Board of Health for
Peterborough Public Health
AGENDA
Board of Health Meeting
Wednesday, September 14, 2016 – 5:30 p.m.
Dr. J. K. Edwards Board Room, 3rd Floor
Jackson Square, 185 King Street, Peterborough

1. **Call to Order**

   1.1. **Opening Statement**
   Scott McDonald, Chair

   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.

   1.2. **Membership Update**
   Scott McDonald, Chair

   1.3. **Staff Introduction – Dale Bolton, Manager, Finance**
   Larry Stinson, Director of Operations

2. **Confirmation of the Agenda**

3. **Declaration of Pecuniary Interest**

4. **Delegations and Presentations**

   4.1. **Kawartha Truth and Reconciliation Support Group Quilt**
   Marilyn Tudhope

5. **Confirmation of the Minutes of the Previous Meeting**

   5.1. **June 8, 2014** p. 4

6. **Business Arising From the Minutes**

7. **Staff Reports**

7.1. **Presentation: Developing and Testing of Indicators to Guide Health Equity Work in Public Health** p. 10
Dr. Rosana Salvaterra, Medical Officer of Health
Reference: *Individual Indicator by Role Details* p. 26

7.2. **Presentation: Environmental Burden of Cancer in Ontario** p.48
Dr. Rosana Salvaterra, Medical Officer of Health
Reference: *Full Report* ***(web hyperlink)***

7.3. **Presentation: Development of New Vision and Mission – 2018-22 Strategic Plan Pre-Work**
Sarah Tanner, Manager, Oral Health, Facilities & Quality Improvement

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 8.2c 8.3a 8.3b 8.3c

8.1. **Correspondence**

a. **Correspondence for Direction** p. 53

b. **Correspondence for Information** p. 91

8.2. **Staff Reports**

a. **Staff Report: Q2 2016 Public Health Programs Report** p. 181
Patti Fitzgerald, Assistant Director, Chief Nursing & Privacy Officer

b. **Staff Report: Q2 2016 Corporate Services Report** p. 183
Larry Stinson, Director of Operations

c. **Staff Report: Toward the Legalization, Regulation and Restriction of Access to Marijuana: Submission to Federal Task Force** p. 191
Hallie Atter, Manager, Community Health & Foundational Standards

8.3. **Committee Reports**

a. **First Nations Committee** p. 229
Dr. Rosana Salvaterra, Medical Officer of Health

b. **Fundraising Committee** p. 236
Kerri Davies, Chair, Governance Committee

c. **Governance Committee** p. 240
Gregory Connolley, Chair, Governance Committee

9. New Business

9.1. **Association of Municipalities of Ontario Conference – Oral Update**
Councillor Lesley Parnell
Reference: *Briefing Note* p. 258

9.2. **Board Member Skills Matrix Inventory** p. 262
Dr. Rosana Salvaterra, Medical Officer of Health

10. In Camera to Discuss Confidential Matters *(Nil)*

11. Motions for Open Session

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

Date: October 12, 2016
Time: 5:30 p.m.
Location: Lower Hall, Administration Building, 123 Paudash St., Hiawatha First Nation
(Tentative)

13. Adjournment

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

Board of Health for the
Peterborough Public Health
DRAFT MINUTES
Board of Health Meeting
Wednesday, June 8, 2016 – 5:30 p.m.
Curve Lake Community Centre
20 Whetung Street East, Curve Lake First Nation

In Attendance:

Board Members:	**Mr. Scott McDonald, Chair**
	Mayor Mary Smith, Vice Chair
	Deputy Mayor John Fallis
	Ms. Kerri Davies
	Councillor Henry Clarke
	Councillor Gary Baldwin
	Mayor Rick Woodcock (5:50 p.m.)
	Councillor Lesley Parnell
Staff:	**Mr. Larry Stinson, Director of Operations**
	Ms. Natalie Garnett, Recorder
	Dr. Rosana Salvaterra, Medical Officer of Health
	Ms. Alida Tanna, Executive Assistant
	Patti Fitzgerald, Assistant Director, Chief Nursing and Privacy Officer
Regrets:	**Chief Phyllis Williams**
	Mr. Andy Sharpe
	Mr. Gregory Connolley
	Councillor Art Vowles

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1. Call to Order

Mr. McDonald, Chair, called the meeting to order at 5:45 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved as circulated.
Moved: Councillor Clarke
Seconded: Mayor Smith
Motion carried. (M-2016-075)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

4.1. Presentation: Curve Lake Water Treatment

Ken Jacobs, General Manager at Curve Lake First Nation, provided a presentation on water treatment issues.

MOTION:
That the presentation on Curve Lake Water Treatment be received for information.
Moved: Councillor Parnell
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-076)

MOTION:
That a letter supporting the request for a central water treatment system for Curve Lake First Nation be sent to the MP Monsef and MPP Leal.
Moved: Deputy Mayor Fallis
Seconded: Councillor Clarke
Motion carried. (M-2016-077)

5. Confirmation of the Minutes of the Previous Meeting

5.1. May 4, 2016

MOTION:
That the minutes of the Board of Health for the Peterborough Public Health meeting held on May 4, 2016, be approved as circulated.
Moved: Councillor Clarke
Seconded: Councillor Baldwin
Motion carried. (M-2016-078)

6. Business Arising From the Minutes

7. Staff Reports

7.1. Presentation: A Day in the Life – Environmental Health Manager

Atul Jain, Manager, Environmental Health provided a presentation on "A Day in the Life – Environmental Health Manager".

MOTION:
That the Staff Presentation "A Day in the Life – Environmental Health Manager" be received for information.

Moved: Councillor Baldwin
Seconded: Mayor Smith
Motion carried. (M-2016-079)

8. Consent Items

MOTION:
That items 8.1a(1), 8.1b, 8.2c, 8.2d and 8.2e, be approved as part of the Consent Agenda.
Moved: Ms. Davies
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-080)

MOTION:
That the Board of Health for the Peterborough Public Health:
- *Receive the letter dated April 29, 2016 from the Association of Local Public Health Agencies (alPHa) regarding 2016-2017 membership fees for approval; and,*
- *Approve the 2016-2017 fee in the amount of $10,065.46*

Moved: Ms. Davies
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-080)

MOTION:
That the following documents be received for information:
- *E-newsletter dated May 2, 2016 from the Association of Local Public Health Agencies (alPHa).*
- *Email dated May 6, 2016 from Premier Wynne to Board of Health Chairs regarding community hubs.*
- *E-newsletter dated June 1, 2016 from alPHa*
- *Letter dated June 2, 2016 from the Board Chair and Medical Officer of Health to the Hon. Eric Hoskins, Minister of Health and Long-Term Care regarding Patients First.*
- *Letter dated June 3, 2016 from alPHa providing a summary of Bill 210, The Patients First Act.*
- *Letters/Resolutions from other local public health agencies:*

Cannabis – Legalization/Public Health Approach
Elgin St. Thomas
Herpes Zoster Vaccine
Algoma
Nutritious Food Basket
Lambton
Patients First
Middlesex London

Smoking and Vaping Laws

Middlesex London

Moved: Ms. Davies
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-080)

MOTION:

That the Board of Health for the Peterborough Public Health:

- *receive the staff report, "Vision, Mission and Values", for information; and*
- *approve the framework for action proposed by staff.*

Moved: Ms. Davies
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-080)

MOTION:

That the Board of Health for Peterborough Public Health approve the 2015/2016 Preschool Speech and Language Program Audited Financial Statements.

