Board of Health for
Peterborough Public Health
AGENDA
Board of Health Meeting
Wednesday, November 8, 2017 – 5:30 p.m.
Council Chambers, Administration Building
22 Winookeedaa Road, Curve Lake First Nation

Opening Prayer: Chief Phyllis Williams

1. Call to Order
Mayor Mary Smith, Chair

1.1. **Opening Statement**
We acknowledge that where we meet is the land and territory of the Anishnaabeg [Ah-nish-naw-beg] people. We gather with gratitude to our Mississauga neighbours. We say "meegwetch" to thank them and other Aboriginal peoples for taking care of this land from time immemorial and for sharing this land with those of us who are newcomers. Out of that gratitude, we are called to treat the land, its plants, animals, stories, and its Peoples with honour and respect. We are all Treaty people.

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Consent Items to be Considered Separately

Board Members: *Please identify which items you wish to consider separately for section 9, and advise the Chair when requested. For your convenience, circle the item(s) using the following list: 9.1.1 a b 9.1.2 a b c d e f g h i j k 9.2.1 a b c 9.2.2 9.3.1 a b c d e f*

5. Delegations and Presentations

5.1. **Curve Lake First Nation Health & Family Services Update**
David Ross, Manager, Curve Lake Health Centre
Joanne Pine, Community Health Representative, Curve Lake Health Centre

- Cover Report (p. 5)

a. Presentation

6. Confirmation of the Minutes of the Previous Meeting

6.1. **October 11, 2017**

- Cover Report (p. 16)

a. Minutes, October 11, 2017

7. Business Arising From the Minutes

8. Staff Reports

8.1. **Staff Presentation: Healthy Hydration Follow Up**
Luisa Magalhaes, RD, Public Health Nutritionist
Lauren Kennedy, RD, Public Health Nutritionist

- Cover Report (p. 23)

a. Presentation

8.2. **Stewardship Committee Report: 2018 Cost-Shared Budget Approval**
Councillor Henry Clarke, Chair, Stewardship Committee

- Cover Report (p. 29)

a. Staff Report – 2018 Cost-Shared Budget Approval

9. Consent Items

9.1. **Correspondence**

9.1.1. **Correspondence for Direction**

a. Child Care Worker Immunization - Durham (p. 37)
b. Smoke-Free Ontario Modernization – Simcoe Muskoka (p. 45)

9.1.2. **Correspondence for Information**

- Cover Report (p. 47)

a. MPP Leal – Minister Couteau / HBHC (p. 49)
b. Provincial Minsters – Energy Drinks (p. 52)
c. Minister Petitpas Taylor – Energy Drinks (p. 54)
d. CE LHIN Quarterly Report (p. 56)
e. alPHa E-newsletter (p. 57)
f. alPHa Expert Panel Responses (web hyperlink)

g. Healthy Menu Choices - Grey Bruce (p. 60)
h. Nutritious Food Basket – KFLA (p. 61)
i. Provincial Alcohol Strategy – Algoma (p. 63)
j. Provincial Alcohol Strategy - Northwestern (p. 65)
k. Provincial Alcohol Strategy – Thunder Bay (p. 67)

9.2. **Staff Reports**

9.2.1. **Staff Report: Q3 2017 Peterborough Public Health Activities Report**
Larry Stinson, Director of Operations

- Cover Report (p. 69)

a. Programs
b. Communications and IT
c. Social Media

9.2.2. **Staff Report: Healthy Babies Healthy Children Program Update**
Patti Fitzgerald, Assistant Director and Chief Nursing Officer

- Staff Report (p. 75)

9.3. **Committee Reports**

9.3.1. **Stewardship Committee**
Councillor Henry Clarke, Chair, Stewardship Committee

- Cover Report (p. 83)

a. Minutes, August 30/17
b. Q3 2017 Finance Report
c. By-Law #1, Management of Property
d. By-Law #4, Appointment of an Auditor
e. By-Law #7, Execution of Documents
f. Policy 2-374, Contractor Performance and Litigation

10. New Business

10.1. **alPHa Conference Update**
Deputy Mayor John Fallis, Board Member
Dr. Rosana Salvaterra, Medical Officer of Health

- Cover Report (p. 102)

11. <u>In Camera to Discuss Confidential Matters</u>

In accordance with the Municipal Act, 2001,

- *Section 239(2)(b), Personal matters about an identifiable individual, including Board employees;*

12. <u>Motions for Open Session</u>

13. <u>Date, Time, and Place of the Next Meeting</u>

Date: December 13, 2017
Time: 5:30 p.m.
Location: Dr. J. K. Edwards Board Room, 3rd Floor, Peterborough Public Health, Jackson Square, 185 King Street

14. <u>Adjournment</u>

ACCESSIBILITY INFORMATION: Peterborough Public Health is committed to providing information in a format that meets your needs. To request this document in an alternate format, please call us at 705-743-1000.

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Curve Lake First Nation Health & Family Services Update**

Date: November 8, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:
Presentation: Curve Lake First Nation Health & Family Services Update
Presenters:
David Ross, Manager, Curve Lake Health Centre
Joanne Pine, Community Health Representative, Curve Lake Health Centre

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Attachments:

Attachment A - Presentation

Curve Lake First Nation Health & Family Services

Joanne Pine & David Ross

Purpose of the Presentation

- Our presentation will focus on two areas:

1. Understanding the complexity in providing Health and Family Services on First Nation territory
2. Highlight Non-insured Health Benefit program administered by our Community Health Representative

Mission and Vision Statements

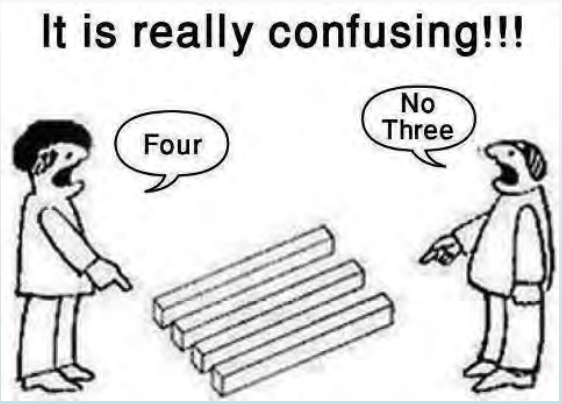
Mission Statement

- The Curve Lake First Nation Health and Family Services Team will work together to support and educate the individuals and families of the Curve Lake First Nation in their self defined pursuit of a healthy and dignified life.

Vision Statement

- That the individuals and families of the Curve Lake First Nation experience a healthy life that is rich in Anishnaabe experiences, personal growth, and a true sense of community being.

My mind is made up, don't confuse me with facts.



Facts Related To Health & Family Services

- 26 separate budget entities
- CE LHIN, MOHLTC, MCYS, Anishinabek Nation (Ontario Union of Indians), Health Canada
- 20 staff
- 1.6 Million
- Numerous in-year amendments to current budgets

Outcomes

- Funding is trapped in numerous silos, each with their own executive controls
- Multiple funders with their own budgeting and reporting requirements
- Federal and Provincial funders often want to fund the similar activities
- Combination of annualized funding and fiscal only funding
- Tracking and reporting on the funding is complex
- Requires a high level of cooperation and coordination
- Most funders do not want their resources used for the cost of administration

Unintended Outcomes

- Instability in funding contributes to instability in the workplace
- Difficult to build capacity if you can't retain staff
- How to build processes that balances the needs of the patient with those of your funders
- Bogged down in administrative processes

Your either part of the solution or your part of the problem?

- Create process to remember our history and transfer knowledge
- Have to be better at succession planning
- Communicate with our funders to broaden their understanding and their support for creating new solutions
- Understand the 'value added' in the reporting requirements, how these reports contribute to financial stability
- Understand how these reports enable us to make the right investments in the community

Overview of Non-insured Health Benefits

Non-insured Health Benefits

- What is NHIB?
- Who is eligible?
- What is covered?

What is NIHB?

The NIHB program is administered by Health Canada and is designed to help First Nations with health benefits, including:

- Dental
- Drugs
- Medical Supplies & Equipment
- Medical Transportation
- Vision Care
- Short-Term Crisis Intervention, Mental Health Counselling
- Chiropractic Care (Ontario only & $150.00 per year)

Who is eligible?

In order to receive any of NIHB Program Benefits, you must be recognized by Health Canada as an eligible recipient.

Eligible recipient is:

- A registered status-Indian according to the Indian Act; and
- An infant less than one year of age, whose parent is an eligible recipient.

How do I obtain NIHB Program Benefits?

CHOOSE A SERVICE PROVIDER THAT IS REGISTERED WITH NIHB

When you/client call or see a health care provider, you need to make sure you are eligible for benefit coverage for the health program, service, or product needed.

ASK:

- Do they direct bill to NIHB Program?
- Is the service is an eligible benefit under the program?

Questions or Concerns about eligibility?

Any concerns or questions about eligibility for a medical item, supply, service, and/or travel provided under the NIHB program can call:

Joanne Pine, Community Health Representative Curve Lake First Nation Health Centre, 1-705-657-2557

General Inquires at NIHB, 1-800-640-0642

Benefit Categories

Open Benefit – a medical item, supply, and/or service that can be accessed right away. No need for prior approval.

Prior Approval – a medical item, supply, service, and/or travel cost that needs to be approved by NIHB for coverage.

Exceptions – a medical item, supply, service, and/or travel cost that is not covered by NIHB. However, it may be approved on a case by case basis.

Exclusions – a medical item, supply, service, and/or travel cost that is never covered by NIHB. Exclusions cannot be appealed.

Anyone who disagrees with a decision made through the NIHB program, has the right to appeal the decision.

NIHB – Appeal Process

There are three levels of appeal. At each level of appeal, supporting medical documentation is needed (additional new information to support appeal).

Information needed to make appeal:

- Signed and dated letter of appeal from client, must include;
  - Name, status number, date of birth, address
  - Reason for appeal, reason NIHB denied the benefit initially
  - Why the initial request was made
- Supporting documentation for your request from a licensed health service provider, doctor, health worker, etc.
- Include diagnosis, diagnostic testing (if applicable), and previous treatments completed
- Attach proper form that applies to request (eg. Dental – Standard Dental Claim Form)
- The denial letter that was issued by NIHB

NIHB-Travel Authorization Process (Prior Approval)

1. Begins with an inquiry about the program(usually a medical appointment), I explain the program and have client complete a Prior Approval Client Agreement Form
2. Prepare Prior Approval Request (Name & Status Number, Date & Location of Appointment, Dr.'s Name & Type of Appointment, Request (transportation, parking, accommodations, meals))
3. Submit TA request to NIHB
4. Wait for NIHB to fax the TA (usually within a couple days). Once I receive TA, I am able to proceed based on approval
5. I prepare a cheque based on TA (transportation, meals), and/or make arrangements for accommodations (accommodations are billed to Curve Lake credit card)
6. Once I receive cheque, I prepare a letter to client explaining amount approved by NIHB. As well, forms that NIHB require for reimbursement.
7. Client proceeds to medical appointment.
8. Client returns the required documentation.
9. I invoice NIHB.

Reimbursements

When a medical item, supply, service has been paid, reimbursement can be submitted to Health Canada.

What is required?

- Completed Client Reimbursement Form
- Original receipts (3rd party insurance letter-if applicable)
- Supporting documentation (prescription, standard dental claim form)

Health Canada determines eligibility and reimbursements are 6-8 week process. Must be submitted within one year of the service or cost/payment was made.

Miigwetch!

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Board of Health Minutes – October 11, 2017**

Date: November 8, 2017

Proposed Recommendation:

That the minutes of the meeting held on October 11, 2017, of the Board of Health for Peterborough Public Health, be approved as circulated.

Attachments:

Attachment A – Board of Health Minutes, October 11, 2017

Board of Health for
Peterborough Public Health
DRAFT MINUTES
Board of Health Meeting
Wednesday, October 11, 2017 – 5:30 p.m.
Dr. J.K. Edwards Board Room, Peterborough Public Health
Jackson Square, 185 King Street, Peterborough

In Attendance:

Board Members:

Councillor Gary Baldwin
Councillor Henry Clarke
Mr. Gregory Connolley
Ms. Kerri Davies
Deputy Mayor John Fallis
Councillor Lesley Parnell
Ms. Catherine Praamsma
Mr. Andy Sharpe
Mayor Mary Smith, Chair
Mr. Michael Williams
Mayor Rick Woodcock

Regrets: **Councillor Kathryn Wilson**
Chief Phyllis Williams

Staff: **Mr. Larry Stinson, Director of Operations**
Ms. Natalie Garnett, Recorder
Dr. Rosana Salvaterra, Medical Officer of Health
Ms. Alida Gorizzan, Executive Assistant

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1. Call to Order

Mayor Smith, Chair called the meeting to order at 5:30 p.m.

1.2 Membership Announcement

The Chair advised that provincial appointees Ms. Kerri Davies and Mr. Greg Connolley have been reappointed for a further three year term.

2. Confirmation of the Agenda

2.1 Confirmation of the Agenda for September 13, 2017

MOTION:
That the agenda be approved as circulated.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2017-087)

3. Declaration of Pecuniary Interest

There were no declarations of pecuniary interest.

4. Consent Items to be Considered Separately

MOTION (9.1.2):
That the following items be passed as part of the Consent Agenda: 9.1.1 , 9.1.2 and 9.2.1.
Moved: Deputy Mayor Fallis
Seconded: Councillor Baldwin
Motion carried. (M-2017-088)

MOTION:
That the Board of Health for Peterborough Public Health receive the following for information:

a. Letter dated October 5, 2017 to Minister Hoskins from the Board Chair regarding a human papillomavirus (HPV) immunization catch-up program for boys.
b. Letter dated October 5, 2017 to Minister Hoskins from the Board Chair regarding the modernization of alcohol retail sales in Ontario.
c. Letter dated October 5, 2017 to Minister Hoskins from the Board Chair regarding municipal levy apportionment.
d. Letter dated October 5, 2017 to Ministers Philpott, Bennett and Zimmer from the Board Chair regarding Curve Lake First Nation drinking water.
e. Letter dated October 5, 2017 to Premier Wynne from the Board Chair regarding Bill 148.
Correspondence from the Association of Local Public Health Agencies (alPHa):
f. E-newsletter dated September 19, 2017.
g. Email dated September 28, 2017, regarding the Ontario Oral Health Alliance Report.
h. Email dated October 6, 2017 regarding the 2017 Fall Symposium.

Letters/Resolutions from other Local Public Health Agencies:
Bill 148
i. Northwestern
Moved: Deputy Mayor Fallis
Seconded: Councillor Baldwin
Motion carried. (M-2017-088)

MOTION (9.2.1):
That the Board of Health for Peterborough Public Health receive the staff report, Health Care Worker Influenza Immunization: 2016-2017, for information.
Moved: Deputy Mayor Fallis
Seconded: Councillor Baldwin
Motion carried. (M-2017-088)

5. Delegations and Presentations

5.1 Peterborough Regional Health Centre: Planning Ahead to 2020 and Beyond

Dr. Peter McLaughlin, President and CEO and Adair Ireland-Smith, Chair of the Board of Directors of the Peterborough Regional Health Centre made a presentation on "Planning Ahead to 2020 and Beyond".

MOTION:
That the Board of Health for Peterborough Public Health receive the presentation "Planning Ahead to 2020 and Beyond", for information.
Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion carried. (M-2017-089)

6. Confirmation of the Minutes of the Previous Meeting

6.1. September 13, 2017

MOTION:
That the minutes of the Board of Health for the Peterborough Public Health meeting held on September 13, 2017 be approved as circulated.
Moved: Councillor Parnell
Seconded: Mr. Sharpe
Motion carried. (M-2017-090)

7. Business Arising From the Minutes

7.1. Board of Health Response to the Expert Panel Report

MOTION:
That the Board of Health for Peterborough Public Health approve the submission of the draft response to the Report of the Minister's Expert Panel on Public Health, to the Ministry of Health and Long-Term Care prior to the October 31, 2017 deadline; and,

That the response also be circulated to the County of Peterborough, the City of Peterborough, Curve Lake First Nation and Hiawatha First Nation.

Moved:	Mayor Woodcock
Seconded:	Mr. Williams
Motion carried.	(M-2017-091)

7.2. Standards for Public Health Programs and Services Update

MOTION:
That the Board of Health for Peterborough Public Health receive the oral report, "Standards for Public Health Programs and Services Update", for information.

Moved:	Deputy Mayor
Seconded:	Mr. Sharpe
Motion carried.	(M-2017-092)

8. Staff Reports

8.1 Staff Presentation: Burden of Occupational Cancer in Ontario: Major Workplace Carcinogens and Prevention of Exposure

Dr. Salvaterra, Medical Officer of Health, provided a presentation on the "Burden of Occupational Cancer in Ontario: Major Workplace Carcinogens and Prevention of Exposure".

MOTION:
That the Board of Health for Peterborough Public Health receive the presentation, "Burden of Occupational Cancer in Ontario: Major Workplace Carcinogens and Prevention of Exposure", for information.

Moved:	Councillor Clarke
Seconded:	Mr. Williams
Motion carried.	(M-2017-093)

9.2 Staff Presentation: Food Insecurity in Peterborough

Carolyn Doris, RD, Public Health Nutritionist provided a presentation on "Food Insecurity in Peterborough".

MOTION:
That the Board of Health for Peterborough Public Health receive the staff report, Food Insecurity in Peterborough, for information, and direct staff to:

- *request a presentation with the Joint Services Steering Committee, along with representatives from the Peterborough Food Action Network, to raise awareness about food insecurity locally beyond emergency food responses;*
- *continue to monitor the cost of the Nutritious Food Basket (NFB) annually with costing to be led by a Registered Dietitian (as per Population Health Assessment and Surveillance Protocol) in order to support efforts to reduce health inequities associated with food insecurity;*
- *send a letter to the Ministers of: Health and Long-term Care/Responsible for Poverty Reduction/Housing/Community and Social Services, with copies to the Ontario Chief Medical Officer of Health, local MPPs, the Association of Local Public Health Agencies and Ontario Boards of Health, requesting that while the Ontario Basic Income Pilot is evaluated, that an immediate increase to Social Assistance Rates be implemented to reflect the cost of NFB and local housing costs and that the Special Diet Allowance be*
- *continued as a critical component for impacting health of food insecure individuals with health conditions;*
- *provide the information to the County of Peterborough, the City of Peterborough, the local municipalities, Curve Lake First Nation and Hiawatha First Nation; and,*
- *provide the information to the Peterborough Chamber of Commerce, Kawartha Chamber of Commerce, the United Way of Peterborough, the DBIA, the Women's Business Network, and local service clubs, along with an offer to make a presentation to them on food insecurity in Peterborough.*

Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2017-094)

10. <u>New Business</u>

11. <u>In Camera to Discuss Confidential Matters</u>

The meeting recessed at 6:42 p.m. and recommenced at 6:49 p.m.

MOTION:
That the Board of Health for Peterborough Public Health enter In Camera to discuss one item under Section 239(2)(d), Labour relations or employee negotiations, and one item under Section 239(2)(e), Litigation or potential litigation, including matters before administrative tribunals affecting the Board.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2017-095)

The Board of Health entered In Camera at 6:49 p.m.

MOTION:
That the Board of Health for Peterborough Public Health rise from In Camera at 7:07 p.m.
Moved: Councillor Parnell
Seconded: Councillor Clarke
Motion carried. (M-2017-096)

12. Report of In Camera Session

The Board received information regarding a litigation matter and provided direction to staff regarding negotiations.

13. Date, Time, and Place of the Next Meeting

The next meeting will be held November 8, 2017 in the Council Chambers, Administrative Building, 22 Winookeedaa Road, Curve Lake First Nation at 5:30 p.m.

14. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Deputy Mayor Fallis
Seconded by: Councillor Clarke
Motion carried. (M-2017-097)

The meeting was adjourned at 7:09 p.m.

Chairperson

Medical Officer of Health

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Healthy Hydration Follow Up**

Date: November 8, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:
Presentation: Healthy Hydration Follow Up
Presenters:
Luisa Magalhaes, Registered Dietitian
Lauren Kennedy, Registered Dietitian

Attachments:

Attachment A - Presentation

HEALTHY HYDRATION

FOLLOW UP

FEBRUARY 2017 STAFF REPORT, "STRATEGIES TO PROMOTE HEALTHY HYDRATION"

JUNE 2017 DIRECTION REGARDING ENERGY DRINKS

PRESENTERS:

LUISA MAGALHAES, RD, MHSC

LAUREN KENNEDY, RD, MSCFN

FOLLOW UP:

- ***FEBRUARY 2017 STAFF REPORT, "STRATEGIES TO PROMOTE HEALTHY HYDRATION"***
  - *UPDATE ON PROVINCE-WIDE HEALTHY HYDRATION PROGRESS AND ADVOCACY*
  - *UPDATE OF PPH ACTIVITIES PROMOTING DRINKING WATER AND REDUCING INTAKE OF SUGAR SWEETENED BEVERAGES (SSB)*
  - *SURVEY HIGHLIGHTING COMMUNITY OPINIONS ON TAXATION OF SSB*
  - *OPPORTUNITIES FOR PPH TO MODEL HEALTHY HYDRATION*
- ***JUNE 2017 BOARD OF HEALTH DIRECTION REGARDING ENERGY DRINKS***
  - *SCAN OF ENERGY DRINK AVAILABILITY, AND PRESENCE OF CONTRACTS, AND POST-SECONDARY RECREATIONAL FACILITIES*
- ***NEXT STEPS***

HOW DO SSB IMPACT HEALTH?

DIET IS THE #1 RISK FACTOR FOR CHRONIC DISEASES; TOO MANY SUGARY DRINKS LEAD TO A HIGHER RISK OBESITY, TYPE 2 DIABETES, AND CAVITIES (1).

