Board of Health for the
Peterborough County-City Health Unit
AGENDA
Board of Health Meeting
Wednesday, April 13, 2016 – 5:30 p.m.
Dr. J. K. Edwards Board Room, 3rd Floor
Jackson Square, 185 King Street, Peterborough

1. Call to Order

Opening Statement
We respectfully acknowledge that we gather and reside on traditional Anishinaabeg land, and we offer our deep gratitude to our First Nations for their care for, and teachings about, our earth and our relations. May we honour those teachings.

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. **2015 Audited Financial Statements**
Richard Steiginga, CA, Partner, Collins Barrow Chartered Accountants
Gloria Raybone, CPA, CA, Manager, Collins Barrow Chartered Accountants

4.2. **Physical Donor Recognition** p. 4
Nicole Beatty, CFRE, nicbea & co.

5. Confirmation of the Minutes of the Previous Meeting

5.1. **March 9, 2016** p. 12

6. Business Arising From the Minutes

7. Staff Reports

8. Consent Items

All matters listed under Consent Items are considered to be routine, housekeeping, information or non-controversial in nature and to facilitate the Board's consideration can be approved by one motion.

Board Members: *For your convenience, circle the items you wish to consider separately:*
8.1a 8.1b 8.2a 8.2b 8.3a 8.3b

8.1. **Correspondence**

a. **Correspondence for Direction** p. 22

b. **Correspondence for Information** p. 25

8.2. **Staff Reports**

a. **Staff Report: Accountability Agreement Indicator Results (2015)** p. 73
Patti Fitzgerald, Assistant Director, Chief Nursing & Privacy Officer

b. **Medical Officer of Health – Coverage Request** p. 78
Dr. Rosana Salvaterra, Medical Officer of Health

8.3. **Committee Reports**

a. **Fundraising Committee** p. 79
Kerri Davies, Chair, Governance Committee

b. **Governance Committee** p. 84
Gregory Connolley, Chair, Governance Committee

9. New Business

9.1. **Annual Mandatory Board Training – Baby-Friendly Initiative** p. 117
Dawn Hanes, Public Health Nurse
30 minute session

9.2. **Selection of Medical Officer of Health Review Sub-Committee**
Gregory Connolley, Chair, Governance Committee

9.3. **Association of Local Public Health Agencies Annual General Meeting and Conference, June 5-7, 2016 - Attendance**
Dr. Rosana Salvaterra, Medical Officer of Health

9.4. **Association of Municipalities of Ontario Annual General Meeting and Conference, August 14 - 17, 2016 – Delegation Requests**
Dr. Rosana Salvaterra, Medical Officer of Health

10. In Camera to Discuss Confidential Matters

11. Motions for Open Session

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

Date: May 4, 2016
Time: 5:30 p.m.
LOCATION CHANGE:
Curve Lake Community Centre, 20 Whetung Street East, Curve Lake First Nation

13. Adjournment

ACCESSIBILITY INFORMATION: The Peterborough County-City Health Unit 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.

Peterborough County-City
HEALTH UNIT
...because health matters!

Physical Donor Recognition

Presentation to Board of Health

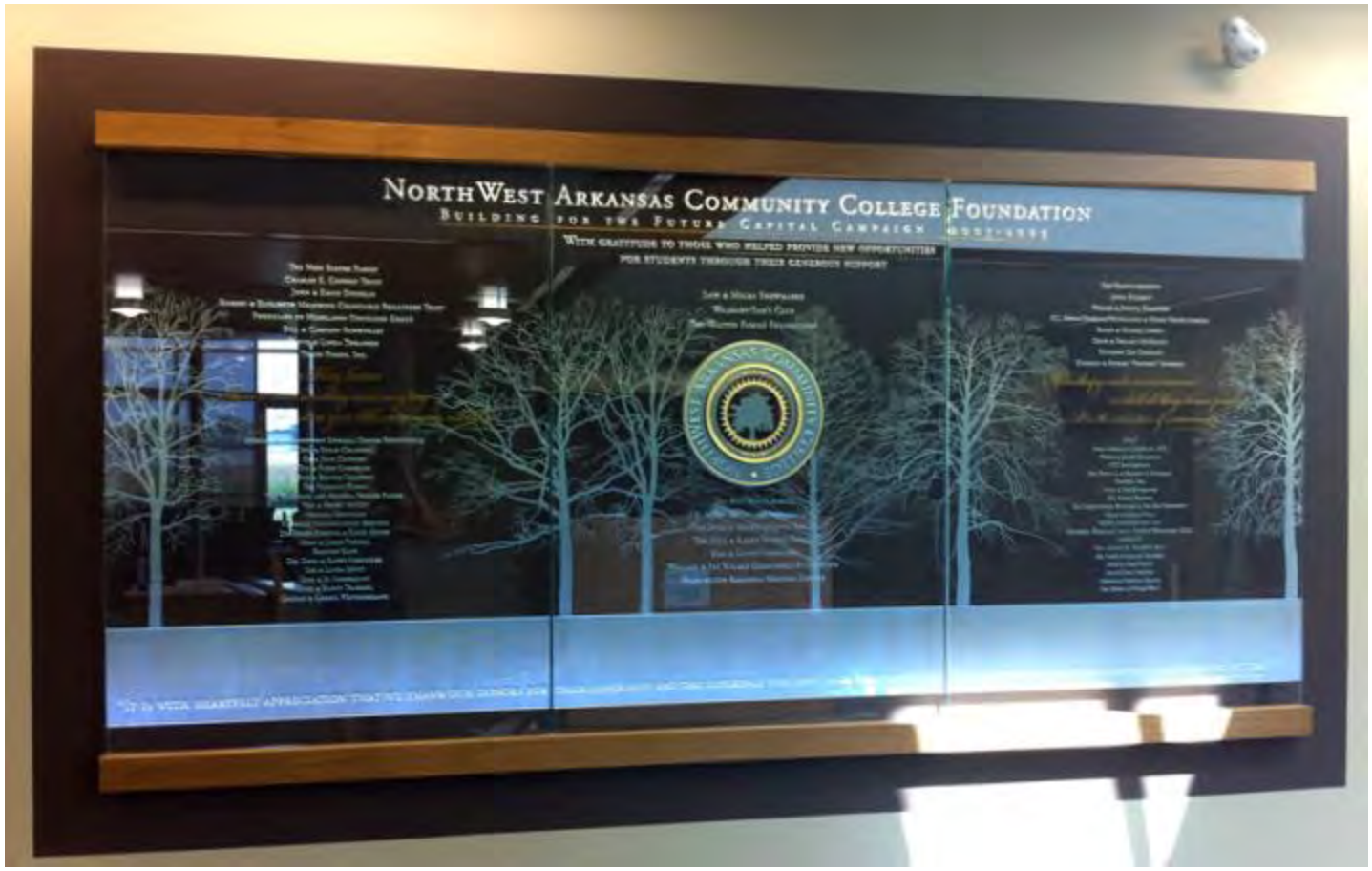
April 13th, 2016

Physical Donor Recognition Best Practices

- Budgeting and cost control; return on investment that assure costs are proportionate to gift amounts.
- Design solutions that are fully integrated with the architecture, interiors and construction.
- Architectural images, stories, material descriptions to help inform the final product.
- Renewable resources and a design that can be easily updated and inexpensively edited.
- Annual updates and administrative requirements.

Sample Donor Walls

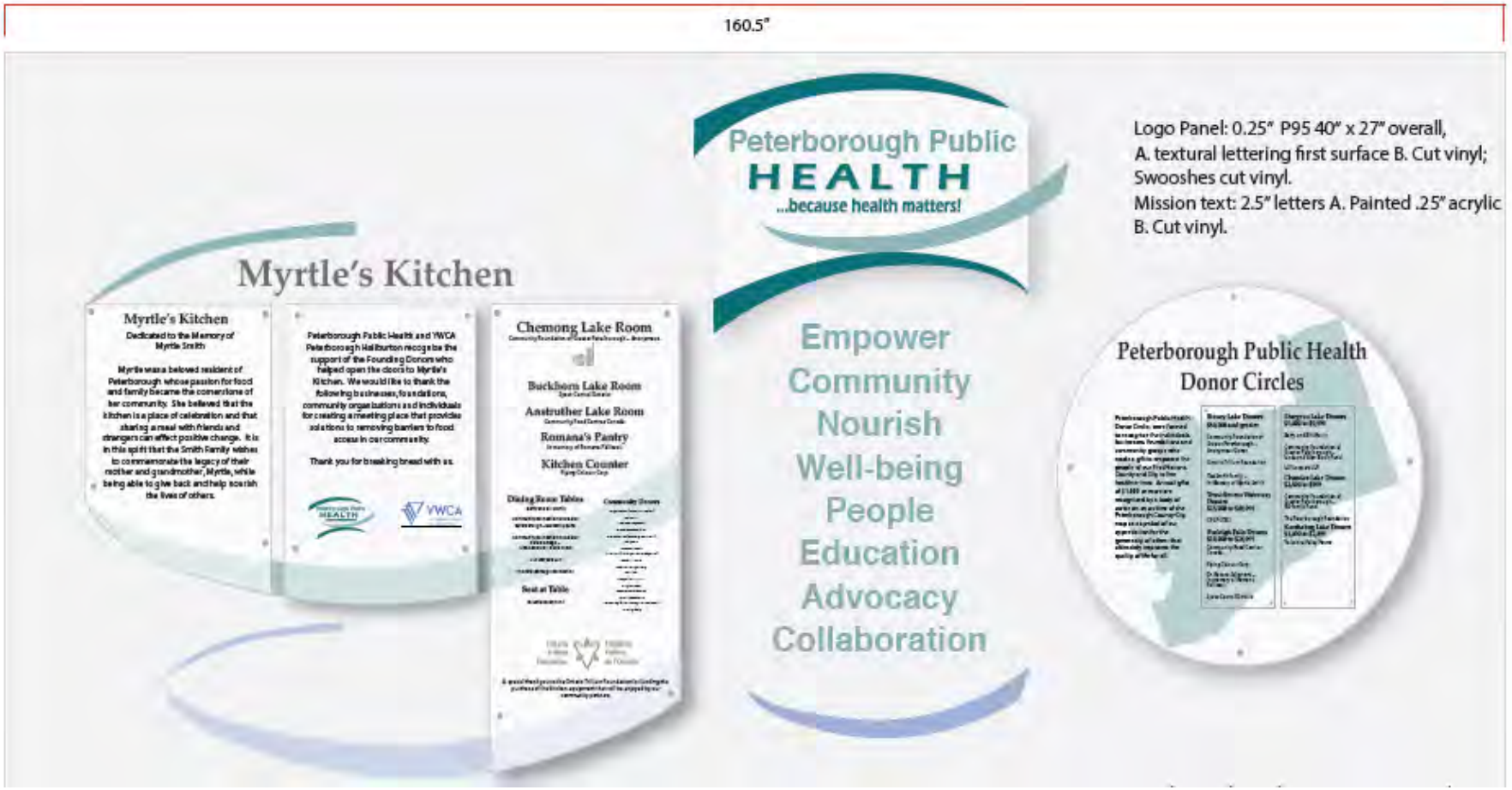
Sample Donor Walls



Sample Donor Walls

Cost Effective and Attractive Walls: Acrylic + Dimensional Letters

Concept Illustration for Myrtle's Kitchen



Production Schedule: Final Stages

Date	Responsibility	Milestone/Deliverable
April 22	Nicole/Supplier	Revisions to concept illustration (based on BOH feedback) – excluding new logo Budget approval
April 29	PPH	New logo to Nicole
May 4	Nicole	Final proofs to BOH, YWCA and lead donors for review – including new PPH logo
May 11	Supplier	Receive sign off from PPH on all drawings and specifications -- project gets green light to move forward
May 13	Supplier	Files to fabrication
May 20	PPH	Final day for all wall/area preparation to be complete (cleaning, painting, etc.)
May 27	Supplier	Installation
June	PPH	Unveiling

Board of Health for the
Peterborough County-City Health Unit
DRAFT MINUTES
Board of Health Meeting
Wednesday, March 9, 2016 – 5:30 p.m.
Council Chambers, Selwyn Township Office
1310 Centre Line Smith, Peterborough

In Attendance:

Board Members:
Mr. Scott McDonald, Chair
Mayor Mary Smith, Vice Chair
Councillor Lesley Parnell
Deputy Mayor John Fallis
Mr. Gregory Connolley
Ms. Kerri Davies
Councillor Henry Clarke
Councillor Gary Baldwin
Councillor Art Vowles
Mayor Rick Woodcock (5:40 p.m.)
Mr. Andy Sharpe
Chief Phyllis Williams

Staff:
Mr. Larry Stinson, Director of Operations
Ms. Natalie Garnett, Recorder
Ms. Brittany Cadence, Manager, Communication Services
Ms. Patti Fitzgerald, Assistant Director; Chie Nursing and Privacy Officer
Dr. Rosana Salvaterra, Medical Officer of Health
Ms. Wendy Freeburn, Executive Assistant
Ms. Jennifer Anderson, Human Resources Supervisor
Ms. Sarah Tanner, Manager Oral Health, Facilities and Quality Improvement
Ms. Donna Churipuy, Manager Healthy Living
Ms. Karen Chomniak, Manager Family Health
Mr. Andrew Kurc, Epidemiologist

Regrets:

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1. Call to Order

Mr. McDonald, Chair called the meeting to order at 5:30 p.m.

2. Confirmation of the Agenda

MOTION:
That item 9.5, Closure of the Lakefield School, be added to the Agenda; and,

That the agenda be approved as revised.
Moved: Councillor Baldwin
Seconded: Councillor Parnell
Motion carried. (M-2016-027)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. Parks and Recreation Initiatives in Selwyn Township

Mike Richardson, Manager of Recreation and Meaghan McGowan, Community Development Intern, provided a PowerPoint presentation on parks and recreation initiatives in Selwyn Township.

MOTION:
That the presentation by Mike Richardson, Manager of Recreation and Meaghan McGowan, Community Development Intern of the Township of Selwyn, on Parks and Recreation Initiatives in the township, be received for information.
Moved: Deputy Mayor Fallis
Seconded: Councillor Parnell
Motion carried. (M-2016-028)

5. Confirmation of the Minutes of the Previous Meeting

5.1. February 10, 2016

MOTION:
That the minutes of the Board of Health meeting held on February 10, 2016, be approved as circulated.
Moved: Councillor Clarke
Seconded: Chief Williams
Motion carried. (M-2016-029)

6. Business Arising From the Minutes

6.1. Appointments: First Nations Committee

MOTION:
That Chief Williams, Councillor Vowles, Ms. Davies and Deputy Mayor Fallis, be appointed as members to the First Nations Committee of the County-City Health Unit Board of Health.
Moved: Councillor Parnell
Seconded: Mayor Woodcock
Motion carried. (M-2016-030)

7. Staff Reports

7.1 Staff Report and Presentation: Child Health Status Report, Part 2

Andrew Kurc, Epidemiologist provided a presentation on the *Child Health Status Report, Part 2*.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Child Health Status Report, Part 2, for information.
Moved: Councillor Parnell
Seconded: Councillor Baldwin
Motion carried. (M-2016-031)

7.2 Staff Presentation: Patients First Discussion Paper and the Transformation of the Ontario Health Care System

Dr. Salvaterra, Medical Officer of Health, provided a presentation on the *Patients First Discussion Paper and the Transformation of the Ontario Health Care System*.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Patients First Discussion Paper and the Transformation of the Ontario Health Care System for information; and

WHEREAS the discussion paper Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care, by establishing links between LHINs and public health which can occur through identifying new roles and responsibilities that do not require changes in the funding or governance of public health in Ontario; and

WHEREAS the wider problem of improving and supporting the health and health equity of Ontarians is mandated to the public health system, through the Health Protection and Promotion Act that has created local boards of

health and has made them accountable for the delivery of public health programs and services as required by the Ontario Public Health Standards and the Ontario Public Health Organizational Standards, and

WHEREAS the direct relationship with the province ensures that the same principles and standards are upheld and implemented for all boards of health, further ensuring that all Ontarians benefit equitably from the public health system; and

WHEREAS municipal and First Nation representation on boards of health ensure valuable connections with decision makers and staff to support local healthy public policy; and

WHEREAS evidence from other jurisdictions where public health funding has been integrated regionally with funding for the rest of the health care system shows that opportunities for system improvement is often not realized and unintended risks to public health have arisen:

BE IT THEREFORE RESOLVED that the board of health for the Peterborough County-City Health Unit calls upon the province of Ontario to ensure a continued strong role for public health in keeping people healthy by
• maintaining independent governance of the public health sector by local boards of health; and
• maintain its direct and transparent funding of local boards of health; and
• continue to directly negotiate Provincial Public Health Funding and Accountability Agreements (PHFAA) with local boards of health.