Moved: Ms. Davies
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-080)

MOTION:

That the Board of Health for Peterborough Public Health:

- *Approve the 2015/2016 Infant and Toddler Development Program Audited Financial Statements in the amount of $242,823; and,*
- *approve the 2015/2016 Infant and Toddler Development Program Annual Program Expenditure Reconciliation.*

Moved: Ms. Davies
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-080)

MOTION:

That the Board of Health for the Peterborough Public Health:

- *Receive correspondence from Porcupine Health Unit regarding their request to require community water fluoridation for all municipal water systems as well as funding and technical support to municipalities for implementation;*
- *Endorse the resolution; and*
- *Communicate this support to Minister Hoskins, local MPPs, the Association of Local Public Health Agencies, and Ontario Boards of Health.*

Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-081)

MOTION:
That the Board of Health for the Peterborough Public Health:

- *receive correspondence from Middlesex-London Board of Health regarding their endorsement of a letter and background document from Toronto Public Health on supporting the Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act,*
- *endorse the letter and document put forward by Dr. David McKeown, Medical Officer of Health, Toronto Public Health, with an additional comment regarding ensuring that the language in the proposed act provides protection for workers involved with temporary agencies and other forms of precarious employment;*
- *communicate this support to MPP Peggy Sattler, with copies to Premier Wynne, MPP Andrea Horwath, MPP Patrick Brown, Hon. Kevin Flynn (Minister of Labour), Hon. Eric Hoskins (Minister of Health and Long-Term Care), Hon. Tracy MacCharles (Minister Responsible for Women's Issues), local MPPs, the Association of Local Public Health Agencies, and Ontario Board of Health.*

Moved: Deputy Mayor Fallis
Seconded: Mayor Smith
Motion carried. (M-2016-082)

MOTION:
That the Board of Health for Peterborough Public Health receive the staff report, Update on Smoke-Free Multi-Unit Housing in the Peterborough Area, for information.
Moved: Councillor Baldwin
Seconded: Mayor Smith
Motion carried. (M-2016-083)

MOTION:
That the Board of Health for Peterborough Public Health receive the Child Health Services 2015/2016: 3. In Summary: Parenting Practices, for information.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-084)

MOTION:
That the Board of Health for Peterborough Public Health:

- *receive for information, meeting minutes of the Governance Committee for March 15, 2016.*

- *Approve changes to: 2-130 By-Law 4, Appointment of an Auditor; 2-160 By-Law 7, Execution of Documents; 2-211 Delegation of Authority; 2-348 Governance Committee Terms of Reference; and*

- *That no further changes be made to 2-20 Authority and Jurisdiction.*

Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-085)

9. New Business

9.1. Oral Report: Association of Local Public Health Agencies – 2016 Conference and Annual General Meeting

Dr. Salvaterra, Medical Officer of Health provided an update on the 2016 alPHa conference and AGM.

MOTION:
That the Board of Health for Peterborough Public Health receive the Oral Report: alPHa Conference and Annual General Meeting, for information.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-086)

10. In Camera to Discuss Confidential Matters

11. Motions from In Camera for Open Session

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

The next meeting will be held September 14, 2016 in the Dr. J.K.Edwards Board Room, 185 King Street, 5:30 p.m.

13. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Councillor Baldwin
Seconded by: Councillor Parnell
Motion carried. (M-2016-087)

The meeting was adjourned at 7:10 p.m.

Chairperson

Medical Officer of Health

Development and Testing of Indicators to Guide Health Equity Work in Public Health

Locally Driven Collaborative Project Team (Health Equity Indicators): Dr. Rosana Salvaterra (PI, Peterborough), Dr. Suzanne Lemieux (Sudbury), K Moran (Durham), D Antonello & J Robson (Algoma), C Wai (Toronto), Dr. A. Kothari & Dr. Marlene Janzen Le Ber (London/Western University), Dr. B. Cohen (University of Manitoba), Katherine Salter (Research Assistant/Western University), Tannisha Lambert (Administrative Assistant).

Acknowledgements

- This research was supported with funding from Public Health Ontario's Locally Driven Collaborative Project (LDCP).
- We acknowledge and appreciate the contributions of time and insight from key experts in the field as well as all participating public health units.

Disclaimer:

- The views expressed in this report are those of the research team and do not necessarily reflect those of Public Health Ontario.

Equity in Public Health

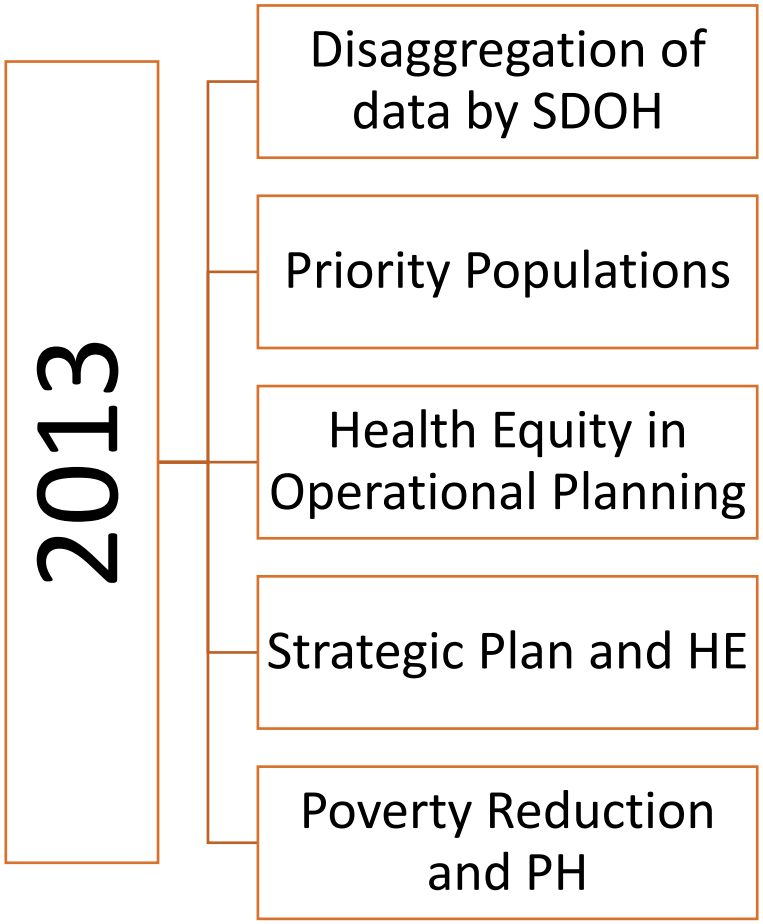
- *Ontario Public Health Standards* (OPHS, 2008) and *Ontario Public Health Organizational Standards* (OPHOS, 2011)

- Boards of health required to have a strategic plan and ensure that, within it, they describe how equity issues will be addressed in the delivery and outcomes of programs and services

However….

- **Lack of standards that *clearly define* the health equity mandate for local PH agencies**

Project Foundations



Research Proposal: Summary

Overall Objective:

- To provide local boards of health with a rigorously tested and comprehensive set of indicators that is relevant to their work to address health inequity as required by OPHS and OPHOS. The indicators will be feasible for application at the local level where boards are active and accountable.

Summary of Phase 1

Scoping review/synthesis of the literature

- Few validated indicators were identified

Consultation with key experts (N=13)

- Identified issues around measurement, appropriateness, gaps, relevance to the ‘roles’

Core set of indicators identified

- developed indicators based on evidence from literature and information from experts; classified into public health roles

Public Health Roles

Assess and Report

Modify and Orient

Partner with other Sectors

Participate in Policy Development

Organizational and Systems Development

Organizational and system development address the policies, structures, procedures and practices of an organization (or system) that need to be in place to address inequities and manage the required change.