OVERWEIGHT AND OBESITY ARE A PUBLIC HEALTH CONCERN IN PETERBOROUGH, WITH 37.5% OF ADULTS CLASSIFIED AS OVERWEIGHT AND 13% AS OBESE (2).

SSBS INCREASE RISK OF DEVELOPING DENTAL CARIES (3), WHICH DISPROPORTIONATELY AFFECT VULNERABLE POPULATIONS WHO HAVE DECREASED ACCESS TO PREVENTATIVE DENTAL CARE (4,5).

1 HEALTH CANADA. LET'S EAT HEALTHY CANADA; 2 KURC A. SELF-REPORTED BODY MASS INDEX 2011/12 (PETERBOROUGH); 3 HEART AND STROKE FOUNDATION. SUGAR, HEART DISEASE AND STROKE: POSITION STATEMENT; 4 DARMAWIKARTA D, ET AL. FACTORS ASSOCIATED WITH DENTAL CARE UTILIZATION IN EARLY CHILDHOOD. PEDIATRICS, 2014; 5 LOCKER D ET AL. INCOME, DENTAL INSURANCE COVERAGE, AND FINANCIAL BARRIERS TO DENTAL CARE AMONG CANADIAN ADULTS. J PH DENT, 2011

CURRENT POLICY ENVIRONMENT

CITY OF LONDON AND THE LONDON-MIDDLESEX HEALTH UNIT: ALL ENERGY DRINKS HAVE BEEN REMOVED. POP REMAINS IN VENDING MACHINES.

TORONTO PUBLIC HEALTH: CONSIDERING: PORTION CONTROL CAP, HEALTHY BY DEFAULT, BAN FREE REFILLS, TAXATION OF SSB

CITY OF HAMILTON: TRANSITION TOWARDS HEALTHIER FOOD CHOICES, IMPROVE MUNICIPAL DRINKING WATER INFRASTRUCTURE, REDUCE SALES AS CONTRACTS EXPIRE

NORTHWEST TERRITORIES: LOOKING TO INTRODUCE SUGARY DRINK TAX IN 2018-19

CANADIAN CANCER SOCIETY: ENDORSEMENT OF SUGARY DRINK LEVY ON MANUFACTURERS

COMPREHENSIVE HEALTHY HYDRATION/EATING STRATEGIES

- INSTALLATION OF 21 WATER FILLING STATIONS IN 9 MUNICIPALITIES
  PRESENTATIONS BY RD, AND BY A RECREATION MANAGER FROM ANOTHER COMMUNITY
- 4500+ WATER BOTTLES DISTRIBUTED TO CHILDREN
- EDUCATION RESOURCES AND SUPPORT FOR 33 EDUCATORS AND SCHOOLS
- EDUCATOR DAY TO SUPPORT FOOD SKILLS AT SCHOOL AND IN THE CLASSROOM
- PROMOTION OF VEGGIES & FRUIT AND WATER AS HALF-TIME SNACKS FOR MINOR SOCCER LEAGUES
- IMPROVEMENT OF HEALTHY FOOD AND BEVERAGE OFFERINGS IN LICENSED CHILDCARE AND EARLY-YEARS SETTINGS
- EQUIPMENT AND FUNDING FOR STUDENT NUTRITION PROGRAMS
- 43 AFTER SCHOOL PROGRAM STAFF TRAINED ON FOOD AND HYDRATION PROGRAMMING
- PROMOTION OF HEALTHY FOODS AT PETERBOROUGH PETES STUDENT NIGHTS
- HEALTHY FOOD/BEVERAGES PROMOTION IN RECREATION PILOT IN 3 MUNICIPALITIES

GATHER BASELINE INFORMATION

"SOME PEOPLE SUGGEST PLACING A HIGHER TAX ON SUGARY DRINKS TO REDUCE CONSUMPTION, WITH PROCEEDS GOING TOWARDS ACTIVITIES THAT SUPPORT HEALTHY BEHAVIOURS (SIMILAR TO TOBACCO AND ALCOHOL). HOW WOULD YOU FEEL ABOUT SUCH A TAX?"

RESULTS WERE MIXED:

- I WOULD SUPPORT THIS: 38%
- I MIGHT SUPPORT THIS: 30%
- I PROBABLY WOULDN'T SUPPORT THIS: 23%
- I WOULD DEFINITELY NOT SUPPORT THIS: 9%

CAFFEINATED ENERGY DRINKS IN THE PETERBOROUGH COUNTY AND CITY

- **CAFFEINATED ENERGY DRINKS (CED)**: CONTAIN CAFFEINE, MAY CONTAIN HERBAL INGREDIENTS, AND CLAIM TO BOOST A PERSON'S ENERGY, REDUCE FATIGUE, AND ENHANCE CONCENTRATION. ENERGY DRINKS ARE DISTINCT FROM SPORTS DRINKS.

Energy Drinks

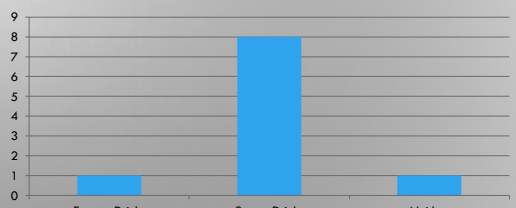
Sports Drinks

- **CAFFEINATED ENERGY DRINKS ARE NOT RECOMMENDED FOR CONSUMPTION BY CHILDREN AND ADOLESCENTS** (CANADIAN PAEDIATRIC SOCIETY, 2017).
  - ADDITIONALLY, SPORTS DRINKS ARE NOT REQUIRED FOR MOST CHILDREN. WATER IS THE MOST APPROPRIATE FLUID REPLACEMENT FOR ROUTINE PHYSICAL ACTIVITY.

SCAN OF ENERGY AND SPORTS DRINK AVAILABILITY

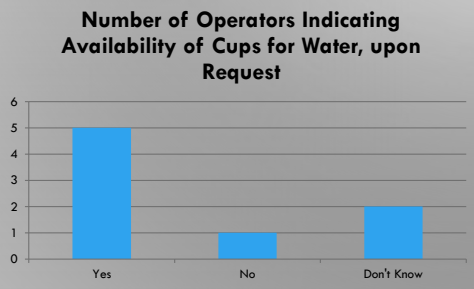
- **PARTICIPATION**: 8 OF 9 MUNICIPALITIES (ONE OF WHICH OPERATED A JOINT FACILITY WITH A POST-SECONDARY INSTITUTION), 1 INDEPENDENTLY OPERATED POST-SECONDARY ATHLETICS FACILITY
- **CONTRACTS:**
  - NO INFLUENCE OF ENERGY DRINK OFFERINGS BY CONTRACTS
  - 6 FACILITIES REPORTED SSB CONTRACTS.
- **OTHER PRODUCTS SOLD CONTAIN CAFFEINE:**
  - PRODUCTS THAT LOOK SIMILAR TO ENERGY DRINKS, AND CONTAIN CAFFEINE, BUT ARE SLIGHTLY UNDER THRESHOLDS REQUIRED TO BE CONSIDERED ENERGY DRINKS.
  - VARIETIES OF POP, ICED/HOT TEA, AND ICED/HOT COFFEES

Municipalities or Operators of Post-Secondary Recreation Centres Indicating Availability of Beverages at Centres they Operate (n=9)



AVAILABILITY OF WATER IN RECREATION CENTRES

- TOTAL OF 21 WATER STATIONS REPORTED
- # OF WATER STATIONS PER FACILITY RANGED FROM 0-4



NEXT STEPS

- RD STAFF CONTINUE OFFERING SUPPORT TO MUNICIPALITIES AND CENTRES DOING RFP REVISIONS, OR NEARING THE END OF CONTRACTS; PROVIDE OPPORTUNITIES FOR RECREATION MANAGERS TO SHARE PRACTICAL STRATEGIES TO IMPROVE NUTRITION ENVIRONMENTS
- ADVOCATE FOR WATER STATIONS/WATER AVAILABILITY IN DEVELOPMENT OF NEW MUNICIPAL OR POST-SECONDARY ATHLETIC FACILITIES
- CONTINUE PUBLIC EDUCATION RE: SPORTS DRINKS AND ENERGY DRINKS
- DEVELOP INTERNAL POLICY FOR WATER AVAILABILITY AT PPH. THIS SHOULD INCLUDE:
  - WATER JUGS AVAILABLE FOR ALL STAFF TO USE AT ALL INTERNAL AND EXTERNAL EVENTS HOSTED BY PPH
  - SIGNAGE TO PROMOTE WATER FOUNTAINS AND WATER FILLING STATION ON SECOND FLOOR
  - REQUIREMENT TO USE NUTRITION CHECKLIST FOR ALL FOOD PROVISION AT PPH MEETINGS

To: All Members
Board of Health

From: Councillor Henry Clarke, Chair, Stewardship Committee

Subject: **Stewardship Committee Report: 2018 Cost-Shared Budget Approval**

Date: November 8, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive the staff report, 2018 Cost-Shared Budget Approval; and,*
- *approve the 2018 cost-shared budget for public health programs and services in the amount of $7,975,438 including Mandatory Public Health Programs, Small Drinking Water Program, Mandatory Program Building Occupancy and the Vector Borne Diseases Program.*

Background:

The Stewardship Committee met last on October 18, 2017. At that meeting, the Committee requested that is item come forward to the Board of Health.

Attachments:

a. Staff Report - 2018 Cost-Shared Budget Approval

Staff Report

2018 Cost-Shared Budget Approval

Date:	October 18, 2017
To:	Stewardship Committee - Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Dale Bolton, Manager, Finance and Property

Proposed Recommendation

That the Stewardship Committee for the Board of Health for Peterborough Public Health:

- receive the staff report, 2018 Cost-Shared Budget, for information; and
- recommend Board approval of the 2018 cost-shared budget for public health programs and services in the amount of $7,975,438 including Mandatory Public Health Programs, Small Drinking Water Program, Mandatory Program Building Occupancy and the Vector Borne Diseases Program.

Financial Implications and Impact

The budget includes all cost-shared programs funded by the Ministry of Health and Long-Term Care (MOHLTC) as well as City, County and First Nations, but does not include other programs and services of the Health Unit funded 100% MOHLTC or by other Ministries of the Province.

Many assumptions are factored into the formulation of the budget for the purposes of determining costs including increases for salary and benefits due to contractual agreements and allowance for the impact of inflation rate on ongoing operating expenditures. The most significant variable in the calculation of the cost-shared budget is the cost of wages and benefits. For 2018, there is a 1.5 Full-Time Equivalent (FTE) reduction in staffing levels due to a

reduction of .30 FTE in finance staff due to program efficiencies and 1.20 FTE due to removal of the travel clinic program from the program requirements as of 2018.
Within the 2018 budget, the immunization and consulting fees received and related program expenditures including staffing and benefits for 1.2 FTE (.60 Registered Nurse and .60 Administrative Assistant) have been removed. A business plan to operate the travel program as a cost-recovery program is being considered.

Budgeted wages reflect the current collective agreements and a projection of settlement for the bargaining units including the Canadian Union of Public Employees (CUPE), the Ontario Nurses' Association (ONA) and the Ontario Public Service Employees Union (OPSEU). The smallest bargaining unit agreement, OPSEU, settled a five year agreement commencing April 1, 2016. Agreements for both CUPE and ONA expired September 30, 2017.

The 2018 cost-shared budget presented reports a deficit from operations of $238,564. The 2018 budget will be balanced, only if funded through the Property Reserve and Program Reserve. The use of reserve funds will help maintain program operations and services at existing levels, with the exception of the program changes previously noted. The 2017 approved budget was balanced using Program Reserve of approximately $92,000 and deferred revenue of $100,000. At this time, due to program efficiencies and some staff gapping, the current projection for 2017 does not require the Program Reserve or the deferred funding to balance operations. As a result, the Program Reserve balance of approximately $189,000 will be available to offset the deficit in 2018. The Reserve would be reduced to approximately half in 2018, if used to balance the budget. The deficit amount for 2018 would have been larger if it were not for the inclusion of the deferred revenue in the amount of close to $100,000.

The second most significant assumption considered in the budget is that there will be no anticipated increase in provincial funding and we have proposed no increase in funding from our local funding partners. We have informed the City and County staff that they can expect a request of 0% increase in 2018.

Decision History

The Health Protection and Promotion Act section 72(1) states that the budget for public health programs and services is the responsibility of the obligated municipalities. In 2004, the provincial government announced, “the Ministry will review Board of Health-approved budgets in relation to guidelines and approve its share according to the following” funding ratio; “75% province, 25% municipalities”.

The County of Peterborough, City of Peterborough fund the Health Unit based on census population data. Curve Lake First Nation and Hiawatha First Nation contribute based on funding agreements with the Board of Health.

Background

On November 9, 2016, the Board approved the 2017 cost-shared budget in the amount of $7,975,438, including Mandatory Public Health, Small Drinking Water, Mandatory Program Building Occupancy and Vector Borne Diseases. The Provincial share of the cost-shared budget was $5,915,900, reflecting a 0% budget increase over the previous year approval.

At this time, the board has not received the 2017 budget approval from the Ministry, however it is anticipated shortly. No increase in provincial contribution to the cost-shared budget is expected, however some additional one-time opportunities, funded 100% may be provided with the approval.

A preliminary 2018 projection was shared with the Board last year that reported a deficit of approximately $350,000 for cost-shared budgets, if the existing staffing levels and services are maintained at the current level assuming no increase in funding from the province or local partners. It was reported that it would be very difficult to maintain existing levels of services and staffing positions may be impacted. Through savings recognized due to changes with staffing mix, program efficiencies and removal of the travel clinic program, the projected deficit for 2018 has now been reduced to approximately $238,000.

Historical Ministry approvals have been:

	Increase
Increase in 2017 over 2016	0.00% (anticipated, no approval at this time)
Increase in 2016 over 2015	0.00%
Increase in 2015 over 2014	7.34% (includes increase to occupancy costs)
Increase in 2014 over 2013	2.00%
Increase in 2013 over 2012	2.00%
Increase in 2012 over 2011	1.62%
Increase in 2011 over 2010	2.85%
Increase in 2010 over 2009	3.00%

While the Province has not released a 2018 budget target, recent messages from the Ministry indicate no funding increase should be expected for 2018 for cost-shared programs. The budget presented is based on a 0% increase. Although “equity funding” formula was applied in 2015 and 2016, it is uncertain if and how the Ministry will apply the formula for either 2017 or 2018. Any “equity funding” previously received has not provided additional funding for the organization because any increase for mandatory programs has been clawed back through the building occupancy budget.

For the 2018 budget the following assumptions have been made:

1) Minimal reduction in total FTE staffing due to changes in the Travel Clinic Program and Financial Services;
2) Salaries are based on existing union settlements and projection of settlement for OPSEU, CUPE and ONA;
3) There will be no new Pay Equity adjustments;
4) Non-union compensation projected as per April 1, 2017 approved rates;
5) General inflation will be 1%;
6) There will be no significant change in Influenza, HPV or Meningitis C immunization rates;
7) OMERS pension rates are known all other benefit costs are estimates;
8) Allocation of local contributions between the City and County are based on published 2016 population census data and First Nation contributions are an estimate of per capita cost based on population data provided by the First Nations.

There are many uncertainties for 2018 that may potentially impact the budget including the implementation of the new Ontario Public Health Standards and Ministry financial reporting requirements, in effect January 2018. The Province anticipates these changes will provide the necessary information to make better informed and evidence based decisions about public health programs. With this information, the Ministry will demonstrate to the Province the value of money for the investment in public health programs that may ultimately provide the needed increase in Ministry funding to address forecasted deficits, without impact on staffing or depleting reserves. If no additional funding is secured from the Ministry, existing staffing positions and services will be impacted. If program delivery expectations or funding levels do not change by the July 2018, difficult decisions will be need to be made regarding cuts to services and staffing.

Rationale

Under the *Ontario Public Health Standards*, the Board is required to approve an annual budget that does not forecast an unfunded deficit.

The 2018 cost-shared budget presented reports a deficit from operations of $238,564. The 2018 budget will be balanced, if funded through the Property Reserve and Program Reserve and will not result in a deficit. The use of reserve funds will help maintain program operations and services at existing levels in anticipation of a potential increase in funding from the Ministry. The Program Reserve would be reduced would be reduced by approximately half of the current balance, if used in 2018 to balance the budget. If the organization recognizes savings during the year through efficiencies, part of the reserve may be maintained for future years.

Strategic Direction

The 2018 approved budget allows the Board to address all its strategic priorities.

Contact:

Dale Bolton
Manager, Finance and Property
(705) 743-1000, ext. 302
dbolton@peterboroughpublichealth.ca

Peterborough Public Health **DRAFT 2018 PUBLIC HEALTH (Including SDW, VBD & Building Occupancy) BUDGETS – Operations Only (October 16, 2017)**

		2018 Budget	2017 Budget	Change	% Increase	
	EXPENDITURES					
1	Salaries and wages	5,532,242	5,485,443	46,799	0.85%	Increase includes estimate for contract settlements, net of reduction in staffing for Travel Clinic Program
2	Employee benefits	1,554,835	1,539,832	15,003	0.97%	Directly relates to increase in salaries and anticipated benefit rates, net of reduction in Travel Clinic Program staffing
3	% benefits of salary and wages	28.10%	28.07%			
4	Staff Training	42,539	46,573	-4,034	-8.66%	Reduction for Travel Clinic Program
5	Board Training and Employee Recognition	55,498	50,988	4,510	8.85%	Allowance for new board member honorariums and increase for related board committees
6	Travel	40,400	40,000	400	1.00%	
7	Building Occupancy	712,050	705,000	7,050	1.00%	
8	Office Expenses, Printing, Postage	36,534	36,172	362	1.00%	
9	Materials, Supplies	277,071	367,892	-90,821	-24.69%	Reduction for Travel Clinic Program
10	Office Equipment	12,840	12,713	127	1.00%	
11	Professional and Purchased Services	318,920	315,762	3,158	1.00%	
12	Communication costs	96,111	95,159	952	1.00%	
13	Information and Information Technology Equipment	61,189	60,583	606	1.00%	
	EXPENDITURES	**8,740,229**	**8,756,117**	**-15,888**	**-0.18%**	
	FEES & OTHER REVENUES					
14	Expenditure Recoveries Flu, HPV, MenC	22,500	22,500	-	0.00%	
15	Expenditure Recoveries & Offset Revenues	503,727	616,046	-112,319	-18.23%	Decrease due to Reduction for Travel Clinic Program net of other deferred funds to be expended in current year
	FEES & OTHER REVENUES	**526,227**	**638,546**	**46,740**	**7.32%**	
	NET EXPENDITURES - Cost Shared Budget	**8,214,002**	**8,117,571**	**142,133**	**1.75%**	
	PARTNER CONTRIBUTIONS – 2018					
16	Ministry of Health & Long-Term Care	5,915,900	5,915,900	-	0.00%	
17	County of Peterborough	841,241	841,241	-	0.00%	
18	City of Peterborough	1,205,955	1,205,955	-	0.00%	
19	Curve Lake First Nation	9,328	9,328	-	0.00%	
20	Hiawatha First Nation	3,014	3,014	-	0.00%	
	FUNDING PARTNER CONTRIBUTIONS	**7,975,438**	**7,975,438**	**-**	**0.00%**	
	Projected Deficit	**-238,564**	**-142,133**			
	Property Reserves	**50,000**	**50,000**	***Condo contribution funded by Property Reserve***		
	Program Reserves	94,500	92,133	***Program Reserve Funding available to offset Deficit in 2018***		
	Program Gapping	94,064	0			
	Balanced Budget - Net surplus in funding	**0**	**0**			

NOTICE: Proposed recommendations as noted within the posted agenda package may not be indicative of the final decision made by the Board of Health at the meeting. Should a member of the public or media outlet wish to confirm or clarify any Board position following the meeting, please contact the PPH Communications Manager or refer to the meeting summary issued shortly thereafter. Final motions are recorded in posted approved Minutes.

Salary & Benefit Assumptions

ONA & CUPE agreement increases October 1, 2017.
OPSEU agreement increases per contract in effect April 1, 2016.
OMERS rates are not known, YMPE is estimate.
All other benefits are based on estimated rate increases over 2017 rates.
Increase to non-union compensation effective April 1, 2017.

Other Assumptions

Budget includes Cost-shared: Mandatory programs, cost shared SDW , VBD and Flu, HPV and Men C activities.
Allows for 1% inflation in 2018 for other operating costs.
Assumes province will continue funding 100% of enhanced MOH salary.
Allocation of local contributions between City and County based on published 2016 population census data.
First Nation allocations are estimate of per-capita cost based on band provided population number.

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Correspondence for Direction – Immunization of Child Care Workers, Durham

Date: November 8, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive for information, the memo dated October 4, 2017 from Dr. Robert Kyle, Commissioner and Medical Officer of Health, regarding Vaccine Recommendations for Child Care Workers, recommending that the Government of Ontario amend the Publicly Funded Immunization Schedule such that vaccinations recommended for child care workers by Medical Officers of Health would be publicly funded for those workers; and,*
- *support their positions and communicate this support to Minister Hoskins, with copies to Dr. David Williams, Chief Medical Officer of Health, local MPPs, the Association of Local Public Health Agencies, and Ontario Boards of Health.*

Background:

The Council of Ontario Medical Officers of Health (COMOH) has agreed that all Medical Officers of Health will, at a minimum, recommend that all child care workers receive vaccines recommended by the National Advisory Committee on Immunization (NACI). Two of these vaccines are not currently publicly funded in Ontario (unless they meet high-risk eligibility criteria). The Canadian Immunization Guide recommends:

1. vaccination for all child care workers with hepatitis B vaccine since children with hepatitis B are usually asymptomatic and the hepatitis B status of children in child care settings is generally unknown; and,

2. vaccination for all varicella-susceptible child care workers with varicella vaccine since outbreaks can occur in child care and educational settings where there are unimmunized children.