Local municipal and First Nation Councils are called upon to endorse this motion and advise Premier Kathleen Wynne, Minister of Health and Long Term Care, the Honourable Eric Hoskins, and local MPPs, Minister of Agriculture and Rural Affairs Jeff Leal, and Laurie Scott, in writing.

Moved: Mr. Sharpe
Seconded: Chief Williams
Motion carried. (M-2016-032)

Councillor Clarke left the meeting at 6:30 p.m.

8. Consent Items

MOTION:
That items 8.1, 8.1b, 8.2b, and 8.3a be approved as part of the Consent Agenda.

Moved: Councillor Parnell
Seconded: Mayor Smith
Motion carried. (M-2016-033)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit:
- *receive correspondence from the Haliburton, Kawartha Pine Ridge District Health Unit regarding supporting legislation to enforce infection prevention and control practices within invasive personal service settings under the Health Protection and Promotion Act for information;*
- *endorse the resolution; and,*
- *communicate this support to Premier Wynne, Minister Hoskins, local MPPs, the Ontario Chief Medical Officer of Health, the Association of Local Public health Agencies, and Ontario Boards of Health.*

Moved: Councillor Parnell
Seconded: Mayor Smith
Motion carried. (M-2016-034)

MOTION:
That the following documents be received for information:
- *E-mail dated February 4, 2016 from Mr. Craig Niziolek to the Board of Health regarding Electro Hyper Sensitivity.*
- *E-newsletter dated February 5, 2016 from the Association of Local Public Health Agencies.*
- *Letter dated February 5, 2016 from Minister Duclos to the former Board Chair, in response to her letter dated December 2, 2015 regarding food security and the transformation of social assistance in Ontario.*
- *E-newsletter dated February 23, 2016 from the Association of Local Public Health Agencies.*
- *Letter dated February 25, 2016 from the Board Chair to Minister Hoskins regarding the Herpes Zoster vaccine.*
- *Letter dated February 29, 2016 from alPHa to Minister Hoskins regarding the Patients First Discussion Paper.*
- *Letter dated February 29, 2016 from the Ontario Public Health Association to Minister Hoskins regarding the Patients First Discussion Paper.*
- *Resolutions/Letters from other local public health agencies:*

  <u>Basic Income Guarantee</u>
  North Bay Parry Sound District

  <u>Cannabis Regulation and Control</u>
  Grey Bruce

Middlesex London
Windsor Essex

<u>Patients First</u>
Haliburton Kawartha Pine Ridge District
Ottawa

Moved: Councillor Parnell
Seconded: Mayor Smith
Motion carried. (M-2016-035)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit approve the 2016 budget for the Healthy Babies, Healthy Children (HBHC) program in the total amount of $928,413.
Moved: Councillor Parnell
Seconded: Mayor Smith
Motion carried. (M-2016-036)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit approve the 2016/2017 budget for the Infant and Toddler Development Program (ITDP) in the total amount of $242,423.
Moved: Councillor Parnell
Seconded: Mayor Smith
Motion carried. (M-2016-037)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Property Committee for August 11, 2015.
Moved: Councillor Parnell
Seconded: Mayor Smith
Motion carried. (M-2016-038)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff report, Jackson Square Move Update, for information.
Moved: Councillor Parnell
Seconded: Mayor Smith
Motion carried. (M-2016-039)

9. New Business

9.1. Annual Mandatory Board Training – Emergency Preparedness

Ms. Churipuy, Manager, Healthy Living, provided a training session on emergency preparedness.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the staff training presentation, Emergency Preparedness, for information.
Moved: Councillor Parnell
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-040)

9.2. Property Recommendations – Oral Report

Mr. Andy Sharpe, Chair, Property Committee, provided an update on property matters.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit dissolve the Property Committee.
Moved: Mayor Smith
Seconded: Councillor Baldwin
Motion carried. (M-2016-041)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit appoint Larry Stinson, Director of Operations and Sarah Tanner, Manager Oral Health, Facilities and Quality Improvement, to the Condo Committee for 185 King Street; and,

That quarterly reports on the Condo Committee be brought forward to the Board of Health for information.

Moved: Ms. Davies
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-0420)

9.3. **alPHa Winter Symposium – Oral Report**

Mayor Mary Smith, Ms. Davies and Mr. Stinson, provided an update on the alPHa Symposium.

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the alPHa Winter Symposium update for information; and,

That the Governance Committee examine risk management issues and assess the current policies and practices, and that any recommended changes be brought forward to the Board for consideration.
Moved: Mayor Smith
Seconded: Mayor Woodcock
Motion carried. (M-2016-043)

MOTION:
That the Governance Committee examine upcoming Board vacancies and determine the member skills needed to ensure Board strength.
Moved: Mayor Smith
Seconded: Councillor Parnell
Motion carried. (M-2016-044)

9.4. **alPHa Annual General Meeting Resolutions – Discussion**

Dr. Salvaterra, Medical Officer of Health, led a discussion on possible resolutions for the alPHa Annual General Meeting. Comments were made regarding the lack annual increase from the province, the timing of the receipt of the budget from the province, and the concerns with the impact of gambling on the community.

Board members were requested to forward issues of interest to Dr. Salvaterra.

9.5. **Closure of the Lakefield High School**

Mayor Woodcock outlined concerns with the closure of the Lakefield High School and the impact on the welfare of children.

MOTION:
That Dr. Salvaterra prepare a health hazard investigation report on the impacts of the closure of the Lakefield High School on the affected students.
Moved: Mayor Woodcock
Seconded: Chief Williams
Motion carried. (M-2016-045)

Chief Williams left the meeting at 7:45 p.m.

10. In Camera to Discuss Confidential Personal and Property Matters

MOTION:
That the Board of Health for the Peterborough County-City Health Unit go In Camera to discuss one item under Section 239(2)(d) Labour relations or employee negotiations, at 7:46 p.m.
Moved: Mr. Sharpe
Seconded: Councillor Parnell
Motion carried. (M-2016-046)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit rise from In Camera at 7:52 p.m.
Moved: Councillor Parnell
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-047)

11. Motions from In Camera for Open Session

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

The next meeting will be held April 13, 2016 in the J. K. Edwards Board Room, Peterborough County-City Health Unit, 185 King Street, 5:30 p.m.

13. Adjournment

MOTION:
That the meeting be adjourned.

Moved by: Deputy Mayor Fallis
Seconded by: Councillor Parnell
Motion carried. (M-2016-048)

The meeting was adjourned at 7:54 p.m.

Chairperson

Medical Officer of Health

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Correspondence For Direction**

Date: April 13, 2016

Proposed Recommendation:

That the Board of Health for the Peterborough County-City Health Unit:

- endorse the letter dated February 22, 2016 sent by North Bay Parry Sound District Health Unit regarding environmental health program funding; and,
- advise the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Boards of Health, local Members of Provincial Parliament and local Councils.

Staff recommend that the Board endorse the motion from the North Bay Parry Sound District Health Unit for increased funding of 2.5 full-time equivalent (FTE) public health inspectors (PHI) in the Environmental Health program. The rationale is as follows:

1. Various new policies and legislation are being implemented by the Ministry of Health and Long-Term Care;
2. Capacity will be an issue in the event of a major outbreak or emergency that involves the redeployment of PHIs, as has occurred in the past; and,
3. The implications of the review of the Food Safety and Safe Water legislations and the Modernization of the Ontario Public Health Standards will likely have an impact on staff that are already at full capacity.

February 22, 2016

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

Dear Minister Hoskins:

Subject: Environmental Health Program Funding – BOH Resolution #BOH/2016/01/13

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/13:

Whereas, *the Board of Health is responsible to oversee the implementation of the Ontario Public Health Standards (OPHS), related protocols/guidelines and Health Protection and Promotion Act (HPPA) and related regulations, and*

Whereas, *the Board of Health works towards improvement of the overall health of the population through surveillance, health promotion, disease prevention, health protection and enforcement of provincial public health policy, and legislation, and*

Whereas, *the Board of Health supports the Province of Ontario enacting new policy and legislation which will improve the health of the population, and*

Whereas, *recent changes to provincial policy and new legislation has resulted in the expansion of the Environmental Health program mandate in recent years, and*

Whereas, *in 2014 the Skin Cancer Prevention Act (Tanning Beds) went into effect and public health inspectors (PHIs) were required to complete education visits of tanning bed establishments and respond to future public complaints with these facilities, and*

Whereas, *the Recreational Water Protocol was updated by the Ministry of Health and Long-Term Care in 2014 and included a broadening of the definition of a public beach which resulted in doubling the number of municipal public beaches that require annual water sampling, and*

Whereas, *in 2015, the Ministry of Health and Long-Term Care released the new Infection Prevention and Control Lapse Disclosure Guidance document requiring the Health Unit to actively investigate public complaints related to infection prevention and control (IPAC) in regulated health care settings where previously the Health Unit was not mandated, and*

Whereas, *in 2017, the Ministry of Health and Long-Term Care advises that menu labelling requirements will come into force for certain restaurants and will require PHIs to enforce, and*

Whereas, *recent amended environmental health protocols require the disclosure of public facility inspection reports to the public on request and resulting in increased workload for Health Unit staff, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any additional resources and where current Environmental Health program staff are already at full capacity implementing existing mandated programs, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any support for staff training,*

Now Therefore Be It Resolved, *that the Board of Health for the North Bay Parry Sound District Health Unit endorse the following actions to support the Environmental Health program in implementing new provincial public health policy and legislation:*

1) *Encourage the Ontario Ministry of Health and Long-Term Care to provide dedicated, predictable recurring funding to public health units for the purpose to enhance Environmental Health program field staff and management capacity to implement new provincial public health policy and legislation;*

2) *Encourage the Ontario Ministry of Health and Long-Term Care to fund an additional 2.0 full-time equivalent (FTE) public health inspectors in the Environmental Health program;*

3) *Encourage the Ontario Ministry of Health and Long-Term Care to adopt as standard policy for providing of training to public health staff whenever new provincial public health policy and legislation is implemented; and*

4) *Encourage the Ministry of Health and Long-Term Care to develop a staffing model for health units to use to determine adequate levels of environmental health staffing which include field staff, supervisory staff and management staff necessary to fully implement provincial environmental health policy and legislation.*

Furthermore Be It Resolved, *that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.*

Sincerely,

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

C: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Linda Stewart, Executive Director, Association of Local Public Health agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member Municipalities (31)

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Correspondence For Information**

Date: April 13, 2016

Proposed Recommendation:

That the Board of Health for the Peterborough County-City Health Unit received for information the following:

1. E-newsletter dated March 10, 2016 from the Association of Local Public Health Agencies (alPHa). (p. 27)

2. Letter dated March 15, 2016 from the Board Chair to Premier Wynne regarding legislation to enforce infection prevention and control practices within invasive personal service settings. (p. 30)

3. Email dated March 17, 2016 from alPHa regarding an update to their 2015-16 leadership. (p. 34)

4. Email dated March 24, 2016 from alPHa regarding the February 24, 2016 Risk Management Workshop. (p. 35)

5. E-newsletter dated March 30, 2016 from alPHa. (p. 36)

6. Letter dated March 31, 2016, from the Board Chair to Premier Wynne and Minister Hoskins regarding the Patients First Discussion Paper. (p. 38)

7. Letters/Resolutions from other local public health agencies:

   Basic Income Guarantee
   Wellington-Dufferin-Guelph (p. 40)

   Environmental Health Program Funding
   Grey Bruce (p. 53)

   Herpes Zoster Vaccine
   Grey Bruce (p. 56)

   Legislation to Enforce Infection Prevention and Control Practices

within Invasive Personal Service Settings
Grey Bruce (p. 59)
Sudbury and District (p. 62)

Patients First Discussion Paper
Grey Bruce (p. 64)

Smoke-Free Multi Unit Housing
Porcupine (p. 70)

Smoke –Free Schools Act
North Bay Parry Sound District (p. 71)

March 10, 2016

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

Patients First Response Activities

On February 29 alPHa submitted its response to the government's discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario.* The letter makes five key recommendations to Minister Hoskins on strengthening patient care in Ontario from the public health perspective, and seeks further opportunities to engage with him and his staff on the Patients First discussion.
Read alPHa's response to the Patients First discussion paper here
Read the Patients First discussion paper here
Read alPHa's news release here
View results of alPHa's member survey on Patients First here

Deputy Minister of Health and Long-Term Care, Dr. Bob Bell, met with alPHa's members on February 25 to discuss Ontario's health transformation agenda. It was a lively session marked by frank comments and questions from attendees, with some of the discussion being used to inform alPHa's response to the Patients First paper.
Read alPHa's thank you letter to the DM here

Risk Management Work Shop II

Many thanks to those who attended alPHa's second Risk Management workshop on February 24 in Toronto. Attendees learned how to build a healthy risk management culture in their own organizations and practiced identifying, assessing and mitigating health unit risks. Special thanks to the alPHa Risk Management Working Group, who organized this event, and Corinne Berinstein of the Treasury Board Secretariat for consulting and facilitating.

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alPHa 2016 Fitness Challenge

It's time again to gear up for alPHa's Annual Fitness Challenge to health unit employees. This year the Challenge takes place on Thursday, May 5, 2016. Health units across Ontario will go head to head with each other to see which organization can involve the most number of staff in physical activity for 30 minutes on May 5. At stake is a lovely award (not to mention staff pride) that will be presented to the

winning health unit at the alPHa Annual Conference.
Learn more about the 2016 Fitness Challenge here

Ontario Pilot on Basic Income Guarantee

In the February 25 budget announcement, the provincial government indicated plans to fund a basic income pilot project as part of its poverty reduction strategy. alPHa will be writing a letter of support to government on this encouraging initiative, with reference to its own resolution endorsed last year by members calling for government support of a basic income guarantee. Many thanks to associate medical officer of health Dr. Lisa Simon of Simcoe Muskoka District Health Unit for leading advocacy efforts on this topic.
Read alPHa's 2015 resolution on a basic income guarantee
Learn more about the 2016 Ontario Budget

Correspondences

alPHa has written a number of letters to government, including support for the Canadian Senate's recent recommendations to address obesity. alPHa has also submitted a recommendation that the Public Health Expert Panel include alPHa's Acting President Dr. Valerie Jaeger as a member.
Read alPHa's latest correspondences here

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alPHa 30th Anniversary

alPHa turns 30 this year, hence the refreshed logo at the top of this column. We will be celebrating this milestone at the June annual conference. Stay tuned for further information!

Upcoming Events

April 4-6, 2016 - TOPHC 2016, Collaborate.Innovate.Transform, Allstream Centre, Toronto, Ontario. Register before March 18.
Click here for TOPHC program information

June 5, 6 & 7, 2016 - alPHa Annual General Meeting and Conference - 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.
Click here for Notices and Calls

March 15, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
premier@ontario.ca

Dear Premier Wynne,

Re: Legislation to enforce infection prevention and control practices within invasive personal service settings under the Health Protection and Promotion Act

At its meeting held on March 9, 2016, the Board of Health for the Peterborough County-City Health Unit considered correspondence from the Haliburton, Kawartha, Pine Ridge District Health Unit regarding the above noted matter.

The Board echoes the recommendations outlined in their letter (attached) and it is our hope that you will consider enacting legislation for infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording in the *Provincial Offences Act.*

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Dr. David Williams, Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Boards of Health

HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT
HEALTH UNIT

1-866-888-4577 • www.hkpr.on.ca • info@hkpr.on.ca

21 January 2016

The Hon. Kathleen Wynne
Premier of Ontario
Legislative Building - Queen's Park
Toronto ON M7A 1A1

Re: Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings under the *Health Protection and Promotion Act*

Dear Premier Wynne

Ontario has no legislation regulating infection prevention and control practices to minimize the risk of blood borne disease transmission from practices/procedures performed at invasive Personal Service Settings (PSS). The PSS Protocol under Ontario Public Health Standards (OPHS) govern the activities of Public Health Units regarding PSS infection control such as causing one inspection per year for invasive services which is the same frequency for non-invasive PSS such as a hair salon.

Public Health Inspectors (PHIs), in accordance with the OPHS and best practices, inspect invasive PSS without provincial legislation that outlines legal requirements for infection control needs and operator responsibilities. Infection prevention and control practices are a major component of assessing invasive PSS to minimize the transmission risks of blood-borne disease.

Invasive PSS such as tattoo/body modification establishments or other invasive PSS require extra attention and time for PHIs to mitigate risk to the public by ensuring operators have adequate infection prevention and control practices in place. The Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit views the importance of public health regulations to minimize the risk of blood-borne disease transmission from invasive personal service settings.

