Board of Directors has agreed on the following principles as a foundation for its separate and formal submissions to the consultation process.

PRINCIPLES

Foundational Principle

1) Any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services.

Organizational Principles

2) Ontario's public health system must remain financially and administratively separate and distinct from the health care system.

3) The strong, independent local authority for planning and delivery of public health programs and services must be preserved, including the authority to customize centralized public health programming or messaging according to local circumstances.

4) Parts I-V and Parts VI.1 – IX of the Health Protection and Promotion Act should be retained as the statutory framework for the purpose of the Act, which is to "provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario".

5) The *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* should be retained as the foundational basis for local planning and budgeting for the delivery of public health programs and services.

6) Special consideration will need to be given to the effects of any proposed organizational change on Ontario's many Indigenous communities, especially those with a close relationship with the boards of health for the health units within which they are located. Opportunities to formalize and improve these relationships must be explored as part of the modernization process.

Capacity Principles

7) Regardless of the sources of funding for public health in Ontario, mechanisms must be included to ensure that the total funding envelope is stable, predictable, protected and sufficient for the full delivery of all public health programs and services whether they are mandated by the province or developed to serve unique local needs as authorized by Section 9 of the Health Protection and Promotion Act.

8) Any amalgamation of existing public health units must be predicated on evidence-based conclusions that it will demonstrably improve the capacity to deliver public health programs and services to the residents of that area. Any changes to boundaries must respect and preserve existing municipal and community stakeholder relationships.

9) Provincial supports (financial, legal, administrative) must be provided to assist existing local public health agencies in their transition to any new state without interruption to front-line services.

Governance Principles

10) The local public health governance body must be autonomous, have a specialized and devoted focus on public health, with sole oversight of dedicated and non-transferable public health resources.

11) The local public health governance body must reflect the communities that it serves through local representation, including municipal, citizen and / or provincial appointments from within the area. Appointments should be made with full consideration of skill sets, reflection of the area's socio-demographic characteristics and understanding of the purpose of public health.

12) The leadership role of the local Medical Officer of Health as currently defined in the Health Protection and Promotion act must be preserved with no degradation of independence, leadership or authority.

DESIRED OUTCOMES

- Population health in Ontario will benefit from a highly skilled, trusted and properly resourced public health sector at both the provincial and local levels.
- Increased public and political recognition of the critical importance of investments in health protection and promotion and disease prevention to population health and the sustainability of the health care system.
- Local public health will have the capacity to efficiently and equitably deliver both universal public health programs and services and those targeted at at-risk / vulnerable / priority populations.
- The geographical and organizational characteristics of any new local public health agencies will ensure critical mass to efficiently and equitably deliver public health programs and services in all parts of the province.
- The geographical and organizational characteristics of any new local public health agencies will preserve and improve relationships with municipal governments, boards of education, social services organizations, First Nations communities, Ontario Health Teams and other local stakeholders.
- The geographical and organizational characteristics of any new local public health agencies will reflect the geographical, demographic and social makeup of the communities they serve in order to ensure that local public health needs are assessed and equitably and efficiently addressed.
- Local public health will benefit from strong provincial supports, including a robust Ontario Agency for Health Protection and Promotion (Public Health Ontario) and a robust and independent Office of the Chief Medical Officer of Health.
- The expertise and skills of Ontario's public health sector will be recognized and utilized by decision makers across sectors to ensure that health and health equity are assessed and addressed in all public policy.

Association of Local Public Health Agencies
Speaking Points
Standing Committee on Finance and Economic Affairs
Re: 2020 Ontario Budget
Friday, January 17, 2020

- Good afternoon, Chair and Members of the Standing Committee on Finance and Economic Affairs.

- I am Dr. Eileen de Villa, Vice-President of the Association of Local Public Health Agencies, better known as alPHa, and Toronto's Medical Officer of Health and with me is Loretta Ryan, alPHa's Executive Director.

- alPHa represents all of Ontario's 34 boards of health and medical officers of health (MOHs).

- As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows:

    - Chronic Disease Prevention and Well-Being
    - Emergency Management
    - Food Safety
    - Health Equity
    - Healthy Environments
    - Healthy Growth and Development
    - Immunization
    - Infectious and Communicable Diseases Prevention and Control
    - Population Health Assessment

- Safe Water
- School Health
- Substance Use and Injury Prevention

- Last January, in the alPHa Pre-Budget Submission, alPHa noted that:

  - Public Health is on the Front Line of Keeping People Well
  - Public Health Delivers an Excellent Return on Investment
  - Public Health is an Ounce of Prevention that is Worth a Pound of Cure
  - Public Health Contributes to Strong and Healthy Communities
  - Public Health is Money Well Spent

- Furthermore, alPHa recommended that:

  - The integrity of Ontario's public health system be maintained
  - The Province continue its funding commitment to cost-shared programs
  - The Province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway medicine

- As regards to this last point, Public Health's contribution to ending hallway medicine is summarized in alPHa's Public Health Resource Paper .

- Despite this advice, the 2019 Ontario Budget announced that the Government would be changing the way the public health system was organized and funded.

- On October 10, 2019, Ontario named Jim Pine as its Advisor on Public Health (and Emergency Health Services) consultations.

- Subsequently, on November 18, the Ministry of Health launched renewed Public Health consultations and released a Discussion Paper.

- alPHa was pleased with these recent announcements and has been fully engaged with the consultation.

- For example, on November 15, alPHa released a Statement of Principles respecting Public Health Modernization.

- On a funding note, as was reported by alPHa on September 11, the Ministry of Health confirmed the cost-sharing formula for public health will change to 70% provincial/30% municipal to be applied to almost all mandatory public health programs and services.

- That said, as the Premier announced on August 19 at the AMO Conference, and which alPHa welcomed, municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%.

- Despite this, many boards of health have reported that they have had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities .

- A more positive announcement in the 2019 Ontario budget was the decision to proceed with a new 100% provincially funded, public health unit delivered Ontario Seniors Dental Care Program (OSDCP), which was officially launched on November 20.

- alPHa believes that a modernized, effective and efficient public health system that is adequately resourced is needed more than ever.

- alPHa agrees, for example, with the Standing Committee on Public Accounts Report about the importance of addressing key chronic disease risk factors such as physical inactivity, unhealthy eating, alcohol consumption and

tobacco use of which the attributable burden of illness places huge demands on the health care system.

- Moreover, in its presentation to the Standing Committee on Social Policy, alPHa warned about the unforeseen consequences of the legalization of cannabis and the promotion of vapour products, such as e-cigarettes and other similar products.

- Finally, as the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China; as our experience with SARS demonstrated, infectious diseases "know no borders".

- With all the foregoing in mind, alPHa respectfully recommends the following:

    - Led by Ontario's Advisor, the Ministry of Health continue to pursue meaningful consultations with key stakeholders, including alPHa, respecting Public Health Modernization
    - Any changes to the public health system be implemented in accordance with alPHa's Statement of Principles and pending response to the Public Health Modernization discussion paper
    - The public health system receives sufficient and sustainable funding to address population health needs
    - Ontario preferably restore the previous provincial-municipal cost-sharing (75/25) formula for Public Health and, at the very least, make no further changes to the current (70/30) formula
    - Ontario continue to invest in Public Health operations and capital, including 100% funding for priority programs, such as OSDCP

- Thank you for your attention. We would be pleased to answer any questions.

Association of Local Public Health Agencies

The Chair (Mr. Amarjot Sandhu): Next, I would like to call upon the Association of Local Public Health Agencies. Please state your name for the record. You have seven minutes for your presentation.

Dr. Eileen de Villa: Thank you very much. Good afternoon, Chair and members of the Standing Committee on Finance and Economic Affairs. I'm Dr. Eileen de Villa, vice-president of the Association of Local Public Health Agencies, better known as ALPHA, and I'm also Toronto's medical officer of health. I'm joined today by my colleague Loretta Ryan, ALPHA's executive director.

ALPHA represents all of Ontario's 34 boards of health and medical officers of health. As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows: chronic disease prevention and well-being, emergency management, food safety, health equity, healthy environments, healthy growth and development, immunization, infectious and communicable diseases prevention and control, population health assessment, safe water, school health, substance use, and injury prevention.

Last January, in the ALPHA pre-budget submission, ALPHA noted that public health is on the front line of keeping people well. Public health delivers an excellent return on investment. Public health is an ounce of prevention that is worth a pound of cure. Public

health contributes to strong and healthy communities, and public health is money well spent.

Furthermore, ALPHA recommended that the integrity of Ontario's public health system be maintained, that the province continue its funding commitment to cost-shared programs and that the province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway health care. In regard to this last point, public health's contribution to ending hallway health care is summarized in ALPHA's public health resource paper.

Despite this advice, the 2019 Ontario budget announced that the government would be changing the way the public health system was organized and funded.

On October 10, 2019, Ontario named Jim Pine as its adviser on public health and on emergency health services for the consultations. Subsequently, on November 18, the Ministry of Health launched renewed public health consultations and released a discussion paper. ALPHA was pleased with these recent announcements and has been fully engaged with the consultation. For example, on November 15, ALPHA released a statement of principles respecting public health modernization.

On a funding note, on September 11, the Ministry of Health confirmed that the cost-sharing formula for public health will change to 70% provincial and 30% municipal, to be applied to almost all mandatory public health programs and services. This said, as the Premier announced on August 19 at the AMO conference—and which ALPHA welcomed—municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%. Despite this, many boards of health have reported that they have had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities.

A more positive announcement in the 2019 Ontario budget was the decision to proceed with a new, 100% provincially funded, public-health-unit-delivered Ontario Seniors Dental Care Program, or OSDCP, which was officially launched on November 20.

ALPHA believes that a modernized, effective and efficient public health system that is adequately resourced is needed more than ever. ALPHA agrees, for example, with the Standing Committee on Public Accounts report about the importance of addressing key chronic disease risk factors, such as physical inactivity, unhealthy eating, alcohol consumption and tobacco use, of which the attributable burden of illness places huge demands on the health care system. Moreover, in its presentation to the Standing Committee on Social Policy, ALPHA warned about the unforeseen consequences of the legalization of cannabis and the promotion of vapour products, such as e-cigarettes and other similar products.

Finally, as the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China. As our experience with SARS demonstrated, infectious diseases know no borders.

With all the foregoing in mind, ALPHA respectfully recommends the following:

—led by Ontario’s adviser, the Ministry of Health continue to pursue meaningful consultations with key stakeholders, including ALPHA, respecting public health modernization;

—any changes to the public health system be implemented in accordance with ALPHA’s statement of principles and pending response to the public health modernization discussion paper;

—that the public health system receive sufficient and sustainable funding to address population health needs—

The Chair (Mr. Amarjot Sandhu): One minute.

Dr. Eileen de Villa:—that Ontario preferably restore the previous provincial-municipal cost sharing 75-25 formula for public health and, at the very least, make no further changes to the current 70-30 formula; and

—that Ontario continue to invest in public health operations and capital, including 100% funding for priority programs such as the Ontario Seniors Dental Care Program.

I'll thank you for your attention, and we would be very pleased to address any questions you might have.

The Chair (Mr. Amarjot Sandhu): Thank you. We'll go to the opposition side this time. MPP Shaw.

Ms. Sandy Shaw: Thank you very much for your presentation. I commend you for your work. I would say that people didn't understand what public health did previous to these abrupt changes; we understand it now.

I would also like to say, we remember when SARS happened, and Dr. Sheela Basrur—the heroic efforts that we took to prevent that from being a full-blown crisis. It was 15 or 16 years ago; how quickly we forget, right? So I think we need to keep reminding ourselves that when we need public health to be able to mobilize, we really, really need it.

So I want to commend you. I understand the work that you do. I always did. I want to say that we're fully supportive of what you do. There's no misunderstanding on the part of the New Democrats of what you do.

My question is very specific because we've got a short time. About the changes to the public health unit, the geographic deployment—so 35 units that are going to now, perhaps, be shrunk down to 10. This is a question about my riding in Hamilton, where our medical officer of health, Dr. Richardson, has expressed some of her concerns, particularly now that we are an Ontario health team and we do not know how the Ontario health team is trying to get on with their work without any direction—really clear direction, I would say—from the government and without the understanding that this public health unit will now maybe be beyond the geographic area of the Ontario health team.

So there's a lot of confusion out there in terms of what's happening. I'm wondering if you have any understanding of that or any advice around what the impact will be when these health units shrink.

1620

Dr. Eileen de Villa: Thank you for the question. At this stage of the game and as alluded to in my remarks, there are ongoing consultations right now in respect of public health modernization as proposed by the current provincial government. My understanding at this stage is that there is still open discussion with respect to what will be the configuration of local public health units. You're right: Right now, there are currently 34. There were some original proposals made last year. We're understanding at this stage of the game that there is some revisiting, a "reset," I believe, is the word that has been used. So we don't know yet where the discussions will land.

However, I would say that there are some important questions to ask here and some important considerations for the committee. First public health as a system is separate from the health care system. There are important areas of interaction that we need to have between public health and health care, but they are in fact distinct and separate. The Ontario health teams fall more within the context of health care, and that's a very important role that needs to be played. I think there are certainly some questions as to how that will manifest itself in the future. However, it is in fact separate from public health.

The Chair (Mr. Amarjot Sandhu): One minute.

Dr. Eileen de Villa: That's not to take away from its importance.

Ms. Sandy Shaw: Thank you.

The Chair (Mr. Amarjot Sandhu): MPP Arthur.

Mr. Ian Arthur: Thank you so much for your presentation. I echo the sentiments of my colleague.

Just very quickly: The upstream causes of health care costs were talked about for a long time. It seems to have receded a bit in terms of the discussion. With skyrocketing health care costs, do you see any avenue other than dealing with those upstream causes for bringing those expenditures under control?

Dr. Eileen de Villa: Thank you for the question. As a public health practitioner, we are all about the upstream. That is our focus. That is where we live, and that's where we provide the most value to the system. There will always be some need for health care, which is downstream. However, we know that what constitutes and what maintains

health are the social determinants of health, the conditions within which people live and the environments within which they live—

The Chair (Mr. Amarjot Sandhu): Thank you. I apologize to cut you off. We'll have to move to the government side now. MPP Skelly.

Ms. Donna Skelly: Thank you for your presentation. This year our government committed over $700 million—close to $800 million—in funding for public health units right across Ontario. Yes, we believe that there is an opportunity and several challenges moving forward in the restructuring and modernization of delivery of those services, and we are consulting, I believe under the leadership and direction of Jim Pine. He is the emergency health services adviser. He is leading the dialogue, meeting with representatives from municipalities, meeting with health service sector representatives from right across the province, in order to understand what the challenges are, in order to identify perhaps some of the duplication of services. We have seen examples that have been brought forward to our government.

I'm just wondering if maybe you could, while we have this opportunity at this committee hearing, share with this committee some of the areas that you have identified as duplication in the delivery of health care services under these current boards.

Dr. Eileen de Villa: Thank you for the question. I'm going to talk about duplication in respect of public health as opposed to health care.

Ms. Donna Skelly: I should say "public health." Thank you.

Dr. Eileen de Villa: Yes, because they are quite distinct, as I indicated earlier. You're quite right around the consultations; I think that there is an opportunity to engage in conversation around what's best for public health. The public health system, however, does require the co-operation and collaboration of several partners. There's certainly a

role for provincial entities. There's a role for local entities, some of which are governmental and some of which are community-based.

Where are there areas that we could improve? There are always areas for improvement, whether we're talking about public health or health care. When it comes to public health, I think what we have seen through the various reports—some of which emanated from local public health; some of which have come through Auditor General-type reports—would include areas like research.

I think there is an opportunity, as well, to confer across the province around what are some of the directions and priorities that we should be seeking together, because we know that where we have had success in public health in the past, most of the successes have come through the collaborative efforts of a variety of local or regional public health entities, as well as the province.

I think those are just a few examples of some areas where we could collaborate better and perhaps reduce duplication.

Ms. Donna Skelly: One of the programs that you raised involves dental care for seniors, which is, of course, something I think most of us really believe is long overdue.

The Chair (Mr. Amarjot Sandhu): One minute.