By increasing the eligibility criteria for these two vaccines to include child care workers, both the protection of young children as well as the occupational health and safety of the worker will be enhanced.

DURHAM REGION

October 12, 2017

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

COPY RS – to BOH please

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 ROSSLAND ROAD EAST
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Don Beaton, B.A.S., M.P.A.
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health – re: Vaccine Recommendations for Child Care Workers
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on October 11, 2017, Council adopted the following recommendations of the Committee:

"A) That the correspondence from the Council of Ontario Medical Officers of Health (COMOH) requesting the Government of Ontario to amend the Publicly Funded Immunization Schedule such that vaccinations recommended for child care workers by Medical Officers of Health would be publicly funded for those workers, be endorsed; and

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

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health, dated October 4, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

"Service Excellence for our Communities"

c. The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
The Honourable Tracy MacCharles, MPP, (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP, (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Chief Medical Officer of Health
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health

DURHAM REGION

The Regional Municipality of Durham

HEALTH DEPARTMENT

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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: October 4, 2017

Re: Vaccine Recommendations for Child Care Workers

On July 18, 2017, the Council of Ontario Medical Officers of Health (COMOH) sent the attached correspondence to the Chief Medical Officer of Health of Ontario and the Assistant Deputy Minister, Population and Public Health Division, Ministry of Health and Long-Term Care. The correspondence outlines COMOH's recommendations regarding public health requirements in the *Immunization of School Pupils Act* and the *Child Care and Early Years Act, 2014* (CCEYA).

One of the recommendations requests the Government of Ontario to amend the Publicly Funded Immunization Schedule such that vaccinations recommended for child care workers by Medical Officers of Health (MOHs) would be publicly funded for those workers.

As articulated in *Ontario Regulation* 137/15 of the CCEYA, child care operators are required to ensure that employees have immunizations as recommended by the local MOH. COMOH has agreed that all MOHs will, at a minimum, recommend that all child care workers receive vaccines recommended by the National Advisory Committee on Immunization (NACI). NACI recommends two immunizations for child care workers which are not currently publicly funded for adults (unless they meet high-risk eligibility criteria). These include immunization against varicella (i.e., chickenpox) and hepatitis B.

Given the low wages of child care workers and the high cost of these vaccines, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from COMOH as regards vaccine recommendations for child care workers is endorsed; and

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

Respectfully submitted,

Original signed by

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

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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

July 18 2017

Dr. David Williams
Chief Medical Officer of Health
393 University Ave 21st Flr
Toronto, ON M5G 2M2

Ms. Roselle Martino
Assistant Deputy Minister, Health and Long-Term Care
777 Bay St #1903
Toronto, ON M7A 1S5

Dear Dr. Williams and Ms. Martino,

Re: COMOH Recommendations – ISPA and CCEYA

On behalf of members of the Council of Ontario Medical Officers of Health (COMOH), I am writing to inform you of the Council's adoption of recommendations for local medical officers of health (MOHs) to follow regarding public health requirements for the Child Care and Early Years Act and the Immunization of School Pupils Act.

The recommendations are meant to encourage coordinated practice across all 36 health units, and prevent discrepancies, especially as children and adults move between health units.

1. The Child Care and Early Years Act – Vaccine Recommendations for Child Care Workers:

Under section 57, any vaccinations recommended by MOHs for child care workers become mandatory under the Act. COMOH has agreed that all MOHs will at minimum recommend that all child care workers receive vaccines that the National Advisory Committee on Immunization (NACI) recommends* for this group, excluding influenza vaccine.

Some of these vaccinations are not publicly-funded, and the costs of purchase and clinician's fees must be borne by individual. Unfortunately, child care workers are identified in the Ontario Poverty Reduction Strategy as in need of income supplementation given their low wages and we want to ensure that financial barriers are not an obstacle to protecting these individuals and the children in their care.

- **COMOH therefore requests that the Publicly Funded Immunization Schedule be amended such that vaccination recommended for child care workers by MOHs (per NACI recommendation) would be publicly funded for those workers.**

Currently the gaps are varicella and hepatitis B vaccinations, however, as hepatitis B is included in the school vaccination program and many adults have pre-existing natural immunity for varicella, the financial impact is expected to be relatively small. This also supports the Ministry's Immunization 2020 Action #18, to develop targeted health equity approaches for vulnerable communities.

2. The Immunization of School Pupils Act (ISPA):

I) Period of Grace for Vaccination Given up to 4 Days before the Required Date:

COMOH has received for information the recommendation that MOHs consider a 4-day grace period when using the discretionary provision to decide whether to suspend a student under the ISPA. This grace period is meant to strike a balance between the goal of ISPA (to ensure that children are properly vaccinated) and its inflexible timing requirements that are in some cases an impediment to reaching it.

It is up to each MOH to decide, based on his/her discretionary provision, how to implement this in their health unit. Currently, the administrative exemption is the only tool in Panorama for a health unit to use for this purpose and is being recommended for health units to utilize when accepting a vaccine that was administered before the required date.

- **COMOH therefore requests that the Ministry consider a new tool for health units to utilize when implementing a period of grace.**

In particular, the following features should be considered:

- The early dose should be accepted as valid meaning no exemption is required, similar to the estimated vaccination date. There should be no increase to the number of exemptions in the database and no need to analyze these numbers in local/provincial coverage reports.
- There are no impacts to the forecaster and the client will proceed through screening activities without any follow up required.
- These clients will not appear on at-risk reports during an outbreak. If an administrative exemption is used, these clients will appear on 'at risk' reports during an outbreak and staff involved with outbreak management need to asses these records individually prior to contact/case management.
- There is less risk for errors in forecasting and/or screening practices if a separate Panorama function is created.

II) Communication Campaign for Health Care Providers by Ministry

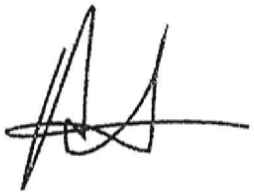
As part of Immunization 2020 Action #8, the Ministry has agreed to launch a coordinated immunization communication strategy. COMOH is requesting the Ministry to work closely with health care partners to share important immunization information to make informed immunization decisions.

- **COMOH therefore requests that the Ministry provide clear guidance to all physicians in Ontario to vaccinate children according to Ontario's Publicly Funded Immunization Schedule, especially adhering to provide vaccinations on or after the specified age (with particular attention to MMR and Meningococcal C vaccinations given on or after the 1st birthday and Tdap-IPV vaccine given on or after the 4th birthday).**

COMOH is fully supportive of ensuring high vaccination rates and preventing disease outbreaks in child care centres and schools. We would be pleased to share further background from the COMOH ISPA

Working Group that developed these recommendations should you require it, and we look forward to working with you to implement the above recommendations.

Sincerely,



Dr. Penny Sutcliffe
Chair, Council of Ontario Medical Officers of Health

COPY: Dr. Jessica Hopkins, Chair, COMOH ISPA Working Group

*https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-3-vaccination-specific-populations/page-11-immunization-workers.html#p3c10t3

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Correspondence for Direction – Smoke-Free Ontario Modernization, Simcoe Muskoka

Date: November 8, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive for information, letter dated October 25, 2017 from Scott Warnok, Board Chair, Simcoe Muskoka District Health Unit regarding the Smoke-Free Ontario Modernization; and,*
- *support their positions and communicate this support to Minister Hoskins, with copies to Dr. David Williams, Chief Medical Officer of Health, local MPPs, the Association of Local Public Health Agencies, and Ontario Boards of Health.*

Background:

Staff are encouraged by the comprehensive and progressive nature of the Executive Steering Committee's October 10th report and recommendations to modernize the Smoke-Free Ontario Strategy and reduce commercial tobacco use in Ontario. The enhanced focus on the tobacco industry strikes at the root cause of the epidemic of tobacco-related illness in Ontario. Ontario's modernized strategy must move beyond incrementally increasing restrictive measures to changing how the tobacco industry operates in Ontario.

The recommendations proposed by the Executive Steering Committee are the range of strategies that are critical to meeting Ontario's goal of the lowest rates of tobacco use in Canada and the tobacco endgame target of less than 5% of the population using tobacco products by 2035.

simcoe muskoka
DISTRICT HEALTH UNIT

October 25, 2017

Dr. Eric Hoskins
Minister – Minister's office
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor St.
Toronto, ON M7A 2C4

Dear Minister Hoskins,

On March 15, 2017, the Board of Health for the Simcoe Muskoka District Health Unit passed a motion to write to the federal government in supporting the approaches identified at the 2016 summit, A Tobacco Endgame for Canada and its target of reducing tobacco use to less than five per cent by 2035. Accordingly, we communicated with the Ministry of Health and Long-Term care in recommending that modernization of the Smoke-Free Ontario Strategy include the recommendations identified in the tobacco endgame. In supporting these recommendations, the Province and its partners can successfully address and minimize the preventable death and disease caused by tobacco product use and reduce the unmaintainable drain it places on our health care system.

The Board of Health is therefore pleased to review the recently released "Smoke-Free Ontario Modernization" Report of the Executive Steering Committee. In particular, the Board of Health is encouraged by the report's evidence-based recommendations, supports and strategies which identify actionable and achievable outcomes for future action that are in keeping with the resolutions by the Association of Local Public Health Agencies that identified the need for intensified and targeted tobacco controls to protect and promote the health of Ontario residents. Further, the Board of Health commends the Executive Steering Committee in recognizing that Ontario is closer to ending the tobacco epidemic despite on-going efforts by the tobacco industry who demonstrate a profound, self-serving disinterest in its customers' health and a calculating, sophisticated determination to resist any regulation. Thus, The Board of Health recommends that the province proceed with developing a renewed Smoke-Free Ontario strategy committing to the endgame target with a smoking prevalence of less than 5% by 2035, by employing the bold strategies recommended in the Smoke Free Ontario Modernization report.

Ontario's success in alleviating this tobacco epidemic requires strong leadership and action by your Ministry to strengthen and create legislation and supports that will diminish addiction to products that are the single greatest threat to the health of Ontarians. We look forward to working with the province as it updates the Smoke-Free Ontario strategy.

Sincerely,

ORIGINAL SIGNED BY

Scott Warnock,
Chair, Board of Health

c. Simcoe Muskoka Municipal Councils
Ontario Boards of Health
Central Local Health Integration Network
North Simcoe Muskoka Local Health Integration Network
Association of Local Public Health Agencies

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

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: Correspondence for Information

Date: November 8, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:

a. Letter dated October 11, 2017 from MPP Leal to Minister Couteau regarding the Healthy Babies, Healthy Children Program.

b. Letter dated October 31, 2017 from the Board Chair to Ministers Hoskins, Hunter and Matthews regarding energy drinks.

c. Letter dated October 31, 2017 from the Board Chair to Minister Petitpas Taylor regarding energy drinks.

d. Email dated November 1, 2017 from the Central-East Local Health Integration Network regarding the release of their quarterly report, Strengthening Connections.

Correspondence from the Association of Local Public Health Agencies (alPHa):

e. E-newsletter dated November 1, 2017

f. Expert Panel Responses* ***(web hyperlink)***
(alPHa has collected responses from member agencies to the Expert Panel Report)

Letters/Resolutions from other Local Public Health Agencies:

<u>Healthy Menu Choices Act*</u>
g. Grey Bruce

<u>Nutritious Food Basket*</u>
h. KFL&A

<u>Provincial Alcohol Modernization and Strategy*</u>
i. Algoma
j. Northwestern

k. Thunder Bay

**The Board has previously taken a position on this item.*

JEFF LEAL, MPP
Peterborough

October 11th, 2017

The Honourable Michael Coteau
Minister of Children and Youth Services
Minister Responsible for Anti – Racism
14th Floor, 56 Wellesley St. W
Toronto, Ontario
M5S 2S3

Dear Michael,

I have been approached by the Chair, Mary Smith and staff representatives from Peterborough Public Health regarding the funding of the Healthy Babies/ Healthy Children Program budget shortfall. I understand a delegation from Peterborough took the opportunity at A.M.O. in Ottawa in August to chat with you on this issue. I have provided you with a detailed backgrounder on this matter for your review.

I want to thank you for taking the time to review this matter.

Yours sincerely,

Original Signed by
Jeff Leal, MPP

Jeff Leal

CC: Ms. Mary Smith, Chair
Peterborough Public Health
Jackson Square
185 King Street
Peterborough, Ontario
K9J 2R8

Constituency Office
236 King Street, Peterborough, ON K9J 7L8
Tel 705-742-3777 | Fax 705-742-1822 | Email jleal.mpp.co@liberal.ola.org

The Premier of Ontario

Legislative Building, Queen's Park
Toronto, Ontario M7A 1A1

Ontario

La première ministre de l'Ontario

Édifice de l'Assemblée législative, Queen's Park
Toronto (Ontario) M7A 1A1

October 16, 2017

Her Worship Mary Smith
Chair
Peterborough Public Health
Jackson Square
185 King Street
Peterborough, Ontario
K9J 2R8

Dear Mayor Smith:

Thank you for your letter on behalf of the Board of Health for Peterborough Public Health regarding the Changing Workplaces Review. I appreciate your sharing your kind words of support for Bill 148, Fair Workplaces, Better Jobs Act, 2017.

I note that you have sent a copy of your correspondence to my colleague the Honourable Kevin Flynn, Minister of Labour. I trust that he will also give your comments his consideration.

Thank you once again for raising this topic with me. Please accept my best wishes.

Sincerely,

Kathleen Wynne
Premier

c: The Honourable Kevin Flynn

Health Canada Santé Canada

SEP 2 8 2017

RECEIVED

OCT 1 1 2017 RS

Peterborough Public Health

Mayor Mary Smith
Chair, Board of Health
Peterborough Public Health
Jackson Square, 185 King Street
Peterborough, ON
K9J 2R8

Dear Mayor Smith:

I am writing in response to your email correspondence of May 30, 2017, addressed to the Honourable Jane Philpott, former Minister of Health, by the Office of the Prime Minister, concerning the inquiry to the TRC call to Action #89 legislation. As you may be aware, the Honourable Ginette Petitpas Taylor was appointed federal Health Minister on August 28, 2017. I regret the delay in replying.

Health Canada and the Public Health Agency of Canada are dedicated to helping First Nations people and Inuit care for, improve and maintain their health. A wide range of community-led and culturally relevant health promotion and prevention activities are offered in over 600 First Nations and Inuit communities to promote healthy lifestyles, including physical activity.

Activities varied from one community to another, and included walking clubs, weight-loss groups and fitness classes, community kitchens and gardens, and a range of activities for children in schools. If you want to learn more about our initiatives, please consult: https://www.canada.ca/en/health-canada/services/first-nations-inuit-health/diseases-health-conditions.html.

I would like to thank you for taking the time to outline your views.

Yours sincerely,

for
Sony Perron
Senior Assistant Deputy Minister
First Nations and Inuit Health Branch

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

October 31, 2017

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

The Honourable Mitzie Hunter
Minister of Education
22nd Floor, Mowat Block
900 Bay Street
Toronto, Ontario M7A 1L2
mhunter.mpp.co@liberal.ola.org

The Honourable Deborah Matthews
Minister of Advanced Education and Skills Development
3rd Floor, Mowat Block
900 Bay Street
Toronto, Ontario M7A 1N3
dmatthews.mpp.co@liberal.ola.org

Dear Honourable Ministers:

Re: Restriction of Marketing and Sale of Caffeinated Energy Drinks to Children and Youth

Caffeinated energy drinks (CEDs) present a health concern for children and youth. These beverages replace healthy choices, have caffeine levels that may exceed maximum daily recommendations, and contain added sugar and other ingredients. Cases of serious medical reactions linked to CEDs have also been reported. The Canadian Paediatric Society also recently released a position statement outlining the risks of CEDs for children and youth.[1] However, in 2014, in Ontario, 29% of students in grades 7-12 reported consuming energy drinks.[2] CEDs are available for sale to children, and youth, and are heavily marketed to these demographics.

The Ontario Ministry of Education's School Food and Beverage Policy, Policy/ Program Memorandum 150 (2010), has classified CEDs as "not permitted for sale". As review of this policy is conducted, we recommend that caffeinated energy drinks, and other foods and beverages high in caffeine and sugar, continue to be restricted from sale in elementary and secondary schools.

Although not currently available for purchase at elementary and secondary schools, school-aged children and youth still have ample opportunity to purchase CEDs at local convenience stores, gas stations, grocery stores, municipal facilities, and post-secondary recreation facilities where many children participate in activities on a regular basis. It would be our recommendation that the school policy be extended into a broader strategy to protect children and youth in additional settings. This strategy could include development of legislation complementing PPM 150 to restrict marketing and sale of CEDs and other foods and beverages high in sugar and caffeine in facilities operated by post-secondary institutions that are frequented by children and youth.

The Canadian Medical Association also supports a ban on the sale of CEDs to Canadians under legal drinking age.[3] Any provincial strategy to restrict the sale and marketing of CEDs to children and youth should complement changes at the federal level to restrict marketing to children under 17 currently outlined in Bill S-228 and the consultation document, "Restricting Marketing to Children".

On behalf of Peterborough Public Health and the residents of Hiawatha and Curve Lake First Nations, and the County and City of Peterborough, we ask you to continue your work on moving this important issue forward.

Sincerely,

Original signed by

Mayor Mary Smith
Chair, Board of Health

/ag

cc: Local MPPs
Dr. David Williams, Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Boards of Health

References:

1. Pound, C., and Blair, B. 2017 (September). Energy and sports drinks in children and adolescents. Canadian Paediatric Society Position Statement.
Retrieved from: http://www.cps.ca/en/documents/position/energy-and-sports-drinks

2. Cumming, T., Patton, R., Rynard, V., Manske, S. 2016 (December). 2014/2015 Canadian Tobacco, Alcohol and Drugs Survey: Health Profile for Ontario. Waterloo (ON): Propel Centre for Population Health Impact, 1- 14.
Retrieved from: https://uwaterloo.ca/canadian-student-tobacco-alcohol-drugs-survey/sites/ca.canadian-student-tobacco-alcohol-drugs-survey/files/uploads/files/cst14_provincialprofile_ontario_20170116_a.pdf

3. Canadian Medical Association. 146th annual meeting of the Canadian Medical Association, August 19–21, 2013, Calgary, AB. DM 5–25.
Retrieved from: https://www.cma.ca/En/Pages/ 2013-resolutions.aspx

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

October 31, 2017

The Honourable Ginette Petitpas Taylor
Minister of Health
Government of Canada
House of Commons
Ottawa, ON K1A 0A6
Ginette.PetitpasTaylor@parl.gc.ca

Dear Minister Petitpas Taylor:

Re: Restriction of Marketing and Sale of Caffeinated Energy Drinks to Children and Youth

Caffeinated energy drinks (CEDs) present a health concern for children and youth. These beverages replace healthy choices, have caffeine levels that may exceed maximum daily recommendations, and contain added sugar and other ingredients. Cases of serious medical reactions linked to CEDs have also been reported. The Canadian Paediatric Society also recently released a position statement outlining the risks of CEDs for children and youth.[1] However, in 2014, 29% of Ontario students in grades 7-12 reported consuming energy drinks.[2] CEDs are available for sale to children, and youth, and are heavily marketed to these demographics. Peterborough Public Health commends the Federal Government for identifying the restriction of marketing of unhealthy foods to children under 17 as a priority for action, and supports Bill S-228. We request that CEDs and other foods and beverages high in caffeine and sugar are included as the complementary definition of unhealthy food is developed.

Beyond the restriction of marketing, we would like to see more done to protect our young people. Currently there are no federal regulations restricting the sale of CEDs to children and youth. Elementary, secondary, and post-secondary school students have ample opportunity to purchase energy drinks at post-secondary recreation facilities, local convenience stores, gas stations, grocery stores, and municipal facilities. The Canadian Medical Association supports a ban on the sale of CEDs to Canadians under legal drinking age in their jurisdiction.[3] The Peterborough Board of Health also supports restricting the sale of CEDs to children and youth. We request that this be considered when amendments to the Food and Drug Regulations are enacted after the conclusion of the Temporary Marketing Authorization period.

On behalf of Peterborough Public Health and the residents of Hiawatha and Curve Lake First Nations, and the County and City of Peterborough, we ask you to continue your work on moving this important issue forward.

Sincerely,

Original signed by

Mayor Mary Smith
Chair, Board of Health

/ag

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

References:

1. Pound, C., and Blair, B. 2017 (September). Energy and sports drinks in children and adolescents. Canadian Paediatric Society Position Statement.
   Retrieved from: http://www.cps.ca/en/documents/position/energy-and-sports-drinks

2. Cumming, T., Patton, R., Rynard, V., Manske, S. 2016 (December). 2014/2015 Canadian Tobacco, Alcohol and Drugs Survey: Health Profile for Ontario. Waterloo (ON): Propel Centre for Population Health Impact, 1- 14.
   Retrieved from: https://uwaterloo.ca/canadian-student-tobacco-alcohol-drugs-survey/sites/ca.canadian-student-tobacco-alcohol-drugs-survey/files/uploads/files/cst14_provincialprofile_ontario_20170116_a.pdf

3. Canadian Medical Association. 146th annual meeting of the Canadian Medical Association, August 19–21, 2013, Calgary, AB. DM 5–25.
   Retrieved from: https://www.cma.ca/En/Pages/ 2013-resolutions.aspx

From: Rogoski, Sheila [mailto:Sheila.Rogoski@lhins.on.ca]
Sent: Wednesday, November 01, 2017 3:47 PM
Subject: SENT on BEHALF of DEBORAH HAMMONS, CEO Central East LHIN
Importance: High

We are pleased to introduce the Central East LHIN quarterly report to the community. The report, titled "Strengthening Connections" highlights the deliberate and constructive steps that the Central East LHIN takes, in collaboration with its partners to continue to lead the advancement of an integrated sustainable health care system that ensures better health, better care and better value so that local residents are living healthier at home. To view this newsletter, please see the attached jpeg or go to the Central East LHIN website and click on News and Events – press releases. Please share this with your own stakeholders. Thanks for your ongoing interest and support of the Central East LHIN.