The Haliburton, Kawartha, Pine Ridge District Board of Health therefore urges the Government of Ontario to enact legislation for infection prevention and control requirements for invasive PSS under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act*.

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT HEALTH UNIT

Mark Lovshin
Board of Health Chair

.../2

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Encl. 2

Cc:

The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Ms. Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Mr. Lou Rinaldi, MPP, Northumberland-Quinte West
Mr. Patrick Brown, MPP, Simcoe North – Leader of the Progressive Conservative Party of Ontario
Ms. Andrea Horwath, MPP, Hamilton Centre – Leader of the New Democratic Party of Ontario
Dr. David Williams, Chief Medical Officer of Health
Board of Health Chairs
Association of Local Public Health Agencies

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT BOARD OF HEALTH RESOLUTION

TITLE: Enactment of Legislation to enforce infection prevention and control practices within invasive Personal Service Settings (PSS) under the *Health Protection and Pramotion Act.*

SPONSOR: Haliburton, Kawartha, Pine Ridge District Health Unit

WHEREAS Ontario has no legislation governing infection prevention and control practices to minimize the risk of blood borne disease transmission from practices/procedures performed at invasive Personal Service Settings (PSS); and

WHEREAS The Personal Service Setting Protocol under the *Ontario Public Health Standards* (OPHS) governs the activities of public health units regarding PSS infection control; and

WHEREAS The OPHS mandate one inspection per year for invasive personal service settings, which is the same frequency for non-invasive PSS such as a hair salon; and

WHEREAS Public Health Inspectors (PHIs), in accordance with the OPHS and best practices, inspect invasive PSS without provincial legislation that outlines legal requirements for infection control needs and operator responsibilities; and

WHEREAS Infection prevention and control practices are a major component of assessing invasive PSS to minimize the transmission risks of blood-borne disease; and

WHEREAS Invasive PSS such as tattoo/body modification establishments or other invasive PSS require extra attention and time for PHIs to mitigate risk to the public by ensuring operators have adequate infection prevention and control practices in place.

NOW THEREFORE BE IT RESOLVED that the Haliburton, Kawartha, Pine Ridge District Board of Health strongly recommends and urgently requests the Government of Ontario to enact legislation implementing infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act*.

AND FURTHER that the Haliburton, Kawartha, Pine Ridge District Board of Health strongly recommends and urgently requests that the Association of Local Public Health Agencies advocate to the Premier of Ontario and the Minister of Health and Long-Term Care, to enact legislation implementing infection prevention and control requirements for invasive personal service settings under the *Health Protection and Promotion Act* with a suitable enforcement program such as short-form wording under the *Provincial Offences Act* to allow for the enforcement of non-compliance with the legislation under the *Health Protection and Promotion Act*.

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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

alPHa Sections:

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

Affiliate Organizations:

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

March 17, 2016

Association of Local Public Health Agencies Announces
UPDATE to Officers for 2015-16

Dear Colleague:

Due to some in-year changes, I am pleased to provide you with an update regarding the 2015-16 leadership for the Association of Local Public Health Agencies. Please join me in welcoming into her new role:

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

Assuming an alPHa Section Leadership role is:

Chair, Board of Health Section	Mrs. Julie Roy Board of Health Public Appointee Northwestern Health Unit Board of Health

Please note that:	*Dr. Miriam Klassen* *Medical Officer of Health & Chief Executive Officer* *Perth District Health Unit*

continues in her role as Chair, Council of Medical Officers of Health (COMOH)

For a fuller introduction to alPHa's Board, please visit http://www.alphaweb.org/?page=BOD_2015.

Yours truly,

Linda Stewart
Executive Director

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Susan Lee
Sent: Tuesday, March 29, 2016 1:46 PM
To: All Health Units
Subject: [allhealthunits] Proceedings and Presentations from alPHa Risk Management Work Shop II - February 24, 2016

ATTENTION:

All Board of Health Members & Members of Regional Health/Social Committees
All Health Unit Directors/Senior Managers
Attendees of alPHa February 24th Risk Management Work Shop
****

alPHa is pleased to inform you that the proceedings and presentations from our second Risk Management Work Shop held on February 24, 2016 in Toronto is now available for viewing. Please note the file is large and may take a few seconds longer to download.

Thanks to everyone who participated in this successful learning event.

Click here to view the February 24 alPHa Risk Management Proceedings.

Regards,

Susan

Susan Lee
Manager, Administrative & Association Services
Association of Local Public Health Agencies (alPHa)
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Tel. (416) 595-0006 ext. 25
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Please visit us at http://www.alphaweb.org

Information Break

March 30, 2016

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

Proceedings of Risk Management Work Shop II

A summary of the presentations and discussion that took place at alPHa's second Risk Management Work Shop held on February 24 is now available for viewing by clicking the link below. Many thanks to those who attended and presented in helping us to deliver another successful learning event.
Read the February 24 Risk Management Work Shop proceedings and presentations here

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Ontario Government Report on Patients First Action Plan

The province has released a progress report on its investments into the Ontario health system since February 2015. The Patients First: Action Plan Progress Report summarizes activities in four key areas, including access, services, health information for the public, and patient protection.
Read the Ontario Government news release here
Read Year One Results - Patients First Action Plan for Health Care here

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Correspondences

alPHa has written a number of letters to government, including support for federal infrastructure funding and the Ontario 2016 Spring Budget.
Read alPHa's latest correspondences here

Severe Asthma Conference - May 6 & 7

On **May 6th** and **May 7th**, 2016, the Asthma Society of Canada will be holding its Third Annual Conference, *Fighting for Breath*, to examine the health, social and economic issues related to Severe Asthma. Interested health unit staff can find more information on the event at www.fightingforbreath.ca

Upcoming Events

April 4-6, 2016 - TOPHC 2016, Collaborate.Innovate.Transform, Allstream Centre, Toronto, Ontario. **Registration now closed.**
Click here for TOPHC program information

June 5, 6 & 7, 2016 - alPHa Annual General Meeting and Conference - 30th Anniversary, Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario.
Click here for Notices and Calls

Peterborough County-City HEALTH UNIT

...because health matters!

March 31, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
premier@ontario.ca

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

Dear Premier Wynne and Minister Hoskins

Re: Patients First Discussion Paper

At its meeting held on March 9, 2016, the Board of Health for the Peterborough County-City Health Unit passed the following resolution:

> "WHEREAS the discussion paper Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care, by establishing links between LHINs and public health which can occur through identifying new roles and responsibilities that do not require changes in the funding or governance of public health in Ontario; and
>
> WHEREAS the wider problem of improving and supporting the health and health equity of Ontarians is mandated to the public health system, through the Health Protection and Promotion Act that has created local boards of health and has made them accountable for the delivery of public health programs and services as required by the Ontario Public Health Standards and the Ontario Public Health Organizational Standards, and
>
> WHEREAS the direct relationship with the province ensures that the same principles and standards are upheld and implemented for all boards of health, further ensuring that all Ontarians benefit equitably from the public health system; and

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

WHEREAS municipal and First Nation representation on boards of health ensure valuable connections with decision makers and staff to support local healthy public policy; and

WHEREAS evidence from other jurisdictions where public health funding has been integrated regionally with funding for the rest of the health care system shows that opportunities for system improvement is often not realized and unintended risks to public health have arisen:

BE IT THEREFORE RESOLVED that the board of health for the Peterborough County-City Health Unit calls upon the province of Ontario to ensure a continued strong role for public health in keeping people healthy by

- maintaining independent governance of the public health sector by local boards of health; and
- maintain its direct and transparent funding of local boards of health; and
- continue to directly negotiate Provincial Public Health Funding and Accountability Agreements (PHFAA) with local boards of health.

Local municipal and First Nation Councils are called upon to endorse this motion and advise Premier Kathleen Wynne, Minister of Health and Long Term Care, the Honourable Eric Hoskins, and local MPPs, Minister of Agriculture and Rural Affairs Jeff Leal, and Laurie Scott, in writing."

Moved:	Mr. Andy Sharpe
Seconded:	Chief Phyllis Williams
Motion carried.	(M-2016-032)

On behalf of our communities, the Board of Health would like to thank you for the opportunity to provide input on the discussion paper. Our concerns echo those of other public health units, it is our hope that the Province will consider these recommendations.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at

cc: MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Jackson Square, 185 King Street, Peterborough, Ontario K9J 2R8 T: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

March 2, 2016

The Honourable Jean-Yves Duclos
Minister of Families, Children and Social Development
House of Commons
Ottawa, Ontario K1A 0A6

Dear Minister Duclos:

I am writing today on behalf of Wellington-Dufferin-Guelph Public Health to request that the federal government study the merits of a basic income guarantee as a policy option for reducing poverty and as a measure to improve the health of all Canadians. Wellington-Dufferin-Guelph Public Health's Board of Health believes that health equity is an important part of building healthy communities which is why we urge you to give serious consideration to a basic income guarantee.

Income inequities are increasing in Canada as described in a number of recent reports, including a report released by Wellington-Dufferin-Guelph Public Health in 2011. The Low Income Measure (LIM) revealed that 11.4 percent of households in Wellington-Dufferin-Guelph (WDG) were low income. The rate of low-income households in WDG ranged widely among communities from 4.6 to 19.8 percent. Although just under 7 percent of children in WDG were living in households with low income, the rate in one Guelph neighbourhood was over 30 percent.

Another well-documented fact is that poverty has considerable negative impacts on health. Income may be the most important determinant of health as it influences health-related living conditions. A Wellesley Institute report presented compelling evidence that low income almost inevitably ensures poor health and significant health inequity in Canada. Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis and heart disease, and to live with a disability. The report, *Poverty Is Making Us Sick* offered a comparison between the highest and lowest-income quintiles among Canadians and found that the lowest quintile had double the rates of diabetes and heart disease than those in the highest one. Those in the lowest quintile were 60 percent more likely to have two or more chronic conditions, four times more likely to live with disability, and three times less likely to have additional health and dental coverage.

Research conducted across multiple countries found that countries with higher rates of income inequality had higher levels of health and social problems across all income levels. This pattern was consistent and included health issues such as mental illness, higher levels of obesity and lower life expectancy, educational achievements such as math and literacy scores, and community issues such as violence.

There has been widespread support for an investigation into and consideration of a basic income guarantee for all Canadians. In the public health sector, resolutions have been passed by the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA). Prior to the last federal election, the Canadian Public Health Association released a fact sheet calling on the next federal government to take leadership in adopting a national strategy to provide all Canadians with a basic income guarantee.

Support for a basic income guarantee has also emerged from municipalities. In December of 2015, the City of Kingston passed a resolution advocating for the federal and provincial governments to consider, investigate and develop a basic income guarantee for all Canadians. The City of Kingston resolution was forwarded to all municipalities in Ontario with a request that they consider supporting the initiative. To date the resolution has been endorsed by the cities of Cornwall, Belleville, Pelham, Peterborough and Welland.

Wellington-Dufferin-Guelph Public Health's strategic directions include "health equity" and "building healthy communities." Both of these strategic directions are intended to support advocacy efforts for the investigation into and consideration of a basic income guarantee for all Canadians. We urge you to move the government's intentions from the well-documented evidence in a number of recent reports to action, by studying the merits of a basic income guarantee. Poverty results in poor health and a basic income guarantee is a cost-effective policy option that will impact the lives and health of the poorest Canadians.

Sincerely,

Doug Auld, Board of Health Chair
Wellington-Dufferin-Guelph Public Health

Attachment: Basic Income Guarantee Board of Health Report

cc. The Right Honourable Justin Trudeau, Prime Minister of Canada
The Honourable Kathleen Wynne, Premier of Ontario
Dr. David Williams, Ontario Chief Medical Officer of Health
Linda Stewart, Association of Local Public Health Agencies
Pegeen Walsh, Ontario Public Health Association
Ontario Boards of Health
Wellington-Dufferin-Guelph Members of Parliament
Wellington-Dufferin-Guelph Members of Provincial Parliament
Waterloo Wellington Local Health Integration Network
Central West Local Health Integration Network
Brock Carlton, Chief Executive Officer, Federation of Canadian Municipalities
Wellington-Dufferin-Guelph Municipalities

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

BOH Report – BH.01.MAR0216.R06
March 2, 2016

Report to:	**Board of Health**
Submitted by:	**Dr. Nicola Mercer, Medical Officer of Health & CEO**
Prepared by:	**Jennifer MacLeod, Manager, Health Analytics**
Approved by:	**Andrea Roberts, Director, Family Health & Health Analytics**
Subject:	**BASIC INCOME GUARANTEE**

RECOMMENDATION(S)

(a) That the Board of Health send a letter to the Minister of Families, Children and Social Development requesting that the federal government study the merits of a basic income guarantee as a policy option for reducing poverty and as a measure to improve the health of all Canadians.

Nicola J. Mercer, MD, MBA, MPH, FRCPC
Medical Officer of Health & CEO

EXECUTIVE SUMMARY

A Basic Income Guarantee is intended to ensure universal income security.[1] There are currently individuals and families who are living in poverty in Wellington County, Dufferin County and the City of Guelph.[2] There have been widespread advocacy efforts to support an investigation into and consideration of a Basic Income Guarantee for all Canadians. Pilot studies have demonstrated that Basic Income Guarantee initiatives can achieve intended outcomes.[3]

BACKGROUND

Basic Income Guarantee (BIG) is an income transfer from government to citizens that is not tied to labour market participation.[1] The objective of basic income guarantee is universal income security.[1] A basic income guarantee ensures that income for all individuals is at a level that is sufficient to meet basic needs and live with dignity, regardless of work status.[4] There are different models of basic income guarantee and it is known by other names such as Guaranteed Annual Income (GAI), Basic Annual Income, Guaranteed Liveable Income, and Citizen's Income.[4] A Basic Income Guarantee has the potential to alleviate or even eliminate poverty.[5]

One of the proposed models of Basic Income Guarantee is the negative income tax model (NIT). The NIT model depends on the tax system to administer income. Within this model there are three basic elements:

1. The benefit level – which delineates the maximum benefit payable to an individual
2. The reduction rate – which is the amount by which the benefit is decreased for additional income that exceeds the maximum allowable level
3. The break-even rate – which is the amount of income at which an individual will receive no benefit because the reduction rate has reached 100% [6]

Glen Hodgson, Chief Economist of the Conference Board of Canada stated that there are solid economic, fiscal and social reasons to give a guaranteed annual income serious consideration. He outlined three main advantages:

1. Its approach to addressing poverty would reduce public administration by streamlining existing social welfare programs into one universal system. The system used would be the already existing tax system.
2. Earned income for the working poor could be taxed at low marginal rates. This would provide a strong incentive for recipients to work to earn additional income.
3. Through reducing the prevalence of poverty, a guaranteed annual income could create better health outcomes and therefore reduce health care spending. [7]

Senator Hugh Segal has enumerated other compelling reasons to support a Basic Income Guarantee. He believes that it will result in supporting people to become productive, taxpaying, full participants in our economic mainstream. In contrast, continued societal poverty will result in "serious economic, stability and social cohesion costs that are not sustainable." In addition, he points out that a Basic Income Guarantee would result in

significant economic savings from reducing the administration costs of current systems.[8]

A Basic Income Guarantee has many advantages over minimum wage. It is financed through the tax and transfer system. Those who earn more money pay more for it. It is available whether an individual is working or not. In contrast the minimum wage is only of benefit to those who have a job and the cost of minimum wage is borne entirely by employers. As a result, employers may hire fewer workers or provide fewer hours of work. [9]

In 2011 it was estimated by the National Council of Welfare that it would cost $12.6-billion to top up the 3.5 million Canadians living under the poverty line. At that time the amount was less than five percent of the federal budget. It was also less than half the cost imposed on the economy by poverty and its effects. [10] Allowing poverty to continue is far more expensive than investing to improve the economic well-being of those who are impoverished.[4] The cost of poverty has been estimated at 5.5 to 6.6 percent of Canada's Gross Domestic Product (GDP). This is attributed to costs of health care, criminal justice and lost productivity. Canada's GDP is currently in the range of $1.5-$2.0 trillion a year. As a percentage of the current GDP, poverty costs are calculated to be in the range of $82-$132 billion per year.[4]

> *"Given that basic income is designed primarily to bring individuals out of poverty, it has the potential to reduce the substantial, long-term social consequences of poverty, including higher crime rates and fewer students achieving success in the educational system."*[4]