Ms. Donna Skelly: Can you speak to some of the limitations, some of your observations, since we've started introducing that program?

Dr. Eileen de Villa: It's a relatively new program, launched in November and currently being delivered through public health units. I would say that for many of my colleagues around the province, one of the challenges is that they did not have pre-existing seniors'

dental care programs, or facilities through which to deliver such clinical services. Certainly, establishing those facilities is one of the challenges that exist right now.

But as mentioned in our remarks, we at ALPHA are extremely pleased. This was certainly one of the positives in respect of recent funding announcements when it came to public health and public health delivery programs.

Ms. Donna Skelly: Thank you.

The Chair (Mr. Amarjot Sandhu): Thank you so much for your presentation.

Andrea Horwath

Leader of the Official Opposition
Chef de l'Opposition officielle
MPP / Députée, Hamilton Centre

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February 5, 2020

The Hon. Doug Ford
Room 281
Legislative Building, Queen's Park
Toronto,
ON M7A 1A1

Dear Premier:

The world is facing what the World Health Organization is calling a Global Health Emergency in the novel coronavirus.

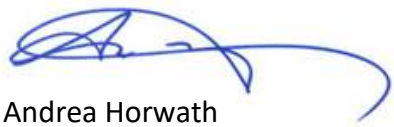
I am so proud of the hard work of our Public Health Units in protecting the public and frontline health care workers and grateful for their dedication. I am confident in their capacity to protect Ontarians.

As we face deep challenges, I am calling on the government to immediately pause any implementation of Public Health "modernization", and return to funding Public Health at 2019 levels. Cuts, uncertainty and administrative re-organization must not interfere with our response at this critical moment.

Ontario learned important lessons in the aftermath of SARS in 2003, which in part led to greater provincial responsibility for Public Health and infectious disease control. Those recommendations led us to the place we are today, where we have funding and plans in place to respond to the Coronavirus. That is why funding and staffing should not decrease during this moment.

Before any further changes are made, we must wait for this Global Health Emergency to pass, conduct a thorough, public review of our response and develop a clear, evidence-based funding model for Public Health that continues to protect every person in this Province.

Sincerely,



Andrea Horwath
Leader of the Official Opposition

Cc: France Gelinas, Official Opposition Health Critic
Hon. Christine Elliott, Minister of Health

Public Health
Santé publique
SUDBURY & DISTRICTS

February 10, 2020

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Mr. Jim Pine, Special Advisor
Ms. Alison Blair, Public Health Modernization Executive Lead
Dr. David Williams, Chief Medical Officer of Health
Ministry of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Mr. Pine, Ms. Blair and Dr. Williams:

Re: Transforming Public Health for the People of Northeastern Ontario

On behalf of the Board of Health for Public Health Sudbury & Districts, I am pleased to submit our agency's response to the Ministry of Health consultations on Public Health Modernization and the November 18, 2019 Discussion Paper. As a diverse board of health with representation from across our vast northern catchment area, we understand our communities, our people, and our partners. Our longstanding engagement with our local communities in support of public health uniquely positions us to comment on system improvements that would benefit public health in our area.

The enclosed submission was informed by rich dialogue among Public Health Sudbury & Districts management and careful review by the Board of Health. It was also informed by our collaborations with our North East public health partners and with the communities we serve.

I would be remiss to not raise the current global response to the novel coronavirus in the context of this consultation on Public Health Modernization. Our agency is responding to this Public Health Emergency of International Concern by activating our Emergency Response Plan. This ensures local public health readiness and coordination of community stakeholder responses and communications. Over the December holidays and into the New Year, our agency's Emergency Response Plan was also activated to enable our response to two sequential cases of hepatitis A in local food handlers.

These two very different incidents highlight the same point – the public health system needs to be robust. It needs to be robust enough to be able to surge and respond to the unexpected needs of our communities. At the same time, our responsive work needs to be accomplished without compromising the long-game of public health – our resilient forging ahead with carefully planned health promotion and disease prevention activities that achieve longer term health benefits. We believe that our submission contains critical considerations for Government which if implemented, would lead to the successful achievement of these ends in an effective modernized public health system.

Our Board has worked diligently over the years to ensure the best use of existing resources. This has resulted in many accomplishments, some of which are highlighted in the enclosed submission. We encourage the Government to not to lose sight of these hard-earned strengths in the public health system in Ontario.

We are grateful for the opportunity to provide input on Public Health Modernization. We respectfully request that you continue to engage with us going forward. We value the continued transparency of this process and anticipate further communication about the next steps following these consultations.

Thank you for this opportunity to share with you the enclosed submission.

Sincerely,

Original signed by

René Lapierre
Chair, Board of Health

Encl.

cc: Board of Health, Public Health Sudbury & Districts

Public Health Modernization
Submission of Public Health Sudbury & Districts

The Board of Health for Public Health Sudbury & Districts is pleased to submit for the Ministry's and Special Advisor's consideration the Board's comments in response to the Ministry of Health November 18, 2019, Discussion Paper on Public Health Modernization and the related field consultations. Our submission is the result of extensive dialogue at the agency's management level followed by thoughtful review at the January 16, 2020, Board of Health meeting. The submission is also informed by our ongoing collaborations with our North East public health partners and with the communities we serve.

Context

Who we are

Public Health Sudbury & Districts is a progressive local public health agency committed to working with our communities to promote and protect health and to prevent disease for everyone. Our 2018–2022 Strategic Plan affirms our attention to equitable opportunities, practice excellence, meaningful relationships, and organizational commitment as we strive to achieve our vision of healthier communities for all. Our work is based on the values of humility, respect, and trust.

Board of Health

The Board of Health for Public Health Sudbury & Districts is the governing body of Public Health Sudbury & Districts. The Board of Health is comprised of municipal members (either elected officials or individuals appointed by the municipalities) and members appointed by the Lieutenant Governor in Council. The diversity of the Board of Health membership ensures geographic representation from across our vast service area in addition to broad range of interests and skills.

Service area and population

Public Health Sudbury & Districts serves 18 municipalities (17 rural and one urban) and two unorganized areas within 46 551 square kilometers. We have one main office and two additional offices in the City of Greater Sudbury, as well as four district offices in Chapleau, Espanola, Manitoulin Island, and Sudbury East. Travel time between the main office and district offices ranges from less than one hour (58 km) to up to five hours (420 km). The City of Greater Sudbury accounts for 82% of the population and 7% of the total landmass of our service area.

Of the 196 448 residents in our service area (Statistics Canada, 2016), over 24 000 people identify as Indigenous, representing 13% of the region's total population. More than 5 000 people live in one of the 13 First Nation communities that intersect with our service area. There is a high proportion of Francophone residents (26%) compared to the provincial average (4%). Ensuring that our services are offered in both official languages and are culturally appropriate is a priority.

Priority areas of focus

Public Health Sudbury & Districts strategically delivers tailored public health programs and services to ensure equal opportunities for health for all. This means that we pay particular attention to social and economic determinants of health. We are guided by research, ongoing education, and the development of innovative programs and services that are responsive to community needs. This includes of particular note, developing an Indigenous Engagement Strategy focused on building meaningful relationships with Indigenous communities in our service area; a Racial Equity Action Framework to reduce systemic racism to ensure those affected have equal opportunities for health; and a Public Mental Health Action Framework to create better mental health for all through prevention, promotion, and early intervention and referral in our community.

Overall considerations

1. The Board of Health endorses the central proposition of the Ministry of Health Discussion Paper that there is an **opportunity to transform and strengthen the role of public health as a foundational partner in improving the health of all Ontarians** and to ensure that the public health system is coordinated, resilient, and responsive to the province's evolving health needs. We strongly reinforce the key strengths as described on page two of the Discussion Paper. We particularly highlight the importance of the relationships that the public health system has with sectors outside the health care system and the role of public health as a **broker of relationships** with health care, social services, municipal governments, and other sectors to create healthier communities. These are strengths to be leveraged in the pursuit of healthier Ontarians, especially Ontarians who do not have equal opportunities for health because of social and economic disadvantage.

2. The Board of Health endorses the Statement of Principles released by the Association of Ontario Public Health Agencies (**alPHa**) in November 2019 and agrees that these are foundational for any modernization considerations.

3. The Board of Health highlights the significant work of the North East Public Health Transformation Initiative (NEPHTI) and in particular, the lessons learned throughout the process. NEPHTI was developed in response to the April 2019 provincial budget announcement of the creation of one North East (NE) regional public health entity. Under the leadership of the five NE Medical Officers of Health, NEPHTI brought together management from all five NE boards of health[1] to develop recommendations aligned with the budget announcement. **While the creation of one regional**

[1] Algoma Public Health, North Bay Parry Sound Health Unit, Porcupine Health Unit, Public Health Sudbury & Districts, and Timiskaming Health Unit.

public health entity in the NE is not the Board of Health's recommended direction, there are important lessons from this collective work across the NE that are relevant to the current consultations. These lessons include the following:

a. **Systematically improving collaboration** across the local public health agencies in the region is essential to achieve enhanced sector capacity, effectiveness, and efficiency in the NE.
b. The **values**[2] and **operating principles**[3] developed for NEPHTI are relevant to the current consultations and the Board endorses these for this purpose.
c. The determination of **regional versus local public health functions** as undertaken by NEPHTI is relevant to the current consultations, including, overall:
    i. The public health **programs and services**, as described the the Ontario Public Health Standards (OPHS) *Program Standards,* are largely **local functions** that would benefit from some regional coordination; this includes consideration of local implementation based on specific community needs, with supports at a regional level.
    ii. The **corporate services and foundational standards work**, are largely **regional functions** requiring local implementation.
d. A critical element to ensure effective collaboration and implementation of local and regional functions – as described in c(ii) – across multiple organizations is the establishment of **new and mandated structures and related processes and accountabilities**.[4]

4. The Board of Health acknowledges that the four challenges described in the Discussion Paper are issues impacting the provincial public health system. However, the Board of Health also observes that Public Health Sudbury & Districts has made a number of strategic investments over many years to mitigate the impacts of these system challenges on our organization and communities. The result is the maintenance of critical capacity, including capacity for innovation to respond to emerging issues, at the local level. Examples include strategic budget decisions to maintain capacity post-SARS and beyond; commitment to teaching health unit principles post-dissolution of the provincial Public Health Research, Education and Development (PHRED) program; embracing intersectoral collaboration to advance critical issues such as climate change and built environment, mental health

[2] Values: The best interests of the health of the people of NE Ontario guide all decisions; Current NE public health unit staff are valued and respected; We are stronger together than apart and united in our commitment to collaboration

[3] Operating Principles: Public health budgets are protected or ring-fenced from health care budgets; Local flexibility for programming based on needs occurs at the local service delivery areas; Connection to local communities is essential for effective public health actions; A balance in long- and short-term investments, i.e. between health protection/disease protection and health promotion, is maintained; Innovation balanced with evidence-informed practice is critical to an effective future state for the NE

[4] Should there be implementation of public health functions across multiple organizations, new and mandated structures would be required to ensure success. Such structures would need to be supported by related processes and accountabilities. Previous work can inform exploration of potential models. For example, a "hub-and-spoke" model was proposed in the 2007 *Final Report on Knowledge to Action (K2A): Building a Stronger System of Workforce Development, Applied Research, and Knowledge Exchange for Public Health in Ontario*; wherein regional geographic-based hubs and topic-specific nodes were recommended to support foundational standards and shore up access to specialist knowledge. Structures to support accountability could include regional councils, ensuring oversight and governance alignment. The Ontario Health Team deliberations include collaborative governance approaches with supportive structures such as steering committees and action teams.

and addictions, opioids and substance use, the potential for primary care to prevent disease prevention/promote health, and Indigenous engagement.

The Board of Health strongly cautions against the erosion of these critical investments within the context of public health modernization. As evidenced by the evolution of recent issues demanding effective public health responses – from the novel coronavirus to the opioid crisis; from the steep uptick in mental health issues to the unabated epidemic of obesity; from the acceleration of climate impacts on health to hospitals overcrowded with aging patients facing multiple preventable chronic diseases – Ontario requires a strong public health system to respond to the multiple and increasingly complex issues affecting health. Public health modernization must serve to strengthen the public health system as part of a comprehensive approach to health in Ontario; it certainly cannot result in erosion of capacity.

5. The Board of Health not only cautions against erosion but also asserts that the province should itself make strategic investments in this critical part of the health system. Public health aims to prevent illness, ultimately improving people's health, quality of life, and productivity, in addition to reducing their need for expensive care.

   The Government priority of ending hallway health care will not be successful without a robust public health system. In a recent report by Cancer Care Ontario (CCO) and Public Health Ontario (PHO), the estimated annual direct health care costs in Ontario are $10.5 billion per year, compared to only $192 million invested in chronic disease prevention in 2016/17.[5] Investments in public health on upstream efforts, grounded in a population health approach, can influence the leading causes of death in Ontario and help end hallway health care.

   The ability to carry out this important mandate must not be contingent on local municipalities' abilties to pay. The Board of Health recognizes that local municipalities are approaching financial limits, jeopardizing system sustainability. Significant changes in provincial funding must be implemented in order for Ontarians (and residents of the Board's jurisdiction) to continue to benefit from critical public health programs and services.

6. The Board of Health highlights the uniqueness of the context, geography, and demographics within our jurisdiction and Northern Ontario which impacts public health needs, service provision, and resources. Our service area is vast and dispersed geographically, with the largest proportion of the population in the City of Greater Sudbury and a small proportion of the population in more rural settings. Delivering quality public health services in such contexts is challenging, particularly when combined with increasing demands and diminshing capacity in other sectors whose work also affects health opportunities (e.g. social services, housing, transportation, acute and long-term care, mental health supports, employment supports, etc.). Many of our communities have resource-based economies with corresponding instabilities in employment and tax base. Responding appropriately to the needs of area Francophone and Indigenous populations is also a critical consideration. It is essential that deliberations on public health modernization factor in geographic, cultural, economic, and other characteristics versus a "one-size fits all" approach applied to future recommendations.

[5] Cancer Care Ontario and Ontario Agency for Health Protection and Promotion (2019, July). The burden of chronic diseases in Ontario: key estimates to support efforts in prevention. Toronto: Queen's Printer for Ontario.

7. The Board of Health urges the province to carefully consider the system disruption and related opportunity costs associated with significant changes to the public health system. While the Board of Health concurs with the Discussion Paper that improvements can be made to the public health system, it is very cognizant of the substantial distraction and staff insecurity that can result. Our Board of Health's response to the 2019 budget announcement included a heavy investment of leadership time. The announcement generated challenges in staff recruitment and retention related to budget and employment insecurity. The Board of Health believes that there is a careful balance to be struck between the benefits of change and the costs – calculated in terms of productivity and human costs – of such change. This balance needs to be carefully considered prior to any announcements. The aim must be to maximize overall system gains while minimizing service disruption and warding against any reduction in our ability to respond to urgent issues as noted above.

8. The Board of Health appreciates the opportunity to engage in this important consultation process. We were pleased to participate in the face-to-face consultation held in North Bay in January 2020, and to submit our specific comments in this document. The Board anticipates ongoing involvement and respectfully requests opportunities to further engage as the Ministry's deliberations progress and decision-making milestones are approached.

Discussion paper questions

Insufficient Capacity

a) What is currently working well in the public health sector?

Overall, many areas in public health are working well: local governance, local response to needs and capacities, partnerships/collaborations, and the work within the OPHS Foundational Standards. More specifically:

- The ability of public health, throughout, Ontario to respond to local needs and capacities and ensure programs and services are relevant and effective.
- The ability to build and leverage local partnerships to achieve common health aims, including partnerships with the education sector.
- The fact that there are board governance bodies that involve locally elected officials and local citizens who are from the communities we serve.
- Recognition of, and value for, evidence-informed practice, planning, and evaluation.
- Investment in population health assessment, data analysis, and epidemiological skills.
- Emphasis on ongoing professional practice and development.
- Regional/provincial collaborations (networks, research groups, strategy development, etc.), including strengthened research through Locally Driven Collaborative Projects.
- The ability to collaborate using both formal and informal communication networks.

b) What are some changes that could be considered to address the variability in capacity in the current public health sector?