Link:
http://www.centraleastlhin.on.ca/Page.aspx?id=0596452B1A0C4C5692F4D8F9633A9BE4

Sheila Rogoski
Executive Coordinator/Executive Assistant to Deborah Hammons, CEO

Central East Local Health Integration Network
920 Champlain Court | Whitby, Ontario | L1N 6K9
Sheila.Rogoski@lhins.on.ca
Tel: 905 427 5497 x 3220 or Toll Free: 1-866-804-5446 | 310-2222
Cell: 905-409-3482
Fax: 905-444-2562

Living Healthier at Home / Vivre en meilleure santé chez eux

centraleastlhin.on.ca and healthcareathome.ca/centraleast

Find the community and health care resources you need:
Trouvez la communauté et les ressources qu'il vous faut sur les soins de santé:

From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: Wednesday, November 01, 2017 11:22 AM
To: Alida Gorizzan <agorizzan@peterboroughpublichealth.ca>
Subject: alPHa Information Break - November 1, 2017

alPHa
Association of Local PUBLIC HEALTH Agencies

Information Break

November 1, 2017

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

alPHa Responds to Report by Expert Panel on Public Health

Both alPHa and the COMOH section have submitted their responses to government on the Expert Panel on Public Health's report, *Public Health within an Integrated Health System*. The submissions have been shared widely with the alPHa membership, and can be viewed by clicking the links below. A special resource page has also been created on the alPHa website to house these responses as well as those by various health units, and other background materials related to the Expert Panel's report.
Read alPHa's response to the Expert Panel report
Read COMOH's response to the Expert Panel report
View alPHa's Expert Panel report response web page

New alPHa Executive Director

The alPHa Board of Directors has appointed Loretta Ryan as the association's Executive Director, effective November 6, 2017. A certified professional planner, Loretta joins alPHa after 17 years with the Ontario Professional Planners Institute where her work intersected with local public health on the Institute's initiatives on healthy and sustainable communities. Members will have a chance to meet Loretta as she will be attending the alPHa meetings on

November 3 in Toronto. Welcome, Loretta!
Learn more about Loretta here

Government News: Round Up

Canada invests in cannabis education and awareness campaign (Oct. 31)

Ministry of Finance shares next steps on establishing cannabis retail stores with municipalities (Oct. 27)

Chief Public Health Officer of Canada releases Annual Report on State of Public Health, Designing Healthy Living (Oct. 26)

New school policy requires care plans for students with medical needs (Oct. 24)

Ontario expands Early Years programming (Oct. 24)

Federal health minister marks one-year anniversary of Healthy Eating Strategy (Oct. 20)

Minister of Community Safety & Correctional Services and Attorney General make statement on cannabis enforcement summit (Oct. 19)

Bill 148, *Fair Workplaces, Better Jobs Act*, passes second reading (Oct. 18)

Ontario funds 48 programs to tackle poverty, increase food security(Oct. 17)

Province releases Smoke-Free Ontario Modernization report (Oct. 10)

Health System Integration update (Oct. 10)

Update on Ontario Basic Income pilot (Oct. 4)

Province creating Opioid Emergency Task Force (Oct. 4)

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alPHa Website Feature: Current Consultations

alPHa lists current consultation opportunities for health units and boards to provide input to government on a range of public health-related legislation, regulations and issues. Click the link below to view.
Visit the alPHa Current Consultations page here

Upcoming Events - Mark your calendars!

November 3, 2017 - Fall alPHa Meetings (COMOH, BOH Section), DoubleTree by Hilton Downtown Toronto Hotel. Registration has now closed. Questions? Send them to karen@alphaweb.org

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

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

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

October 25, 2017

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

Dear Minister Hoskins:

Re: Assessment of the Healthy Menu Choices Act

On June 23, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Peterborough Public Health and Leeds, Grenville and Lanark District Health Unit regarding the indicators of success of the newly implemented Healthy Menu Choices Act. The following motion was passed:

Moved by: David Shearman Seconded by: Mike Smith

"THAT, the Board of Health supports the positions of Leeds, Grenville and Lanark District Health Unit and Peterborough Public Health calling for transparency regarding the indicators of success of the newly implemented Healthy Menu Choices Act, and further THAT the Board requests transparency regarding the evaluation of related promotional activities."

Carried

Sincerely,

David Inglis, Chair
Board of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

KFL&A Public Health

October 26, 2017

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

Dear Minister Hoskins,

RE: Advocacy for the Nutritious Food Basket

At its meeting of October 25, 2017, the Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion:

> **THAT the KFL&A Board of Health recommend to the Ontario Minister of Health and Long-Term Care that the Ontario Ministry of Health and Long-Term Care provide and support an updated Nutritious Food Basket Protocol with the modernized Standards for Public Health Programs and Services to ensure consistent data collection and methodology for community-level food costing across the province.**
>
> **FURTHER THAT the KFL&A Board of Health recommend that a copy of this memorandum be forwarded to Hon. Peter Milczyn, Minister of Housing (Responsible for the Poverty Reduction Strategy and the Food Security Strategy); Hon. Helena Jaczek, Minister of Community and Social Services; the Ontario Society of Nutrition Professionals in Public Health; members of provincial parliament, S. Kiwala, Kingston and the Islands, and R. Hillier, Lanark-Frontenac-Lennox and Addington; Ontario boards of health; and the Association of Local Public Health Agencies**

The Nutritious Food Basket (NFB) is an important surveillance tool used by all Ontario local public health agencies to inform food security programs and policy work. The modernization of the Ontario Standards for Public Health Programs and Services (OSPHPS) provides an opportunity to update it. Food Insecurity is an ongoing public health issue and the removal of the NFB Protocol could have negative consequences on food security programs, policies and partnerships.

Not having a mandatory, consistent, ministry-supported approach to collecting and using community-level data on the cost of food across the province is concerning. We may be left with more work to create a patchwork of poor data sets without year-to-year comparability. Furthermore,

KFL&A Public Health

the provincial government's decision not to monitor household food insecurity as part of the Canadian Community Health Survey for 2015 and 2016 will have a significant impact on food security monitoring and program planning.

The lack of adequate food cost and food security surveillance data limits the ability to monitor these trends for program planning, limits our ability to assess the impact of policies over time, and could negatively impact our agency's ability to comply with the modernized OSPHPS expectations related to health equity, evidence-informed practice, and addressing community needs. In addition, the lack of this surveillance data could have serious consequences on other ministry-supported initiatives including the Ontario Basic Income Pilot, the Ontario Poverty Reduction Strategy, and the Ontario Food Security Strategy, and specifically Bill 6, Ministry of Community and Social Services Amendment Act, 2016. Bill 6 calls for the establishment of a Social Assistance Research Commission to annually determine the cost of living in different parts of the province, with recommended rates of provincial social assistance based on analysis of the cost of regional basic necessities including the NFB.

The KFL&A Board of health urges the Ministry of Health and Long-Term Care to provide and support an improved Nutritious Food Basket Protocol with the modernized Standards for Public Health Programs and Services to ensure consistent data collection and methodology for community-level food costing across the province.

Yours truly,

Denis Doyle

Denis Doyle, Chair
KFL&A Board of Health

Copy to: KFL&A Board of Health Members
Hon. Peter Milczyn, Minister of Housing (Responsible for the Poverty Reduction Strategy and the Food Security Strategy)
Hon. Helena Jaczek, Minister of Community and Social Services
Ontario Society of Nutrition Professionals in Public Health
S. Kiwala, MPP, Kingston and the Islands
R. Hillier, MPP, Lanark-Frontenac-Lennox and Addington
Boards of Health, Local Public Health Agencies
Association of Local Public Health Agencies

Algoma
PUBLIC HEALTH
Santé publique Algoma

www.algomapublichealth.com

October 30, 2017

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

Dear Minister Hoskins:

Re: Urgent provincial action needed to address the potential health harms from the modernization of alcohol retail sales in Ontario

On behalf of the Board of Health of Algoma, I am writing to call on the Government of Ontario to fulfil its commitment (as announced in December 2015) to develop a comprehensive, province wide strategy to minimize harm and support the safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario. Alcohol remains the most harmful drug in society, impacting tens of thousands of Ontarians every year.

Alcohol is no ordinary commodity; alcohol causes injury, addiction, disease, and social disruption and is one of the leading risk factors for disability and death in Canada. Alcohol has significant costs to the individual and society from both a health and financial perspective. These costs include health care, law enforcement, prevention, lost productivity and premature mortality. As such, a comprehensive, evidence-based approach is critical to limit these harms.

The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by the government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians. Such developments include the increased availability of alcohol at up to 450 grocery stores, wine and cider in farmers' markets, online sales of alcohol through the LCBO and the expansion of bars, restaurants and retail outlets permitted at alcohol manufacturing sites.

Blind River
P.O. Box 194
9B Lawton Street
Blind River, ON P0R 1B0
Tel: 705-356-2551
TF: 1 (888) 356-2551
Fax: 705-356-2494

Elliot Lake
ELNOS Building
302-31 Nova Scotia Walk
Elliot Lake, ON P5A 1Y9
Tel: 705-848-2314
TF: 1 (877) 748-2314
Fax: 705-848-1911

Sault Ste. Marie
294 Willow Avenue
Sault Ste. Marie, ON P6B 0A9
Tel: 705-942-4646
TF: 1 (866) 892-0172
Fax: 705-759-1534

Wawa
18 Ganley Street
Wawa, ON P0S 1K0
Tel: 705-856-7208
TF: 1 (888) 211-8074
Fax: 705-856-1752

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

In order to address the health and social harms of alcohol, and the impact of increased access, a comprehensive strategy is needed. We are calling on the government to both fulfil its promise and prioritize the health and wellbeing of Ontarians by enacting a comprehensive, evidence-based alcohol strategy as soon as possible.

Sincerely,

Lee Mason

Mr. Lee Mason
Board Chair

cc: The Honourable Charles Sousa
Premier Kathleen Wynne
Boards of Health

Northwestern Health Unit
www.nwhu.on.ca

210 First Street North
Kenora, ON P9N 2K4

October 31, 2017

DELIVERED VIA E-MAIL

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

Attention: The Honourable Eric Hoskins

Dear Hon. Hoskins:

Re: Urgent provincial action needed to address the potential health harms from the modernization of alcohol retail sales in Ontario

On behalf of Northwestern Health Unit Board of Health, I am writing to call on the Government of Ontario to fulfil its commitment (as announced in December 2015) to develop a comprehensive, province wide strategy to minimize harm and support the safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario. Alcohol remains the most harmful drug in society, impacting tens of thousands of Ontarians every year.

Alcohol is no ordinary commodity; alcohol causes injury, addiction, disease, and social disruption and is one of the leading risk factors for disability and death in Canada. Alcohol has significant costs to the individual and society from both a health and financial perspective. These costs include health care, law enforcement, prevention, lost productivity and premature mortality. As such, a comprehensive, evidence-based approach is critical to limit these harms.

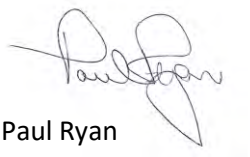
The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians. Such developments include the increased availability of alcohol at up to 450 grocery stores, wine and cider in farmers' markets, online sales of alcohol through the LCBO and the expansion of bars, restaurants and retail outlets permitted at alcohol manufacturing sites.

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

targeted interventions such as drinking and driving countermeasures, enforcement of the minimum legal drinking age as well as screening, brief intervention and referral activities.

In order to address the health and social harms of alcohol, and the impact of increased access, a comprehensive strategy is needed We are calling on the government to both fulfil its promise and prioritize the health and wellbeing of Ontarians by enacting a comprehensive, evidence-based alcohol strategy as soon as possible.

Sincerely,



Paul Ryan
Board Chair

C: The Honourable Charles Sousa
Premier Kathleen Wynne
Office of the Minister

Thunder Bay District
Health Unit

MAIN OFFICE
999 Balmoral Street
Thunder Bay, ON P7B 6E7
Tel: (807) 625-5900
Toll Free in 807 area code
1-888-294-6630
Fax: (807) 623-2369

GERALDTON
P.O. Box 1360
510 Hogarth Avenue, W.
Geraldton, ON P0T 1M0
Tel: (807) 854-0454
Fax: (807) 854-1871

MANITOUWADGE
P.O. Box 1194
Manitouwadge Health
Care Centre
1 Health Care Crescent
Manitouwadge, ON P0T 2C0
Tel: (807) 826-4061
Fax: (807) 826-4993

MARATHON
P.O. Box 384
Marathon Library Building
Lower Level,
24 Peninsula Road
Marathon, ON P0T 2E0
Tel: (807) 229-1820
Fax: (807) 229-3356

NIPIGON
P.O. Box 15
Nipigon District
Memorial Hospital
125 Hogan Road
Nipigon, ON P0T 2J0
Tel: (807) 887-3031
Fax: (807) 887-3489

TERRACE BAY
P.O. Box 1030
McCausland Hospital
20B Cartier Road
Terrace Bay, ON P0T 2W0
Tel. (807) 825-7770
Fax: (807) 825-7774

TBDHU.COM

October 18, 2017

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

Dear Minister Hoskins:

Re: Urgent provincial action needed to address the potential health harms from the modernization of alcohol retail sales in Ontario

On behalf of the Thunder Bay District Board of Health, I am writing to call on the Government of Ontario to fulfil its commitment (as outlined in its 2015 Budget) to develop a comprehensive, province wide strategy to develop initiatives to support safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario. Alcohol remains the most harmful drug in society, impacting tens of thousands of Ontarians every year.

Alcohol is no ordinary commodity; alcohol causes addiction, disease, and social disruption and is one of the leading risk factors for disability and death in Canada. Alcohol has significant costs to the individual and society from both a health and financial perspective. These costs include health care, law enforcement, prevention, lost productivity and premature mortality. As such, a comprehensive, evidence-based approach is critical to limit these harms.

The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians. Such developments include the increased availability of alcohol at 450 grocery stores, wine and cider in farmers markets, online sales of alcohol through LCBO and the expansion of bars and restaurants permitted at alcohol manufacturing sites.

It is well established that increased alcohol availability leads to increased alcohol-related harms. A provincially led alcohol policy can help mitigate the harms of alcohol. Effective interventions to reduce alcohol-related problems include socially responsible pricing of alcohol, limits on the number of retail outlets and hours of sale and alcohol marketing controls. These three policy levers have strong evidence to show that they are among the most effective interventions especially when paired with targeted interventions such as drinking and driving counter measures, enforcement of minimum drinking age as well as screening and brief intervention and referral activities.

.../2

In order to address the health and social harms of alcohol a strategy is necessary, particularly in light of the expanded sales in grocery stores, farmers markets and online. We are calling on the government to both fulfil its promise and prioritize the health and wellbeing of residents by enacting a comprehensive, evidence-based alcohol strategy as soon as possible.

Thank you for your consideration of this matter.

Sincerely,

Joe Virdiramo, Chair
Thunder Bay District Board of Health

cc: The Honourable Charles Sousa
Premier Kathleen Wynne
Ontario Boards of Health

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Q3 2017 Program Report**

Date: November 8, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the Q3 2017 Program Report for information.

Attachments:

Attachment A – Q3 2017 Public Health Programs
Attachment B – Q3 2017 Communications and Information Technology
Attachment C – Q3 2017 Social Media

Quarter 3 2017 Status Report (July 1 – September 30, 2017)

Overall Compliance Status

Ontario Public Health Standard Mandated Programs	Status
Child Health	7/7
Chronic Disease Prevention	11/14
Food Safety	7/7
Foundational Standards	11/13
Health Hazard Prevention and Management	9/9
Infectious Diseases (including tuberculosis) Prevention and Control	24/24
Oral Health	14/14
Prevention of Injury and Substance Misuse	0/5
Public Health Emergency Preparedness	8/8
Rabies Prevention and Control	7/8
Reproductive Health	6/6
Safe Water	14/14
Sexual Health, Sexually Transmitted Infections and Blood-borne Infections	12/12
Vaccine Preventable Diseases	12/13
100% Funded Programs	**Status**
Healthy Babies, Healthy Children	ME
Infant and Toddler Development	ME
Safe Sewage Disposal	ME

ME: Meeting Expectations PME: Partially Meeting Expectations

Chronic Disease Prevention
Hallie Atter, Manager, Community Health;

Program Compliance:
Due to limited staff capacity, not all areas of focus listed in the requirements can be completed. Areas that are not fully addressed include healthy eating, healthy weights, physical activity and alcohol use.

Foundational Standards
Jane Hoffmeyer, Manager

Program Compliance:
We continue to have minimal epidemiology support and were only able to conduct minimal surveillance. We were not able to start all activities scheduled for the third Quarter and unanticipated demands are arising as a result of Ministry changes. Support received from other public health agencies has been completed.

Recruitment processes for regular and temporary support in 2017 began in the third quarter and are not yet completed.

Prevention of Injury and Substance Misuse
Hallie Atter, Manager, Community Health

Program Compliance:
All five requirements include comprehensive work to be completed in four areas. Due to staffing resource limitations including an extended leave of absence, we are partially compliant in all five requirements.

Program Policy and Funding Issues:
Harm Reduction
In October 2016, the Minister of Health and Long-Term Care (MOHLTC) released a comprehensive *Strategy to Prevention Opioid and Addiction and Overdose*. As part of this strategy's harm reduction pillar, on June 12, 2017, the MOHLTC announced that funding would be provided to boards of health to improve local opioid response. This funding will increase Peterborough Public Health's (PPH) capacity (with the addition of a health promoter and some epidemiology support) to work with community partners to build on our community's existing harm reduction programs and services**.**

Rabies Prevention and Control
Atul Jain, Manager, Environmental Health

Program Compliance:
One animal bite report was not received by Peterborough Public Health within 24 hours. This report did receive follow-up the next business day.

Vaccine Preventable Diseases
Edwina Dusome, Manager, Communicable Diseases

Program Compliance:
The collection and assessment of child care attendees will not be completed in 2017. A new process will be in introduced in early 2018 for the parents/guardians of these attendees, whereby immunization information will be entered directly online into our immunization portal (available on our website).

Communications – Q3 2017

Brittany Cadence, Manager, Communications & IT Services

Media Relations

Activity	Q3 comparison	
	2017	2016
Total media products produced (news releases, audio files, letters to the editor, monthly Examiner columns, op eds, BOH meeting summaries, etc.)	37	31
Number of media interviews	25	15
Number of media stories captured directly covering PPH activities	103	75

Activity	Yearly Totals				
	2017 (ytd)	2016	2015	2014	2013
Press releases/media products issued	135	158	165	111	141
Media interviews	62	92	82	109	118
Number of media stories directly covering PPH activities	249	340	540	475	427

Communications Highlights:

- 2016 Annual Report released this quarter.
- Communications Team developed pilot electronic version of the FYI Newsletter for healthcare providers (for launch in the fourth quarter).
- The total number of communications tickets was 173.

Information Technology - 2017 Q3

Note: this report is provided from the Information Technology (IT) team and is intended to summarize major projects and provide a snapshot of the overall health of PPH systems.

System Status This Quarter:

Service Description	Planned Outage Time/ % downtime of total	Unplanned Outage Time/ % downtime of total	Total Uptime
MS Exchange Email server	0 mins/ 0%	0 mins	100%
Phone server	0 mins/ 0%	0 mins	100%
File server	0 mins/ 0%	15 mins	99.999%
Backup server	0 mins/ 0%	0 mins	100%

Total Number of Helpdesk Tickets Served:

350 tickets from July 1, 2017 – September 30, 2017.

IT Highlights:

- Security Audit completed, no significant concerns noted.
- IT Check Up project (system upgrades and staff training) initiated.

Peterborough Public Health

Follow us @Ptbohealth

SOCIAL MEDIA Q3 REPORT

July 1 – Sept 30

Breadth… How many people are connecting with us on our social media channels?

Twitter: In Q3 our followers grew

5.4%

to **1958**

81 tweets ***Q3***

-5

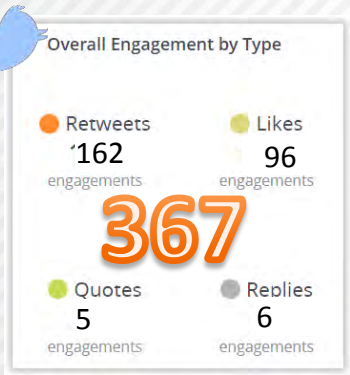
804 fans

164 new fans

46,586

webpage views +17%

Direct Engagement… How did people interact with us on social media?

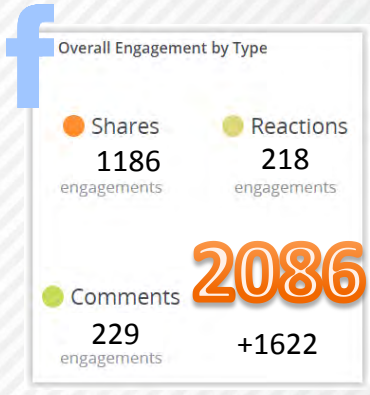


most popular tweet

5.6%

engagement rate

34 engagements



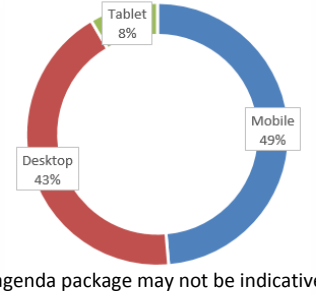
Depth… How are people reaching us and what are they looking for?