The Low Income Measure After Tax (LIM-AT) identifies individuals living in households with an income that is lower than 50% of the median adjusted income for all households of the same size in that year. The adjustment for household size reflects that fact that a household's needs increase as the number of household members increases, although not by the same proportion per additional member. For 2010, the LIM-AT threshold for a household of two people was $27,521. That same year, the LIM-AT threshold for a household of four people was $38,920.[11]

Living below this threshold is an indication of poverty. There are individuals and families who are living in poverty in Dufferin County, Wellington County, and the City of Guelph. The National Household Survey data shows that 10.5% percent of WDG residents live in low income circumstances as measured by the LIM-AT (10.1% in Dufferin County, 8.4% in Wellington County and 12.1% in the City of Guelph).[2] Since 2008, Ontario Works caseloads at the County of Wellington and Dufferin County have risen by approximately 60% and 42%, respectively.[12, 13]

Poverty has a negative and lasting impact on health and well-being. Income may be the most important determinant of health as it influences health related living conditions.[14] A Wellesley Institute report presented compelling evidence that low income almost inevitably ensures poor health and significant health inequity in Canada.[15] People living in poverty use health services more frequently and often are more seriously sick or injured. Low income results in poor health and is attributable to 20% of total health care spending in Canada.[16] Children who live in low income households are particularly affected. They are more likely to have a range of

health problems throughout their life, even if their socioeconomic status changes later in life.[16] Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis, and heart disease, and to live with a disability. The Wellesley Institute study, *Poverty Is Making Us Sick* offered a comparison between the highest and lowest income quintiles among Canadians and found that the lowest quintile had double the rates of diabetes and heart disease than those in the highest one. Those in the lowest quintile were 60% more likely to have two or more chronic conditions, four times more likely to live with disability, and three times less likely to have additional health and dental coverage.[15]

Research conducted across multiple countries found that countries with higher rates of income inequality had higher levels of health and social problems across all income levels. This pattern was consistent and included health issues such as mental illness, higher levels of obesity and lower life expectancy, educational achievements such as math and literacy scores, and community issues such as violence.[17]

Politicians have acknowledged the benefits of a Basic Income Guarantee. The Senate of Canada in 2009 released a report on poverty which called for a study on the costs and benefits of a basic income supplement.[18] Conservative Senator Hugh Segal has long been a proponent of a Basic Income Guarantee. In 2012 he wrote that, "if the federal tax system topped up everyone who was beneath the poverty line to above it, there would be no Canadians eligible for provincial welfare." As a result the lowest income Canadians "would not occupy homeless shelters, prisons, court rooms and mental hospitals disproportionately to their percentage of the population, because they would be liberated from poverty-caused pathologies by having a basic income guarantee." [19]

At a 2014 convention, Liberal party members passed a policy resolution pledging to create a basic annual income. Priority Resolution 100: Creating a Basic Annual Income to be Designed and Implemented for a Fair Economy resolves "that a Federal Liberal Government work with the provinces and territories to design and implement a Basic Annual Income in such a way that differences are taken into consideration under the existing Canada Social Transfer System." [20]

Minister of Families, Children and Social Development, Jean-Yves Duclos, a veteran economist, has a mandate to come up with a poverty-reduction strategy for Canada. He stated that he appreciates the principles behind the idea of a guaranteed income, "greater simplicity for the government, greater transparency on the part of families, and greater equity for everyone." [21]

There have been widespread advocacy efforts to support an investigation into and consideration of a Basic Income Guarantee for all Canadians. Public Health agencies recognize that poverty and income inequality have well-established relationships with adverse health outcomes. In the Public Health sector, resolutions have been passed by the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA), calling for governments to "prioritize joint federal-provincial consideration and investigation into a basic income guarantee, as a policy option for reducing poverty and income insecurity and for providing opportunities for those in low income."[6] Prior to the last federal election the

Canadian Public Health Association released a fact sheet calling on the next federal government to take leadership in adopting a national strategy to provide all Canadians with a basic income guarantee.[22]

In a 2014 report the Canadian Association of Social Workers proposed the development of a basic income to encourage pan-Canadian income, social and health equity.[23] In August 2015, prior to the Federal election, members of the Canadian Medical Association passed a motion in support of a basic income guarantee.[24] The motion passed with a sizeable majority.

Support for a Basic Income Guarantee has also emerged from municipalities. In December of 2015 the City of Kingston passed a resolution advocating for the federal and provincial governments to consider, investigate and develop a basic income guarantee for all Canadians. The City of Kingston resolution was forwarded to all municipalities in Ontario with a request that they consider supporting the initiative. To date the resolution has been endorsed by the cities of Cornwall, Belleville, Pelham, Peterborough and Welland.[4]

ANALYSIS/RATIONALE

One of the only major studies on Basic Income Guarantee in a high-income country that examined outcomes beyond labour market effects was conducted in Canada in the 1970s. This study, "MINCOME", was conducted in the province of Manitoba between 1974 and 1979. The research design involved selecting families from two communities: the city of Winnipeg, and the small rural community of Dauphin, Manitoba. A unique design element in the study was that Dauphin was a saturation site; everyone was entitled to participate in the study. About a third of Dauphin families qualified for MINCOME stipends at any point in time. Families from other small, rural communities were selected as study controls for the Dauphin families.[3]

One of the advantages of the saturation site was that it reproduced the conditions that would be present in a universal program. It was believed that this would result in a greater ability to understand administrative and community outcomes in a less artificial environment. In addition, a saturation site can result in a "social multiplier effect" - outcomes that are stronger than one might expect because the broader community benefitted from changing social circumstances.[3] Details of the MINCOME stipend are described:

> *"The Dauphin cohort all received the same offer: a family with no income from other sources would receive 60% of Statistics Canada low-income cut-off (LICO), which varied by family size. Every dollar received from other sources would reduce benefits by fifty cents. All benefits were indexed to the cost of living. Families with no other income and who qualified for social assistance would see little difference in their level of support, but for people who did not qualify for welfare under traditional schemes – particularly the elderly, the working poor, and single, employable males – MINCOME meant a significant increase in income. Most important for an agriculturally dependent town with a lot of self-employment, MINCOME offered stability and predictability; families knew they could count on at least some support,*

no matter what happened to agricultural prices or the weather. They knew that sudden illness, disability or unpredictable economic events would not be financially devastating."[3]

At the end of the four-year study virtually no analysis was done by project staff, and a final report was not produced. This is attributed to a change in the intellectual and economic climate. There were also changes in both the federal and provincial governments.[3]

Dr. Evelyn Forget, an economist and professor at the University of Manitoba, conducted an analysis of the MINCOME study in 2009 and published her findings in 2011. She was interested in determining what impact MINCOME may have had on population health. The results were impressive. The MINCOME study demonstrated higher rates of school completion (Figure 1), and a reduction in hospitalizations (Figure 2).[25]

Figure 1

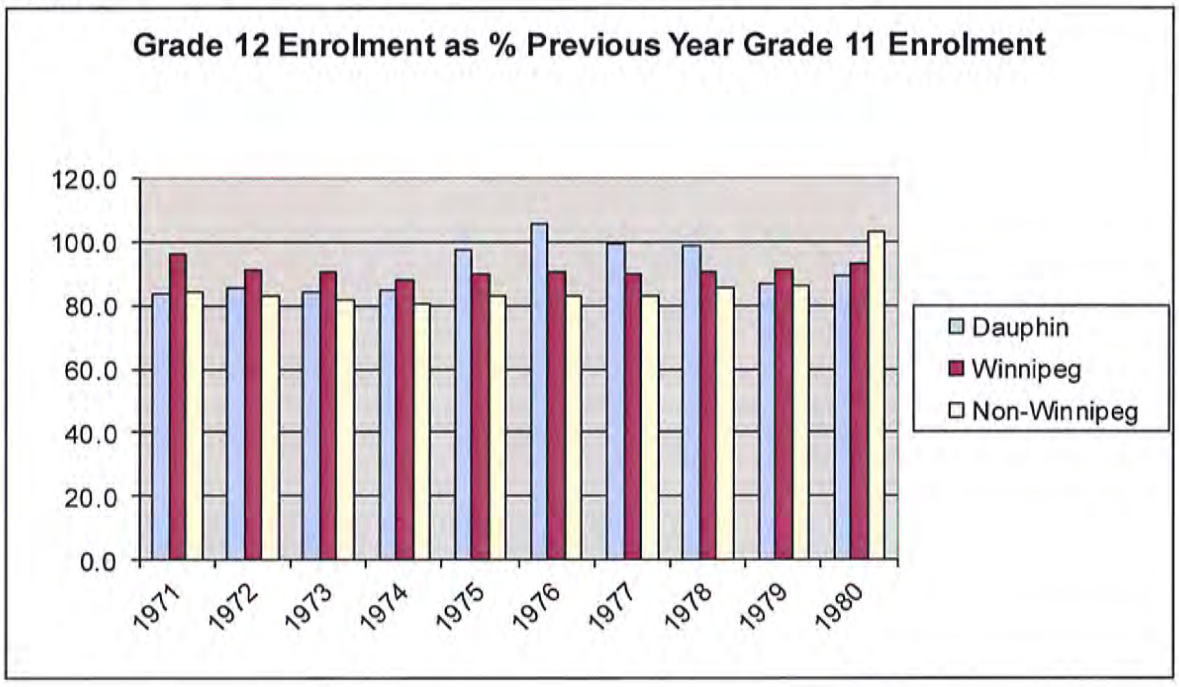
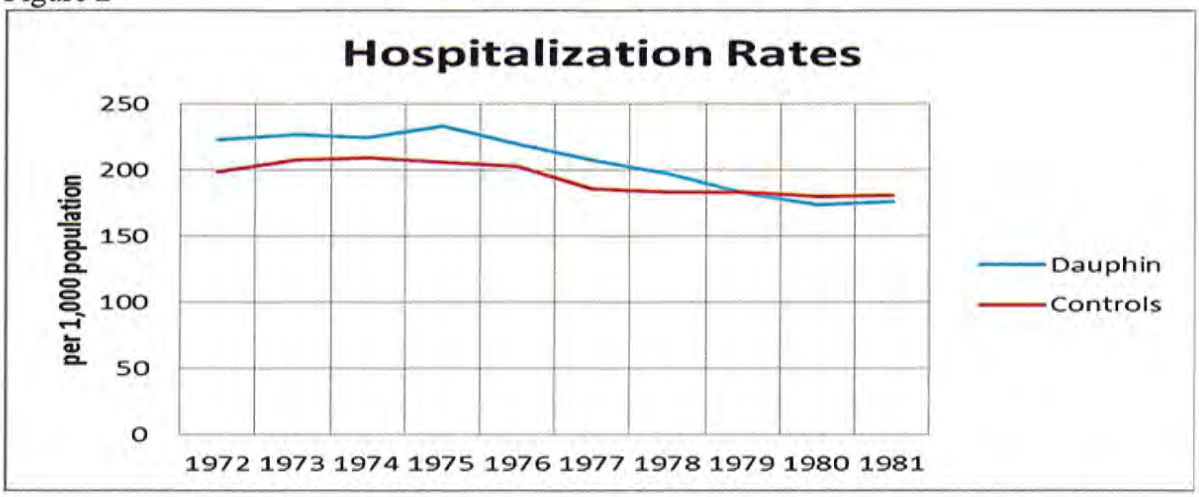


Figure 2



The results of Dr. Forget's analysis of the MINCOME study concluded that the findings suggest that a Guaranteed Annual Income, implemented broadly in society, may improve health and social outcomes at the community level.[3] Dr. Forget has been invited by the federal Liberals to review the findings of this Canadian study at pre-budget hearings. [26]

ONTARIO PUBLIC HEALTH STANDARD

"Addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. Effective public health programs and services consider the impact of the determinants of health on the achievement of intended health outcomes." (p.2)[27]

WDGPH STRATEGIC COMMITMENT

Health Equity
Our programs and services use health equity principles to reduce or eliminate health differences in our communities.

Building Healthy Communities
We will work with communities to support the health and well-being of everyone.

HEALTH EQUITY

A Basic Income Guarantee will ensure that all individuals living below an identified income threshold will be supported at a level that is sufficient to meet basic needs. There is strong evidence that reducing poverty will result in improved long term health outcomes.

APPENDICES

None.

REFERENCES

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March 24, 2016

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

Dear Minister Hoskins:

Re: Environmental Health Program Funding

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached resolution #BOH/2016/01/13 from North Bay Parry Sound District Health Unit regarding the Environmental Health Program Funding. A motion to endorse this resolution was passed.

Sincerely,

Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Ontario Boards of Health
Ontario Medical Officers of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies

Encl.

February 22, 2016

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

Dear Minister Hoskins:

Subject: Environmental Health Program Funding – BOH Resolution #BOH/2016/01/13

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/13:

Whereas, *the Board of Health is responsible to oversee the implementation of the Ontario Public Health Standards (OPHS), related protocols/guidelines and Health Protection and Promotion Act (HPPA) and related regulations, and*

Whereas, *the Board of Health works towards improvement of the overall health of the population through surveillance, health promotion, disease prevention, health protection and enforcement of provincial public health policy, and legislation, and*

Whereas, *the Board of Health supports the Province of Ontario enacting new policy and legislation which will improve the health of the population, and*

Whereas, *recent changes to provincial policy and new legislation has resulted in the expansion of the Environmental Health program mandate in recent years, and*

Whereas, *in 2014 the Skin Cancer Prevention Act (Tanning Beds) went into effect and public health inspectors (PHIs) were required to complete education visits of tanning bed establishments and respond to future public complaints with these facilities, and*

Whereas, *the Recreational Water Protocol was updated by the Ministry of Health and Long-Term Care in 2014 and included a broadening of the definition of a public beach which resulted in doubling the number of municipal public beaches that require annual water sampling, and*

Whereas, *in 2015, the Ministry of Health and Long-Term Care released the new Infection Prevention and Control Lapse Disclosure Guidance document requiring the Health Unit to actively investigate public complaints related to infection prevention and control (IPAC) in regulated health care settings where previously the Health Unit was not mandated, and*

Whereas, *in 2017, the Ministry of Health and Long-Term Care advises that menu labelling requirements will come into force for certain restaurants and will require PHIs to enforce, and*

Whereas, *recent amended environmental health protocols require the disclosure of public facility inspection reports to the public on request and resulting in increased workload for Health Unit staff, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any additional resources and where current Environmental Health program staff are already at full capacity implementing existing mandated programs, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any support for staff training,*

Now Therefore Be It Resolved, *that the Board of Health for the North Bay Parry Sound District Health Unit endorse the following actions to support the Environmental Health program in implementing new provincial public health policy and legislation:*

1) *Encourage the Ontario Ministry of Health and Long-Term Care to provide dedicated, predictable recurring funding to public health units for the purpose to enhance Environmental Health program field staff and management capacity to implement new provincial public health policy and legislation;*

2) *Encourage the Ontario Ministry of Health and Long-Term Care to fund an additional 2.0 full-time equivalent (FTE) public health inspectors in the Environmental Health program;*

3) *Encourage the Ontario Ministry of Health and Long-Term Care to adopt as standard policy for providing of training to public health staff whenever new provincial public health policy and legislation is implemented; and*

4) *Encourage the Ministry of Health and Long-Term Care to develop a staffing model for health units to use to determine adequate levels of environmental health staffing which include field staff, supervisory staff and management staff necessary to fully implement provincial environmental health policy and legislation.*

Furthermore Be It Resolved, *that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.*

Sincerely,

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

C: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Linda Stewart, Executive Director, Association of Local Public Health agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member Municipalities (31)

March 24, 2016

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

Dear Minister Hoskins:

Re: Herpes Zoster Vaccine

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached correspondence from Peterborough County-City Health Unit regarding the Herpes Zoster Vaccine. A motion to endorse this correspondence was passed.

Sincerely,

Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Ontario Boards of Health
Association of Local Public Health Agencies

Encl.

Peterborough County-City HEALTH UNIT
...because health matters!

February 25, 2016

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

Dear Minister Hoskins:

The board of health for Peterborough County-City Health Unit recently received a staff report on the Herpes Zoster Vaccine, at our request. As individual board members, we are aware of both the serious complications of Herpes Zoster reactivation, or "Shingles", and the significant cost of the vaccine. We are also aware that the currently available vaccine, Zostavax II™, produced by Merck Canada Inc., appears to have a limited length of time where it is considered protective.

The burden of illness associated with Herpes Zoster reactivation is considerable, with a lifetime risk of 30%. For persons over 80 years of age, the incidence has been estimated to be 8.4/1,000. The debilitating neurogenic pain syndrome that can occur following shingles, called post-herpetic neuralgia, occurs in 20% of all cases, but increases to more than a third of octogenarians.