Changes to address the variability in capacity should consider opportunities for provincial support and enhancing local resources. More specifically:

- Examine how the Ministry and Public Health Ontario can support individual health units with content expertise and cross-cutting resource development.
- Determine if there are functions that could be coordinated at a regional or provincial level (programming and corporate services functions).
- Provide support to ensure adequate resources at the local level. This includes consideration of the development of recruitment supports that account for unique geographies and its impact on retention, assisting with the development of local recruitment/retention strategies, considering outreach opportunities to post-secondary institutions, especially in areas of identified need, and considering exploring return-of-service agreements for learners in identified areas.
- Explore cross-agency platforms and processes for maintaining/enhancing relationships (e.g. communities of practice, digital repositories/inventories, regional networks, etc.).
- Explore digital solutions to help bridge capacity gaps.

c) What changes to the structure and organization of public health should be considered to address these challenges?

Changes to the structure and organization of public health should consider collaboration, consolidation, and system functions. This could include:

- Identify root causes of varying capacity (e.g. recruitment challenges, inconsistent investment in capacity over time, salary and benefits, etc.).
- Support net growth rather than re-distribution of existing capacity.
- Explore “functional mergers” or enhanced collaborations to develop cross-regional (or cross provincial) teams of public health expertise serving multiple agencies (program, foundational, and corporate).
- Consider consolidation of existing health units where capacity and economies of scale are an issue.
- Explore development of a regional council with a regional budget, separate from local governance/ budget, that has specific defined responsibilities.
- Ensure that public health functions and resources are not redirected to stop-gap or support primary care functions.

Misalignment of health, social, and other services

a) What has been successful in the current system to foster collaboration among public health, the health sector, and social services?

The public health system has a long history of local relationships that successfully foster collaboration among public health, the health sector, and social services. Facilitators of this collaboration include:

- Relationships – longstanding connections and strong interpersonal relationships facilitate effective collaboration between sectors.
- Understanding of each other's mandates, priorities, capacity, strengths, and challenges, and being open to exploring how our respective mandates are more effectively achieved by working together.
- Shared goals, reciprocal benefits from engaging together, and recognizing values and respective drivers of intersectoral partners.

b) How could a modernized public health system become more connected to the health care system or social services?

A modernized public health system can become better connected through common linkages, understanding of respective roles, and common accountabilities. This could include:

- Further defining, clarifying, and understanding roles and areas for collaboration and consideration of intersection of roles. This also includes more clearly defined linkages with Ontario Health Teams/Ontario Health. This could also include expanding scope of practice, including creating new roles to cross-over between sectors, such as Health System Navigators.
- Requirements for reciprocal engagement on common priorities with jointly held accountability measures. This could include shared frameworks, goals, and mutual accountability, including cross-sector accountabilities for population health, determinants of health, health equity, and health impact assessment, recognizing "false economy" of not investing upstream in all sectors. Consideration could be given to incentivizing sectors to ensure connections are taken seriously.
- Local intersectoral connections are more effective if they are also established at the provincial level (e.g. regional council of leaders from multiple sectors mirroring provincial council of inter-ministerial leadership).
- Common geographic boundaries where possible to help make collaborations more seamless.
- Ensure adequate capacity in all sectors to mitigate the risk of each sector needing to protect its "core business" and less engaged in cross-sectoral work and innovative thinking/approaches.
- Consider secondments between sectors to enhance further understanding of one another and relationship building.
- Examine how privacy is a barrier between sectors.

c) What are some examples of effective collaborations among public health, health services and social services?

Public Health Sudbury & Districts has many examples of effective collaborations with partners in health and non-health sectors, including municipalities, school boards, and regional and provincial health and social services partners. More specifically, these include:

- Collaborations with municipalities on a number of initiatives (e.g. housing, community safety and well-being, built environment and planning, recreation, tobacco/vaping).
- Collaborations with school boards on ongoing initiatives on many issues (e.g. mental health and resiliency, sexual health, infection control and immunizations, nutrition and physical activity).
- Numerous local collaborations/partnerships in the areas of mental health, poverty reduction, substance use and misuse, family health.
- Regional collaborations and partnership in health equity and family health.
- Provincial collaborations and partnerships in a number of areas including research, population health assessment, education, mental health, and chronic disease prevention.

Duplication of Effort

a) What functions of public health units should be local and why?

Local public health functions should include board of health/governance, service and program delivery, risk assessment, municipal engagement, and emergency response.

- Governance: a local board of health ensures effective representation and understanding of social, political, and community context.
- Service Program Delivery: this includes local implementation of programming and local adaptability of programming based on local needs, community capacity, and local priorities.
- Risk assessments: these should be community based and consider social/political impact.
- Municipal engagement: this allows for engagement with the funder and strengthens both accountability requirements and the local planning function.
- Emergency response: in order to ensure timely response with consideration of local context and partnerships and familiarity with the communities, emergency response should be local.
- Some functions that could be provided regionally (with some local linkages) include:
  - Quality improvement: regional approaches with local service delivery standards;
  - Identifying and assessing local need: regional approaches with link to local context and programming;
  - Communications: regional oversight with local capacity to respond to local requests, inclusion of local context, trusted source within the community;
  - Human resource presence: consultations for management, staff;
  - Surveillance: local context/experience/interpretation.

b) What population health assessments, data, and analytics are helpful to drive local improvements?

Shared data systems would help drive local population health assessment, and data and analytic improvements. More specifically:

- Data across the system with large sample sizes and oversampling to be able to analyze for small rural communities.
- Locally relevant and specific data (e.g. Rapid Risk Factor Surveillance System).
- Overarching models and approaches for community needs assessments with population health data and local evidence (community engagement and context, political preference, etc.).
- Use of multiple data sets from various sectors.

c) What changes should the government consider to strengthen research capacity, knowledge exchange, and shared priority setting for public health in the province?

The government should consider provincial and regional coordination to strengthen research capacity, knowledge exchange, and shared priority setting for public health. This includes more specifically:

- Exploring a regional hub model that clearly defines expectations and optimizes effectiveness, efficiency and accountability, builds capacity, and sets research priorities (province-wide and region-specific), as referenced in the 2007 *Final Report on Knowledge to Action (K2Aa): Building a Stronger System of Workforce Development, Applied Research, and Knowledge Exchange for Public Health in Ontario.*
- Support and/or strengthen province-wide research and evaluation communities of practice (e.g. Ontario Public Health Evaluators Network) and create opportunities for and support the development of common tools and frameworks.
- Enhance knowledge exchange opportunities across sector (e.g. leverage opportunities for use of technology in addition to public health-specific face-to-face conferences, explore pan-national initiatives such as National Collaborating Centres) and ensure research and knowledge exchange continue to be a function of local public health.
- Fund collaborative research (e.g. PHO's Locally Driven Collaborative Project model).
- Formalize agreements with post-secondary institutions for data/research.
- Where relevant and appropriate, ensure the inclusion of Indigenous and First Nations peoples in planning processes at inception.

d) What are public health functions, programs or services that could be strengthened if coordinated or provided at the provincial level? Or by Public Health Ontario?

Some public health functions and services could be strengthened if coordinated or provided at the provincial level; and it should be noted that some of these functions could also be coordinated or provided at a regional level depending on how public health is organized. These functions include:

- Data functions, such as interpretation of provincial/national trends in health status and risk behaviours (upstream and downstream), enhanced provincial public health data and evidence repository and provincial reporting systems, legal framework for data access, collection and management.
- Evidence functions, such as best practice evidence reviews, platform for knowledge exchange.
- Support services such as research ethics reviews and library support (both of which are currently provided to some public health units), as well as communities of practice such as the French-language public health services Community of Practice.
- Support for policy and program development and advice, consultation, and policy interpretation.
- Workforce development functions, including continued education, professional development, student placement coordination/clearing house, guidelines for succession planning, support for human resources/labour relations issues, market reviews, development of consistent job titles and role descriptions, workplace well-being initiatives, orientation module development (e.g. Accessibility for Ontarians with Disabilities Act – AODA).
- Emergency preparedness supports such as guidance documents and guidelines, frameworks, system resources, to support local emergency preparedness efforts.
- Support for administrative and technology functions where provincial consistency makes sense or generates efficiencies. Examples to explore could include a shared benefits provider, shared inspection software and report generation, case management system, calibration systems; standardized client health databases and client appointment booking systems; coordinated functions, such as bulk buying; centralized/one-system operation centre for network administration.

e) Beyond what currently exists, are there other technology solutions that can help to improve public health programs and services and strengthen the public health system?

A variety of other structural and infrastructure systems could help improve public health programs and services and strengthen the public health system. These include:

- Information technology: inter-operability structures, meeting platforms, IT infrastructure, telemedicine for client assessments, web content/web content management systems, and social media management systems can improve public health programs and services and strengthen public health systems.

- Research: data management systems, research infrastructure, access to databases, software licenses, and platforms could strengthen the public health system.
- Labour relations: a provincial information portal with salaries, collective agreements, and benefits can strengthen the public health system.

Inconsistent priority setting

a) What processes and structures are currently in place that promote shared priority setting across public health units?

Many processes and structures are in place that promote shared priority setting. These include:

- Evidence-informed decision-making tools that ensure local need is one of the defining parameters.
- OPHS requirement to assess and develop programs of public health interventions – priorities themselves may be different but criteria to establish are similar.
- Provincial funding at 100% for provincial priorities (e.g. seniors' dental).
- PHO's Locally Driven Collaborative Projects with province-wide research priorities.
- Networks and working groups, at all levels, that identify common issues for collaborative action.

b) What should the role of Public Health Ontario be in informing and coordinating provincial priorities?

Public Health Ontario should have a role to support local priority setting, knowledge exchange, and research. More specifically, support could include:

- Consistent frameworks, infrastructure, and facilitation to support local and regional priority setting and shared processes for setting priorities while respecting local needs.
- Shared mechanism for knowledge exchange between local public health units.
- Support for the coordination of data and the synthesis of best practice evidence.

c) What models of leadership and governance can promote consistent priority setting?

Various models could be considered to support consistent priority setting. These include:

- Autonomous skill-based boards of health with singular leadership (i.e. MOH/CEO model) reporting to the board.
- Representation at governance level from funders (municipal and provincial), balanced with competency-based representatives to address potential inherent conflicts.

- Regional councils with specific accountabilities to the province, in addition to board of health-specific accountabilities.
- Competency-based leadership within public health units, representing public health multi-disciplinary practice.

Indigenous and First Nation communities

a) What has been successful in the current system to foster collaboration among public health and Indigenous communities and organizations?

Building local, respectful relationships paired with public health unit actions have helped foster collaboration with Indigenous First Nation communities. There are a number of facilitators to this ongoing relationship development, including:

- Taking the time to develop respectful local relationships with Indigenous Peoples and communities and practicing the principles of respect, trust, self-determination, and commitment in engagement activities. This includes informing our work through Indigenous community voices and seeking Indigenous community guidance (e.g. Indigenous advisory committee).
- Strengthening capacity for a culturally safe workforce through ongoing staff training.
- Commitment to a path forward for working with area Indigenous Peoples and communities (e.g. Public Health Sudbury & Districts Indigenous Engagement Strategy: Finding our Path Together).
- OPHS requirement for work in this area.
- Collaboration between Northeast public health units with inclusion from an Indigenous Circle and First Nations representatives to identify mutually beneficial, respectful, and effective principles and practices of engagement.

b) Are there opportunities to strengthen Indigenous representation and decision-making within the public health sector?

Opportunities to strengthen Indigenous representation and decision-making should include meaningful dialogue, representation, and participation. More specifically:

- Meaningful dialogue at a nation-to-nation level regarding jurisdictional issues and regarding funding.
- Requirement for meaningful Indigenous representation on boards of health if the same is supported by local communities.
- Requirement for external Indigenous advisory committee for boards of health if the same is supported by local communities.

Francophone communities

a) What has been successful in the current system in considering the needs of Francophone populations in planning, delivery, and evaluation of public health programs and services?

The availability of French-language services, local relationships, and demographic data have been successful in considering the needs of Francophone populations in planning, delivery, and evaluation of public health programs and services. More specifically:

- The implementation of active offer of French-language services within our agency, including reference to such services in local Client Service Standards and a financial commitment to translation of materials and resources have been a demonstration of our agency commitment to serving the needs of the Francophone community. This work is supported by a Francophone Advisory Committee which helps support capacity and skill development.
- The provincial French-language public health services Community of Practice has provided support to our agency and the public health system in Ontario for the provision of services in French.
- Locally, strong relationships with the Francophone community, particularly in the school system and with post-secondary institutions, has supported our ability to delivery services in French.
- Demographic data on Francophone populations (when available) assists our agency with planning and priority setting for this community. Additional data on language would further enhance this work.

b) What improvements could be made to public health service delivery in French to Francophone communities?

Policy, practices, and resources could improve public health service delivery in French to Francophone communities. These include:

- Designated Francophone representation on boards of health.
- Exploring and ensuring further clarity about the application of the French Language Services Act.
- Financial support for translation and training/competency building and supports for recruitment of bilingual candidates and training of personnel.
- Expansion of/further support for French-language public health services Community of Practice
- Locally, need for enhanced communication with Francophone communities about needs, and increased engagement with new French-speaking immigrants, including service delivery, and consider intersectionality with other racialized populations.
- Locally, institute a designated point-person for complaints, comments, and questions within public health units and improve service delivery by aligning Francophone service expectations in all sectors.

Learning from past reports

a) What improvements to the structure and organization of public health should be considered to address these challenges?

The structure and organization of public health should consider funding, capacity, infrastructure, a common identity, and provincial priorities. Specifically:

- Funding: adequate and sustainable funding to support population health and long-term gains, including supporting the government priority of ending hallway medicine. This includes consideration of economies of scale and restructuring, while also maintaining adequate levels of public health service at the local level.
- Capacity: consideration of strategies to ensure surge capacity within public health across the province, particularly to support response to emerging trends and emergencies.
- Infrastructure: modernization of the infrastructure supports to public health, including physical structure and information technology.
- Strengthened common identity for public health.
- Provincial priorities: increased focus on prevention at the population health level by Ontario Health and other areas of the health care sector. This includes emphasis on evidence-informed decision-making based on population level need and impact.

b) What about the current public health system should be retained as the sector is modernized?

The current public health system should leverage strengths, retain autonomous boards of health, balance funding, retain the OPHS, and retain local program delivery with a multidisciplinary focus. This includes:

- Autonomous boards of health with singular MOH/CEO leadership reporting to the board of health.
- Continued balance of provincial and municipal funding contributions, with consideration of long-term financial sustainability. Ensure funding to public health is kept separate from funding to health care to avoid the risk of erosion of investments in upstream efforts.
- The Ontario Public Health Standards (OPHS), including focus on priority populations. Overall work of public health should include continued focus on population health, health equity, and upstream approaches, and on promotion, prevention, and protection. Work of public health should be informed by evidence of need and impact and consider community and stakeholder engagement.
- Local program delivery, connections and relationships, including meaningful links to municipalities.
- Multidisciplinary leadership and workforce, and supports for workforce development.
- Leverage the strengths in current capacity and ensure it is not weakened as system capacity issues are addressed (i.e. re-allocations).
- Exclusion of commercial interests.

c) What else should be considered as the public health sector is modernized?

Other considerations as the public health sector is modernized should include the exploration of synergies and expanded disciplines, along with continued communication and consultation, continued local decision-making, and continued financial support. This includes:

- Continued communication and consultation with local public health units throughout the process is critical.
- Continued support for local decision-making and discretion in the delivery of public health services is essential.
- Financial support for responsive municipal engagement.
- Exploration of synergies with other ministries for supporting public health mandate and consideration of the development of provincial advisory bodies before launching new initiatives to ensure local context during planning/implementation.
- Consideration of expanded disciplines in public health, including social work, to support the ever-changing face of public health work.