TOP 10

pages: peterboroughpublichealth.ca

Homepage: 7079
Beaches: 6634
Employment: 2724
Contact Us: 2244
Food Handler Course: 1384
Sexual Health Clinic: 1354
Mumps Media Release: 1137
Clinics and Classes: 656
Food Handler Course Dates: 616
Safe Water: 573

website visitors by device

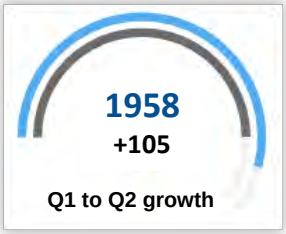


Click throughs from tweet/post to our website

1100

1222

Loyalty… How are we doing at keeping our visitors engaged?



Steady growth and 0 unfollows

twitter

453 more reactions

FROM

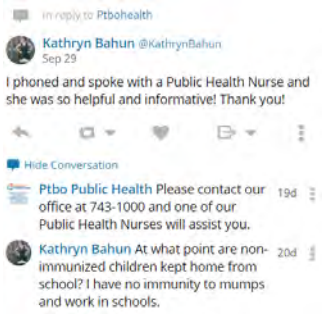
facebook

www.peterboroughpublichealth.ca

Customer Experience… What are people saying about us on social media?

@MENTIONS

76



Campaigns… How did our coordinated social projects perform?

Ad Campaigns – No ad campaigns this quarter

Social Media Push Campaigns – Run to Quit. Quit for Life

Engagements Total number of times a user interacted with a Tweet.

Engagement rate: Number of engagements divided by impressions

Impression: Times a user is served a Tweet in timeline or search results

Promoted Tweet: Are ordinary Tweets purchased by advertisers who want to reach a wider group of users to spark engagement

Impression: Times a user is served a Tweet in a timeline or search results

Handle: another word for username specific to Twitter and represented by an @ symbol (e.g. @Ptbohealth)

Mention: A Tweet that contains another user's @handle anywhere in the body of the Tweet. Used to "call out" to someone and will land in their notifications timeline.

Peterborough Public Health

Staff Report

Healthy Babies Healthy Children Program Update

Date:	November 8, 2017
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Karen Chomniak, Manager, Family Health

Proposed Recommendations

That the Board of Health for Peterborough Public Health receive the staff report, *Healthy Babies Healthy Children Program Update,* for information.

Financial Implications and Impact

The Healthy Babies Healthy Children Program (HBHC) is funded by the Ministry of Children and Youth Services (MCYS). Currently the program expenditures are within budget with approximately 74.8% of the operating budget spent after nine months of program activity. Over the past six months, the program has consistently carried a wait list of 15 to 20 families. The Public Health Nurses (PHNs) (4.8 FTEs) have carried full caseloads averaging 20 clients each. Despite these pressures, it is anticipated that the program will be within budget by the end of 2017.

Decision History

The Board of Health has hosted and supported the HBHC program since its inception in 1998. Letters have been sent by the Board to the provincial government and government ministers. These letters have advocated that HBHC be maintained as a 100 percent provincially-funded program; and that sufficient increases to the annual budget be granted to meet service demands. In August 2017, Board representatives met with Minister of Children and Youth Services Michael Coteau to discuss its concerns about the impact of this underfunding on the

well-being and future health of infants and children in Peterborough. Subsequently, a meeting was held with Minister of Provincial Parliament Jeff Leal to reiterate the Board's stance and to provide information to Mr. Leal for a follow-up meeting with Mr. Coteau.

Background

In May 2016, then Minister of Children and Youth Services Tracy MacCharles asked her ministry officials to undertake a third party review of the HBHC program. The purpose of the review was to assess if the existing HBHC delivery model best met Ontario's needs, and to identify opportunities to address program sustainability and alignment with MCYS's mandate.

In September 2017, a letter (see Attachment A) was received from Assistant Deputy Minister Darryl Sturtevant outlining the process by which MCYS will develop a revised HBHC Protocol. Details of this process were shared at the October 2017 HBHC Provincial Meeting. MCYS representatives indicated that the HBHC Program third-party review findings will inform the 2018 work going forward. In addition, as a mandated provincial program, HBHC is part of the Ontario Standards for Public Health Programs and Services (OSPHPS) modernization process.

Several major opportunities were identified from the third-party review findings:

- Improve the effectiveness of HBHC Screening results – the current screen of 36 questions identifies a family "with risk" as screening positive to two or more questions. However, depending on the responses, some families may not require the full home visiting program. Work will be conducted to refine the risk criteria to best identify the target population for home visiting.
- Streamline the process for obtaining client consent – client families will only have to give consent for service once, rather than at multiple points.
- Improve the use of technology - provide access to the current electronic system for documentation (ISCIS) via the use of tablets in the field (similar to the method that Public Health Inspectors use). MCYS indicated that they would be providing funding for this project and recommendations regarding technical specifications.
- Strengthen HBHC's ability to support the complex needs of families – continue with staff training opportunities and resources provided through the provincial Best Start Resource Centre. Continue to strengthen relationships with community partners such as the hospital, midwives, physicians, Children's Aid Society, etc.
- Outcome measurement - develop indicators to monitor short-term outcomes for the HBHC program. Continue to refine the annual Continuous Quality Improvement (CQI) plan to monitor performance for all outcomes.

In preparation for the upcoming changes to the standards, MCYS management and staff participated in the Healthy Growth and Development (HGD) Guideline Work Group meetings over August and September 2017. MCYS participation supported alignment of the HBHC Protocol within the OSPHPS. As well, aligned with HBHC program review findings, a HBHC Protocol Workgroup was convened with representation from 14 local public health agencies

(LPHAs) for the development of a revised HBHC protocol. The following activities were in-scope and out-of-scope for the HBHC Protocol Working Group and ongoing consultation:

- In-scope:
  - input and advice on the protocol content and related program design elements;
  - assisting with the compilation of research and best practices;
  - input in drafting sections of the protocol; and
  - input and advice on identifying potential implementation challenges and opportunities.
- Out-of-scope
  - content in the OSPHPS;
  - funding;
  - human resources/capacity; and
  - detailed approaches (efficiency/effectiveness) for policy and program implementation.

The provincial meeting held in October provided the opportunity for all LPHAs to provide feedback to the draft protocol. The final draft HBHC protocol (2018) is expected for completion in November 2017, with approval and implementation in January 2018. Appendix B outlines the changes in the draft HBHC Protocol.

With final approval of the HBHC Protocol, work will begin in winter 2018 to improve the quality and delivery of the HBHC Program, with a greater focus on effectiveness and efficiency as identified through the third-party review findings. LPHAs will continue to participate and provide input. Work will be ongoing over 2018 with an anticipated draft reference document developed by December 2018. This timeline is consistent with OSPHPS process for their reference documents.

Strategic Direction

The HBHC program supports Peterborough Public Health's strategic directions of:

- Community-Centred Focus; and
- Determinants of Health and Health Equity.

Contact:

Patti Fitzgerald, Assistant Director and Chief Nursing Officer
(705) 743-1000, ext. 295
pfitzgerald@peterboroughpublichealth.ca

Attachments:

Attachment A – Letter from Assistant Deputy Minister Darryl Sturtevant
Attachment B - Changes in the Draft HBHC Protocol

On a personal note, I have been Manager of HBHC since 2002. I will be retiring as of December 31, 2017 with November 3, 2017 being my last day of work. I would like to extend my appreciation to the members (current and past) of the Board of Health for their advocacy efforts and on-going support of this program.

Sincerely, Karen Chomniak, RN, BScN, MA, Manager, Family Health.

Ministry of Children and Youth Services

Assistant Deputy Minister

Strategic Policy and Planning Division

14th Floor
56 Wellesley Street West

Toronto ON M5S 2S3
Tel: (416) 327-9481
Fax: (416) 314-1862

Ministère des Services à l'enfance et à la jeunesse

Sous-ministre adjoint

Division des politiques et de la planification stratégiques

14e étage
56, rue Wellesley Ouest
Toronto ON M5S 2S3

Ontario

September 6, 2017

MEMORANDUM TO: Medical Officers of Health

FROM: Darryl Sturtevant
Assistant Deputy Minister

RE: Healthy Babies Healthy Children

As you are aware, Ontario is undertaking a modernization process of the Ontario Standards for Public Health Programs and Services. As a mandated provincial program, Healthy Babies Healthy Children (HBHC) is part of this process. The recently completed HBHC program review findings are well aligned to inform this priority initiative.

To support the modernization process in moving forward, the ministry will be convening a working group with representation from public health units (PHUs) for the development of a revised HBHC Protocol. Additional working groups will also be initiated to support the development of a reference document, which will focus on introducing opportunities to improve the quality and delivery of the HBHC program, toward greater effectiveness and efficiency. Specifically, the key changes to the HBHC Protocol and reference document, informed from the HBHC program review, will include:

- Improving the effectiveness of the response to screening results;
- Introducing streamlined processes for consent and the use of technology;
- Strengthening the program's ability to support the complex needs of some families; and
- Streamlining data requirements and targeted efforts toward outcome measurement.

The timelines for a new HBHC Protocol and reference document are in keeping with the broader modernization initiative which is being led by the Ministry of Health and Long-Term Care (MOHLTC). The effective date of the revised HBHC Protocol will be January 1, 2018, consistent with the date on which all Standards, Protocols and Guidelines will come into effect.

PHU involvement will be important in revising the HBHC Protocol and developing the reference document. Given the tight timelines, the HBHC Protocol Working Group will commence in September 2017 and ministry staff will contact PHUs shortly to confirm participation. A broad consultation across all the PHUs on the revised HBHC Protocol will also be held at the Annual HBHC meeting scheduled for October 11 and 12, 2017.

.../2

I would like to take this opportunity to thank all of you for your invaluable participation and that of your staff in the program review process and in moving forward with updating of the Protocol and reference document. Stacey Weber, A/Director of the Early Child Development Branch will be pleased to address any questions with respect to this upcoming work. She may be contacted at 416-327-7386 or stacey.weber@ontario.ca.

The ministry appreciates the commitment and work of the PHUs in supporting families with challenges to healthy child development in order to help children achieve their full potential and we look forward to our ongoing collaboration.

Darryl Sturtevant
Assistant Deputy Minister

c: HBHC Directors
HBHC Managers
Stacey Weber, Director, ECDB

Appendix B

Section	HBHC Protocol Proposed Changes
General Revisions	• Streamlining and improving flow reflective of program service delivery, all program components for HBHC program are included as headings • Updating to 2017 or latest references (i.e., updated footnote) • Removing specific references to tools (i.e., removed NDDS) • Ensuring consistency of language and changes in language: -"women" has been replaced with "individuals" -"vulnerable" has been replaced with "experiencing and/or at risk for challenges"
Preamble	• Language updated to reflect the standard and requirement as part of the modernization process - updated to reference Ontario Standards for Public Health Programs and Services
Purpose	• Section kept high level and focused on overall purpose of program with indication that detailed information will be found in the HBHC Reference Document
Reference to the Ontario Standards for Public Health Programs and Services	• Reflects new naming as part of the modernization process – standard and requirement Included reference to the Health Care Consent Act
Operational Roles and Responsibilities 1) General Policy/Practice	• Language of "serious occurrence" added and "Serious Occurrence Notification" • Updating client consent to refer to receipt of all program components • New subsection included outlining family withdrawal from the program as aligned with the principles and requirements of the Health Care Consent Act • Revised heading – "Collection, Use and Disclosure of Information" to be in line with legislation • Inclusiveness – language reflects an intersectional approach (aligns with other government priorities) • In the Data Collection section included reference to HCD-ISCIS to reflect the current information system used
2) Access to Information and Resources	• Retitled heading to indicate "Access to Information and Resources" to reflect better description of the program services provided. No substantive changes to the section content.
3) Early Identification and Intervention	• New heading. Sub-headings are consistent with the 2012 HBHC Protocol.

Screening	• Consolidated language to reflect "promote, offer and use of the HBHC Screen" • Included a broader, more inclusive, description of provider that health units interact with – "board of health shall work with primary care providers, educators, community partners, and others working within the field of early learning and child development"
Assessment	• Streamlined and consolidated sub-sections i) and ii) • Used general references to tools and approaches
Blended Home Visiting Services	• Updated language for the Family Service Plan (found in clause e) to reflect in collaboration with families
Service Coordination	• Streamlined clauses and updated language to reflect current LPHA service coordination practices • Introduced language of "develop policies, procedures, and/or protocols" in reference to service coordination
Referral to/from Community Services	• Updated heading to reflect referral practices (e.g., to/from), removed "Recommendations" • Subsection d) now includes referral and referral status to community programs and/or services for entry into HCD-ISCIS
4) Service and System Integration	• Broadening the description to reflect current program practice (e.g., representation, participation and active engagement in community networks)
5) Research	• No changes
6) Evaluation	• Updated language to also reflect monitoring activities (e.g., HBHC Program evaluation and monitoring activities).
Glossary	• Added, revised and updated definitions • Early child development, early identification and intervention: now consistent with MOHLTC; • Expanded definition of diversity; and • Intersectional approach now defined. • Removed definitions not referenced in Protocol
References	• Updated, confirmation pending

To: All Members
Board of Health

From: Councillor Henry Clarke, Chair, Stewardship Committee

Subject: **Committee Report: Stewardship**

Date: November 8, 2017

Proposed Recommendations:

a. *That the Board of Health for Peterborough Public Health receive meeting minutes of the Stewardship Committee from August 30, 2017, for information.*

b. *That the Board of Health for Peterborough Public Health receive the Q3 2017 Finance Report for information.*

c. *That the Board of Health for Peterborough Public Health approve revisions to By-Law #1, Management of Property.*

d. *That the Board of Health for Peterborough Public Health approve revisions to By-Law #4, Appointment of an Auditor.*

e. *That the Board of Health for Peterborough Public Health approve revisions to By-Law #7, Execution of Documents.*

f. *That the Board of Health for Peterborough Public Health approve revisions to Policy 2-374, Contractor Performance and Litigation.*

Background:

The Stewardship Committee met last on October 18, 2017. At that meeting, the Committee requested that these items come forward to the Board of Health.

Attachments:

a. Stewardship Committee Minutes, August 30, 2017
b. Q3 2017 Finance Report
c. By-Law #1, Management of Property
d. By-Law #4, Appointment of an Auditor
e. By-Law #7, Execution of Documents
f. Policy 2-374, Contractor Performance and Litigation

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Stewardship Committee Meeting
Wednesday, August 30, 2017 – 5:00 p.m.
Dr. J.K. Edwards Board Room, 185 King Street, Peterborough

Present:	**Councillor Henry Clarke**
	Ms. Andy Sharpe
	Mayor Rick Woodcock
	Mayor Mary Smith
Staff:	**Larry Stinson, Director of Operations**
	Ms. Natalie Garnett, Recorder

---

1. Call to Order

Councillor Clarke called the Stewardship Committee meeting to order at 4:50 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved as circulated.
Moved: Mayor Smith
Seconded: Mayor Woodcock
Motion carried. (M-2017-015-SC)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

5.1 **June 1, 2017**

MOTION:
That the minutes of the Meeting of June 1, 2017 be approved as circulated.
Moved: Andy Sharpe
Seconded: Mayor Woodcock
Motion carried. (M-2017-016-SC)

6. Business Arising from the Minutes

Discussion was held regarding the deputation made at the Association of Municipalities of Ontario (AMO) regarding the funding for the "Healthy Babies, Healthy Children Program".

MOTION:
That a follow-up letter be sent to Jeff Leal, MPP providing additional program details arising from the meeting held with him on August 30th, 2017 regarding funding concerns with the "Healthy Babies, Healthy Children Program".
Moved: Mayor Smith
Seconded: Mayor Woodcock
Motion carried. (M-2017-017-SC)

7. Staff Reports

7.1 Staff Report: 2016/2017 Infant and Toddler Development Program Audited Statements and Transfer Payment Annual Reconciliation

Larry Stinson, Director of Operations, provided an overview of the report "2016/2017 Infant and Toddler Development Program Audited Statements and Transfer Payment Annual Reconciliation".

MOTION:
That the Stewardship Committee for the Board of Health for Peterborough Public Health:
- *Receive the staff report, "2016/2017 Infant and Toddler Development Program Audited Statements and Transfer Payment Annual Reconciliation", for information; and,*
- *Recommend to the Peterborough Public Health Board acceptance of the 2016/2017 Audited Statements and Annual Reconciliation for the Infant and Toddler Development Program.*

Moved: Mayor Woodcock
Seconded: Andy Sharpe
Motion carried. (M-2017-018-SC)

7.2 Staff Report: 2016/2017 Preschool Speech and Language Program Audited Financial Statements

Larry Stinson, Director of Operations, provided an overview of the report "2016/2017 Preschool Speech and Language Program Audited Financial Statements".

MOTION:
That the Stewardship Committee for the Board of Health for Peterborough Public Health:
- *Receive the staff report, "2016/2017 Preschool Speech and Language Program Audited Financial Statements", for information; and,*
- *Recommend to the Peterborough Public Health Board acceptance of the 2016/2017 Audited Financial Statements for the Preschool Speech and Language Program.*

Moved: Mayor Smith
Seconded: Mayor Woodcock
Motion carried. (M-2017-019 -SC)

7.3 Staff Report: Q2 2017 Finance Report

Larry Stinson, Director of Operations, provided an overview of the report "Q2 2017 Finance Report".

MOTION:
That the Stewardship Committee for the Board of Health for Peterborough Public Health:
- *Receive the Q2 2017 Finance Report, for information; and,*
- *Provide it to the Peterborough Public Health Board at its next meeting for information.*

Moved: Andy Sharpe
Seconded: Mayor Smith
Motion carried. (M-2017-020-SC)

7.4 By-laws, Policies and Procedures for Review

MOTION:
That the Stewardship Committee for the Board of Health for Peterborough Public Health refer By-law 1, 2-100, back to staff to address the Condominium Board responsibilities.
Moved: Mayor Smith
Seconded: Mayor Woodcock
Motion carried. (M-2017-021-SC)

MOTION:
That the Stewardship Committee for the Board of Health for Peterborough Public Health refer By-law 2, 2-110, back to staff to make the proposed changes to the wording and definitions.
Moved: Mayor Smith
Seconded: Mayor Woodcock
Motion carried. (M-2017-022-SC)

MOTION:
That the Stewardship Committee for the Board of Health for Peterborough Public Health refer By-law 9, 2-180, back to staff to address issues related to single sourcing and to clarify the purchasing limits in sections 2 and 3.
Moved: Mayor Woodcock
Seconded: Mayor Smith
Motion carried. (M-2017-023-SC)

8. Consent Items

9. New Business

10. In Camera to Discuss Confidential Matters

11. Motions for Open Session

12. Date, Time and Place of Next Meeting

The next meeting of the Stewardship Committee will be held on Tuesday, October 3, 2017 at 5:00 p.m., in the Dr. J.K. Edwards Board Room, Jackson Square, 185 King Street, Peterborough.

13. Adjournment

MOTION:
That the meeting be adjourned.
Moved: Mayor Smith
Seconded: Andy Sharpe
Motion carried. (M-2017-024-SC)

The meeting was adjourned at 5:55 p.m.

Chairperson

Medical Officer of Health

Financial Update Q3 2017 (Finance: Dale Bolton)

Programs Funded January 1 to December 31, 2017								
	Type	**2017**	**Approved by Board**	**Submission Date**	**Expenditures to Sept. 30**	**% of Budget**	**Funding**	**Comments**
Mandatory Public Health Programs	Cost Shared (CS)	7,202,667	09-Nov-16	submitted 1-Mar	5,325,347	73.9%	MOHLTC	Operating within budget. Board approved $7,975,438 which included Small Drinking Water, Vector Borne Disease and Occupancy Cost - See lines below.
Mandatory Public Health Programs - Occupancy costs	CS	518,267	09-Nov-16	submitted 1-Mar	388,700	75.0%	MOHLTC	Operating within budget.
Small Drinking Water Systems	CS	90,800	09-Nov-16	submitted 1-Mar	67,177	74.0%	MOHLTC	Operating within budget.
Vector- Borne Disease (West Nile Virus)	CS	76,133	09-Nov-16	submitted 1-Mar	41,245	54.2%	MOHLTC	West Nile Virus program finished end of September. Majority of expenditures have been reported to date. Anticipated being underspent for 2017
Infectious Disease Control	100%	228,345	11-Feb-17	submitted 1-Mar	173,542	76.0%	MOHLTC	Operating within budget based on budget request. Year to date expenditures are operating above 2016 budget approval of
Infection Prev. & Control Nurses	100%	94,300	11-Feb-17	submitted 1-Mar	67,875	72.0%	MOHLTC	Operating within budget based on budget request. Year to date expenditures are
Healthy Smiles Ontario (HSO)	100%	763,100	11-Feb-17	submitted 1-Mar	391,332	51.3%	MOHLTC	**Operating within budget approval received in 2016. Overall results from 2017 show program significantly underspent as staffing positions planned for program have not been hired due to potential uncertainty of budget approval. Year to date underspent as negotiations with Ministry re: delivery model have not been finalized at this time.**

	Type	2017	Approved by Board	Submission Date	Expenditures to Sept. 30	% of Budget	Funding	Comments
Enhanced Food Safety	100%	25,000	11-Feb-17	submitted 1-Mar	18,733	74.9%	MOHLTC	Operating within budget.
Enhanced Safe Water	100%	15,500	11-Feb-17	submitted 1-Mar	13,883	89.6%	MOHLTC	Operating above budget. Program will operate within budget by end of year.
Needle Exchange Initiative	100%	60,000	11-Feb-17	submitted 1-Mar	35,852	59.8%	MOHLTC	Operating within budget based on Ministry request. Awaiting final approval. Budget request increased 33.3% over prior year approval of $45,000. Year to date actual is currently above 2016 approval at 79.% of budget. Anticipate program operating above 2016 actuals based on year to date
Social Determinants of Health Nurses Initiative - Nurses Commitment	100%	190,675	11-Feb-17	submitted 1-Mar	135,366	71.0%	MOHLTC	Operating within budget based on budget request. Year to date expenditures are operating at the 2016 budget approval of $180,500.
Chief Nursing Officer Initiative	100%	126,250	11-Feb-17	submitted 1-Mar	89,223	70.7%	MOHLTC	Operating within budget based on budget request. Year to date expenditures are operating within 2016 budget approval of $121,500.
Smoke Free Ontario (SFO) - Control	100%	100,000	11-Feb-17	submitted 1-Mar	75,866	75.9%	MOHLTC	Operating just above budget. Anticipate program will operate within budget by end of year.
SFO - Enforcement	100%	202,100	11-Feb-17	submitted 1-Mar	151,327	74.9%	MOHLTC	Operating within budget.