The Provincial Infectious Diseases Advisory Committee (PIDAC) for Ontario released a report in 2013 which examined several options for a publicly funded vaccine program for herpes zoster. PIDAC found that the vaccine was cost-effective under a wide range of assumptions, particularly for adults aged 65-70 years of age. PIDAC recommended that the provision of the vaccine for 65 year olds, as this is also the age eligibility for the pneumococcal polysaccharide vaccine. Providing the vaccine to 60 year olds, as currently recommended by the National Advisory Committee on Immunization (NACI) would be more expensive but also more equitable, as all persons for whom the vaccine is recommended by NACI would be eligible.

We understand that there is a new vaccine currently in development that may present a much more effective and longer lasting option. The availability of this promising vaccine would only enhance the economic evaluations that have already been done.

We call upon you and your government to seriously consider adding the herpes zoster vaccine to the list of publicly funded vaccines available to Ontario's adults. Immunization continues to be one of our most effective tools in the prevention of disease and promotion of health, and this remains true through-out the life cycle, including into our later years.

Jackson Square, 185 King Street, Peterborough, ON K9J 2R8 T: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

We appreciate your consideration of this important addition as you move forward with Vision 20/20, the modernization of our provincial immunization system.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at

cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
M.P.P. Jeff Leal, Peterborough
M.P.P. Laurie Scott, Haliburton-Kawartha Lakes-Brock
Ontario Boards of Health
Association of Local Public Health Agencies

Jackson Square, 185 King Street, Peterborough, ON K9J 2R8 T: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

March 24, 2016

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

Dear Premier Wynne:

Re: Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached resolution #11-16 from Sudbury and District Health Unit regarding the enactment of legislation to enforce Infection Prevention and Control (IPAC) practices within Invasive Personal Service Settings. A motion to endorse this resolution was passed.

Sincerely,

Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

Encl.

Sudbury & District
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March 7, 2016

VIA ELECTRONIC MAIL

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

Dear Premier Wynne:

Re: Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings

At its meeting on February 18, 2016, the Sudbury & District Board of Health carried the following resolution #11-16:

WHEREAS adherence to Infection Prevention and Control (IPAC) best practices is essential in reducing the risk of infectious disease transmission through invasive procedures performed in personal services settings such as tattoo and body piercing establishment; and

WHEREAS the Ontario Public Health Standards requires that boards of health perform routine inspections of all personal services settings at least once per year to ensure adherence to best practices for IPAC; and

WHEREAS the Ontario Public Health Standards requires that boards of health investigate complaints regarding potential health hazards including IPAC lapses in personal services settings; and

WHEREAS provincial legislation does not currently exist outlining legal requirements for IPAC practices and operator responsibility and;

WHEREAS creation of provincial legislation governing invasive Personal Services Settings would support a consistent progressive enforcement model amongst Ontario's 36 public health units;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Haliburton, Kawartha, Pine Ridge District Health Unit motion recommending that the Government of Ontario enact legislation implementing IPAC requirements for invasive personal services settings under the Health Protection and Promotion Act with short-form wording under the Provincial Offences Act.

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Premiere of Ontario, the Minister of Health and Long-term Care, local members of Provincial Parliament, the Chief Medical Officer of Health, the Association of Local Public Health Agencies (alPHa), and all Ontario Boards of Health.

It is the Board's hope that the Government of Ontario will seriously consider enacting provincial legislation implementing IPAC requirements for invasive personal services settings under the *Health Protection and Promotion Act*, supported with short-form wording under the *Provincial Offenses Act*.

Sincerely,

Original signed by

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

cc: The Honorable Dr. Eric Hoskins, Minister of Health and Long-Term Care
France Gélinas, MPP, Nickel Belt
Michael Mantha, MPP, Algoma-Manitoulin
Glenn Thibeault, MPP, Sudbury
Dr. David Williams, Chief Medical Officer of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

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Health Unit
Service de santé publique

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March 7, 2016

VIA ELECTRONIC MAIL

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

Dear Premier Wynne:

Re: Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings

At its meeting on February 18, 2016, the Sudbury & District Board of Health carried the following resolution #11-16:

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WHEREAS the Ontario Public Health Standards requires that boards of health investigate complaints regarding potential health hazards including IPAC lapses in personal services settings; and

WHEREAS provincial legislation does not currently exist outlining legal requirements for IPAC practices and operator responsibility and;

WHEREAS creation of provincial legislation governing invasive Personal Services Settings would support a consistent progressive enforcement model amongst Ontario's 36 public health units;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Haliburton, Kawartha, Pine Ridge District Health Unit motion recommending that the Government of Ontario enact legislation implementing IPAC requirements for invasive personal services settings under the Health Protection and Promotion Act with short-form wording under the Provincial Offences Act.

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Premiere of Ontario, the Minister of Health and Long-term Care, local members of Provincial Parliament, the Chief Medical Officer of Health, the Association of Local Public Health Agencies (alPHa), and all Ontario Boards of Health.

It is the Board's hope that the Government of Ontario will seriously consider enacting provincial legislation implementing IPAC requirements for invasive personal services settings under the *Health Protection and Promotion Act*, supported with short-form wording under the *Provincial Offenses Act*.

Sincerely,

Original signed by

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

cc: The Honorable Dr. Eric Hoskins, Minister of Health and Long-Term Care
France Gélinas, MPP, Nickel Belt
Michael Mantha, MPP, Algoma-Manitoulin
Glenn Thibeault, MPP, Sudbury
Dr. David Williams, Chief Medical Officer of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

March 7, 2016

Association of Local Public Health Agencies
Suite 1306
2 Carlton Street
TORONTO, ON M5B 1J3

Dear Ontario Boards of Health:

Re: Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

On February 26, 2016 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached 'Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document'. The following motion was passed:

Motion No: 2016-19

Moved by: David Shearman Seconded by: Laurie Laporte

"That the Grey Bruce Board of Health does endorse the Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document."

Carried.

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey

Encl.

Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

February 2016

For More Information:
Drew Ferguson
Public/Media Relations Coordinator
Grey Bruce Health Unit
101 17th Street East Owen Sound ON N4K 0A5
519-376-9420 ext. 1269
d.ferguson@publichealthgreybruce.on.ca

Grey Bruce Health Unit Brief in Response to Patients First Discussion Document

This brief specifically addresses Section Four of the *Patients First* discussion document, titled *Stronger Links Between Public Health and Other Health Services.*

This brief is comprised of two components. The first looks at the population health approach taken by Public Health and issues that arise. The second section provides a Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

THE ISSUE

The initial statement ***Public health has historically been relatively disconnected from the rest of the health care system*** is at the core of this discussion.

The focus of the LHIN-based health care is on individual patient care, service provision and costs. In essence, it is sickness care.

Public Health has a different role than the sickness care system. Our focus is “upstream” through prevention of disease and illness, staying well.

Public Health’s population health approach aims to improve the health of the entire population. It considers the things that influence our health both inside and outside the health care system. It recognizes that at every stage of life, our health is affected by complex interwoven fabric of factors referred to as 'determinants of health'. These include Housing; Income; Social Status; Social Support Networks; Education and Literacy; Employment/Working Conditions; Social Environments; Physical Environments; Personal Health Practices and Coping Skills; Healthy Child Development; Biology and Genetics; Health Services; Gender; and Culture. These factors do not exist in isolation. Rather, the combined influence of these factors determines our health.

This is profoundly different from the health care system’s view of population health. The health care system’s approach to population health is to provide interventions to specific, identifiable groups whose needs are greatest and it is taken that, by extension, this will improve overall population health.

A Public Health-based, population health strategy addresses the factors contributing to dis-ease in the population as a whole. That goes beyond behaviour and lifestyle approaches. Working at the population health level does not translate well to the individual. Using alcohol misuse as an example, greater societal gain is achieved from a small change within the larger population than by addressing the problem on an individual basis. Referred to as the ‘prevention paradox’; preventive measures, through strategies such as policy development, that address health equity or social determinants of health, that bring benefit at the population level, offers little to the individual. Public Health is virtually invisible to the public. In the population health model, success is marked by a non-event.

Public Health is the ounce of prevention. In terms of health funding, Public Health is small potatoes accounting for about 1.4 per cent of the province's over-all health budget. When limited funding for population health initiatives is balanced again individual care, the scale invariable tips to individual care. Referred to as the, "tyranny of the acute", when limited resources are in play, the demands of sick person will always take precedent over the need to better the health of the larger population. The public have a preoccupation with acute and medical care, as that affects them directly.

In identifying the current situation, Section Four states that ***Many aspects of the health care system are not able to properly benefit from public health expertise, including issues related to health equity, population health and the social determinants of health.***

Given that reality, it would be unrealistic to expect a relatively small Public Health sector to have much influence on the larger and more powerful set of illness care-oriented priorities. As seen in other jurisdictions, the larger culture of illness care will steer Public Health to a more clinical orientation and away from population health. As a result, the already scarce Public Health resources are diverted to acute, primary and long-term care issues (e.g., emergency room diversion strategies).

The role with respect to the regulatory functions performed by Public Health is not addressed in the *Patients First* discussion. These roles do not align well with health care and speak to the "disconnect from the rest of the health care system" as. Areas including safe drinking water, beach water testing, food premise inspections, personal service setting inspections (aesthetic/tattoo etc.), tobacco by-law enforcement, environmental hazards, and emergency preparedness are all significant components of the Public Heath portfolio. The transfer and monitoring of accountability and performance in these regulatory areas is a substantial undertaking for LHINs. Additionally, it would seem redundant to require 14 independent LHINs to provide universal regulatory and performance oversight in these non-healthcare areas.

Further to this discussion of accountability and performance, it should be noted that population health does not lend itself easily to quick measurements as compared to acute care. It is easy to count ER visits, but as we have seen with the shift towards tobacco de-normalization, results are often incremental and can take decades.

The LHINs are defined by health-care referral patterns where the patient goes. Owen Sound patients go to London, Blue Mountains patients go to Collingwood and Barrie, Dundalk patients go to Shelburne and Orangeville. Public Health is defined by municipal boundaries. The two do not align. The current proposal puts the Grey Bruce Health Unit in three LHINs; the majority in the South West LHIN, Southgate in the Waterloo Wellington LHIN and Town of Blue Mountains the North Simcoe Muskoka LHIN. The implications of these over-lapping alignments require clarification.

QUESTIONS FOR DISCUSSION

The following provides the Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

How can public health be better integrated with the rest of the health system?

Should it be? As described, the healthcare system is sickness care, the system comes into play once you become ill; Public Health is all about maintain and extending wellness. That question could well be reversed to ask how the rest of the health system can better integrate with Public Health. This would have the health care system acknowledge and adopt a population health approach as fundamental to all significant health issues. By necessity, this is a long-term approach re-directing the focus towards health and not just health care.

What connections does public health in your community already have?

Grey Bruce Health Unit has filaments that thread throughout our community. The list is extensive; these connections can be characterized as being with:

- upper and lower tier municipal partnerships and working groups. We perform regulatory roles but also focus on planning and policy for healthy communities
- health care, primary care/health care and a wide range of health professionals, providing materials, knowledge and resources
- community and community groups supporting capacity in the community around specific issues
- school boards, from frontline services such as dental screening and immunization, to issue specific initiatives such as youth mental health, to broader healthy school initiatives
- post-secondary institutions
- First Nations communities
- Plains Communities, also known as Amish and Mennonite communities
- federal and provincial ministries
- agriculture and veterinary, producer and consumer groups, industry, and
- the community at large.

What additional connections would be valuable?

Many of the areas of public health involvement, including the provision of clinical services, reflect ongoing or historic gaps on a population-wide basis. This has been particularly true for the more vulnerable populations. One of the emerging roles for the Grey Bruce Health Unit is to

identify capacity within a community and seek out the resources and links that can help empower populations or communities to take steps to improve their own health and wellbeing. These types of partnerships may provide examples of collaborative models between primary care and Public Health.

As noted, health inequities and the broader social determinants of health are often outside the immediate scope of healthcare services. In this regard, LHINs not only need to work with Public Health but they should also develop formal relationships with the municipal, social services, housing, education, and voluntary sectors to support service integration. As the Ottawa Charter for Health Promotion suggests, health services should be expanded to include building healthy public policy, creating supportive environments, strengthening community action and supporting development of personal skills.

What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

The Ministry plan would ***create a formal relationship between the Medical Officers of Health and each LHIN, empowering the Medical Officers of Health to work with LHIN leadership to plan population health services.***

A direct role by the Medical Officers of Health in informing or influencing decisions would provide a public health link to healthcare systems. Offering the potential to bring a population health view to health issues and the planning of healthcare services. This can only be achieved with the Medical Officer of Health's routine participation in the executive management team and at the Board level. Experience from other jurisdiction has shown that success requires a strong and interested health sector leadership combined with strong public health leadership and epidemiological capacity. Public health's involvement in providing a population health perspective can only be achieved by design and cannot be left to the discretion of individual LHINs or their Boards.

Without a formal or direct influence on budgets, programs and staffing, it might fall to the Medical Officers of Health to be the lone voice for Public Health. The challenge being to mitigate adverse impacts on Public Health including loss of funding, fragmentation of capacity, diversion of staff through re-orientation to clinical issues, and barriers to engagement with community and municipal partners.

March 21, 2016

Porcupine
Health Unit • Bureau de santé

The Honourable Ted McMeekin
Ontario Minister of Municipal Affairs and Housing
777 Bay Street, 17th Floor
Toronto, ON
M5G 2E5

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

Phone: 705 267 1181
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Dear Minister McMeekin,

On March 18, 2016, the Porcupine Health Unit Board of Health passed the following resolution:

WHEREAS smoking in multi-unit housing results in significant exposure to the health harming effects of tobacco smoke; and

WHEREAS area municipalities and service boards that are landlords of multi-unit housing can adopt no-smoking policies that set an example and protect health;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Porcupine Health Unit support the efforts of the Smoke-Free Housing Ontario Coalition, and others, in the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

(1) Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties;

(2) Advocate that all future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;

(3) Encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties;

(4) Advocate that all future public/social housing developments in Ontario should be smoke-free from the onset;

(5) Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Smoke-Free Housing Ontario Coalition, the Ontario Minister of Municipal Affairs and Housing, local members of Provincial Parliament (MPP), the Chief Medical Officer of Health, the Association of Local Public Health Agencies (alPHa), all Ontario Boards of Health, the Association of Municipalities of Ontario (AMO), the Federation of Northern Ontario Municipalities (FNOM) and Porcupine Health Unit municipalities for their information and support.

Thank you for your attention to this important public health issue.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW: mc

February 22, 2016

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

Dear Minister Hoskins:

Subject: Bill 139: Smoke-Free Schools Act – BOH Resolution #BOH/2016/01/11

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/11:

***Whereas**, tobacco use is the leading cause of preventable death and disability in Canada (Ministry of Health and Long-Term Care, 2010), and*

***Whereas**, the number of daily and occasional cigarette smokers in the North Bay Parry Sound District Health Unit is 7% higher than the provincial average (25.8% vs. 18.7%; NBPSDHU, 2014), and*

***Whereas**, Bill 139: Smoke-Free Schools Act introduced by MPP Todd Smith is slated for third reading in the Ontario Legislature this year, and*

***Whereas**, Bill 139: Smoke-Free Schools Act includes a prohibition on the sale of any tobacco products in schools, increased fines for offenders caught selling illegal tobacco, and increased suspension periods of driver's licenses for people convicted of using a vehicle for unauthorized delivery/transportation of illegal tobacco, sharing the proceeds of disposition of forfeited property with police forces if they were involved in the investigation, a requirement that the Government establish a public education program about the health risks associated with the use of tobacco, and*

***Whereas**, the illegal sale of contraband cigarettes undermines public health's efforts to reduce smoking rates and protect children and youth from the dangers of smoking, and*

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

***Whereas**, plain and standardized packaging is an effective counter measure to the tobacco industry's use of packaging as an important part of tobacco promotion, and*

***Whereas**, Bill 139: Smoke-Free Schools Act has been endorsed by the Canadian Cancer Society, the Heart & Stroke Foundation, and the Ontario Campaign Against Tobacco (OCAT),*

***Now Therefore Be It Resolved**, that the Board of Health for the North Bay Parry Sound District Health Unit support Bill 139: Smoke-Free Schools Act and that legislation for plain and standardized cigarette packaging and higher tobacco taxes be considered by all levels of government, and*

***Furthermore Be It Resolved,** that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, the Association of Local Public Health Agencies (alpha), MPP Todd Smith (Prince Edward-Hastings), MPP Victor Fedeli (Nipissing), MPP Norm Miller (Parry Sound-Muskoka), Premier Kathleen Wynne, and Ontario Boards of Health.*

Sincerely,

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

C: Todd Smith, MPP, Prince Edward-Hastings
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
Hon. Kathleen Wynne, Premier of Ontario
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

Staff Report

Accountability Agreement Indicators (2015)

Date:	April 13, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Patti Fitzgerald, Assistant Director

Proposed Recommendations

That the Board of Health for the Peterborough County-City Health Unit receive the staff report, *Accountability Agreement Indicators (2015),* for information

Financial Impact

There are no financial impacts related to the Accountability Agreement.