KFL&A Public Health

January 28, 2020

VIA: Electronic Mail (Patty.Hajdu@parl.gc.ca)

Honourable Patty Hajdu
Minister of Health, Canada
House of Commons
Ottawa, ON K1A 0A6

Dear Minister Hajdu:

RE: Monitoring of food insecurity and food affordability

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its January 22, 2020 meeting:

THAT the KFL&A Board of Health recommend that the Federal Government

- **commit to annual local measurement of food insecurity in all the provinces and territories by making the Household Food Security Survey Module a core module in the Canadian Community Health Survey, and**
- **update the foods included in the National Nutritious Food Basket to reflect recommendations in the 2019 Canada's Food Guide and develop a national food costing protocol.**

FURTHER THAT a copy of this letter be forwarded to:

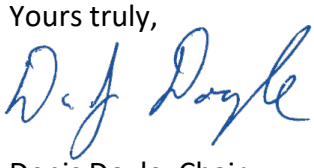
1) **Honourable Christine Elliott, Minister of Health, Ontario**
2) **Honourable Navdeep Bains, Minister of Innovation, Science and Industry**
3) **Mark Gerretsen, MP Kingston and the Islands**
4) **Scott Reid, MP Lanark-Frontenac Kingston**
5) **Derek Sloan, MP Hastings-Lennox and Addington**
6) **Ian Arthur, MPP Kingston and the Islands**
7) **Randy Hillier, MPP Lanark-Frontenac-Kingston**
8) **Daryl Kramp, MPP Hastings-Lennox and Addington**
9) **Loretta Ryan, Association of Local Public Health Agencies**
10) **Ontario Boards of Health**
11) **Mary Ellen Prange, The Ontario Dietitians in Public Health**
12) **Kim Loupos, The Ontario Dietitians in Public Health**

Monitoring food insecurity and food affordability supports KFL&A Public Health in assessing trends over time, identifying community needs and priority populations, supporting and promoting access to safe and healthy food, and informing healthy public policy. Requiring the Household Food Security Survey Module as mandatory rather than optional for provinces and territories would facilitate effective and consistent food affordability surveillance and monitoring.

KFL&A Public Health completes the Ontario Nutritious Food Basket survey tool annually to monitor the cost of healthy food in KFL&A. The National Nutritious Food Basket which serves as the basis for the Ontario Nutritious Food Basket survey tool was last updated using the 2007 Canada's Food Guide. KFL&A Public Health recommends that the Federal Government take leadership in developing a national protocol that would accompany the National Nutritious Food Basket to ensure consistency in monitoring food costing across Canada.

The consistent, systematic and relevant measurement of food insecurity is foundational for measuring and surveilling food insecurity in Canada.

Yours truly,



Denis Doyle, Chair
KFL&A Board of Health

Copy to: Hon. C. Elliott, Minister of Health, Ontario
Hon. N. Bains, Minister of Innovation, Science and Industry
M. Gerretsen, MP Kingston and the Islands
S. Reid, MP Lanark-Frontenac Kingston
D. Sloan, MP Hastings-Lennox and Addington
I. Arthur, MPP Kingston and the Islands
R. Hillier, MPP Lanark-Frontenac-Kingston
D. Kramp, MPP Hastings-Lennox and Addington
L. Ryan, Association of Local Public Health Agencies
Ontario Boards of Health
M. E. Prange, The Ontario Dietitians in Public Health
Kim Loupos, The Ontario Dietitians in Public Health

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January 29, 2020

The Honourable Caroline Mulroney
Minister of Transportation
Sent via e-mail: minister.mto@ontario.ca

The Honourable Christine Elliott
Minister of Health
Sent via e-mail: christine.elliott@ontario.ca

Dear Honourable Ministers,

Re: Off Road Vehicles (ORV) and Bills 107 and 132

Peterborough Public Health (PPH) is mandated by the Ontario Public Health Standards and the Health Promotion and Protection Act to deliver public health programs and services that promote and protect the health of Peterborough City and County residents.[1] One of our stated goals is to reduce the burden of preventable injuries, where road safety is an important factor. Given the Provincial Government's recent passing of Bills 107 and 132, we anticipate changes to Ontario Regulation 316/03 are being drafted and wish to express several concerns and propose recommendations to consider. For the purpose of this letter, the term ORV is inclusive of all-terrain vehicles (ATVs), side-by-side ATVs, utility-terrain vehicles, and off-road motorcycles (i.e., dirt bikes), and does not include snowmobiles.

The popularity of ORVs has greatly increased over the last 30 years and with increased use, ORV-related injuries and deaths have also risen.[2,3] In Canada in 2010 there were 435 ORV users seriously injured and 103 ORV-related fatalities. This compares to 149 seriously injured users in 1995 and 45 fatalities in 1990.[2] These statistics are based on police reported data and medical examiner files. Hospital records are another source of data where Emergency Department (ED) visits, hospitalizations, and deaths may be identified to be caused by an ORV injury. In Ontario in 2015 to 2016, there were over 11,000 ORV-related ED visits and over 1,000 ORV-related hospitalizations.[4] There have been between 29 and 52 fatalities each year relating to ORV or snowmobile use from 2005 to 2012.[4] The most affected demographic group has been males aged 16-25.[2,4] Rollovers, falling off the vehicle, and ejection are the most commonly cited mechanisms for ORV injury.[4] The most common cause of death is due to head and neck injuries.[4]

ORV-related incidents are classified according to whether they occur on roadways ("traffic") or off-roadways ("non-traffic"). Research indicates that there are higher rates of fatalities and serious injuries for ORV riders on roadways compared to off-roadways.[5,6,7] Riding on roadways increases the risk of collisions with other motor vehicles.[5,8,9] Also, design characteristics of certain classes of ORVs make them unsafe on roadways.[5,10,11] Indeed, across the border in 2007 it was found that 65% of ATV rider deaths occurred on roads. There was also a greater increase in on-road than off-road deaths between 1998 and 2007, which coincided with more states increasing legal ATV access to roads in some way.[11]

Some of the associated risk factors related to ORVs used in Ontario include alcohol and drug use, riding at night, lack of helmet use, and excessive speed.[4,12] It has been found that the majority of ORV-related ED visits occur on the weekend (Friday to Sunday), and almost all are related to recreational use of ORVs.[4]

With these factors in mind, in revision of O. Reg 316/03, we recommend the following in PART III:

- Equipment requirements:
    - Maintain current* contents of section, ensuring content is up-to-date and is applicable to all classes of ORVs that will be permitted on roads.
- Operation requirements:
    - Maintain current* contents of section and requirements. Specifically:
        - Requiring the driver to hold a valid driver's licence, with restrictions on number of passengers at night for novice young drivers;
        - Requiring all riders to wear an approved helmet; and
        - Setting maximum speed limits of 20 kilometres per hour, if the roads speed limit is not greater than 50 kilometres per hour, and 50 kilometres per hour, if the roads speed limit is greater than 50 kilometres per hour.
    - Under "Driver's licence conditions", include the condition that the blood alcohol concentration level of young or novice drivers be zero, as per the Highway Traffic Act (2019).

Finally, we encourage the Ministry of Transportation and the Ministry of Health to establish an effective communication strategy to educate all road users about forthcoming changes to ORV road-use laws, as well as to communicate the risks of riding ORVs on roads.

In summary, ORV-related accidents continue to be a significant cause of injury, with on roadway accidents resulting in higher proportions of severe injury (hospitalization) and fatalities than off roadway accidents. We appreciate your consideration of the safety implications of on-road ORV use as you revise O. Reg. 316/03.

If you have any questions or would like additional information about our comments, please contact Deanna Leahy, Health Promoter, at 705-743-1000 ext. 354, dleahy@peterboroughpublichealth.ca.

Sincerely,

Original signed by

Mayor Andy Mitchell
Chair, Board of Health

cc: The Hon. Doug Ford, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health
Local MPPs
Opposition Health Critics
The Association of Local Public Health Agencies
Ontario Boards of Health

**"current" refers to O. Reg. 316/03: Operation of off-road vehicles on highways, dated January 1, 2018*

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alPHa
Association of Local PUBLIC HEALTH Agencies

Information Break

January 22, 2020

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

Update on Public Health Modernization

Thank you to the health units that sent in their responses to the provincial discussion paper on public health modernization to alPHa. As previously announced, the Association is collating this information to develop a formal response to the Ministry of Health consultation on public health modernization. alPHa's response will reflect the common themes and top priorities identified by the local public health sector. It is not intended to replace, but will be in addition to the individual submissions by health units, who are encouraged to share their feedback directly with the Ministry.

A copy of the finalized alPHa submission will be circulated when it becomes available within the next two weeks. Please stay tuned.
Visit alPHa's Public Health Modernization web page
Go to the Ministry of Health's public health consultations website

This week, members and alPHa staff attended the annual conference of the Rural Ontario Municipal Association (ROMA) where Ministry officials provided an update on the consultations on public health modernization and emergency health services. Click the link below to learn more.
Download the Ministry of Health update on consultations at ROMA

On January 17, Dr. Eileen de Villa, alPHa Vice President, made a deputation before the Standing Committee on Finance and Economic Affairs in pre-budget hearings.
Read Dr. de Villa's speaking notes and the Committee transcript

Registration Open for Winter 2020 Symposium & Section Meetings

Registration is now open for alPHa's Winter 2020 Symposium and Section Meetings. These events will be held respectively on February 20 and 21 at the Central YMCA in downtown Toronto. A great program has been planned, including a leadership workshop led by Tim Arnold of Leaders for Leaders and a consultation session with Ministry of Health representatives on public health modernization, among other sessions. Members are advised to book their hotel accommodations now, if they haven't already, at nearby hotels listed on the event page (click link below).
Register here to attend
Visit the Winter 2020 Symposium & Section Meetings page

Members' Corner

Digital Health Update (submitted by Peel Public Health)

The COMOH Digital Health Steering Committee is preparing a response to the Ministry's consultation on Public Health Modernization, which will speak to the following recommendations:

That the province:

- Together with the input of public health units, lead and resource the development and implementation of a province-wide digital public health strategy.
- Strategically invest in the deployment of common digital services and interoperable applications across all pertinent areas of the public health system.
- Prioritize the development of common data standards and terminology and deploy interoperable systems to realize the full benefits and return on investment of digital connectivity, such as integration of public health data with the provincial Electronic Health Record, OLIS and iPHIS, primary care EMR with the DHIR, workflow efficiencies and improved data quality.
- Ensure legislative and policy changes in digital health includes the priorities and approaches of local public health agencies.

For strength in numbers, we kindly request that alPHa member agencies consider also including these important digital recommendations in your own responses to the consultation. These responses will also be incorporated into alPHa's and COMOH section's overall response to the consultation as well.

Please also stay tuned for information on how to register for a pre-TOPHC workshop on the afternoon of March 24. To be hosted by Public Health Ontario, this event will explore opportunities for improved data governance and developing a province-wide digital strategy for Ontario's public health sector.

Resource on Healthy Built Environments in Ontario - Planning for Health (submitted by Simcoe Muskoka District Health Unit)

Communities designed to improve health are also well designed to mitigate and adapt to climate change. Compact, complete, connected and green communities reduce our collective footprint while making us healthier by increasing walking, cycling and public transit. They can also incorporate features that reduce heat and better withstand adverse weather.

On January 16, Simcoe Muskoka District Health Units released website-based reports on promising practices for the promotion of healthy community design. These were the result of a Locally Driven Collaborative Projection (LDCP) hosted by Public Health Ontario, and overseen by a steering committee with representation from a large number of Ontario health units and other organizations. The study included participation by 32 of Ontario's 35 health units.

Government News Roundup

Council of CMOHs highlights increasing e-cigarette use among Canadian youth - 2020/01/22

Minister of Health speaks at Rural Ontario Municipal Association's conference - 2020/01/20

Council of CMOHs makes statement on sale of new cannabis products entering market - 2020/01/06

Ontario releases Minister's Annual Report on Drinking Water 2019 and 2018-2019 Chief Drinking Water Inspector Annual Report - 2019/12/20

Federal government proposes e-cigarette advertising ban to address rising use among youth - 2019/12/19

Chief Public Health Officer releases 2019 annual report, Addressing Stigma: Towards a More Inclusive Health System - 2019/12/18

Federal health minister makes statement on sale of new cannabis products - 2019/12/17

Ontario launches new public consultation on poverty reduction strategy - 2019/12/16

Prime Minister releases new mandate letters for ministers - 2019/12/13

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alPHa's New Address

In case you missed the announcement, alPHa relocated its office in December to 480 University Avenue, Suite 300, Toronto ON M5G 1V2. E-mails and phone numbers remain the same; however, our extensions are now three digits --a '2' has been added to the beginning of our previous extensions. Please update your records accordingly.

Upcoming Events - Mark your calendars!

Winter 2020 Symposium/Section Meetings - February 20 & 21, 2020, Central YMCA, 20 Grosvenor St., Toronto. Register **here** before the February 13 deadline. View the draft program.

The Ontario Public Health Convention (TOPHC) 2020 - March 25-27, 2020; Beanfield Centre, 105 Princes' Blvd., Toronto. Register here. Early bird registration ends February 12, 2020.

June 2020 Annual General Meeting & Conference - June 7-9, 2020, Chestnut Conference Centre, 89 Chestnut St., Toronto. View the notice and calls.

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

Information Break

February 3, 2020

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

Update on Public Health Modernization

On January 30, alPHa submitted its response to the Ministry of Health's discussion paper on public health modernization and shared a copy with all health units afterward. The submission followed a teleconference held the previous day between the alPHa Board of Directors and Ministry of Health representatives that included Jim Pine, Special Advisor. Mr. Pine updated the board on feedback received to date from stakeholders since the release of the discussion paper. He also noted that while several in-person

consultations with stakeholders have been completed to date, others will be taking place in different regions over the next month or so. He further indicated that the February 10 cutoff to respond to the consultation paper is no longer a fixed deadline.
Download alPHa's response on public health modernization
Go to the Ministry of Health's public health consultations website

alPHa invites health units and their boards to share their submissions to the provincial discussion paper with us by emailing them to Gordon Fleming at gordon@alphaweb.org. These will be uploaded to alPHa's dedicated resource page on public health modernization (link below), which contains announcements, responses and updates on related matters.
Visit alPHa's Public Health Modernization resource web page

Novel Coronavirus

As part of the collective effort to communicate timely information about novel coronavirus (2019-nCoV), alPHa is attending daily ministry-led briefings and sending daily situation reports from the Ministry of Health to update health units on this emerging issue. COMOH members are monitoring the situation closely and, through the COMOH Chair, are in frequent contact with provincial officials, including Chief Medical Officer of Health Dr. David Williams, to ensure the health and well-being of the public. For convenience, alPHa has provided links to the Ministry's dedicated website and others on its home page and below.
Go to the Ministry of Health's novel coronavirus website
Visit the Ministry's page for health professionals here
Go to Public Health Ontario's novel coronavirus website
Visit the Government of Canada's website on novel coronavirus

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Winter 2020 Symposium & Section Meetings

alPHa looks forward to members' participation at the upcoming Winter 2020 Symposium and Section Meetings on February 20 and 21 at the Central YMCA in downtown Toronto. The not-to-miss program includes a leadership workshop led by Tim Arnold of Leaders for Leaders, a consultation session with Ministry of Health representatives on public health modernization, and an update from the Association of Municipalities of Ontario (AMO). For more information about this event, please click the link below.
Register here to attend
Visit the Winter 2020 Symposium & Section Meetings page

TOPHC 2020

Members are advised to register for TOPHC 2020 early and and book their preferred workshop as space is limited. The annual event will take place March 25-27 at the Beanfield Centre in Toronto.

Highlights include keynotes on the impact of racism on communities' health, and how persuasive technologies (apps, games) can improve health and wellness behaviours. This year's HOT TOPHC focuses on the causes and characteristics of syndemics and their effect on health. Early bird promotional pricing ends February 12, so register soon.
Learn more about TOPHC 2020 here
Register for TOPHC 2020

Public Health News Roundup

Minister Elliott lauds public health's response to coronavirus - 2020/01/31

Ontario confirms third case of novel coronavirus - 2020/01/31

World Health Organization declares novel coronavirus a global public health emergency - 2020/01/30

British Columbia reports first presumed confirmed case of novel coronavirus - 2020/01/28

Ontario briefs leaders from colleges and universities on novel coronavirus and directs public to trusted information resources - 2020/01/28

Ontario confirms second presumptive case of novel coronavirus - 2020/01/27

Ontario briefs school boards' directors of education on novel coronavirus - 2020/01/26

Toronto reports first presumptive confirmed case of novel coronavirus - 2020/01/25

Ontario confirms first case of new coronavirus - 2020/01/25

Canada announces screening measures for novel coronavirus at major airports - 2020/01/24

US Surgeon General releases first report on smoking cessation in 30 years - 2020/01/23

Ontario Minister of Health designates novel coronavirus as a reportable disease - 2020/01/22

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OPINION

A forgotten lesson of SARS: The need for public health specialists and expertise

DAVID BUTLER-JONES
CONTRIBUTED TO THE GLOBE AND MAIL
PUBLISHED 3 DAYS AGO

Dr. David Butler-Jones was Canada's first chief public health officer and deputy minister of the Public Health Agency of Canada

There are few things that focus the mind quite like the fear of contagion. With the emergence of a new coronavirus, the world is once again reminded of the outbreak of SARS in 2003.