Phase 2: Exploratory, multiple case study

Table 1. Description of test sites

Pilot Test Site	Governance	Peer Group
Site 1	Regional council acts as the board	A (urbal/rural mix)
Site 2	Autonomous board	C (sparsely populated urban/rural mix)
Site 3	Autonomous board	E (mainly rural)
Site 4	Semi-autonomous board	G (metro centre)

Phase 2: Summary

- Data collection took place over a 16-week period
  - 2 rounds of data collection at test sites (concurrent)
  - 3 telephone focus groups that included data collectors from all test site

- Sites completed indicators + a worksheet that addressed feasibility, understandability and relevance + participated in focus groups

Facilitators

The importance of organizational commitment:

- *"There was a lot of push to be a part of this and to learn how we can improve".*
- *"We have strong leadership support for this…prioritizing this work".*
- *"If there is a desire to get it done then you can make it happen"*

It was noted by all of the test sites that commitment was essential to a successful data collection process –

Barriers

- Availability of data
  - "*Not being able to access the right data at the right time*", "*struggling to have enough sources of data that focus specifically on priority and vulnerable populations*" and "*we can't get local data on neighbourhoods*"
- Perceived quality of data sources, especially local data for smaller agencies
  - *"Sample size for us is going to be a constraint because it will be very difficult for our populations to be stratified"; "it wasn't a public health resource, so our epis questioned it"*
- Time and resource capacity
  - "*we don't have the people or the time to put toward this the way that we'd like to"*

Application

- Highlighted a need for a strong, organizational approach to health equity activities
- Prompt for future planning
- Helped participants to think about doing things differently
- Emphasized need for internal communication

HEALTH EQUITY INDICATORS
FOR ONTARIO LOCAL PUBLIC HEALTH AGENCIES

USER GUIDE | APRIL 2016

User Guide Overview

- Purpose and Preamble
- “How to” page
- 5 Sections, align with public health roles, plus 1
    - Role 1 - Assess and Report
    - Role 2 - Modify/Orient
    - Role 3 - Engage in Community and Multi-Sectoral Collaboration
    - Role 4 - Lead/Participate and Support
    - Role 5 - Organization and System Development
- Each section - explanation of the role, followed by background/rationale
- Glossary, References, Worksheets

Recommendations

- Use the indicators (User Guide and Worksheets) as a self-assessment tool and to document and share experiences
- Create a centralized repository where Local Public Health Agencies could access the materials
- Conduct further evaluation of the indicators reliability and validity

Thank-you!

Questions?

Development and Testing of Indicators to Guide Health Equity Work in Public Health

Locally Driven Collaborative Project Team (Health Equity Indicators): Dr. Rosana Salvaterra (PI, Peterborough), Dr. Suzanne Lemieux (Sudbury), K Moran (Durham), D Antonello & J Robson (Algoma), C Wai (Toronto), Dr. A. Kothari & Dr. Marlene Janzen Le Ber (London/Western University), Dr. B. Cohen (University of Manitoba), Katherine Salter (Research Assistant/Western University), Tannisha Lambert (Administrative Assistant).

Presentation of Individual Indicators: By Role

Role 1

Assessing and reporting on health status and what could be done to improve it:

- Using data collection methods to ensure the needs of marginalized and priority populations are identified
- Engaging the community to seek meaning and understanding of the findings
- Providing results to foster community discussion, problem solving and action

ROLE 1 INDICATORS: Indicator 1

- Does your board of health conduct routine data analysis of health outcomes of public health importance stratified by demographic and socioeconomic variables? (yes/no)

- Complete 3 checklists --
  - How frequently?
  - Please check each variable for which information is included and stratified (as appropriate)
  - Please check which health outcomes of interest are explored

ROLE 1 INDICATORS: Indicator 2

- Does your Board of Health identify and plan for priority populations that have experienced (or are at risk for experiencing) health inequities?

- If yes, what is the process
  - 3 follow-up questions that are intended to identify the type of process and definition for priority population used within your health unit via a series of ‘tick box’ responses.

ROLE 1 INDICATORS: Indicator 3

- In addition to surveys, are community members from priority populations who are experiencing (or who are at risk for experiencing) health inequities involved in data collection activities (e.g. using community asset mapping, photovoice, digital storytelling, walking audits, focus group, or other methods)? (yes/no)
    - If yes, please provide examples.

ROLE 1 INDICATORS: Indicator 4

- Is there a written plan in place for the dissemination of your board of health reports to the community? (yes/no)

- Are there specific plans to include dissemination to identified priority populations that have experienced health inequities? (yes/no)

- Please list the strategies used by your board of health to disseminate information to priority populations that have experienced health inequities.

Role 2

Modify/re-orient public health programs:

- Requires an understanding of needs among populations, which itself requires engagement with community
- Requires an understanding of existing services available in the community, which requires engagement with other providers

ROLE 2 INDICATORS: Indicator 1

- In the past 12 months, has your Board of Health assessed cultural competencies in programs/services provided to priority populations experiencing health inequities? (yes/no)
- If yes, in what proportion of these programs/services was there an assessment of cultural competence conducted?
  - What form did your assessment take? Please describe.
  - Did the assessment include an evaluation of participant perception of cultural safety? (yes/no)
  - (if yes) Please provide an example of the evaluation or assessment used to assess cultural safety from the client perspective
- Do program plans incorporate the information gathered from cultural competence assessments? (please provide an example)

ROLE 2 INDICATORS: Indicator 2

- Does your Board of Health employ a mechanism to ensure that operational planning includes a health equity assessment of programs and services provided by the health unit? (yes/no)
  - Does the Board of Health provide a standardized health equity assessment tool for staff to assess programs and services? (yes/no)
    - If yes, please provide a list of tools used.
  - Have any Board of Health programs or services been modified as the result of a health equity assessment? (yes/no)
    - If yes, please list and describe

ROLE 2 INDICATORS: Indicator 3

- Please indicate (and describe where possible) in which of the following ways members of priority populations experiencing health inequities have participated in the development and delivery of Board of Health programs and services (checklist provided)

Role 3

Engage in community and multi-sectoral collaboration in addressing the health needs of these populations through services and programs:

- Requires an understanding of needs among populations, as well as services from other providers
- Requires collaboration with other service providers to prioritize gaps and identify steps to address them

ROLE 3 INDICATORS: Indicator 1

- Does your Board of Health have a community engagement strategy? (yes/no)
- If so, does this strategy include or address priority populations experiencing health inequities? (yes/no)
- If yes, please elaborate.

ROLE 3 INDICATORS: Indicator 2

- Does your board of health establish and participate in collaborative partnerships and/or coalitions to address health equity and social determinants of health issues? (yes/no)
- Please identify with which partners active partnerships or coalitions have been formed: (checklists are provided for potential partners in both the health and non-health sectors)
- Please add partners who may not appear among those listed.

Role 4

Lead/support/participate with others to address policies:

- Requires community and multi-sectoral collaboration
- Supporting community and other stakeholders in policy advocacy participate and support.

ROLE 4 INDICATORS: Indicator 1

- How many position and policy statements, produced by the Board of Health (over the past year), reflect advocacy for priority populations experiencing health inequities?

ROLE 4 INDICATORS: Indicator 2

- Please indicate in which SDoH area(s) public health unit staff have been engaged in cross-sectoral advocacy for policy development:
    - Checklist provided for response
    - SDoHs are those listed in the document entitled "Social Determinants of Health: The Canadian Facts " (Mikkonen and Raphael, 2010)

Role 5

Organizational and system development -- addressing the policies, structures, procedures and practice of an organization (or system) to be in place to address inequities and managing the required change

One of the additional suggested 'roles' meant to foster achievement of the four public health roles to address health determinants to reduce inequities

ROLE 5 INDICATORS: Indicator 1

- Does the Board of Health's (BOH) strategic plan describe how equity issues will be addressed? (yes/no)
  - If yes, please explain.
- What time period (in years) does the current strategic plan cover? Please provide dates.
- Does the strategic plan include outcome targets? (yes/no)
  - If yes, please explain.

ROLE 5 INDICATORS: Indicator 2

- Does the Board of Health have a human resource strategy in place to consider the workforce diversity (e.g. by age, gender, race/ethnicity, disability, Indigenous/ Aboriginal identity) within the public health unit? (yes/no)
  - If yes, please describe.
  - How does this distribution compare to the overall population diversity of your geographic catchment?