	Type	2017	Approved by Board	Submission Date	Expenditures to Sept. 30	% of Budget	Funding	Comments
SFO - Youth Prevention	100%	80,000	11-Feb-17	submitted 1-Mar	55,507	69.4%	MOHLTC	Operated within budget. Savings due to some gapping in first quarter of year. Anticipate being
SFO - Prosecution	100%	6,700	11-Feb-17	submitted 1-Mar	2,803	41.8%	MOHLTC	Operating within budget based on program demand.
Electronic Cigarettes Act - Protection & Enforcement	100%	30,500	11-Feb-17	submitted 1-Mar	22,671	74.3%	MOHLTC	Operating within budget based on budget request. Year to date expenditures are operating slightly above 2016 budget approval of $29,300.
Medical Officer of Health Compensation	100%	51,054	NA	submitted 1-Mar	38,291	75.0%	MOHLTC	Operating within budget.
Healthy Babies, Healthy Children	100%	928,413	12-Apr-17	submitted 18-Apr	694,090	74.8%	MCYS	Operating within budget.

One-Time Programs Funded January 1 to December 31, 2017								
	Type	2017	Approved by Board	Submission Date	Expenditures to Sept. 30	% of Budget	Funding	Comments
Inclusive Prenatal Curriculm	100%	10,000	11-Feb-17	submitted 1-Mar	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Evidence Based Decision Making	100%	10,000	11-Feb-17	submitted 1-Mar	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Arts Based Health Promotion	100%	20,000	11-Feb-17	submitted 1-Mar	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
File Server Update	100%	53,000	11-Feb-17	submitted 1-Mar	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
AODA Website	100%	26,500	11-Feb-17	submitted 1-Mar	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.

Healthy Menu	100%	50,300	11-Feb-17	submitted 1-Mar	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
PHI Practicum	100%	30,000	11-Feb-17	submitted 1-Mar	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Radon Kits	100%	10,000	11-Feb-17	submitted 1-Mar	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Enhanced Tobacco Cessation	100%	30,000	11-Feb-17	submitted 1-Mar	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.

Programs funded April 1, 2017 to March 31, 2018								
	Type	**2017 - 2018**	**Approved by Board**	**Approved**	**Expenditures to Sept. 30**	**% of Budget**	**Funding**	**Comments**
Infant Toddler and Development Program	100%	245,821	March 8/17	Submitted 17-Mar	117,918	48.0%	MCSS	Operated within budget.
Speech	100%	12,670	Annual Approval	NA	6,335	50.0%	FCCC	Operated within budget.
Healthy Communities Challenge Fund		206,250	NA	NA	101,498	49.2%		Operating within budget.

Funded Entirely by User Fees January 1 to December 31, 2017								
	Type	**2017**	**Approved By Board**	**Approved By Province**	**Expenditures to Sept. 30**	**% of Budget**	**Funding**	**Comments**
Safe Sewage Program		382,389	12-Nov-14	NA	304,066	79.5%	FEES	Program funded entirely by user fees. Expenditures are slightly above budget. Revenue from User Fees are below budget resulting in a deficit of $22,083. Anticipate increase in revenues as building season continues through final quarter and inspections finalized to offset deficit.
Mandatory and Non-Mandatory Re-inspection Program		99,500	12-Nov-14	NA	37,010	37.2%	FEES	Program funded by user fees. Re-inspection program activity began late May. Anticipate increase in activity until end of year. Expect program to operate within budget.

Programs funded through donations and other revenue sources January 1 to December 31, 2017								
	Type	**2017**	**Approved By Board**	**Approved By Province**	**Expenditures to Sept. 30**	**% of Budget**	**Funding**	**Comments**
Food For Kids, Breakfast Program & Collective		50,042	NA	NA	44,727	89.4%	Donations	Budget based 2016 actuals. Operating above budget. Excess expenditures offset by donations.

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-100	**Title:** By-Law Number 1, Management of Property
Approved by: Board of Health		**Original Approved by the Board of Health On** (YYYY-MM-DD)**:** **1989-10-25**
Signature:		**Author:** Director of Operations ~~Corporate Services~~
Date (YYYY-MM-DD)**:** 2017~~12~~-08~~12~~-24~~12~~		
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

By-Law Number 1
A By-Law for the Management of Property

1. In this By-law:
   (1) "Act" means the Health Protection and Promotion Act;
   (2) "Board" means the Board of Health for ~~the~~ Peterborough Public Health~~County City Health Unit~~; and
   (3) "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the Act and Regulations.
   ~~(3)~~(4) "Real property" means land, building, furnishings, equipment and any interest, estate or right of easement affecting same.

2. The Board shall hold title to any real property acquired by the Board for the purpose of carrying out the functions of the Board and may sell, exchange, lease, mortgage or otherwise charge or dispose of real property owned by it in accordance with the Act. The Medical Officer of Health/CEO has the authority to approve the acquisition or disposal of real property upto the value of $100,000. Purchases above this amount requires Board approval.

3. The Director of ~~,~~ Operations~~Corporate Services~~ shall be responsible for the care and maintenance of all property. Such responsibility shall include, but not be limited to, the following.
   (1) The care and maintenance of any owned or leased~~:~~
      (i) ~~the parking areas and exterior of the building~~land, buildings and condominium units;
      (ii) ~~the grounds of the property~~furnishings; and

(iii) equipment.~~the interior of the building.~~

(2) The replacement of or repairs to capital items. ~~such as the heating, cooling and ventilation systems, the roof and structural work and the plumbing, lighting and wiring.~~

(3) The maintenance of up-to-date property insurance coverage.

4. The Board shall ensure, through the Medical Officer of Health, that all such property complies with applicable statutory requirements contained in municipal, provincial and/or federal legislation. The Medical Officer of Health will designate staff representatives for property boards or councils (e.g.~~ie.~~ Condominium Board), and will ensure regular reporting on the status of the property to the Stewardship Committee at least annually.

This By-law shall be deemed to have come in to force on the 11th day of October, 1989.

Dated at the City of Peterborough the 25th day of October, 1989.

Historical Record

Revisions:
Board of Health, December 12, 2012
Board of Health, July 7, 2010
Board of Health, October 28, 1998

Review:
Governance Committee, November 3, 2014
Governance Committee, November 26, 2012
By-Laws, Policies and Procedures Committee, June 3, 2010
Medical Officer of Health, October 9, 2007
Chair, Board of Health, March 6, 2006
Medical Officer of Health, April, 2005

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-130	**Title:** By-Law Number 4 – Appointment of an Auditor
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 1989-10-11**
Signature:		**Author:** Director of Operations
Date (YYYY-MM-DD)**:** **2016-06-08**		
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

By-Law Number 4
A By-Law to Provide for the Appointment of an Auditor

1. In this By-law:
   (1) "Board" means the Board of Health for Peterborough Public Health; and
   (2) "meeting" means an official gathering of the Board in one place to transact business.

2. In accordance with the Municipal Act, Section 296, Subsection (10), as the Board is a local board of more than one municipality, the auditor of the municipality which is responsible for the largest share of the operating costs of the local board is required to audit the local board.

3. The auditor(s) must be licensed under the Public Accounting Act.

~~2.~~4. The auditor is entitled to attend any meeting of members of the Board, to receive all notices relating to any such meeting and to be heard at any such meeting that he/she attends on any part of the business that concerns him/her as auditor.

5. The auditor shall:

(1) meet with the Stewardship Committee of the Board a minimum of twice a year; once to present the planning letter for the audit and the second meeting to present the draft audited financial statements;
(2) provide the Board with a letter of independence and a management letter annually;

(3)~~(1)~~ audit the accounts and transactions of the Board;

(4) examine financial statements and express an opinion thereon;

(52) perform such duties as are prescribed with respect to local boards under the Municipal Act and the Municipal Affairs Act;

(63) perform such other duties as may be prescribed by the Board that do not conflict with the duties as set out in subsection (52) of section 53 of this By-law;

(74) have a right of access at all reasonable hours to all books, records, documents, accounts and vouchers of the Board; and

(8) and is be entitled to require from the Medical Officer or Health/Director of Operations and members of the Board such information and explanation that, as in his/her opinion may be necessary to carry out prescribed such duties as set out in subsections (52) and (63) of section 53 of this By-law; and

(75) be entitled to attend any meeting, to receive all notices relating to any such meeting and to be heard at any such meeting that he/she attends on any part of the business that concerns him/her as auditor; and .

(96) meet with the Board as requested. .

(7) meet with the Board Committee responsible for audits twice annually.

This By-Law shall be deemed to have come in to force on the 11th day of October, 1989.

Dated at the City of Peterborough the 12th day of October, 1989.

Review/Revisions

On (YYYY-MM-DD): **2016-06-08 (Board)**
On (YYYY-MM-DD): **2014-09-03 (Governance Committee Review)**
On (YYYY-MM-DD): **2008-01-09**
On (YYYY-MM-DD): **2006-04-12**
On (YYYY-MM-DD): **2005-01-12**

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-160	**Title:** By-Law Number 7 – Execution of Documents
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 1989-10-11**
Signature:		**Author:** Director of Operations
Date (YYYY-MM-DD)**:** 201~~7~~67-10~~0~~6-~~0~~8		
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

By-Law Number 7
Execution of Documents

1. In this By-law:
   1) "Act" means the Health Protection and Promotion Act;
   2) "Board" means the Board of Health for Peterborough Public Health;
   3) "Chairperson of the Board" means the Chairperson elected under the Act;
   4) "Vice-Chairperson of the Board" means the Vice-Chairperson elected under the Act;
   5) "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the Act and Regulations; and
   6) "Director of Operations" means the business administrator of the Board as defined in the Regulations under the Act.

2. Except as otherwise directed by the Board, the Chairperson and Vice-Chairperson of the Board, the Medical Officer of Health, Director of Operations shall be authorized to sign any class of or particular contract, arrangement, conveyance, mortgage, obligation or other document.

3. Only one signature of the signing officers set out in section 2 of this By-law shall be required for a contract, arrangement, conveyance, mortgage, or other document with a pecuniary value of less than $40,000. For a contract, arrangement, conveyance, mortgage, or other document with a pecuniary value of $40,000 or more, two signatures of the signing officers set out in section 2 of this By-law shall be required. One signature will be the Chairperson of the Board of Health or in the absence of the Chairperson, the Vice-Chairperson of the Board of Health. The second signature will be the Medical Officer of Health or in the absence of the Medical Officer of Health, the Director of Operations.

4. The Medical Officer of Health and/or Director of Operations are authorized to sign Provincial Accountability Agreements as required.

5. An electronic signature may be affixed for the Medical Officer of Health, Director of Operations, Chairperson or Vice Chairperson in compliance with ~~pending on~~ the terms of the agreement, contract or other document, and provided written approval is received from the individual prior to affixing his/her signature to the document.

This By-law shall be deemed to have come in to force on the 11th day of October, 1989.

Review/Revisions
On (YYYY-MM-DD)**: 2016-06-08**
On (YYYY-MM-DD)**: 2014-09-10**
On (YYYY-MM-DD)**: 2012-09-12**
On (YYYY-MM-DD)**: 2010-10-28**
On (YYYY-MM-DD)**: 2006-03-06**
On (YYYY-MM-DD)**: 1998-10-28**

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-374	**Title:** Contractor Performance and Litigation
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2013-02-13**
Signature:		**Author:** Director of Operations~~Corporate Services~~
Date (YYYY-MM-DD)**:** ~~2013-02-13~~		
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

Purpose:

To ensure the work of contractors meets the requirements of the tender or contract, and minimize risk to the organization~~.~~

Definitions:

a) "award" means the authorization to proceed with the purchase of goods, services or other deliverables ~~construction~~;

b) "bid" means an offer or submission from a vendor received in response to a request for quotation, tender, proposal or call for bids, which is subject to acceptance or rejection;

c) "bidder" means any legal entity that submits a bid in response to a call for bids;

d) "call for bids" means a formal request for bids and includes a request for quotations, a request for tenders and a request for proposals;

e) "contract" means any form of binding agreement between Peterborough Public Health and another ~~two or more~~ legal entity~~ies~~, awarded under purchasing policies for the purchase of deliverables;

f) "contractor" means any legal entity to whom a contract is awarded;

g) "litigation" means any dispute between the ~~Region~~ Peterborough Public Health ~~-~~and any other party or related party adverse in interest, including third party and cross-claims, where either a legal proceeding has ~~been~~ commenced for an injunction, a mandatory order, a declaration for the recovery of money, or a threat of legal action has been made in writing;

Policy:

The Director of Operations~~Corporate Services~~ shall be responsible for monitoring the performance of contractors and documenting evidence of such performance and shall advise the Medical Officer of Health where the performance of a contractor has failed to comply with the terms and conditions of the ~~a~~ contract or other requirements.

For the purpose of this policy, unsatisfactory performance means past performance by a contractor under a contract with the organization that is inconsistent with the expected standard of service delivery including but not limited to any of the following:

a) consistent or significant failure to meet specified schedules or delivery requirements; or

b) consistent or significant failure to follow specified contract requirements or authorized direction; or

c) consistent or significant failure to comply with legislative requirements.

Unsatisfactory performance is addressed as timely as possible after it ~~-~~occurs. To ensure the identification and ~~address~~appropriate response to escalating ~~contract issues, the following .....~~compliance issues:

1. The Program ~~m~~Manager ~~(??) should~~responsible will inform the supplier/contractor of their non-performance and request the appropriate corrective action in writing. ~~C~~All communication with supplier/contractor should be documented.

2. If supplier/contractor response not satisfactory, the Program Manager should issue a formal letter, documenting the supplier/contractor specific non-performance and request for corrective action. A copy of the letter should be provided to the Director of Operations.

3. If supplier/contractor response or corrective action remains unsatisfactory, the Program Manager along with the Director of Operations, should arrange a meeting with the supplier/contractor. A formal letter should be issued by the Director of Operations, notifying the supplier/contractor of being in default of the contractual obligations.

4. If supplier/contractor does not respond or correct performance by the required date, the Director of Operations shall inform the Board or designated committee of the Board in writing of compliance issues in order to consider legal action against the supplier/contractor.

The Medical Officer of Health in consultation with the Board may prohibit a contractor whose performance has been unsatisfactory from submitting a bid in response to a call for bids in accordance with policies adopted by the Board.

Unless otherwise permitted, no bid or proposal shall be accepted from, nor shall any contract be awarded or extended to any contractor or related party as determined in the discretion of the Medical Officer of Health, or any other party with whom the Board is engaged in unresolved litigation.

Review/Revisions

On (YYYY-MM-DD)**:** 2015-05-19 (Governance)
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**

To: All Members
Board of Health

From: Deputy Mayor John Fallis, Board Member
Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **alPHa Conference Update**

Date: November 8, 2017

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the following for information:

- *Oral Report, alPHa Conference Update; and,*
- *Board of Health Section Agenda Package; November 3, 2017.*

Background:

Deputy Mayor Fallis and Dr. Salvaterra attended the Association of Local Public Health Agencies (alPHa) fall conference, held on Friday November 3rd in Toronto. Materials from the conference have been attached for your reference.

Attachments:

Attachment A – Board of Health Section Agenda Package, Nov. 3/17

alPHa
Association of Local PUBLIC HEALTH Agencies

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Providing leadership in public health management

To All Members of Ontario Boards of Health

AGENDA
Boards of Health Section Meeting

Friday, November 3, 2017 • 8:30 AM – 3:45 PM
Toronto Ballroom, DoubleTree by Hilton
108 Chestnut, Toronto

CHAIR: Trudy Sachowski, North West Region

7:30		Registration and Continental Breakfast
8:30		**Welcome and Introductions** *This is an opportunity for new and returning members of boards of health across Ontario to say hello.*
8:40		**Section Business** *Approval of Minutes from June 13, 2017 BOH Section Meeting (attached).*
		alPHa Update *Update on the Association's latest activities*
9:00		**Municipal Act** *Update on changes to the act.*
	Speaker:	***Raymond MacKinnon, Dunsmore Law***
9:30		**Patients First** *Learn about research being led by Ottawa Public Health - Public Health Units and LHINs working together for population health.*
	Speaker:	***Dr. Vera Etches, Deputy Medical Officer of Health, Ottawa Public Health***
10:15		**BREAK**
10:45		**Expert Panel on Public Health** *Review the alPHa and AMO responses to the recommendations for public health reform from the Expert Panel on Public Health (attached) and discuss elements of a Boards of Health Section response.*
	Speakers:	***Linda Stewart, Executive Director, alPHa*** ***Monika Turner, Director of Policy, AMO***
12:15		**LUNCH** - *Lunch Buffet in Ottawa Room*

1:15 **CMOH Update**
Update from Ontario's Chief Medical Officer of Health
Speaker: ***Dr. David Williams***

2:00 **WORKSHOP – Transformation and Governance**
Explore governance considerations in times of change.
Speakers: ***Linda Stewart, Executive Director, alPHa***
Glen Paskiw, Change Consultant

3:45 **Adjournment**

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Providing leadership in public health management

DRAFT MINUTES
Boards of Health Section General Meeting
Tuesday, June 13, 2017 – 8:00 AM to 12:00 PM
Meeting Room 1B, Chatham Kent Convention Centre, 565 Richmond St., Chatham, Ontario

PRESENT:

Trudy Sachowski (Chair)	Northwestern		Andrew Taylor	Lambton
David Neumann	Brant		Michael Clarke	Middlesex-London
Jo Ann Tober	Brant		Yolaine Kirlew	Northwestern
Teresa Bendo	Chatham-Kent		Paul Ryan	Northwestern
Noreen Blake	Chatham-Kent		Helen Dowd	Perth
Joe Faas	Chatham-Kent		Claude Bourassa	Porcupine
Carmen McGregor	Chatham-Kent		Gilles Chartrand	Porcupine
Sharon Pfaff	Chatham-Kent		Sue Perras	Porcupine
April Rietdyk	Chatham-Kent		Drago Stefanic	Porcupine
Gerry Bertrand	Eastern Ontario		Don West	Porcupine
Andre Rivette	Eastern Ontario		Thomas Ambeau	Simcoe-Muskoka
Cynthia St. John	Elgin St. Thomas		Paul Myre	Sudbury
David Inglis	Grey Bruce			
Judith Masters	HKPR		Linda Stewart	alPHa
Patricia Hewitt	Halton		Susan Lee	alPHa
Denis Doyle	KFL&A			
Wess Garrod	KFL&A			
Jim Neill	KFL&A			

GUESTS:				
Nancy Wai	Supervisor, Continuous Quality Improvement, Lambton Public Health			
Alex Berry	Manager, Communications & Foundation Services, Northwestern Health Unit			

WELCOME AND INTRODUCTIONS

T. Sachowski, Section Vice Chair, called the meeting to order at 8:23 AM. She acknowledged the sacred grounds on which the meeting was being held in recognition of alPHa's resolution on Truth and Reconciliation. Members introduced themselves. The staff of alPHa and Chatham Kent Public Health were thanked for their work in organizing the conference, particularly the memorable awards dinner.

SECTION BUSINESS

The minutes of the last meeting held on February 24, 2017 were approved on a motion by C. McGregor that was seconded by J. Neil and carried.

SECTION REGIONAL REPRESENTATIVE ELECTIONS

A handout with the backgrounds of regional representative candidates was distributed.

The following Section Regional Representatives on the alPHa Board of Directors were acclaimed for two terms (2017-2018 and 2018-2019):

Region	Acclaimed Representative	Board of Health
East	Wess Garrod	Kingston, Frontenac Lennox & Addington
South West	Carmen McGregor	Chatham Kent

There were no nominations submitted for the **Central West** region.

The alPHa BOH Section Executive will issue a call for a Central West region after the conference.

Board of health members who are continuing on the alPHa Board of Directors and BOH Section Executive were identified.

PUBLIC HEALTH SYSTEM TRANSFORMATION UPDATE

L. Stewart presented an update on alPHa and provincial activities related to public health system transformation as follows:

- alPHa/OPHA Health Equity work group is preparing a response from a health equity perspective.
- Regarding Patients First, the Ministry of Health and Long-Term Care (MOHLTC) has hired consulting firm KPMG to support LHINs with change management. The COMOH Executive will meet with LHIN CEOs. The Public Health Work Stream held its latest meeting on April 5.
    - Members suggested that an alPHa/public health representative be allowed at each LHIN-PH table, and that KPMG consult with health units as they assist the ministry with change management.
- alPHa has received a summary of comments made during the Ministry's regional consultations on the modernized Standards. Health units are expected to start implementing the new standards on January 1, 2018.
- alPHa will be responding to the new Accountability Framework and supporting the business administrators' response while emphasizing that 2018 is too soon for the first Annual Service Plan (ASP). Ministry documents are under development including templates for ASP and Budget Submission, and BOH Attestation. An Accountability Implementation Task Force has been struck; alPHa has not been invited to participate on this task force.
- The Minister's Expert Panel on Public Health that is focusing on public health organization and effective functioning will release recommendations at some point before the end of the year.
- Four health units are being audited by the provincial Auditor General Office (AGO), which is focused on value for money. The Ministry's Population and Public Health Division as well as Public Health Ontario are being audited. A. Rietdyk indicated that a survey from the AGO has gone out to all BOH members. Boards of health were advised to provide a common, consistent response in the survey. Members were further advised to provide only facts in audit surveys and interviews. L. Stewart offered alPHa's assistance to health units undergoing an audit.
- alPHa has completed its Budget Impact Survey and will be circulating results shortly to all boards. Health units appear to be achieving efficiencies through a number of methods (CQI, program based marginal analysis, service prioritization review, business process re-engineering, etc.). Impacts include reduced frequency of health unit services, reduced communications,

reduced program support, and the creation of waitlists, etc. A full analysis has yet to be done on impacts. This was identified as a potential next step. It was noted that while the Healthy Babies Healthy Children program is theoretically funded by a different ministry envelope (Children and Youth Services), a number of health units can no longer subsidize this program with their Ministry of Health & Long-Term Care grant.
- alPHa's election task group will make recommendations on key messages to the alPHa board in September.