Public-health officials and governments across the country are responding quickly and diligently to the current outbreak, applying lessons from SARS (severe acute respiratory syndrome) with better co-ordination and public information, so that appropriate action can be taken. Public-health experts involved in both SARS and the pandemic of H1N1 in 2009 are still around to reinforce the lessons. As this crisis eventually fades, we must remember the overarching lesson from SARS that seems to have been forgotten.

In spite of courageous efforts in 2003, the Canadian systems of health care and public health were not up to the challenge. These have been well documented in numerous inquiries, including the federal government review led by Dr. David Naylor, and the Ontario government review, led by Justice Archie Campbell.

The Naylor report was appropriately titled Learning from SARS, Renewing Public Health in Canada. Public health is a first order of public good for which governments are responsible, requiring co-operation and co-ordination across multiple levels, as public-health threats respect no jurisdiction, borders, socio-economic structures, religion or political perspective.

During the 1990s, as governments struggled with deficits and rapidly rising health-care costs, public-health budgets and capacity diminished in support of the short term, sacrificing long-term investments that would support greater health over all in the population and reduce risks. Recognizing this, deputy ministers across the country commissioned a review of public-health capacity.

In brief, the conclusions were that the health system was missing key opportunities to better understand what makes us healthy, promote health and well-being, reduce the burden of illness and injury, and protect against health threats, among others. And when it came to combatting major outbreaks, public health was coping, but barely. Then came SARS.

After the 2003 SARS epidemic, governments increased focus on public health, and new organizations dedicated to public-health issues and expertise, such as the Public Health Agency of Canada (PHAC) and Public Health Ontario, were formed. New capacities and investments were built upon. The agency and its development became recognized internationally for the PHAC's expertise and organization, approach to collaboration and as a model for other national or multinational public-health organizations.

In positive contrast was the management of the H1N1 pandemic in 2009, a far more severe threat to health, with millions at risk. What few realize is that the 2009 virus was just as virulent as the flu strains from 1917-18 that killed an estimated 50 million people. It disproportionately attacked the young and healthy, with rapid progression

in many to respiratory failure. Canada, with its new capacities and focus on public health, for the first time in history stopped a pandemic in the same year. Few, if any other countries could make the same claim as their ICUs continued to fill in the spring and the following winter.

Unfortunately, many governments seem to have forgotten those lessons as changes since 2014 have diminished the capacity of public health to prepare for and respond to new and inevitable threats, as well as to carry out their mandate to protect and promote health and prevent illness and injury.

There is good reason that medical specialists in public health and preventive medicine require five-plus years of postgraduate training after medical school. To understand and apply public health effectively requires expertise in everything from epidemiology and statistics, to prevention and control of disease and injury, to health policy. You also need proficiency from the management of organizations, to the complex interactions of animal and human health, the environment and economy, as well as knowledge of the biological, physical and social sciences.

Some jurisdictions have since divided public-health programs and expertise among different departments, reducing their ability to co-ordinate planning and responsiveness. Many have replaced public-health managers and analysts with generic public servants. Resources, expertise and capacity have been reduced, and expertise positioned further away from where organizational decisions are made on budget, policy, communications, programs and services and so forth.

We've seen this movie before. While many capacities in public health remain, and public health has always done remarkable things with little support, both the trend and our current state are worrying moving forward. It should not take another crisis and subsequent inquiries to remind us.

351 King Street East, Suite 1600, Toronto, ON Canada, M5A 0N1

Phillip Crawley, Publisher

OPPORTUNITIES FOR HEALTH FOR ALL

A FOCUS ON INCOME

February 2020

Public Health
Santé publique
SUDBURY & DISTRICTS

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This report is available online at www.phsd.ca.

Citation

Public Health Sudbury & Districts. (2020). *Opportunities for Health for All: A Focus on Income*. Sudbury, ON: Author.

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CONTENTS

LIST OF FIGURES

The quotes appearing in this report were shared by Circles Sudbury participants.

Circles Sudbury is a program designed to provide individuals living in poverty with social support and practical tools to transition into economic self-sufficiency through education and employment pathways. Circles helps participants assess their current resources, learn how to build on their resources and create a personal action plan based on their hopes for a prosperous future to exit poverty. Circles supports participants with service navigation, added layers of social support, and community connections. Participants are matched with one or two community volunteers who serve as Allies. Volunteers provide support through coaching, friendship, and practical and emotional support. The goal for Circles participants is to achieve economic self-sufficiency within 18–48 months of joining the program. Participants and their children, volunteers, and staff attend Circles meetings three times per month for a shared meal and programming. Support between meetings is provided to Circles participants by staff and volunteers tailored to meet the needs of each participant.
Circles Sudbury is delivered by Public Health Sudbury & Districts with support from community partners from the Partners to End Poverty Steering Committee. The introduction of the Circles Sudbury initiative was made possible through financial support from Ontario's Poverty Reduction Fund. For more information visit www.phsd.ca/change

This report is intended to help planners, leaders and everyday people use local data to inspire meaningful action.

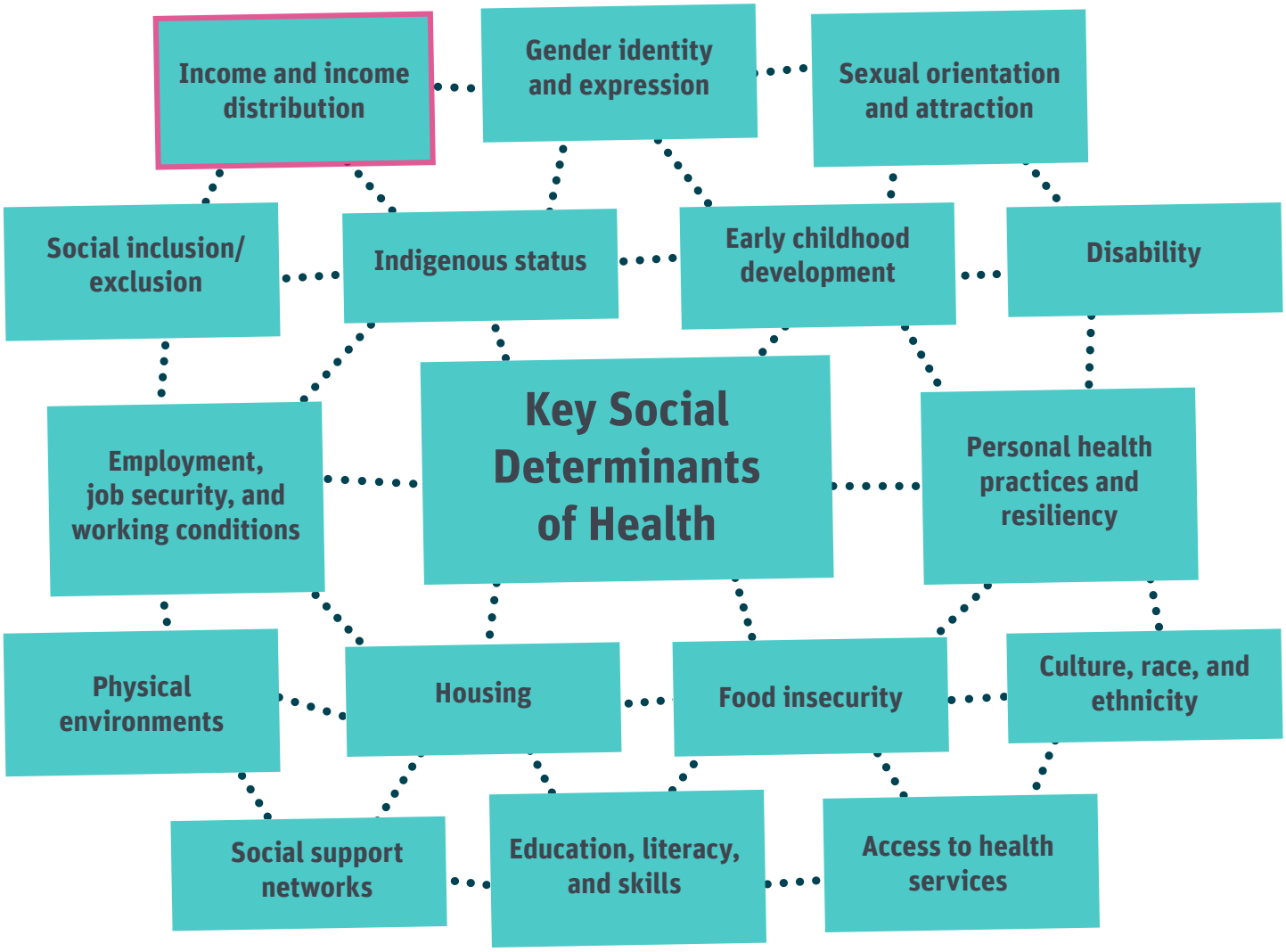
HEALTH IS MORE THAN HEALTH CARE[1]

The social and economic environments where we live, work, play, learn, and grow are critical to our health and well-being. Collectively, these factors and conditions are known as the determinants of health. The determinants of health have a powerful impact on how health is experienced and distributed in our communities. The impact of these factors on health is, in fact, more powerful than the impact of biology and access to the health care system.[2] These social factors, or determinants of health, contribute to the health experienced by individuals and by communities overall.

HEALTH INCLUDES MENTAL AND PHYSICAL HEALTH

Mental health and physical health are equally important to our overall picture of health. We can't truly be healthy without mental health. It involves how we feel, think, act, and interact with the world around us. Mental health is about realizing our potential and coping with the normal stresses of life. In other words, there is no health without mental health.[3]

Figure 1: Social Determinants of Health[4]



INCOME IS ONE OF THE STRONGEST PREDICTORS OF HEALTH

Not everyone has the same opportunities for health. Opportunities for health are largely influenced by the everyday social and economic conditions of life.[5] Most simply, we know that income alone is the single strongest predictor of health, and that health improves at every step up the income ladder.[6,7]

Income provides access to and improves experiences with nearly all other determinants of health. Adequate income removes barriers, stressors, and challenges to achieving health. On the other hand, poverty increases the risk of poor mental and physical health across the lifecourse. Lack of income reduces our ability to cope and makes healthy lifestyle choices more difficult in the face of the day-to-day challenges and crises of living in poverty.

The poorer we are, the earlier we die and the more illness and disability we experience in our lifetimes. This is a fact that is borne out locally, just as it is provincially and nationally. Despite the global evidence of the powerful link between income and health, a common response in thinking about health is to focus on what we need when we are not healthy, namely health care or illness care. This common view of health care as the key to good health is also held here locally. A survey in 2017 of residents from Sudbury and districts found that people consider health care to be more important to a person's overall physical and mental health than money.

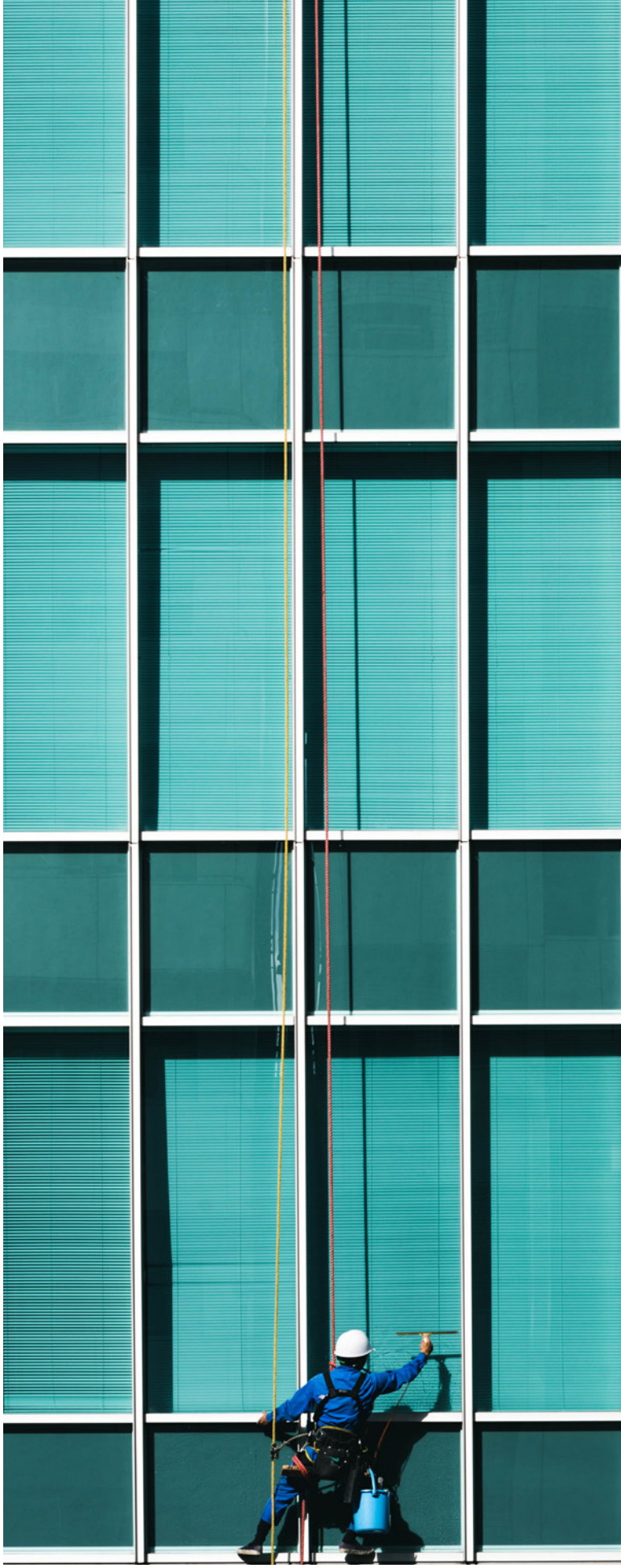
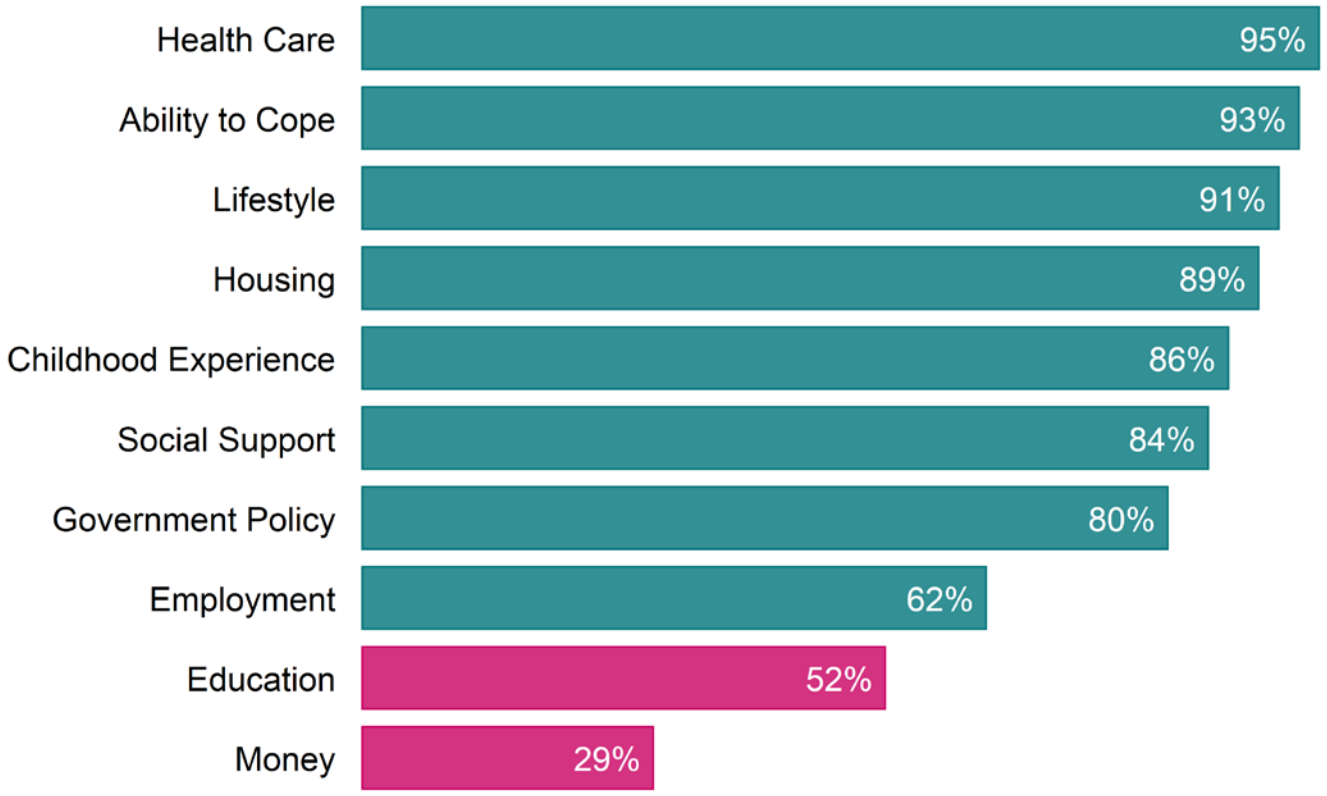


Figure 2. Social Determinants of Health Indicators by Level of Importance, Sudbury and districts, ages 16+, RRFSS 2017

Question to participants: I am going to read you a list of things that could help make a person healthy. By "healthy" we mean both a person's physical and mental health, being free from disease and pain and being satisfied with life. Please tell me if you think each of the following are extremely important, very important, somewhat important, not very important, or not at all important in helping to make a person healthy?