Background

In 2010, as part of a commitment by the provincial government to simplify board of health reporting requirements, the Ministry of Health and Long-Term Care (MOHLTC) developed a public health accountability agreement for the first time in Ontario. The process involved extensive consultation between the MOHLTC and all 36 local public health agencies. It was designed to support public health programming and its continuous quality improvement in the areas of: local program management and service delivery; communicable disease surveillance; policy development and risk assessment; and, public reporting. Since that time PCCHU has reported annually to the board of health on its progress.

Rationale

Receipt and consideration of this staff report allows the board of health to carry out its legislative duties and responsibilities under the Health Protection and Promotion Act. It summarizes PCCHU's performance under the Accountability Agreements with the MOHLTC. Accountability agreements are an important tool in the provincial Public Health Performance Management Framework. By setting performance targets, and measuring outcomes, we can incrementally move the whole public health sector along a quality improvement continuum.

Analysis

In 2013, the MOHLTC set up another consultation process to develop the next three year Accountability Agreement (2014-2016). The 27 indicators include 17 Health Protection and 10 Health Promotion indicators. The performance indicators, targets and 2015 performance are detailed in Appendix 1.

For 2015 PCCHU did not meet performance targets for the following six indicators.

Indicator # 1.5: The % of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act (SFOA)

> Details: Four sites were not inspected. Two were identified as detention and custody facilities for young persons in conflict with the law and are not considered a secondary school, these two centres have since been removed from the database. The other two sites not inspected were very small, private, rural schools that also serve as small elementary schools. The Tobacco Enforcement Officer made several attempts to meet with the principals however this was not successful. When contacted by telephone, both schools denied any tobacco use on the property. Attempts will be made again to meet with the administration of these two schools.

Indicator # 1.6: The % of tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA): non-seasonal

> Details: There were eight vendors not inspected. For a variety of reasons these vendors should have been removed or flagged in the database. Such reasons include one vendor was closed for construction, three vendors no longer sold tobacco, three vendors should have been marked as restricted access and once visit was entered incorrectly as a display and promotion visit. Corrections to the database have been made. Going forward all youth access inspection data will be reviewed for errors by both the Tobacco Enforcement Officer and Manager prior to data extraction by MOHLTC.

Indicator #1.7: The % of tobacco retailers inspected for compliance with display, handling and promotion section of the Smoke-Free Ontario Act (SFOA)

Details: These locations are no longer tobacco vendors and have since been removed from the database.

Indicator #3.2: The % of suspected rabies exposures reported with investigation initiated within one day of public health unit notification

Details: Technical difficulties with the virtual software program that prohibited the email notification to the on-call public health inspector/manager. This has been resolved.

Indicator #4.2: The % of influenza vaccine wasted that is stored/administered by the public health unit.

Details: Product had expired.

Indicator # 4.3: The % of refrigerators storing publically funded vaccines that have received a completed routine annual cold chain inspection

Details: Related to the move to Jackson Square, four of the inpsections were not completed by December 31, 2015. However they were all completed in January 2016.

Strategic Direction

The report applies to the strategic directions of Quality and Performance.

Contact:

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

Appendix 1: 2015 Accountability Agreement Indicators, Target and Performance
Health Promotion Indicators

#	Health Promotion Indicator		2015 Target	2015 Performance
1.1	% of population (19+) that exceeds the Low-Risk Drinking Guidelines		Long-term***	n/a
1.2	Fall- related emergency visit in older adults aged 65+ (rate per 100,000 per year)		Long-term***	n/a
1.3	% of youth (ages 12-18) who have never smoked a whole cigarette		Long-term***	n/a
1.4	% of tobacco vendors in compliance with youth access legislation at the time of last inspection		≥ 90.0%	92.1%
1.5	% of secondary schools inspected once per year for compliance with section 10 of the Smoke – Free Ontario Act		100%	69.2%
1.6	% of tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act	Non-Seasonal	100%	94%
		Seasonal	100%	100%
1.7	%of tobacco retailers inspected for compliance with display, handling and promotion sections of the Smoke-Free Ontario Act		100%	92.5%
1.8	Oral Health Assessment and Surveillance: % of schools screened		100%	100%
	Oral Health Assessment and Surveillance: % of all JK, SK and Gr. 2 students screened in all publicly funded schools		100%	100%
1.9	Implementation status of NutriSTEP® Preschool Screen		Intermediate	Advanced
1.10	Baby-Friendly Initiative (BFI) Status		Designated	Designated

***Long-term: one long-term target will be set in 2016

Health Protection Indicators

#	Health Protection Indicator	2015 Target	2015 Performance
2.1	%of high-risk food premises inspected once every 4 months while in operation	Monitoring*	100%
2.2	% of moderate-risk food premise inspected once every 6 months while in operation	Monitoring*	100%
2.3	% of class A pools inspected while in operation	100%	100%
2.4	%of high risk Small Drinking Water Systems inspections completed for those that are due for re-inspection	100%	100%
2.5	% of public spas inspected while in operation	Monitoring*	92.9%
3.1	% of personal service settings inspected annually	Monitoring*	99.5%
3.2	% of suspected rabies exposures reported with investigation initiated within 1 day of public health unit notification	95%	92.6%
3.3	% of confirmed gonorrhea cases where initiation of follow-up occurred within 2 business days	Monitoring*	100%
3.4	%of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case	Monitoring*	100%
3.5	% of salmonellosis cases where one or more risk factor(s) other than “unknown” was entered to iPHIS	85%	93.9%
3.6	% of confirmed gonorrhea cases treated according to the recommended Ontario treatment guidelines	Baseline**	65.0%
4.1	% of HPV vaccine wasted that is stored/administered by the public health unit	0.0%	0.0%
4.2	% of influenza vaccine wasted that is stored/administered by the public health unit	0.8%	1.3%
4.3	% of refrigerators storing publically funded vaccines that have received a completed routine annual cold chain inspection	100%	97.6%
4.4	% of school-aged children who have completed immunizations for hepatitis B	Monitoring*	69.2%
4.5	% of school-aged children who have completed immunizations for hpv	Monitoring*	52.3%
4.6	% of school-aged children who have completed immunizations for meningococcus	Monitoring*	79.0%

*Monitoring- no targets set, performance is reviewed internally by the MOHLTC (health protection only)
**Baseline- new indicator for 2015, gathering baseline data only

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Medical Officer of Health - Coverage Request**

Date: April 13, 2016

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit approve the appointment of Dr. James R. Pfaff, former Associate Medical Officer of Health for the Simcoe Muskoka District Health Unit, as Acting Medical Officer of Health for the Peterborough County-City Health Unit, for the period of May 9 – 21, 2016.

Dr. Pfaff has provided coverage on a number of occasions for Dr. Salvaterra in the past, Board approval was not required as it was covered by Board policy 2-345, Medical Officer of Health Absence.

Dr. Pfaff has since retired from Simcoe Muskoka however is still a physician in good standing and fully capable of providing coverage for this absence.

To: All Members
Board of Health

From: Kerri Davies, Chair, Fundraising Committee

Subject: **Committee Report: Fundraising**

Date: April 13, 2016

The Fundraising Committee met last on March 7, 2016. At that meeting, the Committee requested that the following items come forward to the Board of Health:

1. Meeting Minutes – February 3, 2016

Proposed Recommendation:

That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Fundraising Committee for February 3, 2016.

2. Community Foundation of Greater Peterborough (CFGP) Grant

Proposed Recommendation:

That the Board of Health for the Peterborough County-City Health Unit receive for information, an update on the Community Foundation of Greater Peterborough Grant.

At the February 3rd meeting, the Fundraising Committee met with John Good from the CFGP to discuss various options on the disbursement of a $25,000 grant which was gifted by a donor through the CFGP: a permanent endowment, a managed fund, or a blended payout. The grant is intended for programming related to Myrtle's Kitchen.

The Committee determined that the best option would be to proceed with a blended payout which would allow for the CFGP to disburse the funds over a three-year period. The Committee also requested that staff report on how these funds have been used each year via the Board's annual report.

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Fundraising Committee Meeting
Wednesday, February 3, 2016 – 4:00 p.m.
Dr. J.K. Edwards Board Room, Peterborough County-City Health Unit

Present:	**Ms. Kerri Davies, Chair** **Mr. Scott McDonald** **Mr. Andy Sharpe**
Regrets:	**Councillor Gary Baldwin**
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health** **Mr. Larry Stinson, Acting Director, Corporate Services** **Ms. Patti Fitzgerald, Acting Director, Public Health Programs; Chief Nursing Officer; Manager, Sexual Health** **Ms. Natalie Garnett, Recorder**
Guest:	**Mr. John Good, Executive Director, Community Foundation of Greater Peterborough (4:30 p.m.)**

1. Call to Order

Dr. Salvaterra, Medical Officer of Health called the meeting to order at 4:05 p.m.

2. Elections

2.1 Chairperson

Dr. Salvaterra called for nominations for the position of Chairperson for the Fundraising Committee for the Peterborough County-City Health Unit for the year 2016.

MOTION:
That Kerri Davies be appointed Chair of the Fundraising Committee for 2016.
Moved: Mr. Sharpe
Seconded: Mr. McDonald
Motion carried. (M-2016-004-FC)

2.2 **Vice Chairperson**

Ms. Davies called for nominations for the position of Vice Chairperson for the Fundraising Committee for the Peterborough County-City Health Unit for the year 2016.

MOTION:
That Scott McDonald be appointed Vice Chair of the Fundraising Committee for 2016.
Moved: Mr. Sharpe
Seconded: Ms. Davies
Motion carried. (M-2016-005-FC)

3. Confirmation of the Agenda

MOTION:
That the Agenda be accepted as circulated.
Moved: Mr. Sharpe
Seconded: Mr. McDonald
Motion carried. (M-2016-006-FC)

4. Declaration of Pecuniary Interest

5. Delegations and Presentations

6. Confirmation of the Minutes of the Previous Meeting

MOTION:
That the minutes of the Fundraising Committee Meeting held January 5, 2016 be approved as circulated and provided to the Board of Health at its next meeting for information.
Moved: Mr. Scott
Seconded: Mr. Sharpe
Motion carried. (M-2016-007-FC)

7. Business Arising from the Minutes

7.1. **Donor Recognition Policy**

Ms. Davies provided a first draft of a Donor Recognition Policy.

MOTION:
That the Fundraising Committee recommend to the Board of Health of the Peterborough County-City Health Unit that it approve a contract with Nicole Beatty for a maximum (subject to verification) of forty hours of service at $60/hr, to conclude work on the Community Kitchen Campaign project and a naming rights/donor recognition policy .
Moved: Mr. McDonald
Seconded: Mr. Sharpe
Motion carried. (M-2016-008-FC)

MOTION:
That the draft Donor and Gift Recognition Program policy and procedures be tabled for discussion at a future meeting.
Moved: Mr. Sharpe
Seconded: Mr. McDonald
Motion carried. (M-2016-009-FC)

7.2. **Canada Helps Donations**

Dr. Salvaterra advised that thank you letters will be provided to individuals who made on-line donations received through Canada Helps.

7.3. **Ongoing Fundraising Infrastructure for the Board**

It was noted that this matter will be dealt with at the Strategic Planning Session on February 6, 2016.

8. Staff Reports

9. Consent Items

10. New Business

10.1 **Community Foundation of Greater Peterborough**

Mr. John Good, Executive Director of the Community Foundation of Greater Peterborough joined the meeting at 4:30 p.m. and provided an overview of the services the Foundation can provide. A donor has made a gift of $25,000 towards the Community Kitchen and Mr. Good discussed how that money could be used.

Three possible options were provided for the Fundraising Committee's information and consideration:

1. A permanent endowment.
2. A managed fund.
3. Blended payout.

Mr. Good was thanked for his presentation.

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

12. <u>Motions from In Camera for Open Session</u>

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

The Fundraising Committee established a tentative date for the next meeting - March2, 2016 at 4:00 p.m.

14. <u>Adjournment</u>

MOTION:
That the Fundraising Committee meeting be adjourned.
Moved by: Mr. McDonald
Seconded by: Mr. Scott
Motion carried. (M-2016-010-FC)

The meeting was adjourned at 5:31 p.m.

Chairperson

Medical Officer of Health

To: All Members
Board of Health

From: Mr. Gregory Connolley, Chair, Governance Committee

Subject: **Committee Report: Governance**

Date: April 13, 2016

The Governance Committee met last on March 15, 2015. At that meeting, the Committee requested that the following items come forward to the Board of Health for consideration. Supporting documentation has been included (and linked) where available.

1. **Governance Committee Meeting Minutes:**

   Proposed Recommendation:

   That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Governance Committee for December 1, 2015.

   Please refer to the following document:

   a. Governance Committee Minutes – December 1, 2015

2. **By-Laws, Policies and Procedures**

   Proposed Recommendation:

   That the Board of Health for the Peterborough County-City Health Unit approve the following:
   - *2-150, Remuneration of Members (revised); and*
   - *2-261, Appointments, Provincial Representatives (no changes recommended).*

   Please refer to the following documents:

   a. 2-150, Remuneration of Members
   b. 2-261, Appointments, Provincial Representatives

3. **Governance Committee Work Plan (2016)**

   Proposed Recommendation:

   That the Board of Health for the Peterborough County-City Health Unit receive for information, the Governance Committee work plan for 2016.

Please refer to the following document:

a. Governance Committee Work Plan 2016

4. Medical Officer of Health Performance Review

Proposed Recommendation:

That the Board of Health for the Peterborough County-City Health Unit approve the following:
- *2-340, Medical Officer of Health Performance Appraisal (revised)*
- *PCCHU Medical Officer of Health Performance Appraisal Form (new);*
- *Performance Planner (no changes recommended); and,*
- *Medical Officer of Health Position Description (revised).*

The Board of Health approved updates to the Medical Officer of Health (MOH) Performance Appraisal policy and procedure on December 9, 2015. The Governance Committee is recommending further amendments to this document arising out of their March 15th meeting.

The Committee reviewed a new performance appraisal form given that the previous tool was deemed to be inadequate. After consulting with a number of local public health agencies, a tool utilized by the Middlesex London Health Unit was selected and adapted for PCCHU.

With respect to a performance review for 2016, the Board Chair will meet with Dr. Salvaterra and finalize goal setting by April 30, 2016, and complete a performance appraisal, with input from internal stakeholders, by October 31, 2016.

Please refer to the following documents:

a. 2-340, Medical Officer of Health Performance Appraisal
b. PCCHU Medical Officer of Health Performance Appraisal Form
c. Performance Planner
d. Medical Officer of Health Position Description

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Governance Committee Meeting
Tuesday, December 1, 2015 – 5:15 p.m.
Mississauga Lake Room, 185 King Street, Peterborough

Present:	**Mayor Mary Smith**
	Mr. Scott McDonald, Chair
	Deputy Mayor Fallis
	Mr. Gregory Connolley
	Councillor Lesley Parnell
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health**
	Mr. Larry Stinson, Acting Director, Corporate Services
	Ms. Natalie Garnett, Recorder

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1. Call to Order

Mr. McDonald called the Governance Committee meeting to order at 5:22 p.m.