CQI AND LOCAL PUBLIC HEALTH

Following introductions, guest speakers Nancy Wai and Alex Berry presented on the Locally Driven Collaborative Project (LDCP), Strengthening Continuous Quality Improvement in Ontario's Public Health Units. They expect to receive two more years of funding for research. Main points from their presentation included the following:

- CQI (Continuous Quality Improvement) is a management philosophy within an organization that drives work.
- CQI is now a requirement under the new provincial Standards for Public Health Programs and Services. All health units are doing QI, but in slightly different ways.
- The Maturity Tool was developed to systematically strengthen CQI across health units. Thirteen health units are in the beginning stage, 10 in the emerging stage and 11 in the progressing stage. General survey results have been emailed to each MOH/CEO; they are available online at Public Health Ontario (PHO).
- A scoping review was done to describe the state of knowledge about CQI and identify questions. Results of the scoping review will be available in a couple of months on the PHO website.
- Five domains that foster CQI are:
    - Organizational culture that is innovative, non-punitive and strategically aligned;
    - Organizational structures that provide staff training and education, human resources (e.g. make quality a job requirement), internal funding resources and multidisciplinary teams;
    - Engaged and supportive leaders (senior leaders, managers, CQI facilitators, front-line leaders)
    - Data (characteristics such as robust, timely; leverage existing systems)
    - External supports (QI collaboratives, accreditation/certification, funding and resources)
- Phase 2 of the LDCP project will focus on action research model and locally appropriate interventions to see if they are effective in increasing CQI.

In the Q&A session afterward, members asked about the feasibility of CQI in the face of budget cutbacks, potential for a seed money request to MOHLTC, and the relationship between the LDCP group and the Ministry, among others.

The guest presenters were thanked by the Chair.

ELECTRONIC BOARD MEETINGS

L. Stewart spoke to the recent updates to the *Municipal Act, 2001* and their implication on the use of technology to attend board of health meetings. The Act, which covers Toronto and all municipalities, indicates that if a board of health meeting is closed to the public, board of health members cannot participate electronically. Electronic participation is allowed only for meetings that are open to the public. ~~As such, electronic participants cannot be counted in quorum for attendance and are not allowed~~

~~to vote at the meeting~~ (see correction). Electronic participants, however, can be listed as having been present at the meeting for the minutes.

Correction - Regarding the question: **if someone participates in an open meeting electronically, do they still have a vote?** According to David Colenbrander with the Ministry of Municipal Affairs, the answer depends on the board's procedural by-laws. The Board can determine what an electronic participant gets to do, i.e., just listen, actively participate in discussion and/or vote on matters put before the board. It is up to the board to decide what they will allow. Even the electronic participation is optional. The Board's procedural by-laws now have to option to spell out:

1. If electronic participation is permitted for open meetings – yes/no
2. By what means will permitted electronic participation take place, e.g., webinar, teleconference, OTN, etc. The means can be limited to what is reasonably available.
3. What an electronic participant has the right to do, e.g., just listen, actively participate in discussion, make motions, and/or vote on matters put before the board.

Boards of health will be expected to update their bylaws to comply with these changes in the Municipal Act, particularly on provisions regarding electronic participation.

L. Stewart noted that the new clauses have yet to be proclaimed. Communication is expected later in the summer about when this will come into force.

Members discussed the issue of whether participants in an open meeting should be allowed to vote if attending electronically. It was recognized that the province is unlikely to re-open the Act to comment on this question. Y. Kirlew suggested that there could be opportunity for alPHa to advocate on the issue given the 2018 election year. There was also a suggestion of further research into other sectors on parameters regarding electronic participation.

ACTION: alPHa will write a letter that will not only congratulate the Ministry of Municipal Affairs on the recent changes to the *Municipal Act, 2001* that have clarified provisions regarding electronic participation at board meetings, but also request that the Act also provide for and allow voting by those participating electronically at such meetings.

ACTION: alPHa will report back to the Section on experiences of the hospital and education sectors regarding electronic participation.

alPHa RESOLUTIONS DEBRIEF

L. Stewart opened the floor for suggestions by local boards of health on actions that could help alPHa move forward on the 2017 resolutions. Members commented as follows:

- Boards of health can encourage their Indigenous populations to sit on the local board of health.
- The Truth and Reconciliation (TRC) resolution can be considered in small incremental steps, e.g. each BOH acknowledges the treaty grounds and/or reviews the board appointment process to create more opportunities for Indigenous representation, etc.
- Boards of health can be encouraged to read the TRC document.

ACTION: L. Stewart will distribute a Truth and Reconciliation summary by the alPHa/OPHA Health Equity Working Group containing sections relevant to public health.

ADJOURNMENT

Prior to adjournment, the Chair thanked alPHa staff member S. Lee for her work today in organizing the conference and executive director L. Stewart for guiding alPHa in her last remaining months before her retirement in the fall. L. Stewart expressed her gratitude to the membership and municipal partners for helping her learn about the municipal world over these past years.

Meeting adjourned at 11:39 AM.

alPHa
Association of Local
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Agencies

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October 17, 2017

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

Dear Minister Hoskins:

On July 20, 2017, you released the report of the Expert Panel (EP) on Public Health, Public Health within an Integrated Health System. This report fulfills part of the proposal introduced in your Patients First discussion paper [2015] "to appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and local public health units, and how to further improve public health capacity and delivery" [p20]. We thank you, and the EP members, for the completion of this effort and for making the recommendations public for consultation in a timely manner.

The Association of Local Public Health Agencies (alPHa) is the non-profit organization that provides support to the 36 local public health agencies (boards of health and public health units) in Ontario to promote a strong, effective and efficient public health system in the province. alPHa brings together the senior leadership of local public health (LPH), including board of health members, medical and associate medical officers of health, and senior managers in each of the public health disciplines – nursing, inspection, nutrition, dentistry, health promotion, epidemiology and business administration.

As such, alPHa is the collective voice of the organizations and professional leadership that are subject to the EP recommendations. It is with this lens that we have reviewed the recommendations of the EP and have surveyed our member boards of health for input. While alPHa will provide comment from a system level perspective, we expect that the Association's sections, affiliates and member boards of health will provide feedback from their own perspectives.

Our members have been consistent and clear that the mandates of LPH and healthcare are and should remain separate and distinct. Irrespective of the influence of local circumstances, we are collectively concerned that the attempt to align these mandates to the degree recommended by the EP will be to the detriment of our ability to promote and protect health at the community level. We are not starting with a blank slate in Ontario. The LPH system has many strengths that we believe would be eroded by the EP proposals. We urge that the following overarching concerns be carefully considered as part of any analysis for potential implementation.

1. **System disruption.** The magnitude of the changes recommended is significant and careful feasibility studies need to be conducted to ensure that the benefits to the effectiveness of the LPH system outweigh the costs. The EP proposes an 'end state' for LPH that will require major disruption of every facet of the system, from governance to program delivery. With so many details yet to be mapped out and given the complexity of on-the-ground implementation, we cannot support the proposed changes. We are not convinced that the EP recommendations are the only or best way forward.

2. **Fit with the work of LPH.** Local public health distinguishes itself from the healthcare system (i.e., hospitals, home care, family physicians, medical specialists, etc.) in that LPH focuses on the primary prevention of illness and injury and the promotion of public policies that impact the health of the general population. A population health approach seeks to improve the health of the entire population and reduce health inequities among certain groups in the population. This helps individuals, groups, and communities to have a fair chance to reach their full health potential. This also prevents disadvantage by social, economic, or environmental conditions.

   The work of LPH is largely focused upstream, using a population health approach as articulated in the Ontario Public Health Standards. Upstream work includes working with healthcare and non-healthcare sectors to advocate, design, implement and evaluate policies and programs that prevent diseases and their risk factors and promote and protect health, before people become patients in the first place. Bringing the LPH population health lens to healthcare service planning and delivery will certainly have a positive impact on the health system, but, healthcare is a relatively minor factor in what makes populations healthy or unhealthy. Addressing the social determinants of health through a collaborative upstream approach yields a much greater return on investment and widespread gains in the health outcomes of Ontario's population. Health, rather than healthcare, is our mandate and it is difficult for us to see the benefit to the aims of LPH of closer alignment with the healthcare system to the degree recommended by the EP. Realigning the boundaries of public health units with those of LHINs places stronger emphasis on the relationship with healthcare than existing relationships that promote health and fall within municipal boundaries such as housing, employment, planning and school boards. We cannot support the goal of better integration with the healthcare system if it comes at the expense of the structures that support upstream work that is most effectively done in collaboration at the local level with sectors outside of healthcare.

3. **Meeting local needs.** Again, using a population health approach, much of the work of LPH is accomplished through partnerships with local governments, schools and other community stakeholders to develop healthy public policies, build community capacity to address health issues and promote environments that instill and habituate healthy behaviours. Local public health has a strong vision for the health of all Ontarians that encompasses providing the best opportunities for health considering the broad spectrum of what is known to cause the best conditions for health, i.e., the social determinants of health. From that perspective, alPHa has already expressed support, with caveats regarding LPH capacity, for the proposal in Patients First that recommends better integration of population health within the health system. We do

see value in formalizing working linkages between LHINs and LPH, as we believe that they will help to build on existing successful collaborations in addition to ensuring that population and public health priorities inform health planning, funding and delivery. We already know that a rigid or one-size-fits-all approach will not equitably meet the needs of Ontarians in all parts of the province and will not permit the public health system to leverage the diversity of systems, organizations and services in different parts of the province. This is one of the strengths of our system, and we recommend the identification and focused examination of areas of the province where needs are not being met through current structures, so that tailored strategies can be developed to enhance capacity.

4. **Local public health capacity.** LPH capacity for most public health units has been steadily eroding over years of no increases in Ministry-approved budgets. The implementation of the new Standards for Public Health Programs and Services, new Accountability Framework, and new requirements under the *Patients First Act, 2016* are expected to stretch LPH capacity even further, and we believe that it will not withstand the large-scale system disruption proposed by the EP. We note that, while more is being asked of LPH, the budgeted amount for the Population and Public Health Division that provides LPH with most of its funding decreased by .42 percent from the previous year in the 2017-18 budget that gave an overall increase of 3.62 percent to the Ministry of Health and Long-Term Care (MOHLTC).

Given the concerns that we have expressed about the massive systemic change proposed by the EP aimed at fostering LPH-LHIN collaboration, we would like to propose that the work of the Public Health Work Stream that was established to define the formal relationship between LHIN Chief Executive Officers (CEOs) and LPH Medical Officers of Health (MOH) under the *Patients First Act, 2016* be allowed to further develop as an alternative solution.

While the EP focused on a 'ideal' end state with little consideration of implementation challenges [implementation was not within the EP's mandate], the work of the Public Health Work Stream resulted in proposed frameworks for LPH and LHIN engagement that were developed considering the current structure and organization of both LPH and LHINs. The mandate of the Work Stream was to define the parameters for engagement and the set of actions required of LHIN CEOs and LPH MOHs to support local health planning and service delivery decision-making, including definition of specific processes and structures to be established. Upon completion of this work, the Population and Public Health Division surveyed MOHs regarding the recommendations presented in the *Report Back from the Public Health Work Stream*. At present, we are awaiting the publication of the survey results and an open and transparent discussion of the results with government representatives.

We suggest that the desired outcomes for a strong public health sector in an integrated health system stated in the EP Report may better be achieved through focusing on the frameworks proposed by the Work Stream as well as the results of research, such as the locally driven collaborative project, *Patients First – Public Health Units and LHINs working together for population health*.

In closing, we recommend that the initiatives underway including the new Standards for Public Health Programs and Services, new Accountability Framework, and findings of the Public Health Work Stream and other provincial and national actions in progress be implemented and evaluated before the EP recommendations are given further consideration.

We look forward to further consultation and transparent discussion of the way forward. alPHa will continue to provide comment as the work underway evolves and becomes public.

Yours truly,

Carmen McGregor,
President

Copy: Dr. Bob Bell, Deputy Minister
Sharon Lee Smith, Associate Deputy Minister
Roselle Martino, Assistant Deputy Minister,
Dr. David Williams, Chief Medical Officer of Health
Dr. Peter Donnelly, President and CEO, Public Health Ontario
Pat Vanini, Executive Director, AMO
Ulli S. Watkiss, City Clerk, City of Toronto
Giuliana Carbone, Deputy City Manager, City of Toronto
Boards of Health (Chair, Medical Officer of Health and CEO)

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

alPHa Sections:

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

Affiliate Organizations:

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

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

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

October 12 2017

Dear Minister Hoskins,

Re: Council of Ontario Medical Officers of Health (COMOH) Response to the Provincial Consultations on the Report of the Minister's Expert Panel on Public Health (Expert Panel)

On behalf of the medical leadership of Ontario's local public health system, I am pleased to share COMOH's response to the provincial consultations on the Expert Panel Report, which is the product of our careful collective review and extensive discussion of its content and recommendations. We commend you for establishing the Expert Panel and commend the Panel members for their work to achieve their mandate.

As you are aware, COMOH is comprised of medical officers of health and associates in whose hands Ontarians place their trust to protect and promote health every day. This is a responsibility we take seriously and to which we have dedicated our professional lives. It is our privilege, with our respective staffs and boards of health, to lead and work within what is recognized by peers as the best public health system in the country. COMOH's 69 members, over half of whom have a decade of experience or more working in local public health in Ontario, are committed to providing you with our best advice on how to continue to improve Ontario's public health system to meet the health promotion and protection needs of Ontarians now and in the future.

COMOH welcomes the review of the public health system that you have embarked upon and we embrace the vigorous debate and reflection that your Patients First initiatives have stimulated. We have been very supportive and highly engaged in a number of Patients First health transformation-related initiatives to date, including the modernization of the Ontario Public Health Standards, the Public Health/LHIN Work Stream, our ongoing work with LHINs and sub-LHINs, and the Accountability Framework review. These initiatives actually meet much of the mandate of the Expert Panel in that they enhance the public health system's capacity, accountability, quality and transparency, including our capacity to contribute to a transformed health system focussing on patient and population health.

Based on our many years of collective experience, COMOH is of the opinion that implementing the Expert Panel recommendations would result in unprecedented change to Ontario's public health system. It is therefore critical to ensure that disruption of such a scale has a reasonable chance of achieving its aims and is worth the anticipated system disruption and potential unintended adverse consequences. To use a medical analogy, we are not convinced that the Expert Panel focused on the correct diagnosis or that the recommended treatment is better than the disease. There will certainly be significant side effects.

While overall we are supportive of health system transformation that envisions a stronger partnership with public health, we cannot support changes that could negatively impact the ability of the public health system to protect and promote the health of Ontarians. As the Expert Panel recommendations are considered for potential implementation, we believe that the following four principles are essential tenets to help mitigate potential risks to the effectiveness of Ontario's public health system.

1. **Public health governance must remain local, ensuring accountability to municipalities, the province, and the local population as a whole.**

    - Health happens locally. A unique feature and key strength of Ontario's public health system is its ties to the municipal sector (e.g. legislation, governance, funding, and infrastructure) where it has longstanding relationships and a direct influence on opportunities for health where people live, work and play. This is an often-cited strength and the envy of local Canadian public health practitioners in other jurisdictions.
    - Consideration must be given to the complexity and diversity of Ontario such that governance approaches ensure accountability to both municipal and provincial governments but remain flexible (versus one-size) to adapt to local circumstances and the population as a whole.
    - Public health must continue to be aligned with municipal boundaries including regional and those in the upper tier.
    - Strong local representation on boards of health must be maintained at the level of the proposed local public health service delivery area versus centralized at the regional level.
    - The province should leverage its current provincial appointment powers to ensure identified skill and competency gaps are filled.

2. **Public health functions must be protected within transformed health systems.**

    - System transformation that privileges health care sector linkages must not come at the expense of public health action on non-health system levers for health.
    - Public health core functions must be protected and enhanced to meet growing needs.
    - Most opportunities for health and health equity are not related to a lack of or inequity in access to health care services, but to the impact of inequalities in other sectors such as education, housing, income or occupation; the public health capacity to work with this complex array of factors must be protected and enhanced.

3. **Decisions must be rational and transparent.**

    - System reform must be based on a clear articulation of the rationale, careful analysis of the evidence and an assessment of options and their related risks and mitigation strategies.
    - There must be transparency and engaged dialogue with stakeholders, including COMOH, about the research and experiential evidence used to inform decision making, and about the critical factors for successful implementation.
    - COMOH recognizes that public health system capacity and equity are ongoing challenges and we have supported more precision-oriented reforms that address specific circumstances (e.g. amalgamations of boards as recommended by the Capacity Review Committee, creation of regional hubs of specialised expertise, shared administrative supports, etc.).

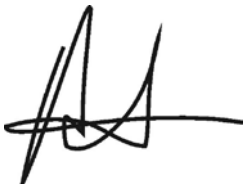
4. **The authority of the medical officer of health position must align with the responsibilities of the position.**

   - The best-practice model of single leadership as opposed to joint leadership must be implemented (i.e. combined MOH/CEO), with flexibility for joint leadership only under limited prescribed circumstances, ensuring there is alignment of responsibility with authority and accountability.
   - The MOH position must report directly to the board of health and continue to be protected by legislation.

COMOH is committed to contributing to a public health system that meets the health promotion and protection needs of Ontarians now and in the future. We are very supportive of system transformation that enhances our capacity and our linkages with the health system, but this cannot occur at the expense of our ability to meet the public health needs of Ontarians.

We appreciate the opportunity to continue to have input into the thinking that is being done by you and your officials regarding difficult choices for the way forward. We are eager to engage in further discussion on these important points as well as the more detailed feedback on specific sections of the Expert Panel Report that we have assembled in the attached document.

Sincerely,



Dr. Penny Sutcliffe
Chair, Council of Ontario Medical Officers of Health

Encl.

COPY: Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Branch
Sharon Lee Smith, Associate Deputy Minister, Health and Long-Term Care, Policy and Transformation
Dr. David Williams, Chief Medical Officer of Health
Dr. Peter Donnelly, President and CEO, Public Health Ontario
Pat Vanini, Executive Director, AMO
Ulli S. Watkiss, City Clerk, City of Toronto
Giuliana Carbone, Deputy City Manager, City of Toronto
Chairs, Ontario Boards of Health

ATTACHMENT to COMOH Expert Panel Response letter October 12, 2017

Council of Ontario Medical Officers of Health (COMOH) Response to the Provincial Consultations on the Report of the Minister's Expert Panel on Public Health (Expert Panel)

The following comments are aligned with the sections of the Expert Panel Report. They support the following four critical themes for government's consideration:

1. Public health governance must remain local, ensuring community and provincial accountability.
2. Public health functions must not be consumed by transforming health systems.
3. Decisions must be rational and transparent.
4. The authority of the medical officer of health position must align with the responsibilities of the position.

OVERALL:

We agree that capacity and equity in public health units need to be improved and we are on record in support of system changes to promote these ends. We also agree that public health expertise can and should be leveraged where appropriate to assist in broader health system planning in an integrated health system. As presented however, we have major concerns that an overemphasis on health system integration has led to a recommendation that would amount to a major systemic disruption, without a clear rationale or explanation of how these changes would actually improve public health capacity or support public health in achieving its goal of health promotion and protection for Ontarians.

With the understanding that the Ministry has not made any decisions on implementation, we hope that the following comments and our above four critical messages will be carefully considered. They are presented under headings that mirror the sections of the Expert Panel Report.

I - EXPERT PANEL MANDATE

The mandate of the Expert Panel was to recommend an optimal structure and governance for public health in Ontario to serve the goals of improved accountability, transparency, quality, capacity and equity within the sector as well as support integration with the broader health system in order to bring the population health perspective to health system planning.

The stated principles guiding the panel's work included:

- ensuring the preservation of the core functions and strong and independent voice of public health;
- the maintenance of relationships with non-health sector partners, and
- the reflection of local needs and priorities in the organization and distribution of public health resources.

COMOH is supportive of the stated principles. However, we would caution that they do not present a clear articulation of the problem that the proposed recommendations are intended to address. We in fact see very little connection between the public health-focused elements of the mandate and stated principles and the report's recommendations.

Public health's closest partnerships that drive the effectiveness of our work are with municipalities, school boards, community service organizations and workplaces and not with LHINs, hospitals, doctors'

offices or clinics. In our view, the recommended changes threaten these relationships and degrade our ability to improve health at the community level with our health protection and promotion approaches.

II THE OPPORTUNITY

Section II of the Expert Panel Report ("The Opportunity") further reinforces this concern.

While it correctly outlines the divergent approaches of public health and health care (upstream community-wide interventions vs. diagnosis and treatment), it repeats at the outset the notion that their operation as distinct systems is a problem. We have always argued that this distinction is in fact one of the great strengths of the Ontario system. Separate public health capacity and resources are ring-fenced from being co-opted by the demands of the acute care sector. Instead, public health units are able to bring these to bear in protecting, promoting, and optimizing the health of communities, which actually has the indirect effect of reducing demand within the acute care sector by preventing and forestalling illness.