Focusing on health care and the immediate benefits of treating illness is a common and understandable preoccupation for many of us. Less common, is a focus and understanding of the health benefits of adequate income and the long-term personal and societal benefits of preventing illness in the first place. Of course, access to health services is essential when we are ill, but no amount of health care can prevent people from getting sick in the first place. It may not be as obvious as we think, but income is critical to the health of individuals and communities. This report uses available data to highlight some of the impacts of income on mental health, physical health, and perceived health in our region. The data show that not everyone has the same or equal opportunities for health. Our neighbours and friends with lower levels of income generally experience worse mental and physical health. Knowing all this compels us to address poverty to improve health for everyone.

INCOME IMPACTS MENTAL HEALTH

Populations living in low income are disproportionately affected by mental health problems and challenges.[8,9] Nationally, the percentage of adults reporting poor or fair self-rated mental health has been increasing among our country's poorest.[10] In Sudbury and districts, the rate of excellent or very good self-rated mental health is lowest among our community members living with the lowest level of income.

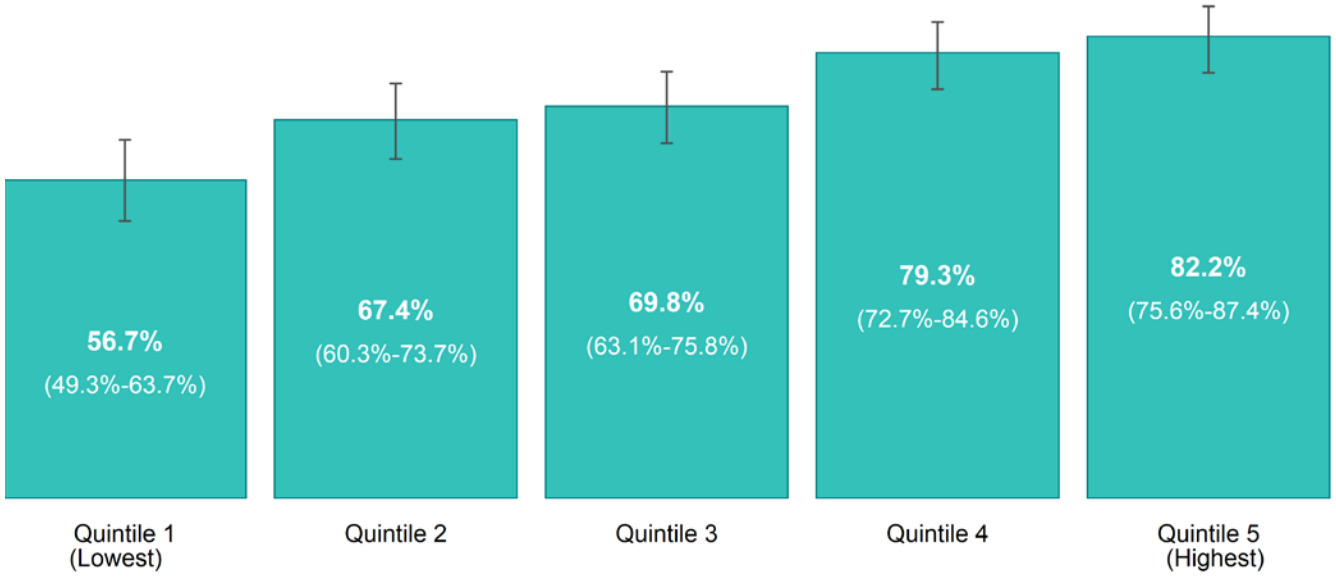
HIGHER RATES OF MENTAL ILLNESS

"I was suicidal for a long time, but wouldn't do it because I have a son, you know, I wouldn't hurt him like that."

~

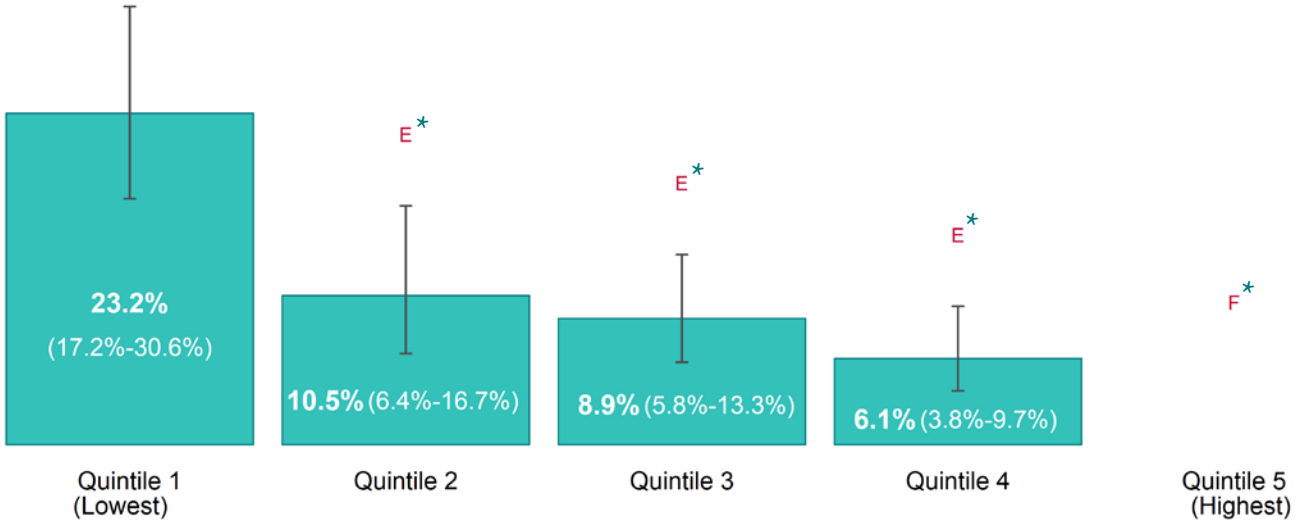
"My son passed away. I took this very hard and things went back to the way they were with me suffering from severe depression and my anxiety took over, along with PTSD."

Figure 3. Prevalence rate, self-rated mental health (excellent or very good), by year and household income, ages 12+, Sudbury and districts, 2011 to 2014



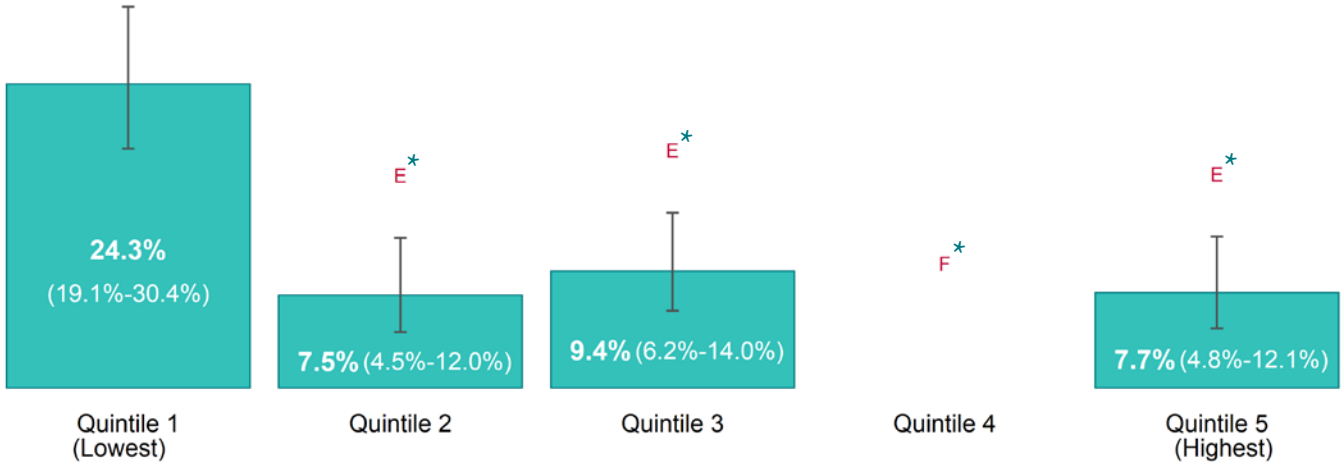
The results are similar when we narrow the focus to mental illness. In Ontario, the poorest people have higher rates of mental illness than the richest people.[11] The same is true in Sudbury and districts; mood disorders, such as depression, bipolar disorder, mania, and dysthymia, are highest among our community members living with the lowest levels of income.

Figure 4. Prevalence rate, mood disorders, by year and household income, ages 12+, Sudbury and districts, 2011 to 2014



The results for anxiety disorders are no different. Anxiety disorders, such as phobia, obsessive-compulsive disorder, and panic disorder, are also highest among our community members living with the lowest levels of income in Sudbury and districts.

Figure 5. Prevalence rate, anxiety disorders, by year and household income, ages 12+, Sudbury and districts, 2011 to 2014



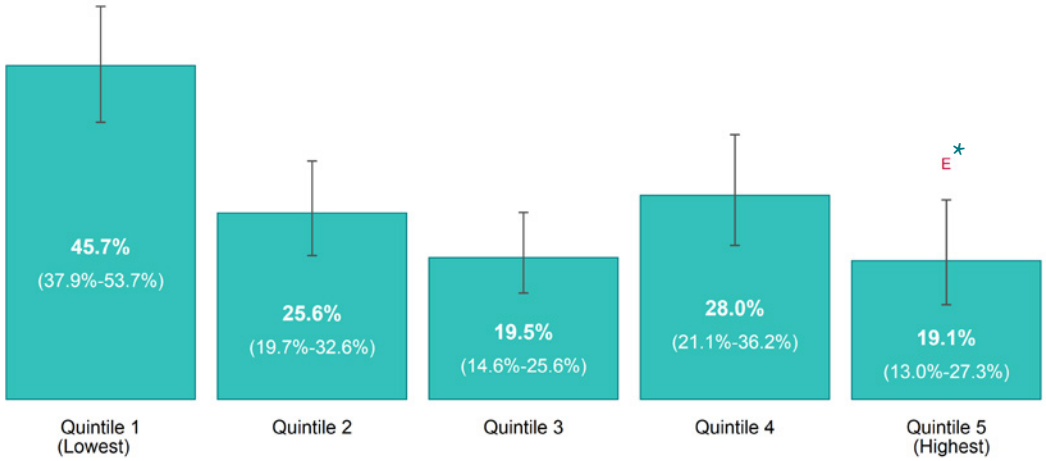
**E: Estimates marked with E should be interpreted with caution due to high margin of error.*
**F: Estimates for categories marked with F cannot be released due to an unacceptable margin of error.*

INCOME IMPACTS PHYSICAL HEALTH

We know that in Sudbury and districts, the two leading causes of death are ischemic heart disease (heart attack) and lung cancer.[12] The percentage of deaths from both diseases is higher in our communities than in Ontario.[13] Lung cancer and heart attacks both contribute to the largest number of early deaths or potential years of life lost in Sudbury and districts.[14] The most common cause of lung cancer is smoking,[15] and we also know that physical activity helps prevent chronic diseases, like heart attacks.[16]

In Ontario, smoking is more common among the poorest people (22.1%) than the richest people (14.4%).[17] Like results of previous factors thus far, these results are not unique. In Sudbury and districts, 25% of adults currently smoke, with the poorest people accounting for the highest rates and the richest people accounting for the lowest.

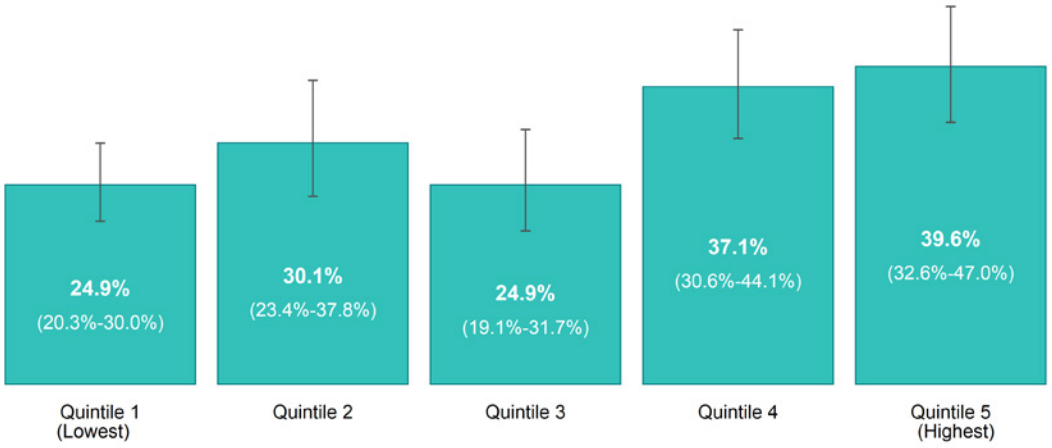
Figure 6. Prevalence rate, current smokers, by year and household income, ages 20+, Sudbury and districts, 2011 to 2014



**E: Estimates marked with E should be interpreted with caution due to high margin of error.*

Several major chronic diseases, like heart attacks, are associated with physical inactivity, yet over half (54.7%) of the province's poorest people remain more physically inactive than the richest people (32.1%).[18] In Sudbury and districts, 43% of the population is inactive. [19] The poorest households remain less physically active than the highest income households.

Figure 7. Prevalence rate, physically active individuals, by year and household income, ages 12+, Sudbury and districts, 2011 to 2014



It is well established that great opportunities for health can come from lifestyle choices such as deciding to not smoke and to exercise regularly. This is where we see again the deep interconnectedness of income and physical health. Maintaining a healthy ability to cope and to make healthy lifestyle choices can be insurmountable when faced with the day-to-day challenges of living in poverty.

Although it is a lifestyle choice, exercise can be very difficult to prioritize based on life circumstances and pressures. Also, exercise necessitates the economic costs of time and money, which are often unaffordable for people living in poverty. Prioritizing healthy lifestyle choices when living moment-by-moment in extreme material deprivation is often simply impossible. Social and economic resources make it easier to make the "healthy choice the easy choice".