2. Confirmation of the Agenda

MOTION:
That the Agenda be accepted as circulated.
Moved: Deputy Mayor Fallis
Seconded: Mr. Connolley
Motion carried. (M-2015-35-GV)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

MOTION:
That the minutes of the Governance Meeting held August 18, 2015 be approved as circulated and provided to the Board of Health at its next meeting for information.
Moved: Councillor Parnell
Seconded: Mayor Smith
Motion carried. (M-2015-36-GV)

6. Business Arising from the Minutes

6.1. MOH Performance Review Policy and Procedure

MOTION:
That the Governance Committee recommend to the Board of Health of the Peterborough County-City Health Unit that it approve revisions to 2-340, Medical Officer of Health Performance Appraisal.
Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-37-GV)

6.2. Ontario Public Health Organizational Standards (Management Operations)

MOTION:
That the Governance Committee:
- *Receive the status update on the Ontario Public Health Organizational Standards (Management Operations) for the Peterborough County-City Health Unit for information; and,*
- *Provide an update to the Board at its next meeting.*

Moved: Deputy Mayor Fallis
Seconded: Mayor Smith
Motion carried. (M-2015-38-GV)

7. Staff Reports

8. Consent Items

8.1 Staff Reports and Presentations

a. Board Remunerations Review

b. Board By-laws and Policies for Review

MOTION:
That item 8.1 b, be approved on consent.
Moved: Mr. Connolley
Seconded: Mayor Smith
Motion carried. (M-2015-39-GV)

MOTION:
That the Governance Committee recommend to the Board of Heath of the Peterborough County-City Health Unit that it approve revisions to 2-120 By-law Number 3, Calling of and Proceedings at Meetings; and

That the Governance Committee recommend to the Board of Heath of the Peterborough County-City Health Unit that no revisions be made to 2-140 By-law 5, Powers, Duties and Term of Office of the Chairperson and Vice-Chairperson of the Board of Health, and 2-251 Orientation for Board of Health Members.
Moved: Mr. Connolley
Seconded: Mayor Smith
Motion carried. (M-2015-40-GV)

8.1 a. Board Remuneration Review

MOTION:
That the Governance Committee for the Board of Heath of the Peterborough County-City Health Unit:
- *Receive the staff report, Board Remuneration Review, for information*
- *Forward the staff report to the Board for its consideration at the January 13, 2016 meeting; and*
- *Recommend an increase of $0.73 to the current honourarium for 2016.*

Moved: Mayor Smith
Seconded: Mr. Connolley
Motion carried. (M-2015-41-GV)

9. New Business

9.1 Orientation/Education Needs for 2016

Discussion was held regarding options for orientation and education in 2016. It was noted that if broad staff training is being undertaken the invitation can be extended to Board members. Staff will look at the possibility of having a meeting at one of the townships once a year.

9.2 **Correspondence Options**

MOTION:
That the Governance Committee receive the report on Correspondence Options for information.
Moved: Councillor Parnell
Seconded: Mayor Smith
Motion carried. (M-2015-42-GV)

10. In Camera to Discuss Confidential Personal Matters

MOTION:
That the Governance Committee go in Camera at 6:11 p.m. to review one item under Section 239 2.b) Personal matters about an identifiable individual, including municipal or local board employees; and one item under Section 238.2d) Labour relations or employee negotiations.
Moved: Deputy Mayor Fallis
Seconded: Mr. Connolley
Motion carried. (M-2015-43-GV)

MOTION:
That the Governance Committee rise from in Camera at 6:45 p.m.
Moved: Mr. Connolley
Seconded: Councillor Parnell
Motion carried. (M-2015-44-GV)

11. Motions from In Camera for Open Session

12. Date, Time and Place of Next Meeting

13. Adjournment

MOTION:
That the Governance Committee meeting be adjourned.
Moved by: Deputy Mayor Fallis
Seconded by: Councillor Parnell
Motion carried. (M-2015-45-GV)

The meeting was adjourned at 6:46 p.m.

Chairperson

Medical Officer of Health

Peterborough County-City HEALTH UNIT
...because health matters!

Board of Health

POLICY

Section: Board of Health	**Number: 2-150**	**Title: Remuneration of Members**
Approved by: Board of Health **Signature:** **Date** (YYYY-MM-DD)**:** 2014-01-08 **Housekeeping Revision** **Approved by:** **On** (YYYY-MM-DD)**:**		**Original Approved by Board of Health** **On** (YYYY-MM-DD)**: 2014-01-08** **Revision** **Approved by:** Board of Health **On** (YYYY-MM-DD)**:** 2014-01-08 **Reviewed by:** Governance Committee **On** (YYYY-MM-DD)**:** 2013-12-03
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.

Definitions

"Board" means the Board of Health for the Peterborough County-City Health Unit;

"Council" means the municipal Councils of the Corporations of the County of Peterborough and the City of Peterborough, and Councils for Curve Lake First Nation and Hiawatha First Nation;

“Committee” means an assembly of two or more members appointed by the Board of Health”;

"Meeting" means an official gathering of members of the Board or its committees in one place to transact business; and

"Member" means a person who is appointed to the board by a Council or the Lieutenant Governor-in - Council or a person who is appointed to a committee by the Board.

Policy

1. At its first meeting, the Board shall confirm which members shall be remunerated for attending meetings and shall determine the amount of the remuneration. The Board shall be provided with a

recommendation from the Governance Committee on proposed adjustments or increases to support their decision.

2. The Board shall reimburse each member for all reasonable expenses incurred as a result of acting in his/her capacity as a member in accordance with the policies of the Board.

3. The Board shall reimburse each member for all reasonable expenses incurred by the attendance at conventions, conferences, seminars, etc. in accordance with the policies of the Board.

4. An honorarium will be paid to each member of the Board of Health who is eligible for compensation in accordance with the Health Promotion and Protection Act.

5. The amount of the honorarium will be established by the Board of Health at the first regular meeting of the Board of Health each year.

6. The honorarium will be paid to each eligible Board member who attends:
   (a) a regular meeting of the Board;
   (b) a committee meeting;
   (c) a conference or convention; or
   (d) a business meeting on behalf of the Board.

7. A Board member who attends one meeting (or consecutive meetings) that extend over six hours, will receive one and one half times the regular honorarium.

8. A Board member will be paid one half of the regular honorarium when required to attend to Board business not covered under item 6. This will include cheque signing when not carried out at regular meetings.

9. Board members will not be compensated for attendance at community events unless representing the Chair of the Board of Health.

10. The quarterly financial report presented to the Board of Health will provide details of all expenses related to the activities of the Board of Health ~~the Board of Health's section of the report~~.

11. Meeting attendance by County representatives on the Board of Health will be forwarded to the County Clerk's office on a biannual basis.

Organizational
PROCEDURE

Section: Board of Health	**Number: 2-261**	**Title: Appointments, Provincial Representatives**
Approved by: Board of Health **Signature:** **Date** (YYYY-MM-DD)**:** 2013-09-11 **Housekeeping Revision** **Approved by:** **On** (YYYY-MM-DD)**:**		**Original Approved by the Board of Health** **On** (YYYY-MM-DD)**: 2011-09-14** **Revision** **Approved by:** Board of Health **On** (YYYY-MM-DD)**:** 2013-09-11 **Reviewed by:** Governance Committee **On** (YYYY-MM-DD)**:** 2013-08-30
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.

Objective:

To ensure that all provincial appointments to the Board of Health are dealt with in accordance with Board of Health by-laws, policies, and procedures.

Procedure:

1. Terms for all provincial appointments to the Board of Health are tracked by the Administrative Assistant to the Board of Health.

2. The Board Chair will be advised by the Administrative Assistant of terms that are due to end one year prior to the expiry of the appointment.

3. The Board Chair will contact the incumbent to discuss his/her intentions.

4. If the member wishes to renew their appointment, and the Board Chair is in agreement, the member must complete a Reappointment Information Form and provide it to the Administrative Assistant for submission to the Public Appointments Secretariat (PAS), as well as

to the Public Appointments Unit of the Ministry of Health and Long-Term Care, Corporate Management Branch.

5. If the member does not wish to renew their appointment, or if a vacancy is predicted, the Board of Health will conduct a needs assessment and determine priorities for representation.

6. The Board of Health will advertise locally. The Public Appointments Secretariat (PAS) also posts upcoming vacancies on their web site (http://www.pas.gov.on.ca/).

7. The Board of Health Governance Committee will interview and rank potential applicants.

8. The preferred candidate will be directed to apply through the PAS web site.

9. A letter will be sent by the Board Chair to the local Member of Provincial Parliament, with a copy to the Public Appointments Unit of the Ministry of Health and Long-Term Care, Corporate Management Branch, identifying and noting support of the preferred applicant.

Historical Record
Revisions:

Review:
Governance Committee, June 9, 2011

Governance Committee Work Plan (2016)

TASK	ACTION	COMMENTS
MAY 2, 2016		
2-20 Authority and Jurisdiction	For Review	
2-130 Appointment of an Auditor	For Review	
2-160 Execution of Documents	For Review	
2-211 Delegation of Authority	For Review	
Risk Management	Decision	Staff to identify current policies, propose new policies.
Board Members Skills Matrix	Review	Skills Matrix developed previously will be brought forward for review.
AUGUST 2, 2016		
2-100 Management of Property	For Review	
2-110 Banking and Finance	For Review	
2-180 Procurement of Goods and Services	For Review	
2-200 Duties and Responsibilities of the Board of Health	For Review	
2-284 Correspondence	For Review	

TASK	ACTION	COMMENTS
NOVEMBER 17, 2015		
2-90 Human Rights and Discrimination		
2-92 Workplace Harassment		
2-270 Conduct, Members of BOH		
2-400 Naming Rights		
Board Remuneration Review	Decision	Staff to recommend changes (if any) for 2016 Board remuneration
Board Leadership and Committee Selection	Decision	Committee to determine recommendations for Board leadership and Committee representation. Callout to occur on October 1.
Orientation/Education Needs for 2017; Board/Management Planning Session Discussion	Decision	

Other

MOH Performance Appraisal:

- Goal Setting with Board Chair – by April 30, 2016

- Completed Performance Appraisal (with feedback from internal stakeholders) – by October 31, 2016

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-340	**Title:** Medical Officer of Health Performance Appraisal
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2009-02-11**
Signature:		**Author:** Medical Officer of Health
Date (YYYY-MM-DD)**:** 2015-12-09		
Reference: Medical Officer of Health Performance Appraisal Form Performance Planner Form		

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POLICY

The Board of Health (BOH) facilitates performance by creating an environment where the Medical Officer of Health (MOH) and all employees of the Peterborough County-City Health Unit (PCCHU) achieve their best. A written appraisal system will be used to provide an objective and uniform way to evaluate employees on the job. It is a constructive process to build on strengths, correct weaknesses, and maximize performance.

1. The MOH's performance is to be appraised before the end of the probationary period, in order to recommend to the BOH appointment to regular appointment status, extension of probationary period, or termination of employment.

2. At the beginning and end of each year, the Board Chair will meet with the MOH to set and review an annual work plan which includes professional development goals.

3. The MOH's appraisal will be conducted by a committee of the BOH chaired by the Chair of the BOH every two (2) years.

4. This review is to be conducted by the current Chair, Vice Chair, and a past Chair of the Board, when possible.

5. The Board will incorporate feedback from internal stakeholders such as board of health members and staff as part of the 360° component every two (2) years. If relevant, the MOH may incorporate

any such processes from their professional college into this appraisal process.

6. External stakeholders will be approached for feedback by the Board at least every five (5) years and where appropriate.

7. As part of the performance appraisal, the MOH is responsible for completing a self-appraisal.

8. Formal performance appraisals do not take the place of ongoing evaluation and feedback. If the MOH's work is not adequate, the matter is to be dealt with while details and facts are fresh and will not wait for the formal review. The MOH's performance must return to the required standard within a specified time period or further action may be taken by the Board.

PROCEDURE

The Chair of the BOH will:

1. Meet with the MOH at the beginning and end of the Chair's term to review the annual work plan, which includes the setting of professional development goals.

2. Schedule the performance appraisal before the end of the probationary period and then at least every two (2) years, preferably around the MOH's anniversary date.

3. Convene a meeting with the immediate past Chair and the Vice Chair to review the required materials, confirm the process, and develop the timeline. This sub-committee can consult with any other persons they feel could provide relevant input to the performance appraisal, review the job description, operational plans, significant events and any other pertinent items from the period under review.

4. Work with the Secretary of the Board to organize the 360^{o} component of the appraisal. This would begin with a request to the MOH for a list of staff and external stakeholders, when warranted, who could be approached for potential feedback.

5. Conduct the interview. This part may require more than one meeting. Begin the process with the MOH's self-appraisal. Use the information collected from the various sources to grade each factor on the appraisal form, using the definitions included in the performance appraisal form and support the decision with comments and examples wherever possible. When weighing all of the feedback, genuinely consider the MOH's input and make changes/additions to the factor comments, examples and even grading where warranted.

6. Complete the Performance Appraisal Form. The appraisal should also include an assessment of performance relative to any learning or performance objectives set in the previous performance appraisal. In the Board's comments, clearly indicate whether the overall performance is satisfactory or not. For probationary MOHs indicate if probation has been completed satisfactorily.

7. Sign and date the Performance Appraisal Form and have the MOH do the same. The MOH's signature means that they have read and understood the review. Ensure that a signed version of the Confidentiality Agreement is received.

8. Provide the MOH a full copy of the completed Performance Appraisal Form. The Director of Operations is to retain the original including the self-appraisal in the MOH's personnel file.

9. Report back to the Board of Health annually, before the end of the first quarter of each year, on the completion of the MOH's previous year's performance planner and/or the performance appraisal, if conducted.

Review/Revisions

On (YYYY-MM-DD)**:** 2015-12-09 (Board; combined with procedure 2-341)
On (YYYY-MM-DD)**:** 2012-12-12 (Board)
On (YYYY-MM-DD)**:** 2012-11-26 (Governance)
On (YYYY-MM-DD)**:** 2010-11-10 (Board)
On (YYYY-MM-DD)**:** 2010-10-27 (By-Laws, Policies and Procedures Committee)

PCCHU MEDICAL OFFICER OF HEALTH PERFORMANCE APPRAISAL FORM

Name:	
Title:	**Medical Officer of Health**

This performance appraisal is due on:	

It reviews the performance for the period:			
From:		**To:**	

And sets objectives for the period:			
From:		**To:**	

The following <u>RATING SCALE</u> is used in this performance appraisal:	
Exceeds expectations	Performance consistently exceeds all expectations/standards. Accomplishments are clearly obvious.
Meets Expectations	Solid reliable performance that substantially meets expectations. In some instances, expectations are exceeded. In some instances, expectations are still being developed.
Partially Meets Expectations	Performance does not meet expectations in certain areas. Improvement in these areas is required. The rationale needs to be explored, goals re-negotiated and/or an action plan established.
Additional Growth Required	Performance associated with the job requires additional resources. An action plan is needed which may include, but not limited to, training, coaching or other support.
Not applicable (n/a)	The Board of Health is not able to rate this area at this time.

Append additional sheets / documentation where required/appropriate.

Provide the MOH with a full copy of the completed Performance Appraisal Form. The Director of Operations is to retain the original including the self-appraisal in the MOH's personnel file.

Program Excellence *– This area reflects on how the MOH has influenced the impact the HU has on: population health measures; the use of health status data; evidence-informed program decision making; delivery of mandated and locally needed public health services as measured by the accountability indicators*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Responds effectively to health hazards and provides effective control of communicable diseases under the Health Protection and Promotion Act (HPPA)					
• Champions coordinated approaches and engagement of clients and community partners in planning and evaluation of programs and services					
• Maintains statutory obligations through the delivery of mandated and locally needed public health services (OPHS)					
• Anticipates and plans for major trends in needs and services					
• Uses evidence-informed decision making in developing programs and services to meet community needs					
• Considers Health Equity in all program work					
• Ensures processes in place to regularly evaluate public health programs and services, seeking ways to improve efficiency and effectiveness					
Comments: (include major strengths in this area of focus and any areas that may need future development; include examples wherever possible, for the above rankings)					

Client and Community Impact – *This area reflects on the MOH's representation of the HU in the community*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Contributes to increasing community awareness about public health					
• Promotes productive relationships with the media and acts as a resource to the media regarding public health issues.					
• Promotes productive relationships, maintains regular communication and strong working partnerships with external stakeholders including Boards of Education, business, labour, government and media, health care providers, community organizations, citizen groups and the Ministry of Health					
• Seeks new and innovative ways to work with partners to advance mutual goals in the community.					
• Promotes excellence in customer service within the health unit. Responds quickly and efficiently to enquiries/complaints/issues from citizens/community groups. Exhibits tact and diplomacy in dealing with citizen/group complaints. Resolves complaints to citizen/groups' satisfaction whenever feasible. Provides helpful explanation where legislatively or otherwise constrained. Researches/facilitates appropriate contact when referral is necessary.					
Comments: (include major strengths in this area of focus and any areas that may need future development; include examples wherever possible, for the above rankings)					

Employee Engagement and Learning – *This area reflects on how the MOH has influenced the HU's organizational capacity, climate and culture and the contribution made to enabling engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Promotes a positive working environment. Advocates integrity, empowerment, collaboration and striving for excellence among staff. Sets a professional example for staff.					
• Allocates resources to maximize departmental and program effectiveness. Proposes revision to staff structure and numbers as necessary. Collaborates with the Management team on opportunities for sharing/reallocating existing staff/resources wherever possible. Explores alternatives such as cost-sharing/joint services with other agencies and/or contract services.					
• Provides adequate supervision and direction of direct-reporting staff. Includes working with them to identify and prioritize short and longer-term goals. Conducts meaningful performance reviews in a timely manner, and identifies their strengths and areas for development. Identifies and takes actions necessary to obtain improved performance where necessary. Recognizes and commends staff for outstanding work. Identifies and deals with performance concerns quickly and effectively by dealing with performance / communication / disciplinary issues in an appropriate manner.					
• Maintains effective communication with staff. Fosters a workplace climate conducive to open communication. Holds regular Management meetings. Institutes feedback mechanisms to gauge leadership effectiveness.					