This section goes on to focus almost exclusively on public health's role in bringing its population health approach into the health care system, suggesting that integration is the only way to achieve this.

The section also states that the strengthened relationship between public health and LHINs will strengthen relationships outside the health system, sharpen the focus on determinants of health and health equity and foster greater recognition of the value of public health without a clear explanation of how it will achieve any of these.

In our view, the description of the opportunity could just as easily be characterized as a threat without a clear enumeration and articulation of the issues that the proposed solution is intended to address, a clear rationale for the proposed solution as the preferred option (and why other options were not presented), and far more detail about how it is expected to strengthen the capacity and partnerships required for public health to carry out its core mandate.

We agree that targeted changes may be required to address long-standing capacity issues within the public health sector. We also agree that the acute care system needs to incorporate population health approaches in planning. Neither of these goals, nor anything in the Expert Panel report, suggest that these would be accomplished by the recommended radical restructuring of the public health sector.

We fear that such a fundamental reorganization will disrupt the public health sector's ability to do its work during the complex transition and would weaken its effectiveness in the long term.

III A STRONG PUBLIC HEALTH SECTOR IN AN INTEGRATED SYSTEM

The Expert Panel provides a sound outline of the strengths and challenges inherent in the current geographical, demographic and capacity disparities of Ontario's 36 public health units, and describes desired outcomes and criteria for a new organizational structure for public health that would maintain its strength and independence, increase influence on health system planning, enhance local presence and municipal relationships, achieve critical mass and surge capacity etc. The structure would have fewer health units with a consistent governance model and better connections to the health system.

Overall, we are pleased that public health remains a separate and distinct organizational entity. However, the proposed structure and boundaries appear to be more strongly aimed at aligning PHUs with the LHINs.

1. THE OPTIMAL ORGANIZATIONAL STRUCTURE FOR PUBLIC HEALTH

Our major concern here is the magnitude of the proposed changes to the public health system in the absence of a clear enumeration / definition of the problem(s) it is intended to solve, an analysis of unintended consequences or a detailed presentation of evidence that the presented option is likely to achieve the stated outcomes.

We certainly agree that amalgamating some health units may be the answer to capacity issues in some areas of the province, but even on a small scale, this is an incredibly complex, disruptive and expensive undertaking (considerations include opportunity costs, wage harmonization, collective agreements, allocation of human resources, etc.). The EP proposal is on such a grand scale that the complexity, disruption and expense will be significantly magnified, and this must be carefully measured against the likely benefits, both to PHU-LHIN partnerships and health protection and promotion at the local level. Further, issues of capacity are not the same across the province and implementing the recommended change everywhere would be expected to actually reduce the capacity of some health units.

We also agree that centralization of certain administrative and specialized public health functions at the regional level may also be an answer to capacity issues, but this could be achieved in many alternative fashions. For example, a "regional hub" system could be established without organizational amalgamations or changes to the governance structure. Other solutions include shared service agreements between health units and the maintaining the existing administrative functions that PHUs that are / are part of large municipalities or regional governments already enjoy.

We worry that the proposed structure will in fact result in a weakening of the municipal voice in public health in that there will be far fewer municipal representatives distributed across far fewer boards of health that are expected to be about the same size as they are now. This means that many municipalities (including rural and remote areas) will not have a direct voice at all, funding and governance accountability will be diluted and the foundation of local governance, autonomy and responsiveness upon which public health is built will be weakened.

2. OPTIMAL GEOGRAPHIC BOUNDARIES

The introductory statement for the "optimal geographic boundaries" section says that "Ontario's existing 36 public health units are organized based mainly on municipal boundaries. The current configuration of health unit areas makes it difficult to operate as a unified system with LHINs and other health system partners following LHIN boundaries".

This assumes two things:

1. That it is imperative that PHUs and LHINs / health system partners operate as a unified system
2. That effective linkages between PHUs and LHINs are not possible unless PHUs conform with LHIN boundaries.

These two assumptions are not supported by evidence and no explanation is provided as to why these assumptions formed the basis for discussion.

The assumptions also demonstrate a significant inconsistency, in that while the EP reiterates the importance of the PH / municipal relationship, both the new organizational structure and proposed boundaries will almost certainly weaken it in favour of stronger ties with the LHINs. In addition, little is

said about the importance of essential public health relationships with sectors such as education, social services, community groups and other local stakeholders.

It is worth reiterating that LHIN boundaries were based on referral patterns within hospital catchment areas. This basis has no relationship with the structures and functions of public health.

COMOH would prefer to see these assumptions tested. We are aware of many of instances in which PHUs work closely with LHINs on various initiatives and we support the evaluation of these interactions in addition to the implementation of the recommendations from the PH-LHIN Work Stream prior to any decisions about restructuring of public health.

3. OPTIMAL LEADERSHIP STRUCTURE

COMOH has significant concerns about the EP recommendation to separate the MOH from the CEO roles. The Panel recognizes the best practice model of single leadership as opposed to joint leadership, however, recommends a separation. Our main concern is that the MOH position must have both the responsibility and the authority to carry out the role. There may be circumstances (that should be defined) wherein the board may require a separation in roles and this flexibility should be accommodated where circumstances require it. The MOH must also report directly to the board of health and continue to be protected by legislation.

Without more details about what is being proposed here and why, we cannot support this model nor can we accept a categorical prohibition of the combination of the two roles. It is not at all unreasonable to foresee that this will result in the marginalization of the MOH at the regional level, an even greater marginalization of the MOH at the local level, and an erosion of their authority to carry out their duties.

We see this part of the Expert Panel's proposal as among the most problematic and contradictory and we do not believe that it meets its own criteria (best practices in leadership structures, reinforce and capitalize on strong public health and clinical skills, capture the roles and functions of current leaders, operate efficiently and effectively).

Finally, we see very little to distinguish the proposed "Local Public Health Service Delivery Areas" and our existing public health units. One could see the proposed Regional Public Health Entities as an additional layer of bureaucracy whose authority, planning functions, analysis, decision-making and authority will be removed from the local context and whose higher-level strategic engagement functions (LHINs, Health System, Government etc.) will dilute their effectiveness in meeting population health needs of the local communities that public health must serve.

4. OPTIMAL APPROACH TO GOVERNANCE

COMOH understands and accepts that improvements to the governance structures of public health should be one of the key outcomes of a renewed public health system. We agree with the Expert Panel's assessment of the ongoing challenges faced by local boards (recruitment, continuity, competencies, sole focus on population health improvements, etc.).

The composition of boards of health and the qualifications of their members is something in which we have taken significant interest and we support measures that would ensure boards with stronger governance, autonomy and an exclusive focus on public health.

Our parent organization, the Association of Local Public Health Agencies, will be providing additional comments on best governance practices and the composition and qualifications of boards of health, but we would reiterate that we see potential problems with such a drastic reduction in the number of boards of health as touched upon in the "Optimal Organizational Structure for Public Health" section above (reduction of municipal interest and political clout, decreased community engagement, dilution of ability to affect health outcomes at the local level, undermining of productive relationships with municipal leaders etc.). Further it is understood that where there are specific governance issues, the current Ministerial authority under the HPPA provide the mechanisms to address these.

We are also very concerned about the suggestion that the key positions on the proposed regional boards (Chair, Vice-Chair, Chairs of Finance & Audit Committees) should be limited to Provincial OIC appointments to ensure accountability to the provincial government. Not only does this have the potential to further marginalize the local governance voice, but we also worry about the implications of adding this explicit accountability requirement to the board's intended autonomy.

CONCLUSION:

The Expert Panel report concludes with a section entitled "Implementation Considerations". This was not within the scope of the Panel's recommendations, but in recognizing the magnitude of change inherent in its proposal, it quite rightly saw fit to enumerate the legislative, capacity and resource, and change management considerations.

We would argue that a full analysis of these considerations, along with those that we have outlined above, will be a prerequisite to any decision to implement the Expert Panel's recommendations, in whole or in part.

In closing, we would note that we have been assured on many occasions that no decisions have been made. As we understand this to be the case, we request that government engage in a full, frank and productive dialogue with the medical leadership of Ontario's public health system as the next steps are contemplated. We are committed to providing our best advice to continue to improve the system

BREAKING NEWS

October 12, 2017

AMO Opposes Proposed Changes to Public Health System

The government is considering far reaching changes to the public health system based on recommendations made by the Expert Panel on Public Health in their report – Public Health within an Integrated Health System, which was released on July 20, 2017.

After careful consideration by AMO's Board of Directors and our Health Task Force, AMO does not support the recommendations of the Expert Panel on Public Health and urges the government not to adopt them.

If the Expert Panel recommendations are implemented, it will completely change and dilute over time the mandate of the local public health system by integrating it with the health care system. There was no analysis provided by either the Expert Panel or the Ministry on the implications of this proposed integration from either a patient, program/service, or cost benefit analysis perspective. Further information on AMO's analysis position is found in the attached briefing note.

AMO is encouraging municipal leaders and councils to review the report and voice their opposition to Minister Dr. Eric Hoskins, Minister of Health and Long-Term Care, and local MPP's.

AMO Contact: Monika Turner, Director of Policy, mturner@amo.on.ca, (416) 971-9856 ext. 318.

Sent via e-mail: Eric.Hoskins@Ontario.ca

October 12, 2017

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

Dear Minister Hoskins:

After careful consideration by our Board of Directors and our Health Task Force, AMO does not support the recommendations of the Expert Panel on Public Health and urges you and the provincial government not to adopt them.

If the Expert Panel recommendations are implemented, it will completely change and dilute over time the mandate of the local public health system by integrating it with the health care system. There was no analysis provided by either the Expert Panel or the Ministry on the implications of this proposed integration from either a patient, program/service, or cost benefit analysis perspective. There was no clear demonstration of any benefits of such a change in the public health system.

Our many concerns on the Expert Panel recommendations include:

- Public health will lose its local and community focus. It is currently integrated within its communities with multiple local linkages with both public and private bodies and organizations.
- A large number of the current public health units are fully integrated within a municipal system that enables coordinated planning, policy and program work with and between municipal services such as land use planning, transit, parks, housing and social services. The health unit staff are also municipal employees.
- For the autonomous public health units, there are also strong and vibrant local linkages with their municipal governments and services that would be severed or at least damaged by moving to a regional public health structure.
- The proposed governance model will reduce the local leadership voice in decision-making.
- Ensuring critical mass for emergencies does not need to be addressed only structurally.
- Serving the populations in rural and northern Ontario is already challenging. Experience has shown that making an entity regional does not generally help such situations.
- Amalgamations are not for the faint of heart and they do not generally produce the expected outcomes or efficiencies.

Municipal governments are your funding partners in public health – not merely stakeholders. In 2015, the last year data is available, municipal governments funded 38%, on average, of the public health costs for mandatory programs. To act upon the Expert Panel's recommendations, would create significant fiscal churn and likely municipal reduction in our cost-sharing world.

Given the grave concerns of what would be lost by implementation of these recommendations without any evidence of benefit lead us to our decision not to support them. The significant municipal interest and stake in this matter cannot be understated. We are asking for your commitment not to adopt all or any of these recommendations.

We would appreciate an opportunity to discuss this with you soon.

Sincerely,

Lynn Dollin
AMO President

cc: The Honourable Kathleen Wynne, Premier
The Honourable Bill Mauro, Minister of Municipal Affairs
Dr. Robert Bell, Deputy Minister, Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister, Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care

BRIEFING NOTE

To: AMO Membership

Date: October 12, 2017

Subject: AMO's Response to the Expert Panel on Public Health

ISSUE: AMO does not support the recommendations of the Expert Panel on Public Health as outlined in the report, Public Health within an Integrated Health System, released on July 20, 2017. In the AMO President's correspondence, AMO demands that the government not change the public health system as recommended. The President's letter dated October 12, 2017 is included in this note in Appendix A.

SUMMARY OF AMO'S RESPONSE:

AMO does not support the recommendations of the Expert Panel on Public Health. We urge the Minister of Health and Long-Term Care and the provincial government not to adopt the recommendations given there is no clear evidence to justify such changes to the public health system. Integrating public health within the health care system would completely change and dilute over time the mandate of the local public health system.

ANALYSIS:

If the Expert Panel recommendations are implemented it will completely change the public health system and place it within the health care system. Neither the Expert Panel nor the Ministry have provided analysis on the implications of integrating from either a patient, program/service, or cost benefit analysis perspective. There is no solid empirical foundation provided to support the proposed change.

Many within the municipal sector are very opposed to integration of public health within the broader health care system for many reasons:

- Public Health will lose its local focus – even if there are local public health service delivery areas.
- The Public Health Units in Regional and Single-Tier municipal governments are fully integrated into the municipal system – regarding governance, as employees and linked to other parts of municipal services (i.e. planning, transit, housing, social services).
- There is a risk that integration will dilute the Public Health mandate and shift away from local population-based services toward clinical services to support the primary care system given those under resourced needs.

Creating coverage in larger geographic areas may help create critical mass, however, integration will be challenging in northern, rural and remote areas given smaller, spread out populations.

The recommendations concerning governance will weaken the local elected official voice by seeking to increase community members (LHINs, school boards) appointed to Boards of Health. The local elected official voice is important to reflect overall community need. The new model will only serve

to dilute municipal government involvement in Public Health. Being an elected official is a core competency. Elected officials bring a lens of value for money and the needs of the broader community.

It is suggested that the further that Public Health gets from the municipal core, the more the Province should be responsible for funding. Municipal governments may be less inclined to top up funding or contribute other in-kind municipal resources especially in the case of single-tier and regional governments where full integration of Public Health into the municipal system is the case. It may also be challenging to maintain close connections between local councils and Boards the larger and more regional they become. Municipal governments should have a strong role. It cannot be assumed that this will continue in a new model. This is a significant risk.

AMO's Health Task Force and the AMO Board carefully considered the matter of the Expert Panel's recommendations. AMO is opposed to the new proposed model for the reasons listed above. It is simply not clear that the benefits are worth the significant proposed disruption to the system. As well, it is also not clear the exact problem that the government is trying to address and, more broadly, what is the vision for the health care system. Until this is known and agreed to, as funding partners, it is challenging to respond to the need for change in Public Health.

In making its decision, the Board was guided by the following principles:

1. **Preserve the mandate of Public Health** – To make sure Public Health and its staff is not overwhelmed by the needs of health care services. Maintaining the distinctive role of Public Health to provide preventative and population-based health services that meet local needs, as a complimentary and equal partner to primary care's provision of clinical treatment services.

2. **Maintain the full range of current functions of Public Health** – To fulfill the mandate and desired public health outcomes ranging from disease prevention and health promotion to research and knowledge transfer. These are essential components to a well-functioning public health system.

3. **Enhance the capacity of Public Health** – To achieve better prevention and population health outcomes for local communities.

4. **Increase access to high quality health care informed by population health planning** – To guide primary care delivery that meets local needs.

5. **Achieve equity in health outcomes** – To benefit all individuals and regions of the Province in an equitable manner.

6. **Maintain local flexibility** – To ensure a One Size Doesn't Fit All model of standardization acknowledges the diversity of Ontario including areas of the Province (north-south, east-west, and rural-urban), and the diverse health need in different regions.

7. **Good public and fiscal policy** – To ensure change is driven by a clear public policy purpose and backed by evidence that any new arrangements will better suit that purpose. Change must be cost neutral for municipal governments.

8. **Facilitate greater partnerships and collaboration** – To maintain and strengthen linkages with the broader health care system but also with municipal and community services.

9. **Achieve good governance relationships** – To ensure that proper oversight models are in place that are appropriate for a public health organization, and for services, which are municipally funded.

10. **Support funding relationships** – To promote long-term sustainability with adequate resourcing and an appropriate direct relationship between Public Health and the Ministry of Health and Long-Term Care, rather than a new funding and oversight relationship with Local Health Integration Networks (LHINs).

11. **Accountable** – To establish clear accountability to both the public at the local level and to the Province.

12. **Transparent** – To build public confidence that models and structures achieve good outcomes at a reasonable cost.

BACKGROUND:

Public Health

Public health services, including both disease prevention and health promotion, are an essential part of Ontario's health services continuum. Municipal governments play a major role, often as the employer, and have significant responsibilities in delivering public health services. Ontarians are served by 36 local boards of health that are responsible for populations within their geographic borders. Most boards are autonomous entities while some have the local municipal council serving as the board of health. Among other requirements mandated by the Province, local boards of health are responsible for implementing the provincially mandated 2008 Ontario Public Health Standards.

Currently, public health services are cost shared as a 75% provincial and 25% municipal responsibility. In 1998, under the *Services Improvement Act*, municipalities became responsible for 100% funding of all public health units and services. This was quickly amended in 1999, when the 50/50 cost sharing arrangement between the municipal and the provincial governments was reintroduced. It stayed at this level throughout the 2000 Walkerton tragedy and the 2003 SARS outbreak.

In 2004, the provincial government launched Operational Health Protection to address long-standing public health system capacity issues that included phased-in increases to the provincial share of public health funding to 75% by 2007. Under the *Health Protection and Promotion Act*, 1990, the Province may provide grants to municipalities to assist with public health costs whereas municipal governments are legislatively responsible for public health funding. In 2006, the Capacity Review Committee's (CRC) report was released. CRC's recommendations on changes to governance and amalgamations of specific health units were not implemented by the Province.

In 2015, the last year data is available, municipal governments funded 38%, on average, of the public health costs for mandatory programs/Ontario Public Health Standards (source: 2015 FIR of conditional grants). So, municipal governments are paying above the required cost sharing amounts.

Expert Panel on Public Health

To review and envision a new role for Public Health with the context of the *Patients First Act* and the revised standards, the government convened an Expert Advisory Panel. Gary McNamara, Mayor of Tecumseh, was appointed to the panel by the Minister, as an individual, not as a municipal representative selected by AMO.

The work of the Expert Panel is important, as it has come up with recommendations to the government intended to redefine the role of Public Health for years to come. The Minister gave the panel a mandate to look at how public health could operate within an integrated health system. The panel tabled the report to the Minister in June 2017.

The key recommendation proposes an end state for Public Health within an Integrated Health System that would have Ontario establish 14 regional public health entities—that are consistent with the LHIN boundaries.

Other Expert Panel Report recommendations include:

Proposed Leadership Structure consisting of:

- Regional public health entity with a CEO that reports to the Board and a Regional Medical Officer of Health (MOH) who reports to the Board on matters of public health and safety.
- Under each regional entity would be a Local Public Health Service Delivery Area with a Local Medical Officer of Health (reporting to the Regional MOH), local public health programs and services.

Proposed Board of Health Governance would be freestanding autonomous boards:

- Appointees would be municipal members (with formula defined by regulation), provincial appointees, citizen members (municipal appointees), and other representatives (e.g. education, LHIN, social sector, etc.).
- varied member numbers of 12 – 15
- diversity and inclusion – board should reflect the communities they serve
- qualifications – skills-based and experience
- Board to have the right mix of skills, competencies, and diverse populations.
- "Municipalities should also be encouraged to appoint a mix of elected officials and members of the community to ensure diversity and continuity and to reduce challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health."

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

Legislation

Funding – It was noted that "as part of implementation planning the Ministry will need to revisit funding constructs in order to implement the recommendations".

Transition Planning/Change Management – with wording that says:

- "The transition from the current 36 local boards of health to a smaller number of regional boards of health will have particular implications for municipalities and municipal members. It is important that the new board structure recognizes and protects municipal interests, while recognizing the potential for competition for municipal seats."
- "To ensure greater consistency across the province, it may be helpful to work with the Association of Municipalities of Ontario to develop the criteria for municipal representation on the new regional boards."
- Effective linkages with LHINs and the Health System.

Appendix A

Association of Municipalities Ontario

Office of the President

Sent via e-mail: Eric.Hoskins@Ontario.ca

October 12, 2017

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

Dear Minister Hoskins:

After careful consideration by our Board of Directors and our Health Task Force, AMO does not support the recommendations of the Expert Panel on Public Health and urges you and the provincial government not to adopt them.

If the Expert Panel recommendations are implemented, it will completely change and dilute over time the mandate of the local public health system by integrating it with the health care system. There was no analysis provided by either the Expert Panel or the Ministry on the implications of this proposed integration from either a patient, program/service, or cost benefit analysis perspective. There was no clear demonstration of any benefits of such a change in the public health system.

Our many concerns on the Expert Panel recommendations include:

- Public health will lose its local and community focus. It is currently integrated within its communities with multiple local linkages with both public and private bodies and organizations.
- A large number of the current public health units are fully integrated within a municipal system that enables coordinated planning, policy and program work with and between municipal services such as land use planning, transit, parks, housing and social services. The health unit staff are also municipal employees.
- For the autonomous public health units, there are also strong and vibrant local linkages with their municipal governments and services that would be severed or at least damaged by moving to a regional public health structure.
- The proposed governance model will reduce the local leadership voice in decision-making.
- Ensuring critical mass for emergencies does not need to be addressed only structurally.
- Serving the populations in rural and northern Ontario is already challenging. Experience has shown that making an entity regional does not generally help such situations.
- Amalgamations are not for the faint of heart and they do not generally produce the expected outcomes or efficiencies.

Municipal governments are your funding partners in public health – not merely stakeholders. In 2015, the last year data is available, municipal governments funded 38%, on average, of the public health costs for mandatory programs. To act upon the Expert Panel's recommendations, would create significant fiscal churn and likely municipal reduction in our cost-sharing world.

Given the grave concerns of what would be lost by implementation of these recommendations without any evidence of benefit lead us to our decision not to support them. The significant municipal interest and stake in this matter cannot be understated. We are asking for your commitment not to adopt all or any of these recommendations.

We would appreciate an opportunity to discuss this with you soon.

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