HIGHER RATES OF SMOKING

"I quit for over a month and then I got really stressed out and it was something I really could not handle, and I was like I don't want to do drugs and I don't want to drink, but I'm going to start smoking again."

LESS PHYSICALLY ACTIVE

"I didn't have exercise equipment, I would just be in the house for months sometimes because of my depression and anxiety."

INCOME IMPACTS HOW WE FEEL ABOUT OUR HEALTH

With everything considered thus far, it should not be surprising that only half (49.4%) of the poorest people in the province rate their health status as excellent or very good, compared to nearly three-quarters of the richest Ontarians (72.9%).[20] The results in Sudbury and districts are similar, with fewer of the poorest households rating their health as excellent or very good, compared to the highest household income groups.

POORER SELF-RATED HEALTH

"My health has gone down so much that I've had to get dentures, from not eating properly, losing weight, all kinds of stuff."

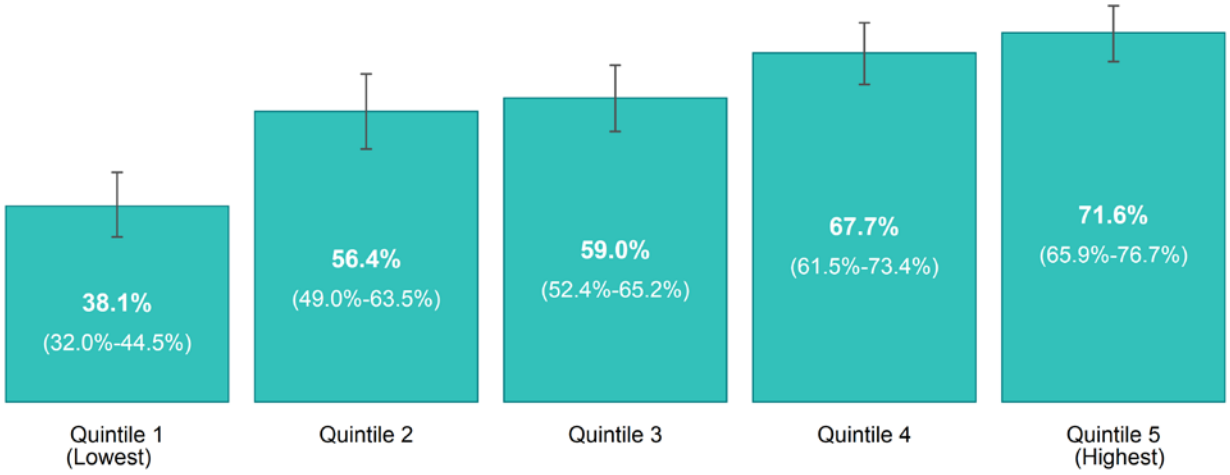
LESSER LIFE SATISFACTION

"You feel stuck, you feel like there's no hope, hope's what keeps you going."

~

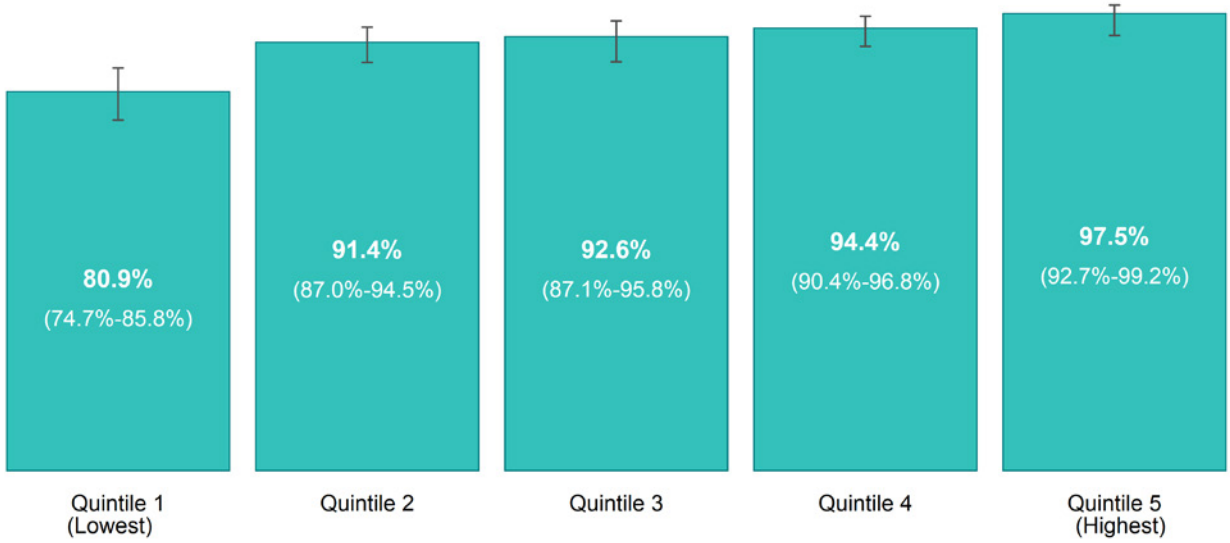
"I have my babies and I have my health...but I'd be happier if I had more money for Christmas and food in my fridge."

Figure 8. Prevalence rate, excellent or very good self-rated health, by year and household income, ages 12+, Sudbury and districts, 2011 to 2014



The lowest income households also rate their life satisfaction lower than in any of the highest income categories.

Figure 9. Prevalence rate, life satisfaction (very satisfied or satisfied), by year and household income, ages 12+, Sudbury and districts, 2011 to 2014



INCOME MATTERS

Not everyone has equal opportunities for health. Income is a powerful determinant of health and one that is modifiable through the decisions we make as a society. Income solutions to health disparities offer the added benefit of incorporating the health enhancing influence of employment itself and the material means to support healthy decisions.

Local data reveal that poor mental and physical health disproportionately affect people who are living in poverty. In general, people living in low income die earlier,[21] are sicker throughout their lives,[22] and have poorer life satisfaction compared to the richest people. Working to address health through income solutions is critical. Poverty is simply too expensive to ignore. Poverty is not only killing us, but it is costing society billions, an estimated $27.1–$33 billon per year in Ontario.[23] **Reducing poverty and its harm to health is possible only through the concerted efforts of all of us.**

Reducing poverty will allow everyone to live with dignity and meet their basic needs and prevent undue suffering of poor health throughout the lifecourse. Poverty reduction also offers a clear return on investment by reducing taxpayers' dollars that go directly into resource-intensive emergency support services that treat the consequences of poverty, like emergency medical services, shelters, social supports, and the justice system. Addressing poverty and improving health also benefits employers in our communities through healthier employees, reduced absenteeism, increased productivity, and increased employee retention.

No single sector or agency can reduce poverty alone. Action across multiple sectors is required to collectively reduce poverty and minimize the impacts of low income on mental and physical health. Improvements in the health of individuals and the health of communities must include action on factors beyond biology and access to the health care system. Data helps us understand these factors and assess where we can take effective action. Healthy people contribute their skills and talents to advancing our society, they actively participate in our communities' economies, and they use fewer health care resources. It is not only the poorest among us who are affected, but all of us.

This report is intended to help planners, leaders and everyday people use local data to inspire meaningful action. Strengthening knowledge and increasing awareness about what impacts our health builds capacity, fosters understanding, and reduces stigma about social and economic influences and promotes dialogue and action. Promoting and protecting health and preventing disease for all means creating better income-based health opportunities for everyone.

METHODOLOGICAL NOTES

Methodology Notes	*Corresponding Indicators*
• Rates are age-standardized using the 2011 Canadian population. • Data source: Canadian Community Health Survey (CCHS), 2007 to 2014, Statistics Canada, Share File, Ontario Ministry of Health and Long-Term Care.	• Adult current smokers by household income • Physical activity by household income • Self-rated health by household income • Self-rated mental health (excellent or very good) by household income • Life satisfaction (very satisfied or satisfied) by household income • Mood disorders by household income • Anxiety disorders by household income
• Rates are for the population aged 20 years and older.	• Adult current smokers by household income
• Rates are for the population aged 12 years and older.	• Physical activity by household income • Self-rated health by household income • Self-rated mental health (excellent or very good) by household income • Life satisfaction (very satisfied or satisfied) by household income • Mood disorders by household income • Anxiety disorders by household income
• In this analysis, individuals are divided into “income quintiles”, or five groups of roughly equal size based on their reported household income. The groups are ranked, so that Quintile 1 represents the 20% of the population with the lowest incomes, and Quintile 5 represents the 20% with the highest incomes.	• Adult current smokers by household income • Physical activity by household income • Self-rated health by household income • Self-rated mental health (excellent or very good) by household income • Life satisfaction (very satisfied or satisfied) by household income • Mood disorders by household income • Anxiety disorders by household income

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BOARD OF HEALTH MOTION: OPPORTUNITIES FOR HEALTH FOR ALL POVERTY REDUCTION

Motion #53-19
Approved by Board of Health for Public Health Sudbury & Districts, November 21, 2019.

WHEREAS income is one of the strongest predictors of health and local data show that low income is associated with an increased risk of poor physical and mental health in Sudbury and districts; and

WHEREAS Public Health Sudbury & Districts annual Nutritious Food Basket reports demonstrate that individuals and families reliant on the current provincial social assistance rates or that earn a minimum wage will experience challenges in supporting their health including meeting their nutrition requirements; and

WHEREAS income solutions incorporate the health enhancing influence of work while addressing food security and the health damaging impacts of insufficient income; and

WHEREAS the Sudbury Workers Education and Advocacy Centre calculated a living wage for Sudbury of $16.98 (current provincial minimum is $14.00), and the City of Greater Sudbury proclaimed November 3 – 9, 2019 as Living Wage Week; and

THEREFORE BE IT RESOLVED that the Board of Health for Public Health Sudbury & Districts formally endorse the principle of living wage employment and direct the Medical Officer of Health to pursue certification; and

FURTHER that the Board encourage all employers across our service area to recognize the serious health and societal costs of inadequate income.

No single sector or agency can reduce poverty alone.

Reducing poverty and its harm to health is possible only through the concerted efforts of all of us.

Public Health
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SUDBURY & DISTRICTS

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2019 Highlights by the Numbers

Public Health
Santé publique
SUDBURY & DISTRICTS

Public Health Sudbury & Districts is a progressive public health agency that is committed to improving health and reducing social inequities in health through evidence-informed practice.

We work with many partners, such as municipalities, schools, health care providers, social services, and community agencies, to keep people healthy and reduce their needs for health care services. Our enriched culture fosters research, ongoing education, and the development of innovative programs and services.

Health Promotion

Smoking cessation

263 nicotine replacement therapy vouchers and **984** nicotine replacement therapy products distributed to clients who attended Quit Smoking Clinics.

Falls prevention

40 Stand Up! exercise programs supported and delivered by partners throughout Sudbury and districts. **462** older adults reached.

Healthy Babies Healthy Children

2 002 home visits completed by family home visitors and **1 538** visits completed by public health nurses for a total of **3 540** visits.

Naloxone

2 276 naloxone kits distributed to individuals by eligible agencies.

School health

117 presentations, skill-building opportunities, workshops, training sessions, and consultations, delivered to the school community on mental health promotion, healthy eating behaviours, healthy sexuality, substance use and harm reduction, healthy growth and development, physical activity and sedentary behaviour, ultraviolet exposure, and injury prevention.

Vape-free programming

450 Grade 7 and 8 students from **6** schools participated in the Inhale, Exhale school mindfulness program.

Northern Fruit and Vegetable Program

19 570 students received fruits and vegetables weekly for **20** weeks. **93** elementary schools throughout Sudbury and districts participated in the program, including First Nations schools.

Health Protection

Immunization records

26 250 student immunization records reviewed for completeness, as per the *Immunization of School Pupils Act*.

Harm reduction

27 900 client visits or contacts to The Point for harm reduction supplies and services.

Preventive services

457 children participated in school-based preventive services.

Vision screening

1 760 senior kindergarten students participated in the school-based vision screening program.

Smoke-Free Ontario Act

138 charges issued for smoking or vaping on school property. **9** charges issued for smoking or vaping on hospital property.

Ontario Seniors Dental Care Program

118 inquiries received for the new Ontario Seniors Dental Care Program.

Food premise inspections

3 745 food premise inspections.

Health hazards

524 health hazard complaint investigations.

Enteric outbreaks

51 enteric outbreaks investigated.

Knowledge and Strategic Services

Population health

11 mental health indicators added to the *Public Health Sudbury & Districts Population Health Profile*.

Research

23 research and evaluation projects where Knowledge and Strategic Services acted in a lead or consultation role.

Student placements

99 students completed placements, from **7** post-secondary institutions, representing **11** disciplines.

Poverty reduction

27 Circles Leaders (participants) with their **33** children, and **56** Circles Allies (volunteers) recruited into Circles Sudbury, a community poverty reduction program.

Indigenous engagement

12 Indigenous engagement training and development sessions delivered to staff.

Social media engagement

1 595 982 Facebook users reached and **421 711** Twitter impressions generated.

Public Health Heroes

8 Public Health Heroes recognized for their efforts to put public health into action and make tangible, positive differences in their communities.

2019 Faits saillants en chiffres

Public Health
Santé publique
SUDBURY & DISTRICTS

Santé publique Sudbury et districts est une agence progressiste de santé publique qui s'est engagée à améliorer la santé et à réduire les iniquités sociales dans le domaine de la santé en fondant la pratique sur les données probantes.

Nous collaborons avec de nombreux partenaires, comme les municipalités, les écoles, les fournisseurs de soins de santé, les services sociaux et les organismes communautaires. Notre but est de garder la population en santé et de réduire ses besoins en matière de soins de santé. Notre culture enrichie favorise la recherche, l'éducation continue et la création de programmes et de services novateurs.

Promotion de la santé

Renoncement au tabac

Les personnes qui ont assisté aux séances sur le renoncement au tabac ont reçu **263** bons et **984** produits pour la thérapie de remplacement de la nicotine.

Prévention des chutes

Des partenaires ont soutenu et fourni **40** programmes d'exercices PIED dans Sudbury et districts, et ont permis de toucher **462** personnes âgées.

Bébés en santé, enfants en santé

Des visiteuses au domicile familial et des infirmières-hygiénistes ont effectué respectivement **2002** et **1538** visites, pour un total de **3540**.

Naloxone

Des organismes admissibles ont distribué **2276** trousses de naloxone.

Santé en milieu scolaire

Il s'est donné **117** exposés, occasions de renforcement des compétences, ateliers, séances de formation et consultations à la communauté scolaire. Les sujets étaient la promotion de la santé mentale, les comportements alimentaires sains, les pratiques sexuelles saines, la consommation d'alcool ou d'autres drogues, la réduction des méfaits, la croissance et le développement sains, l'activité physique et la sédentarité, l'exposition aux rayons ultraviolets et la prévention des blessures.

Programme d'élimination de la vapeur

Le programme sur la pleine conscience en milieu scolaire Inhale, Exhale a attiré **450** élèves de 7e et de 8e année issus de **6** écoles.

Programme de distribution de fruits et légumes dans le nord de l'Ontario

Pendant **20** semaines, **19570** élèves ont reçu des fruits et légumes. Ont participé au programme **93** écoles élémentaires de Sudbury et districts, y compris des écoles des Premières Nations.

Protection de la santé

Dossiers d'immunisation

Nous avons vérifié les dossiers d'immunisation de **26 250** élèves pour nous assurer qu'ils étaient complets, conformément à la *Loi sur l'immunisation des élèves*.

Réduction des méfaits

Le Point a reçu la visite de **27 900** clients ou contacts pour des fournitures et des services de réduction des méfaits.

Services préventifs

Des services préventifs en milieu scolaire ont été fournis à **457** enfants.

Dépistage des troubles de la vue

Le programme de dépistage des troubles de la vue en milieu scolaire a été fourni à **1 760** élèves du jardin d'enfants.

Loi favorisant un Ontario sans fumée

Des accusations ont été déposées dans **138** cas pour tabagisme ou vapotage sur le terrain d'une école, et dans neuf autres pour tabagisme ou vapotage sur celui d'un hôpital.