ROLE 5 INDICATORS: Indicator 3

- Does your Board of Health provide health equity training to all staff? (yes/no)
  - If no, what proportion of staff receive training?
  - Does the training include… (check all that apply) *(Note: There is a matrix provided to clarify what training is provided to which staff)*

- Does your Board of Health conduct evaluations of health equity training efforts? (yes/no)
  - If yes, please describe your evaluation process.
  - How frequently are evaluations conducted?

ROLE 5 INDICATORS: Indicator 4

- Do performance appraisals for your public health unit staff require health equity goals? (yes/no)
  - *If no, what other mechanisms are being used to reflect or appraise staff member's health equity goals? (please describe)*
- Do performance appraisals for your public health unit management require health equity goals? (yes/no)
  - *If no, what other mechanisms are being used to reflect or appraise management's health equity goals? (please describe)*

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Presentation: Environmental Burden of Cancer in Ontario (2016)**

Date: September 14, 2016

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive the presentation, Environmental Burden of Cancer in Ontario (2016), for information.

The Environmental Burden of Cancer in Ontario was released in August 2016 and represents the first attempt to quantify and characterize the risk of cancer from our environmental exposures. The purpose of this report is to highlight the relative importance of environmental carcinogens for the population's health. It excludes exposures from hobby or occupational exposures and specific exposures like the high dietary consumption of caught fish that would occur in First Nations communities.

The report used two different modelling techniques to estimate that 4-8% of cancers in Ontario are due to environmental exposures. Of these, the top three carcinogens are solar radiation, radon and particulate emissions, including diesel. A policy approach to reduce exposures could include a health equity approach, as this was not factored into the estimates of burden. Board of Health members received the report as correspondence for the September meeting. Dr. Salvaterra will highlight the major findings and implications for healthy public policy at the municipal and First Nation level.

Attachment: Presentation, Environmental Burden of Cancer in Ontario (2016)

ENVIRONMENTAL BURDEN OF CANCER IN ONTARIO

HOW ARE WE EXPOSED TO CANCER-CAUSING AGENTS IN OUR DAY-TO-DAY ENVIRONMENT?

We're exposed to cancer-causing agents in three main ways:

1. being in the sun
2. the air we breathe
3. what we eat and drink

Radiation

Inhalation

Indoor and outdoor air

Ingestion

Food, drinking water and indoor dust

Ontario Cancer Care Ontario

Public Health Ontario | Santé publique Ontario

PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

Learn more by visiting:
CancerCare.on.ca/EnvironmentReport
PublicHealthOntario.ca/EnvironmentalCancer

ENVIRONMENTAL BURDEN OF CANCER IN ONTARIO

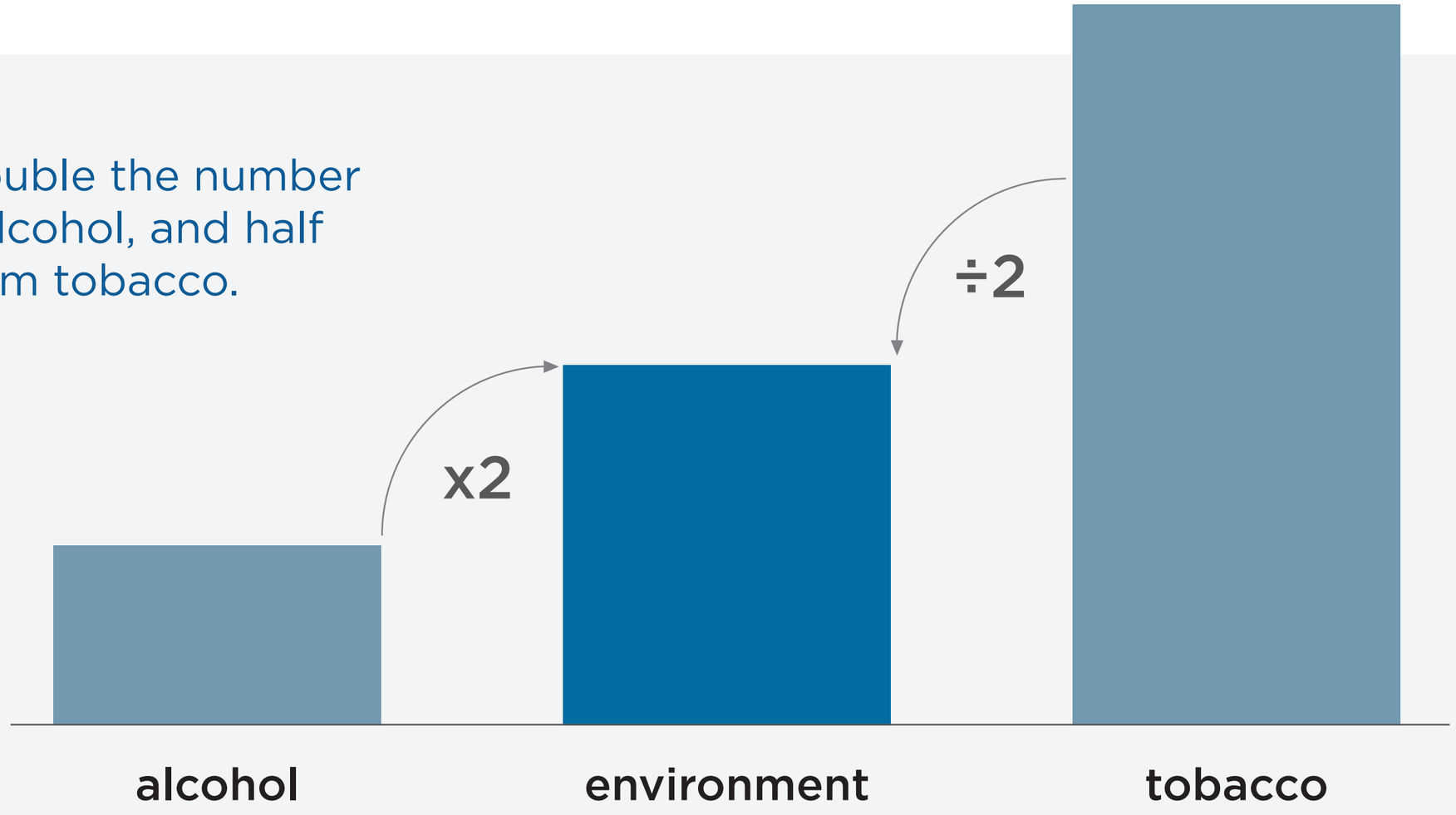
HOW MANY CANCER CASES ARE ENVIRONMENTAL AGENTS ASSOCIATED WITH?

Between:

3,540 and 6,510

new cases every year

That's about double the number from drinking alcohol, and half of the cases from tobacco.