Employee Engagement and Learning – *This area reflects on how the MOH has influenced the HU's organizational capacity, climate and culture and the contribution made to enabling engaged and empowered staff; thoughtful and responsive leadership and organizational structures that support decision-making, innovation and learning*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Identifies areas where staff training and development would be of benefit to the team and/or agency as a whole. Encourages staff commitment and ownership to upgrading and maintaining job related effectiveness. Promotes the view of training as a shared responsibility between staff and the health unit. Supports planning of short and long term departmental training and development initiatives.					
• Regularly evaluates corporate services, seeking ways to improve efficiency and effectiveness.					
• Exhibits excellent time management skills. Systematically organizes own time. Commits to and meets deadlines. Respects others' time. Is punctual for meetings.					
• Sets and achieves personal and professional development objectives.					
Comments: (include major strengths in this area of focus and any areas that may need future development; include examples wherever possible, for the above rankings)					

Governance – *This area reflects on how the MOH has influenced the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This area also reflects on the MOH's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Monitors overall HU financial situation demonstrating effective management of financial resources. Ensures transparency and understanding of financial processes and procedures.					
• Develops innovative approaches to financing and revenue generation. Devises strategies to protect HU assets.					
• Ensures agency compliance with the Ontario Public Health Organizational Standards.					
• Abides by employment and other relevant legislation including Employment Standards Act, Labour Relations Act, Occupational Health and Safety Act, Accessibility for Ontarians with Disabilities Act and the Human Rights Code. Adheres to terms of union and other contracts.					
• Develops and maintains HU by-laws, policies and procedures and ensures adherence within the health unit. Advises and consults with the BOH on significant matters.					
• Communicates regularly with the Chair of the Board and provides support in identifying agenda items for the BOH and Committee meetings.					
• Ensures adequate orientation and on-going education of BOH members.					

Governance – *This area reflects on how the MOH has influenced the alignment of management methods and systems to ensure appropriate structures and resources are in place to achieve the HU's mission and vision. This area also reflects on the MOH's responsibility for actions, decision and policies that impact the HUs ability to achieve the requirements as set out under the strategic plan, the Ontario Public Health Organizational Standards (OPHOS), other funder requirements and direction provided by the Board of Health*	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required	n/a
• Informs BOH of important developments affecting Public Health and the HU (e.g. legislative changes, public health emergencies, organizational problems, system development, environmental trends.) Makes recommendations as appropriate and includes financial analysis for recommendations.					
• Provides appropriate and timely written and verbal reports to the BOH. Writes and speaks clearly. Reports are easily understood by the BOH members.					
Comments: (include major strengths in this area of focus and any areas that may need future development; include examples wherever possible, for the above rankings)					

SUMMARY OF OVERALL PERFORMANCE

AREA OF FOCUS	Exceeds Expectations	Meets Expectations	Partially Meets Expectations	Additional Growth Required
Program Excellence				
Community and Client Impact				
Employee Engagement and Learning				
Governance				

Comments – (Including comments with respect to the major strengths of the MOH and areas for future development.)

GOALS FOR THE NEXT PERIOD – BY AREA OF FOCUS

Program Excellence	Key Performance Indicator

Client and Community Impact	Key Performance Indicator

Employee Engagement and Learning	Key Performance Indicator

Governance	Key Performance Indicator

Personal Development	Key Performance Indicator

Other	Key Performance Indicator

SIGNATURES

Medical Officer of Health

I discussed this performance appraisal with the Chair of the Board of Health.

I have participated in the setting of goals and targets for the next performance period, have reviewed my job responsibilities with the Chair of the Board of Health, and agree to the goals, targets and measurement standards noted above for the next performance period.

Comments

_____

_____

_____

_____ _____

Medical Officer of Health **Date**

For the Board of Health

We have discussed the performance appraisal with the Medical Officer of Health. We have reviewed the past period's work performance and goals and objectives, and have discussed goals and objectives for the coming performance period. We have also discussed professional development and training needs. The goals and objectives for the coming year have been established, including job responsibilities and measurement methods.

_____ _____

Chair, Board of Health **Date**

_____ _____

Vice Chair, Board of Health **Date**

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PERFORMANCE PLANNER *(for management use only)*

Employee Name: _____	**Date:** _____
Title: _____	
Directorate: _____	
Reporting to: Name _____	**Title:** _____
Review Period Covered:	

Objectives

- ☐ ***Develop objectives that are in line with the Strategic Direction of the Board of Health. Make sure your objectives are SMART specific, measurable, achievable, realistic, time specific/observable (Five objectives are considered to be a manageable number for most employees)***
- ☐ ***Write objectives that answer these questions: What will happen? By what date?***

Area of responsibility	Objectives At the start of the performance review period, develop objectives.	Achievements At the end of the annual review period, describe the achievements for each objective and any obstacles or challenges faced.
Community-Centred Focus		
Determinants of Health and Health Equity		

Area of responsibility	Objectives At the start of the performance review period, develop objectives.	Achievements At the end of the annual review period, describe the achievements for each objective and any obstacles or challenges faced.
Capacity and Infrastructure		
Quality and Performance		

If additional space is needed, please use the table provided below.

Area of responsibility	Objectives	Achievements

Professional Development Plan

- ***Describe the competencies needed to achieve objectives.***
- ***Include activities such as special assignments, courses, working with someone who has the skills that you need to develop, special projects……***

Competencies/skills to be developed	Development activities that took place

There are three categories for performance ratings: met objectives, developmental, did not meet objectives.

Please indicate overall performance rating:

☐ **Met Objectives**

☐ **Developmental**

☐ **Did not meet objectives**

Supervisor's comments (include signature and title)

Employee's comments (include signature and title)

Next steps:

Peterborough County-City Health Unit

This document reflects the general details considered necessary to describe the principle functions and duties as required for proper evaluation of the classification and shall not be construed as a detailed description of all the work requirements that may be inherent in the classification.

Classification:	**Medical Officer of Health**
Approved by:	**Board of Health** September 10, 2014
Directly responsible to:	Board of Health
Supervises:	Director~~ of Operations~~s Executive Assistant to the Medical Officer of Health
Provides functional direction and guidance to:	Communications Manager ~~Supervisor~~ Chief Nursing Officer

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Main Purpose

The Medical Officer of Health, is the Chief Executive Officer of the Health Unit and reports to the Board of Health on issues relating to public health, the implementation and management of programs and services under the Health Protection and Promotion Act and any other applicable Act, organizational structure, and the business operations of the Health Unit.

Duties and Responsibilities

1. **Recommends Health Unit structure to the Board of Health.**

2. **Ensures a process is in place for the development and communication of the Health Unit's vision, mission, and values.**

3. **Ensures the development, implementation, communication, review, and evaluation of a strategic plan.**

4. **Recommends appropriate and relevant Board of Health policies and positions.**

5. **Approves organizational policies and procedures.**

6. **Implements all mandatory and local public health programs as prescribed by the Health Protection and Promotion Act, the Ontario Public Health Standards and other programs or services as approved by the Board of Health.**

7. **Provides leadership and co-ordinates response to public health emergencies.**

8. **Identifies fiscal requirements and makes recommendations to the Board of Health.**

9. **Ensures appropriate, competent, adequate, and effective human resources.**

10. **Recruits and supervises the Director of Operations.**

11. **Prepares reports.**

12. **Ensures the appropriate management of property.**

13. **Attends and participates in meetings.**

14. **Establishes and maintains effective communication.**

15. **Enforces relevant Acts, Regulations, and By-laws.**

16. **Executes documents.**

17. **Provides orientation to the Health Unit, and education and training on issues relevant to public health and preventive medicine ~~community health~~.**

18. **Assumes responsibility for related duties as required or assigned by the Board of Health.**

19. **Ensures that a representative of the Health Unit is available to respond to telephone calls placed to the Health Unit outside of regular business hours.**

20. **Exchanges information with members of the Board of Health, Directors, Managers, Health Unit staff, municipal and provincial staff, elected and appointed officials, the public, clients, representatives of other organizations, Health Unit staff, physicians, lawyers, representatives of the media, and service providers for the purpose of completing assigned tasks.**

21. **Ensures back-up coverage for position and provides back-up coverage for other Medical Officers of Health.**

Job Requirements

Formal Education

1. Licensed to practice medicine by the College of Physicians and Surgeons of Ontario.

2. A fellowship in Public Health and Preventive Medicine ~~Community Medicine~~ from the Royal College of Physicians and Surgeons of Canada OR a certificate, diploma, or degree from a university in Canada that is granted after not less than one academic year of full-time post graduate studies or its equivalent in public health comprising:
   i) epidemiology;
   ii) quantitative methods;
   iii) management and administration;
   iv) disease prevention and health promotion; or

   a qualification from a university outside Canada that is considered by the Minister of Health and Long-Term Care to be equivalent to the qualifications se out above.

   ~~Section 2 does not apply to a Medical Officer of Health or Associate Medical Officer of Health who was employed by a Board of Health on the 1st day of July, 1984.~~

Skills

1. Strong leadership, management, team building, and supervisory skills.
2. Strong communication (oral and written), interpersonal, and customer service skills.
3. Strong planning, organizing, multi-tasking, analytical, and problem-solving skills.
4. Strong initiative, dependability, creativity, and attention to quality of work skills and abilities.

Other

1. Current member of the Ontario Medical Association and the Council of Medical Officers of Health.
2. Access to transportation.

NB: The Medical Officer of Health is responsible for obtaining and maintaining coverage through the *Canadian Medical Protective Association* (CMPA) or equivalent.

Physical/Mental/Visual Demands

Must be capable of:

1. concentrating intensely daily for periods up to two hours;
2. meeting strict or multiple deadlines daily;

3. managing conflicting daily demands on time; and
4. driving an automobile weekly for periods up to two hours, monthly for periods up to three hours.

Working Conditions

1. Exposed to normal daily office environment.
2. Exposed to situations monthly that require stringent safety measures to prevent illness or injury.
3. Exposed to angry, upset, weekly or hostile individuals.
4. Can be called in to work 24 hours a day 7 days a week.
5. Drives an automobile bi-weekly.
6. Works overtime weekly.

Consequence of Errors

Physical injury, illness, or death to many individuals.
Permanent or temporary environmental damage.
Embarrassment to the organization and loss of goodwill and trust.
Potential litigation.
Significant financial loss.
Errors would be detected outside of the Health Unit.

The Baby Friendly Initiative

Dawn Hanes

Public Health Nurse, Child Health

Peterborough County-City HEALTH UNIT
...because health matters!

Why Breastfeeding?

For Babies

- Fewer infections
- Decreased obesity and diabetes
- Less SIDS
- Less dental malocclusion
- Enhanced cognitive function

For Mothers

- Less cardiovascular disease
- Less diabetes
- Less breast cancer
- Less ovarian cancer
- Enhanced self-efficacy
- Healthier children

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Social Determinants of Health

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The "WHO Code"

Formula marketing is restricted in these ways:

- No advertising or promotion to the general public;
- No free samples to pregnant women or new mothers;
- No promotion through the health care system, (free supplies or samples);
- No gifts or personal samples for health care workers;
- No financial support from the industry to health professionals.

***The WHO Code is not legislated in** Canada, however as a Baby-Friendly organization the PCCHU adheres to the Code.*

Baby Friendly Initiative

- Breastfeeding → Child Health
- 10 Steps
- World Health Organization & UNICEF

- Accountability Agreements

Breastfeeding Committee for Canada
Comité canadien pour l'allaitement

Peterborough County-City HEALTH UNIT
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Step 1
Have a written breastfeeding policy that is routinely communicated to all staff.

Step 2
Train all health care providers in the skills necessary to implement the policy.

Step 3
Inform pregnant women and their families about the importance and process of breastfeeding.

Step 4
Place babies in uninterrupted skin-to-skin contact with their mothers immediately following birth for at least an hour or until completion of the first feeding or as long as the mother wishes.

Step 5
Assist mothers to breastfeeding and maintain lactation should they face challenges including separation from their infants.

Step 6
Support mothers to exclusively breastfeed for the first six months, unless supplements are medically indicated.

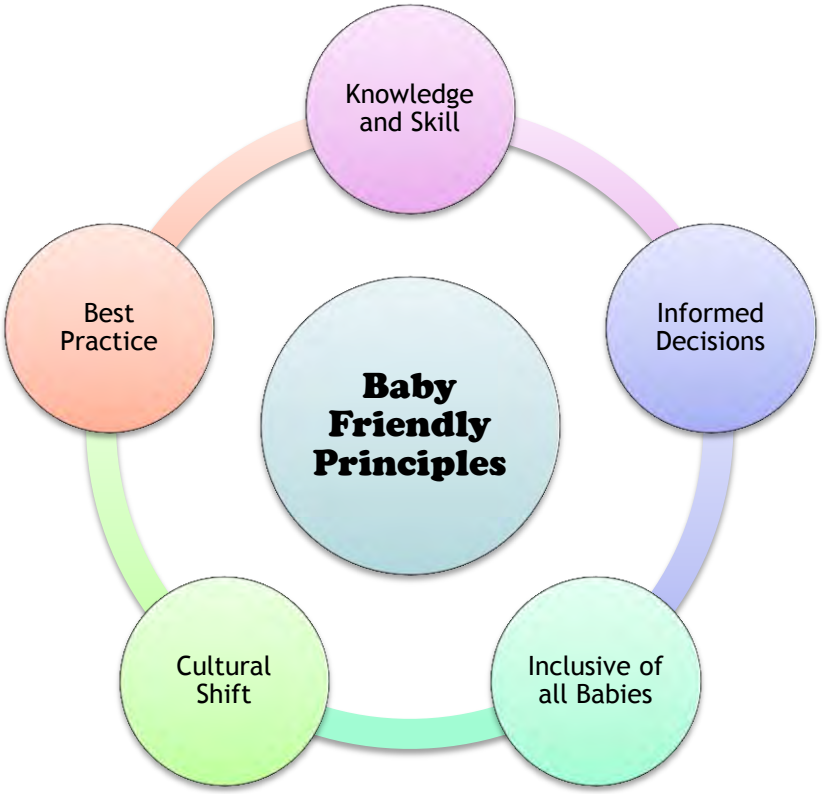
Step 7
Facilitate 24-hour rooming-in for all mother-infant dyads: mothers and infants stay together.

Step 8
Encourage baby-led or cue-based breastfeeding.
Encourage sustained breastfeeding beyond six months with appropriate introduction of complementary foods.

Step 9
Support mothers to feed and care for their breastfeeding babies without the use of artificial teats or pacifiers (dummies or soothers).

Step 10
Provide a seamless transition between the services provided by the hospital, community health services and peer support programs.

Comply with the International Code of Marketing of Breastmilk Substitutes.



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 PCCHU Communications Manager or refer to the meeting summary issued shortly thereafter. Final motions are recorded in posted approved Minutes.

Our Breastfeeding Policy & Procedure

All employees, students, and volunteers are expected to:

- ✓ understand the breastfeeding policy;
- ✓ provide a welcoming environment;
- ✓ accommodate a woman's right to breastfeed in public and in the workplace;
- ✓ address questions or concerns about breastfeeding by providing information about the benefits of breastfeeding and the importance of supportive environments;
- ✓ know that the "WHO Code" on the Marketing of Breastmilk Substitutes protects families against commercial pressure to use formula; and
- ✓ refer families experiencing breastfeeding challenges to the Family HEALTH*line* at 705-743-1000.

Peterborough County-City HEALTH UNIT
...because health matters!

Referral:

- Family **HEALTH*line***
- 705-743-1000
- Child Health PHNs

A welcoming atmosphere

- Signs welcoming women
- Private locations
- Policy
- **Supportive attitude**

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…Key Points…

- ✓ Mothers are welcome to breastfeed in any public areas of the Health Unit. Private areas are available at each Health Unit site if the mother prefers.
- ✓ Families with questions or concerns about feeding their baby can be referred to the Family **HEALTH*line.***
- ✓ Creating a welcoming environment for breastfeeding by supporting breastfeeding in public, providing help with challenges, and enabling working mothers to continue to breastfeed will reduce barriers and help make breastfeeding a cultural norm.