Programme ontarien de soins dentaires pour les aînés

Le nouveau Programme ontarien de soins dentaires pour les aînés a fait l'objet de **118** demandes.

Inspections de dépôts d'aliments

Nous avons effectué **3 745** inspections de dépôts d'aliments.

Risques pour la santé

Nous avons examiné **524** plaintes concernant des risques pour la santé.

Éclosions de maladie entérique

Nous avons enquêté sur **51** cas d'éclosion de maladie entérique.

Services stratégiques et du savoir

Santé de la population

Le profil de santé de la population de Santé publique Sudbury et districts compte maintenant **11** indicateurs de santé mentale de plus.

Recherche

Les Services stratégiques et du savoir ont joué un rôle de premier plan ou de consultation dans **23** projets de recherche et d'évaluation.

Placements d'étudiants

Nous avons placé **99** étudiants de **11** disciplines qui provenaient de sept établissements d'enseignement postsecondaire.

Réduction de la pauvreté

Dans Cercles Sudbury, un programme communautaire de réduction de la pauvreté, nous avons recruté **27** leaders (participants) avec leurs **33** enfants et **56** alliés (bénévoles).

Engagement auprès des Autochtones

Le personnel a suivi **12** séances de formation et de perfectionnement sur l'engagement auprès des Autochtones.

Mobilisation par les médias sociaux

Nous avons touché **1 595 982** utilisateurs de Facebook et généré **421 711** impressions sur Twitter.

Héros de la santé publique

Nous avons souligné les efforts que **8** héros de la santé publique ont déployés pour mettre la santé publique à l'œuvre et apporter des changements concrets et positifs dans leur collectivité.

APPROVAL OF CONSENT AGENDA

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

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health Chair, Public Health Sudbury & Districts

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

Date: February 12, 2020

Re: Novel Coronavirus 2019

☒ For Information ☐ For Discussion ☐ For a Decision

Issue:
The 2019 novel coronavirus outbreak requires public health action at all levels from global to local. This briefing note and accompanying presentation which will be delivered at the Board meeting, informs the Board of Health of the global context and local actions underway to protect health and ensure local system readiness.

Recommended Action:
That the Board of Health receive this briefing note and accompanying presentation for information.

Background:
Global

- On December 31, 2019, Chinese health officials reported a cluster of cases of acute respiratory illness in persons associated with the Hunan seafood and animal market in the city of Wuhan, Hubei Province, in central China.
- On January 7, 2020, Chinese health officials confirmed that a novel coronavirus (2019-nCoV) was associated with this initial cluster.
- On January 30, the World Health Organization (WHO) Director-General declared that the 2019-nCoV outbreak constitutes a Public Health Emergency of International Concern.
- On January 31, the U.S. Department of Health and Human Services (HHS) Secretary declared a U.S. public health emergency including a Presidential Proclamation limiting entry into the United States of persons who traveled to mainland China to U.S. citizens and lawful permanent residents and their families.
- Much has been covered in all media concerning the evolution of this outbreak and of the virus itself.
- At the time of writing 28 countries and territories around the world are affected, however, China has witnessed the vast majority of cases and deaths.
- The virus transmission rate (number of newly affected from one case) is estimated at 3 to 4; the incubation period is estimated at 2 to 14 days; the case fatality rate is estimated at 1 to 2% (with much uncertainty).

- Coronaviruses range in their severity and are the cause of the common cold and of SARS and MERS; the latter two are the result of animal to human interactions and preliminary investigation indicates that this is the case for 2019-nCoV.

National

- Health Canada (Minister of Health, Patty Hajdu, MP for Thunder Bay-Superior North) with the support of the Public Health Agency of Canada (Dr. Theresa Tam), leads the national response.
- The national case definition, as of February 7, 2020, includes travel to mainland China as an exposure risk.

Provincial

- The Ministry of Health (Minister of Health, Christine Elliot, and Chief Medical Officer of Health, Dr. David Williams) with the support of Public Health Ontario (Dr. Peter Donnelley and Dr. Shelley Deeks), leads the provincial response.
- On January 22, 2020, the Ministry of Health announced that novel coronavirus is a designated disease reportable under the *Health Protection and Promotion Act* to the local medical officer of health.
- On January 25, 2020, the first presumptive case of 2019-nCoV was reported in Ontario and at the time of writing there are three cases in Ontario (four in British Columbia).
- The Province develops guidance documents to assist acute and primary care in their management of cases, and public health in our management of cases and contacts.

Local

- Public Health Sudbury & Districts is the lead agency for community emergency response when infectious diseases are the cause and we are implementing measures to ensure preparedness.
- The Sudbury Infectious Disease Planning and Response Committee (IDPRC), an interagency committee implemented originally for clinical sector pandemic preparedness, was convened on January 24, 2020 to discuss sector preparedness and establish regular communications. Similar processes have been established for all district areas involving clinicians, municipal CAO/clerks, Sudbury Paramedic Services, Manitoulin Sudbury District Services Board, Ornge and Indigenous health centre directors and community Chiefs.
- The Public Health Sudbury & Districts Emergency Response Plan was activated on January 26, 2020, to ensure agency coordination and efficient communication.
- We participate 2 to 3 times per week in Ministry of Health teleconferences organized by the Ministry's Emergency Operations Centre during which up to date information is shared and questions from local public health are discussed.
- We are in regular communication with the Greater Sudbury Community Control Group to ensure coordination with municipal partners, including emergency medical services.
- All Ministry guidance materials are adapted for implementation by staff, including staff designated to take client calls.

- Communications include an up to date Public Health Sudbury & Districts website, Advisory Alerts to clinicians, social media on respiratory etiquette, and internal tools.

Financial Implications:
- We have systems set up to track additional costs related to this response, if necessary.
- All work to date has been absorbed into ongoing operations.

Ontario Public Health Standard:
Emergency Management

Strategic Priority:
1, 2, 3, 4

Briefing Note

To: René Lapierre, Chair, Board of Health

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

Date: February 12, 2020

Re: Infrastructure Modernization

☒ For Information ☐ For Discussion ☐ For a Decision

Issue:
Public Health Sudbury & Districts requires physical and technological infrastructure modernization to ensure efficient operations and maintain alignment with evolving legislative requirements and service needs. This briefing note apprises the Board of Health of the imperatives for infrastructure modernization and of the overall plan to accomplish the identified projects. The longstanding strategic financial planning of the Board of Health means that the work will be achieved within the Board's existing resources.

Recommended Action:
That the Board of Health receive this briefing note for information.

Background:
Context requiring infrastructure modernization:

1. Accessibility
    - Client spaces were constructed prior to the Accessibility for Ontarians with Disabilities Act, 2005 and were designed within the social context and demography of the clientele at the time. Accessibility standards have changed including the accessibility standards for the built environment and the demography of our clients and their needs for accessible client spaces have changed and increased.
    - Social norms have evolved and gender-neutral spaces are essential for the respectful provision of our services. PHSD does not provide gender-neutral or universal washroom facilities and this need will be addressed as we undertake necessary upgrades to these facilities.
    - Workplace ergonomics is a key factor in our current context. Our understanding of how the design of workspaces can potentially impact physical health and staff performance and productivity has improved significantly over the past 20 years and our current workspaces need to be adapted to ensure we minimize risks resulting from poor workspace design.

2. Programs and services
    - Ministry of Health has mandated Public Health with the delivery of new programs including Indigenous Engagement, Public Mental Health, Harm Reduction, Vision Screening, and most recently, the Ontario Seniors Dental Care program.
    - These additional programs require reconfigured physical spaces in order to ensure Public Health can deliver and meet the ministry requirements. These have put pressure on what is already, an aging infrastructure.
3. Infrastructure lifespan
    - With an aging infrastructure, major systems and the building envelop begin to deteriorate. Preventative maintenance programs ensure longevity of resources however, infrastructure breakdowns can become more frequent and increasingly costly once equipment has past it's expect life. Our infrastructure has exceeded its expected lifespan and needs significant investments in order for us to ensure continued efficient use and avoid short term and costly stop-gap measures.
4. Environmental sustainability
    - The Board of Health has a responsibility to promote healthy natural and built environments that support health and mitigate existing and emerging risks. Modernizing our infrastructure using environmental sustainability principles will reduce waste and costs and environmental footprint and be in line with the Board's responsibilities under climate change in the Ontario Public Health Standards.
5. Digitization
    - The Ministry of Health launched a digital strategy which aims to enhance access to health information and services; strengthen quality, effectiveness and accountability; and stimulate innovation and growth. Implementing this strategy will change delivery of healthcare in Ontario, and the ministry's efforts and priorities will be targeted accordingly. Public Health is an important stakeholder in this strategy and must also align its services and infrastructure to interact with its clients and partners in a digital environment. (See below for reference to one time funding application in support of these needs.)
6. Privacy
    - With the increased reliance on technology, online information and data integrity breaches have a significant impact on the organization and the individual impacted. Legislation has established requirements that we must meet which requires sustained attention and resources.
7. Security and enterprise risk
    - Network security is one of the most important aspect of any organization today. With an ever-increasing level of network security threats, sophisticated hackers and the potential impact on our organization, investments in network infrastructure has become increasingly important and a risk that needs to be managed.

Assessments:

Five assessments of varying scope have been conducted to inform prioritization and decision making about the modernization of Public Health Sudbury & Districts physical and technological infrastructure:

1. <u>Environmental sustainability</u>
   An environmental sustainability/energy audit was conducted to assess energy consumption and

demands of 1300 Paris Street. Energy consumption was compared to similar buildings and found our utilization index to be at a higher value (46,7 kWh-eq/pi2) than the Building Owners and Managers Association (BOMA) Best average of 30,9. The audit concluded that to improve the energy index, major operational change and capital investment would be required and provided recommendations.

2. Physical accessibility
   In order to understand our compliance with the Ontario Disability Accessibility Standards for build environments, an accessibility audit was conducted in December 2019. Audit results demonstrate noncompliance in operating controls, signage, interior circulation, doors and doorways, stairs, emergency and security, washroom facilities/universal washrooms, and seating, and identified the standards that need to be met.

3. Building condition assessment
   A building condition assessment was conducted to examine the current condition of the building from architectural, structural, mechanical and electrical perspective, to assess the remaining useful life and anticipated replacement or repair costs of current systems. The Building Condition Report (BCR) outlined recommendations prioritized based on the following criteria:
   a. Frequency of use
   b. OHS/Standards & Regulations requirements
   c. Severity
   d. Future costs

4. Information technology external security audit
   With an ever-increasing level of network security threats, sophisticated hackers and the potential impact on our organization should a breach occur, it was decided to engage the services of a professional technology company, to conduct a Security and Network Assessment Audit. This process was used to identify security risks for systems and applications, user security and access rights, and security barriers in place to protect the organization from external threats. Their final report provides recommendations to eliminate identified risks.

5. Electronic medical records
   The Agency conducted a review of our current medical records systems and a scan of other agencies' practices. Records management continues to be paper based, creating significant operational challenges for the organization. Moving to an electronic medical record has been identified as a priority for the organization.

Physical infrastructure modernization:

1. Main Office – 1300 Paris Street
   Public Health Sudbury & Districts main office located at 1300 Paris Street was built almost half a century ago in 1973. Extensive renovations were conducted in 2002 to address safety and functional concerns, growing the space to 47,000 square feet.

   Further investments must now be made to address growing repair costs of aging infrastructure, address opportunity costs of environmental sustainability, client and staff accessibility needs, and program needs. Below is a high-level summary of work to be undertaken:
   - Configure space to provide for new programming and service needs
   - Centralize storage and supplies space to make maximum use of available space

- Address mechanical, electrical and structural issues identified as part of the building condition assessment
- Reconfigure client services area to meet AODA requirements
- Address needs for gender neutral and universal facilities for our clients and staff

2. Rainbow Centre
   The Rainbow Centre location delivers the Sexual Health, Growing Family, and Needle Exchange programs. With the expansion of public health's harm reduction responsibilities and increase in community demand, there are increasing staff health and safety issues as well as client service pressures to be addressed at this site.

   The physical infrastructure needs at the Rainbow Centre coincide with an opportunity presented by the newly mandated Ontario Seniors Dental Care (OSDC) program. Co-locating the OSDC program in the Sudbury downtown area means that we can leverage anticipated OSDC infrastructure funds from the Ministry of Health to offset costs associated with needed Rainbow Centre changes. The Ministry of Health is accepting capital infrastructure applications for this program. The plan is to co-locate all four programs, thereby maximizing the use of common spaces and resources while providing for the development of spaces that are flexible enough to respond to the changing needs of the programming, while meeting our legislative requirements.

Technological infrastructure modernization:

1. Electronic Medical Records (EMR)
   This project requires an investment in staff and software resources. A dedicated project team will be responsible for the development and implementation of this project including detailing the EMR functionalities that would best suit the current and future needs of the agency, assessing the IT infrastructure and resource capacity and needs, sourcing of the software product, and ensuring alignment/interoperability with external partners and the Ministry digitization strategy.

2. IT Security
   Investments are required in our Information Technology infrastructure to address the risks identified in the audit. Vulnerability management has been identify as the most important risk that need to be addressed.

Issue history

A number of assessments have been conducted by management over the years and are noted above. These are all with the aim of strategic planning to ensure we have a current and ongoing assessment of present and future physical and technological vulnerabilities.

The responsibilities of the Board of Health Finance Standing Committee (FSC) include a strategic overview of the agency's financial position and monitoring the agency's physical assets and facilities. At its October 2018 meeting, the FSC received and discussed information on the Building Condition Assessment in the context of the reserve management plan. The aim was to ensure that the reserve funds established continue to be relevant and adequately resourced for these and other identified purposes.

Through its enterprise Risk Management process, the Board of Health identifies and rates residual risks to the organization through a comprehensive review of 14 categories of risks. Implementing the physical

and technological infrastructure modernization projects is responsible mitigation of risks identified by the Board in these categories.

Financial Implications:
The longstanding strategic financial planning of the Board of Health means that the work summarized in this briefing note will be achieved within the Board's existing resources. As the Board is aware, infrastructure projects are not budgeted within the annual operating budget and as such, access to reserve funds to execute the needed projects is necessary.

The Board of Health has long recognized the importance of establishing reserve funds with the understanding that reserves form an integral part of sound financial management. Financial reserves are a prudent way to provide the organization with resources for known future infrastructure investments and future planned projects that support the vision and mission of the organization.

As noted above, the Ministry is accepting applications for capital infrastructure funding for the OSDC program. Public Health Sudbury & Districts has submitted an application and if successful, we will use this funding to offset the physical infrastructure changes to the Rainbow Centre location as described above. In addition, the agency will prepare a one-time funding request through its 2020 Annual Service Plan and Budget submission for funding of the Electronic Medical Records initiative with the hopes of offsetting some of these costs.

Under By-Law G-I-70, the Board establishes and maintains reserve funds for Working Capital, Human Resources Management, Public Health Initiatives and Response, Corporate Contingencies, and Facility and Equipment Repairs and Maintenance. As identified with the FSC, it is the Public Health Initiatives and the Facility and Equipment Repairs and Maintenance reserve funds which would be accessed for the physical and technological infrastructure modernization described here.

The agency will engage in all applicable procurement processes as per our policies and procedures as we move forward with these initiatives. By-Law G-I-70 requires the Board's approval for any transfers from reserves that are in excess of $100,000 per transaction. The Board should expect future project-specific details and requests for approval, as required by this By-Law.

Ontario Public Health Standard:
Organizational Requirements

Strategic Priority:
Organizational Commitment

Contact:
France Quirion, Director, Corporate Services

NOMINATION TO THE ALPHA BOARD OF DIRECTORS FOR THE NORTH EAST REGION

WHEREAS there is currently a vacancy for a North East representative on the alPHa Board of Directors for a two-year term;

THAT the Board of Health for Public Health Sudbury & Districts supports the nomination of René Lapierre, Board Chair, as a candidate for election to the alPHa Board of Directors and for the Boards of Health Section Executive Committee seat from the North East region.

ADDENDUM

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

Please remember to complete the Board meeting evaluation in BoardEffect following the Board meeting.

ADJOURNMENT
MOTION: THAT we do now adjourn. Time: _____