Ontario Cancer Care Ontario

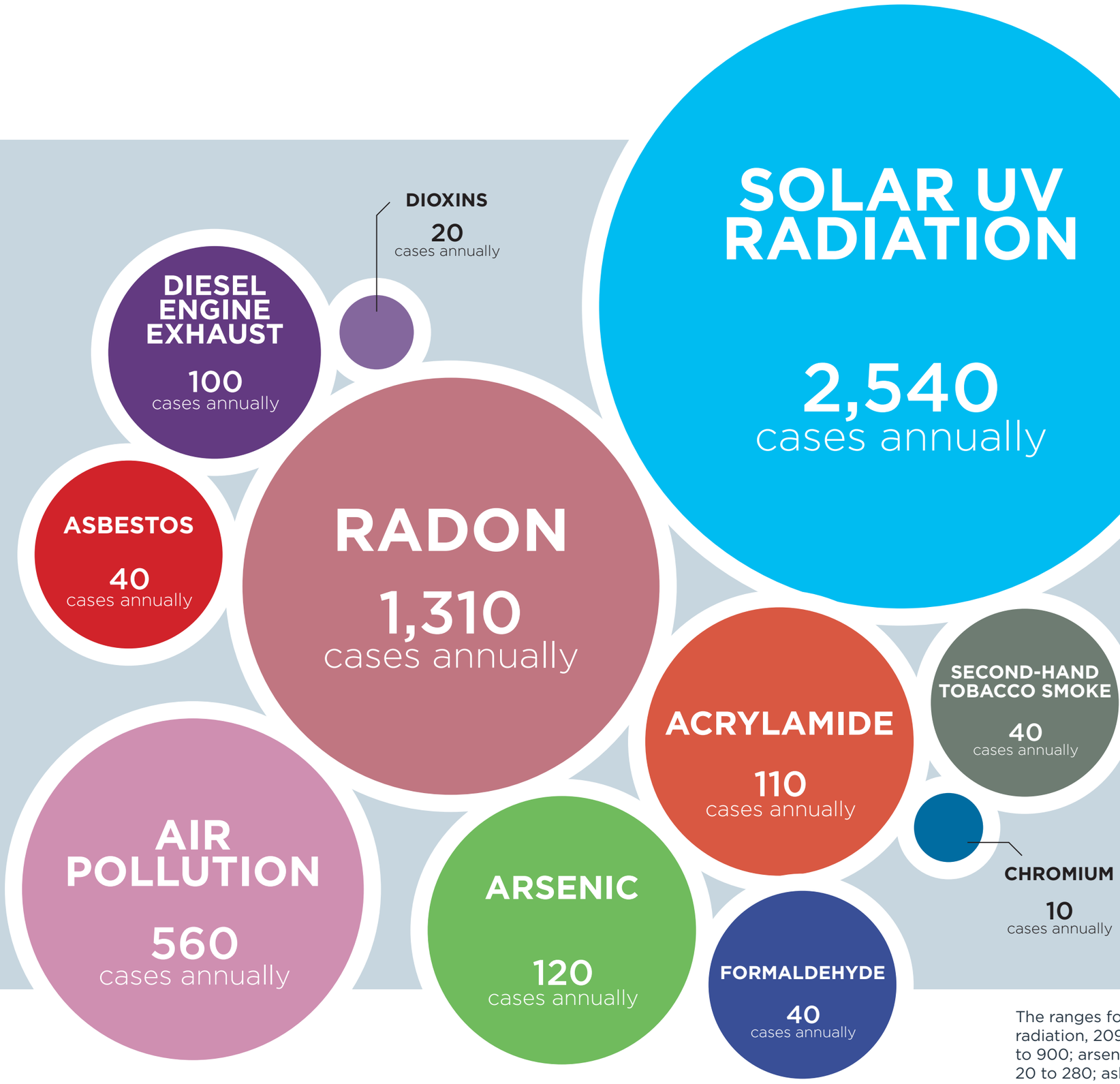
Public Health Ontario | Santé publique Ontario

PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

Learn more by visiting:
CancerCare.on.ca/EnvironmentReport
PublicHealthOntario.ca/EnvironmentalCancer

ENVIRONMENTAL BURDEN OF CANCER IN ONTARIO

WHAT ARE THE MOST IMPORTANT CONTRIBUTORS TO CANCER IN OUR ENVIRONMENT?



The ranges for the estimated annual cancer cases are: solar UV radiation, 2090 to 2990; radon, 1080 to 1550; air pollution ($PM_{2.5}$), 290 to 900; arsenic, 20 to 370; acrylamide, 10 to 320; diesel engine exhaust, 20 to 280; asbestos, 0 to 130; formaldehyde, 10 to 100; second-hand tobacco smoke, 20 to 50; dioxin, 10 to 50; and chromium, 0 to 20.

Ontario Cancer Care Ontario

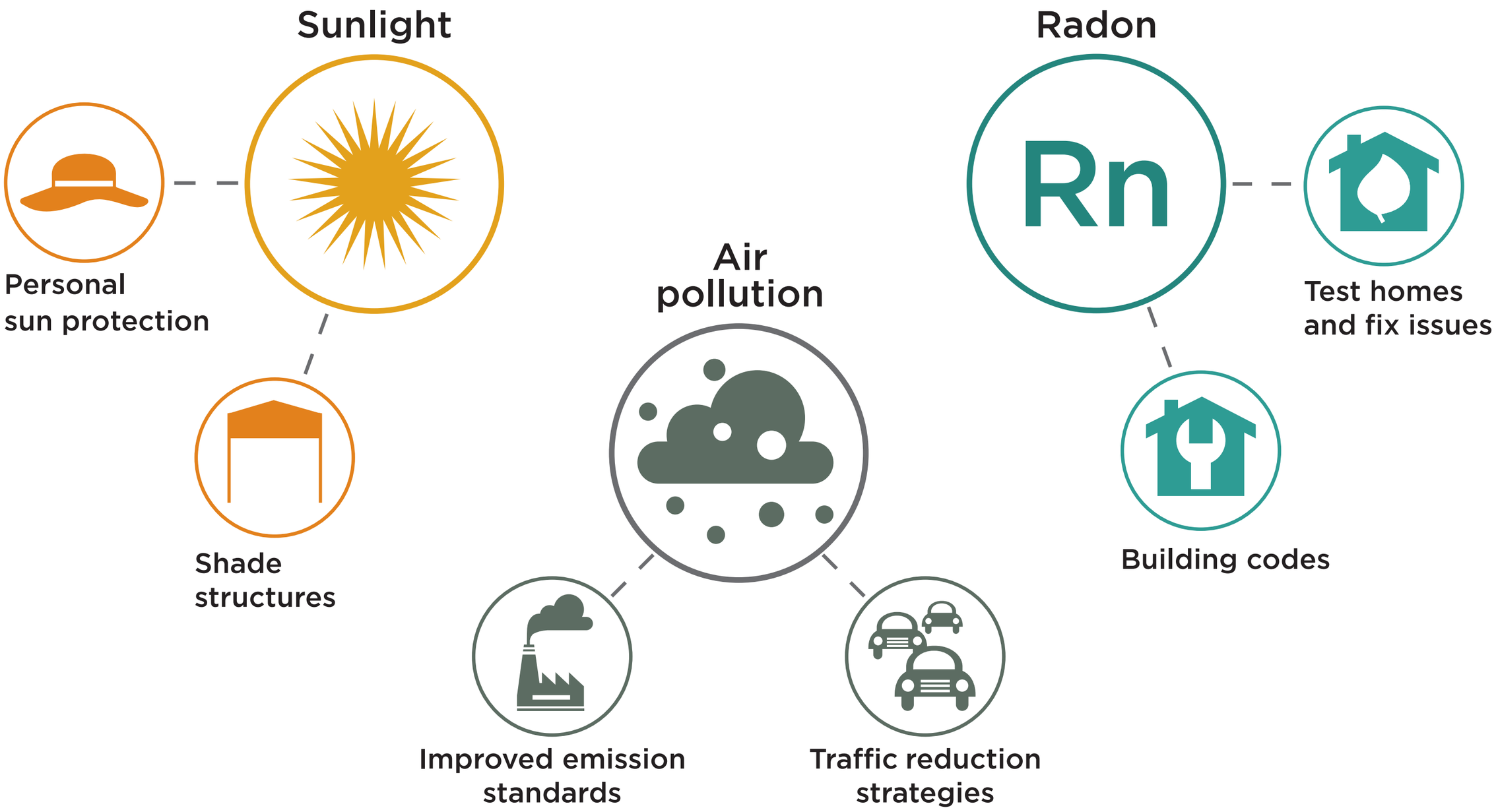
Public Health Ontario | Santé publique Ontario
PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

Learn more by visiting:
CancerCare.on.ca/EnvironmentReport
PublicHealthOntario.ca/EnvironmentalCancer

ENVIRONMENTAL BURDEN OF CANCER IN ONTARIO

HOW DO WE REDUCE THE RISK?

We can work together to **reduce exposure** in our environment:



Learn more by visiting:
CancerCare.on.ca/EnvironmentReport
PublicHealthOntario.ca/EnvironmentalCancer

To: **All Members**
Board of Health

From: **Dr. Rosana Salvaterra, Medical Officer of Health**

Subject: **Correspondence for Direction**

Date: **September 14, 2016**

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1. Letter dated May 31, 2016 from Algoma Public Health to Minister Hoskins regarding changes to the Human papillomavirus vaccine (HPV) program. p. 56

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive the correspondence dated May 31, 2016 from Algoma Public Health regarding changes to the Human papillomavirus vaccine (HPV) program;*
- *endorse the resolution calling on the Province of Ontario to increase annual funding for the Vaccine Preventable Disease program in order to provide the staff resources to meet the newly expanded mandate; and,*
- *communicate this support to the Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care, with copies to the Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Executive Director, Ministry of Health and Long-Term Care, local MPPs, the Ontario Chief Medical Officer of Health, the Association of Local Public Health Agencies, and Ontario Boards of Health.*

Rationale:
Staff recommends the endorsement of Algoma HPV Immunization Program Resolution and writing the Minister of Health and Long-Term Care to express our concerns. It is recommended to share additional context regarding funding arrangements for immunization programs. Since immunization programs, such as HPV, are funded on a per dose delivered basis, it is important that this rate reflects real costs. The current fee for HPV immunization is $8.50 per dose. Based on calculations of real costs for supplies, needle disposal, nursing and clerical staff time, our cost is approximately $14.25 per dose. As immunization programs expand, this differential leads to erosion of our ability to deliver other public health programs.

2. Letter dated May 2, 2016 from Thunder Bay District Health Unit regarding food security and a universal hot meal program. p. 87

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive correspondence from Thunder Bay District Health Unit regarding food security and a*

universal hot meal program;

- *endorse the report and request calling for the Province of Ontario to develop and implement a universal hot meal program in elementary and secondary schools;*
- *further request for enhanced funding to better reflect program costs for existing universal student nutrition programs in elementary and secondary schools across the province; and*
- *communicate this support to the Hon. Mitzie Hunter, Minister of Education and the Hon. Helena Jaczek, Minister of Community and Social Services, with copies to local MPPs, the Ontario Chief Medical Officer of Health, the Association of Local Public Health Agencies, and Ontario Boards of Health.*

Rationale:

The Thunder Bay District Health Unit report, Food Security in the District of Thunder Bay, aligns with a staff report to the Peterborough Public Health (PPH) Board of Health on February 13, 2013 entitled Student Nutrition Programs: Best Practices, Actions for Sustainability and Call to Action. The Board endorsed this report as well as the vision of universal Student Nutrition Programs (SNP), delivered locally by Food For Kids Peterborough and County, ensuring that all local students can achieve the positive health, learning and behavioural outcomes that result from this key nutrition strategy and sound public policy. At that time, the Board of Health sent advocacy letters to the provincial Ministers of Children and Youth Services, Health and Long-term Care requesting further financial support for existing SNP.

Food For Kids Peterborough and County continually advocate for adequate funding for nutritious and locally grown foods in their programs. Currently, 85% of food program costs, including the purchase vegetables and fruit, whole grains and milk, yoghurt and cheese, comes from community donations. In Peterborough County and City, there are currently 49 Student Nutrition Programs within 51 publicly funded elementary and secondary schools. Both the 2013 PPH Staff report and Thunder Bay District Health Unit report notes that currently, Canada remains one of the few G8 countries that does not provide federal funding to SNP.

3. Letters dated:

a. June 2, 2016 from Grey Bruce Health Unit; and p. 87

b. May 9, 2016 from Niagara Region; p. 89

regarding Lyme disease.

Proposed Recommendation:

That the Board of Health for Peterborough Public Health:

- *receive correspondence from Grey Bruce Health Unit (GBHU) and Niagara regarding Lyme Disease;*
- *endorse the resolutions put forward by GBHU and Niagara calling for:*
- *the Government of Canada to increase funding for research aimed to enhance the testing for Lyme disease and determine better treatment for long term outcomes of Lyme disease;*
- *the Province of Ontario to:*
    - *increase funding for research aimed to enhance the testing for Lyme disease;*

- *increase funding to enhance environmental surveillance for the tick;*
- *monitor the pattern of spread of the tick and the rate of tick infection in various areas of the province;*
- *develop control measures for the tick; and,*
- *increase the education to the population regarding personal protection, property management, testing and treatment.*

- *communicate this support to the Hon. Jane Philpott, Minister of Health, and the Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care, with copies to the Hon. Kathleen Wynne, Premier of Ontario, local MPs and MPPs, the Ontario Chief Medical Officer of Health, the Association of Local Public Health Agencies, and Ontario Boards of Health.*

Rationale:
Staff recommends that the board support the two motions related to Lyme disease. In the past few years, Lyme disease (LD) has surpassed West Nile virus as the predominant vector-borne disease of concern in the province of Ontario. As seen in the table below, here in Peterborough County and City, we have seen an increase in the number of tick submissions since 2010 with a corresponding increase in ticks that are tested positive for LD. The Province recently announced a new ten-step plan to increase awareness about LD.

Since the current financial and human resources to continue with the increased public consultations on tick submissions, and adapting the provincial campaign tailored to local needs are inadequate, funding needs to be enhanced for Peterborough Public Health and other local public health agencies in Ontario for vector borne disease prevention.

Year	Total # of tick submissions	# of positive ticks
2010	1	0
2011	12	0
2012	16	0
2013	42	1*
2014	60	2*
2015	73	7*

*Note: Only 3/10 positive ticks were locally acquired (Havelock, North Havelock and Jackson's Park).

Algoma
PUBLIC HEALTH
Santé publique Algoma

www.algomapublichealth.com

May 31, 2016

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

Dear Minister Hoskins:

RE: Changes to the HPV Immunization Progra.

At its meeting on May 25, 2016, The Board of Health for the District of Algoma Health Unit carried the following resolution #2016-50.

WHEREAS Ontario is expanding the publicly funded human papillomavirus (HPV) vaccination program to include boys in Grade 7; and

WHEREAS Algoma Public Health supports the immunization of boys to help prevent the spread of HPV and prevent cancer; and

WHEREAS the HPV vaccine will continue to be provided to girls in Grade 8 for the transition year until all grade 7 students receive the vaccination; and

WHEREAS the Ministry estimates about 154,000 students will be eligible to receive the vaccine each year; and

WHEREAS APH, similar to other PHUs, plans to deliver the vaccination program over the course of three school visits in order to avoid giving more than two doses of vaccine per student per visit, which will increase the number of school clinics by approximately 33% (previously two visits per year); and

WHEREAS the Ministry of Health and Long-Term Care's (MOHLTC) Immunization 2020 Strategy strives to "reduce health risks related to vaccine-preventable diseases in the province"; and

WHEREAS the MOHLTC has not increased funding to the Vaccine Preventable Disease (VPD) program despite adding responsibilities and new vaccines to the program.

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

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

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

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

THEREFORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health commends the Ministry of Health and Long- Term Care for its commitment to expand its HPV vaccination program to young males who are starting grade 7 this September; and

FURTHERMORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health urges the MOHLTC to consider increasing the annual funding for the VPD program in order to provide the staff resources to meet the above mandate.

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, Executive Director, Ministry 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 Medical Officers of Health, and Ontario Boards of Health, and member municipalities.

Sincerely,

Lee Mason
Board of Health Chair

cc: The Honourable Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Roselle Martino, Executive Director, Ministry of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
The Association of Local Public Health Agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member municipalities.

Thunder Bay District
Health Unit

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

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

MANITOUWADGE
1-888-294-6630

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

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

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

TBDHU.COM

May 19, 2016

VIA ELECTRONIC MAIL

Thunder Bay DSSAB
231 May Street South
Thunder Bay, ON P7E 1B5

Attn: Mr. William Bradica
Chief Administrative Officer

Re: Food Security in the District of Thunder Bay

At the regular meeting of May 18, 2016, the Board of Health for the Thunder Bay District Health Unit considered the attached "Report Number 29-2016 (Healthy Living) TBDSSAB Position Paper: Food Security in the District of Thunder Bay" providing information on the TBDSSAB's position that a universal hot meal program should be implemented in Ontario elementary and secondary schools. The following motion was passed:

> "THAT with respect to Report No. 29-2016 (Healthy Living), we recommend endorsement of the TBDSSAB Position Paper: Food Security in the District of Thunder Bay; as presented,
>
> AND THAT we circulate this endorsement to the Association of Local Public Health Agencies (alPHa) for distribution to all Ontario Public Health Units."

It is the Board's hope that this endorsement will add support to the calls for changes to current government policy in addressing food insecurity.

Sincerely,

Original signed by

Joe Virdiramo, Chair
Board of Health for the Thunder Bay District Health Unit

Encl. 2

cc. Association of Local Public Health Agencies
Ontario Boards of Health

Thunder Bay District Health Unit

PROGRAM/ DIVISION	Healthy Living Health Promotion	***REPORT NO.***	29 - 2016
MEETING DATE	May 18, 2016	***MEETING TYPE***	Regular
SUBJECT	TBDSSAB Position Paper: Food Security in the District of Thunder Bay		

RECOMMENDATION

FOR INFORMATION ONLY

REPORT SUMMARY

To provide the Board of Health with information relative to the request to endorse the TBDSSAB Position Paper: Food Security in the District of Thunder Bay.

BACKGROUND

The Thunder Bay District Health Unit is mandated to reduce the burden of preventable chronic diseases of public health importance. The health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions.

Addressing these determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. A key determinant of health is income and related household food security (Public Health Agency of Canada).

Addressing Food Insecurity

It is important that everyone has consistent access to safe, affordable, and nutritious food to promote health and prevent chronic disease. Addressing food insecurity at the individual, household and community levels requires a multifaceted approach; one that calls upon changes to current government public policy and that targets the barriers faced by our most vulnerable populations, as well as addressing the food system as a whole.

Emergency Food in the District of Thunder Bay

Charitable food programs such as food banks, soup kitchens and meal programs provide short-term relief and are only part of a comprehensive strategy needed to fully address food insecurity. They have many limitations related to the quantity and quality of the food provided and do not address the root causes of food insecurity. The Regional Food Distribution Association (RFDA) serves approximately 3,447 people per month through its 38 member food banks and

meal programs in Northwestern Ontario, with an average of 9000 meals being served at 7 emergency daily meal programs every month.

As outlined in the TBDSSAB Position Paper, it is very difficult to ascertain the specific number of unique individuals served by the emergency food system. It should be noted, however, that research shows only 25% of the food insecure population are accessing food banks, making this statistic a serious underestimate of food insecurity in our community.

School Nutrition Programs in the District of Thunder Bay

Student Nutrition Programs have been recommended as an important part of a comprehensive food and nutrition strategy and a key component of health-promoting schools. They help to provide healthy food to children and have shown effective outcomes for short-term relief of food insecurity.

Research has established that proper nutrition, particularly during the morning hours, plays an important role in supporting learning. However, studies have shown that 31% of elementary students and 62% of secondary students in Canada do not eat a healthy breakfast before school. There are a number of reasons why children may start their day without breakfast including lengthy commutes, busy family routines, lack of hunger when first waking and lack of availability of food due to poverty.

Participation in student nutrition programs is associated with positive educational outcomes including improved academic performance, reduced tardiness and improved student behaviour. Recent studies from northern Ontario and British Columbia found that students who participated in a school food program reported higher intakes of fruits and vegetables and lower intakes of non-nutritious foods. Student Nutrition Programs are an opportunity to establish life-long healthy eating habits beyond participation in the program.

Canada remains one of the few industrialized countries without a federally-funded, universal school meal program. The Healthy Kids Panel Report, released in 2012, also includes a recommendation for a universal school nutrition program for all publicly-funded schools, as part of an overall strategy for promoting the health and well-being of children and youth in Ontario.

In Thunder Bay there are 81 school meal and snack programs offered throughout the District, with funding from the Ministry of Children and Youth Services, administered locally through the Red Cross. This funding only covers up to 15% of total costs for the programs. It is up to individual programs to make up the remainder through other fund-raising, in-kind and volunteer contributions. Health Unit staff support these programs by assisting in providing menu suggestions and safe food handling information.

FINANCIAL IMPLICATIONS

None.

STAFFING IMPLICATIONS

None.

CONCLUSION

A universal hot meal program in elementary and secondary schools across the province would make a significant contribution to household and community food security, complementing other policies and programs to comprehensively address the issue.

LIST OF ATTACHMENTS

None.

PREPARED BY: Catherine Schwartz Mendez, Public Health Nutritionist

THIS REPORT RESPECTFULLY SUBMITTED BY: ***DATE:***

Lynda Roberts, Director – Health Promotion May 11, 2016

Chief Executive Officer Medical Officer of Health

	REPORT NO.: **2016-19**
MEETING DATE: **MARCH 24, 2016**	***DATE PREPARED:*** FEBRUARY 16, 2016
SUBJECT: **FOOD SECURITY IN THE DISTRICT OF THUNDER BAY**	

RECOMMENDATION

THAT with respect to Report No. 2016-19, we, The District of Thunder Bay Social Services Administration Board (the Board), approve the Position Paper: Food Security in the District of Thunder Bay, as presented;

AND THAT with respect to Report No. 2016-19, we, the Board, encourage the Ontario Government through their respective responsible Ministers, including the Ministry of Education and The Ministry of Community and Social Services, to develop and implement a universal, hot meal program in elementary and secondary schools;

AND THAT the Regional Food Distribution Association (RFDA) develop and implement a data collection plan that will, minimally, monitor food bank usage in terms of numbers of unique individuals served, client demographics, and amount of food distributed on a monthly basis;

AND THAT we direct Administration to circulate this Position Paper and resolution to Hon. Liz Sandals, Minister of Education, Hon. Helena Jaczek, Minister of Community and Social Services, Hon. Deborah Matthews, Minister responsible for the Poverty Reduction Strategy, Hon. Michael Gravelle, MPP, Hon. Bill Mauro, MPP, Thunder Bay District Health Unit, all Thunder District School Boards and the Regional Food Distribution Association.

REPORT SUMMARY

To provide The District of Thunder Bay Social Services Administration Board (TBDSSAB or the Board) with information on Food Security in the District of Thunder Bay, and the need for a universal, hot meal program in elementary and secondary schools.

BACKGROUND

In the fall of 2014, the TBDSSAB Board Chair attended a meeting in Kakabeka regarding the local food bank. The Chair brought back information to the Board regarding the Rural Cupboard Food Bank's request for funds to build a new building.

This was discussed at the September 24, 2014 Board meeting and a request was made of Administration to review the food resources within the District and complete a report.

COMMENTS: FOOD SECURITY, FOOD BANKS AND SCHOOL NUTRITION PROGRAMS

There are many ways in which to obtain food in the District of Thunder Bay. Most often food is purchased at a retail location including a Grocery Store. Other sources include community cooperatives, pop up markets, good food box, community gardens and gleaning. As drug stores are often situated in many neighborhoods, and rural communities, they are fast becoming a normal source for purchasing food as well.

In addition to the types of food sources listed above, there are sources that have a specifically targeted user group. An example of this is the School Nutrition Program (SNP) run through the Canadian Red Cross and is available in some but not all schools across the District. Where the program is offered it has universal access to safe and nutritious food, and is locally designed. Red Cross has partnered with Ministry of Child and Youth Services as its main funder for the SNP.

Universal access means that all children enrolled in the school have access to the program regardless of the family's ability to pay. The program is designed to be non-stigmatizing. The foods and beverages are purchased by the school or are donated and are compliant with the Ministry of Educations Nutrition Guidelines. The program encourages community volunteering and local fundraising.

Although there is the SNP at some schools in the District, children often go hungry on the weekend without the support provided. A national program called Blessings in a Backpack has begun services in a few Thunder Bay schools. The backpacks are filled with nutritious food that children take home on the weekend to ensure they are fed. The backpack is brought back to the school on Monday to be refilled for the following weekend. This service is available at Ogden Community, McKellar and Sherbrook Public Schools. See attachment #4 for a list of the schools receiving funding from Red Cross for student nutrition programs within the Thunder Bay District.

The TBDSSAB supports this Canadian Red Cross initiative through the Community Social Reinvestment Program (CSRP). In 2016 the Board approved a recommended amount of $18,000.

Another source of food that is "targeted" are Food Banks, however, most food banks are open to the public at large. A **food bank** is a non-profit, charitable organization that distributes food to those who have difficulty purchasing enough food to avoid hunger.[1] Warehouse models are most often used in North America. They are storage and distribution "depots" used to supply smaller front line agencies. Outside of North America, a front line model is used in which all operations deal directly with the front end user of the service. In the Thunder Bay District there is a hybrid of both models employed. The warehouse is the Regional Food Distribution Association (RFDA). There are also many front line models such as local food banks and soup kitchens.[2]

Food Banks in the District of Thunder Bay

Food Banks and Emergency Food Sources in the District of Thunder Bay are available in Oliver Paipoonge, the City of Thunder Bay, Dorion, Red Rock and Nipigon, Geraldton, Longlac, Schreiber and Terrace Bay, Marathon and Manitouwadge.

The Regional Food Distribution Association of Northwestern Ontario has a mandate to create a reliable and accountable emergency food delivery system

[1] https://en.wikipedia.org/wiki/Food_bank
[2] https://en.wikipedia.org/wiki/Food_bank

throughout the region and coordinate collective efforts of stakeholders to meet needs and provide information on programs to better serve the community.

The RFDA receives shipments of food from the National Food Share System through their membership in the Ontario Association of Food Banks (OAFB). Since their first shipment in January of 2005, the RFDA has received approximately 110,000 lbs. of food valued at approximately $220,000. The OAFB membership also gives RFDA access to producer donated foods such as milk, bacon, canned/ processed foods, etc. Local gardeners and other food producers also donate food products in season.
http://www.readperiodicals.com/201403/3330434591.html#ixzz40Mh6rMQR

The TBDSSAB supports the RFDA through the CSRP. In 2016 the Board approved a recommended amount of $70,000.00. See attachment #5 for a list of the 39 partners in the District of Thunder Bay to whom food supplies are provided by the RFDA.

The CSRP offers eligible program applicants financial support for initiatives within the District of Thunder Bay that reduce the depth and breadth of child poverty. Many of these involve core food security issues, and the funding of school food programs.

The Regional Food Distribution Association and The Canadian Red Cross have been identified as two major partners in the District food availability chain. For programs associated with these agencies, it has been identified that the funding from RFDA and Red Cross is not enough to cover the expense of running a food security program. The CSRP often is called upon to support the purchase of perishable vegetable and fruit items and infant necessities of life. Many of these items need to be purchased within the local community due to the perishable nature and immediate child need.

RECOMMENDATIONS AND RATIONALE

As a result of this review of food security and the work of the Thunder Bay District Health Unit (TBDHU-as referenced), Administration recommends the following two recommendations that are put forth in the attached position paper.

1) Given the immediate and long-term impacts of food security on children, it is recommended that the Ontario Ministry of Education implement a universal, hot meal program in elementary and secondary schools. Based on available information, it appears that children in Thunder Bay and surrounding areas are increasingly vulnerable in the domains studied through the Early Developmental Instrument (EDI). Aside from the nutritional benefits, a universally applied hot meal program would limit stigma associated with means testing or self-identification as low income,

and such a program would also help to increase the disposable incomes of families that are on a fixed budget.

2) While broader social trends indicate the strong likelihood of an increase in food insecurity in the District of Thunder Bay, at present time there is insufficient data with which to adequately determine the needs, monitor the trends, or track progress in the area of addressing food security issues. Given that reliable data is necessary for making good, evidence-based decisions and policies, it is recommended that the Regional Food Distribution Association of Northwestern Ontario – as the central hub for charitable food distribution in the District of Thunder Bay – develop and implement a data collection plan that will, minimally, monitor food bank usage in terms of numbers of unique individuals served, client demographics, and amount of food distributed on a monthly basis. The use of free software for this purpose, such as the Homeless Individuals and Families Information System (HIFIS) – as utilized by a growing number of food banks across Ontario – could be employed to help get a better sense of the needs of those using the food bank system.

FINANCIAL IMPLICATIONS

There are no financial implications related to this report.

REFERENCE MATERIALS ATTACHED

Attachment #1: Pamphlet - Where to get Food in Thunder Bay
Attachment #2: List - Food Banks in the District of Thunder Bay
Attachment #3: Food Security Information Report TBDHU
Attachment #4: List - Red Cross Funded Student Nutrition Programs
Attachment #5: List - RFDA Food Partners
Attachment #6: Position Paper – Food Security in the District of Thunder Bay

PREPARED BY:	Jennifer Lible, Manager, Client Services, Client Services Division Saku Pinta, Senior Social Policy Analyst, CAO's Office The District of Thunder Bay Social Services Administration Board
APPROVED / SIGNATURE:	
	Lori Roulston, Director – Client Services Division The District of Thunder Bay Social Services Administration Board
SUBMITTED / SIGNATURE:	
	William (Bill) Bradica, Chief Administrative Officer The District of Thunder Bay Social Services Administration Board

Grocery Delivery

George's Market - 14 Balsam Street, 345 - 7021

- Call in grocery order any time for pick up or same day delivery
- Call for current delivery pricing
- Every Wednesday is Seniors' Day
- Personal service
- Pay by cash, Visa, Mastercard and Amex

Westfort Foods Inc. - 111 Frederica Street, 623-4220

- Delivery to residents South of the Harbourview Expressway: Mondays, Wednesdays and Friday's
- Delivery to residents North of the Harbourview: Tuesday's and Thursday's
- Minimum $30 purchase
- Delivery charges apply
- Deliveries made after 3:00pm
- Phone in orders by 1:30 p.m
- Method of payment: Cash, Mastercard, Visa, Debit
- No deliveries on weekends

Food for Seniors

Senior Lunch A Month
NorWest Community Health Centres
Thunder Bay Site - 525 Simpson Street
622-8235

- Soup & sandwich lunch on last Monday of each month
- Call to register, transportation is available

Thunder Bay 55+ Centre - 700 River Street, 684-2795

- For people 55 and over
- Hot lunches served Monday - Friday, 11:30 a.m. - 1:30 p.m.
- Soup and Sandwiches 8:30am—3:30pm
- Price: $6.75 for main dish
- Takeout available; pick-up only

Our Kids Count Older Adult Kitchen Program
704 McKenzie Street, 623-0292

- Cook and take home healthy meals
- Runs Monday mornings, call to register

Meal Delivery

Meals on Wheels
Southward - 625-3667 Northward 684-2862

- Meals include soup, main plate and dessert
- Cost: $7.25 per meal for eligible customers
- **Delivery between 10:30 a.m. and 12:30 p.m. by qualified volunteers**
- Call to apply, not available on weekends

George's Market - 14 Balsam Street, 345 - 7021

- Daily lunch specials, choice of dinners
- Call for pick up, same day delivery or more information

Blue Door Bistro - 116 S. Syndicate 623-5001

- Frozen meal delivery
- Call for more information

Stretching Your Food Dollars

Community Gardens

- Garden plots for people to grow their own vegetables and lower their food costs.
- Call TBDHU for more details, 625-5956

Community Kitchens

- Small groups of people who get together to cook healthy, economical meals to take home to their families.
- Call TBDHU for more details, 625-5956

Gleaning

- Provides transportation to local farms to pick crops for free after the main harvest.
- Call TBDHU for more details, 625-5956

Good Food Box

- A program for people who want to buy quality, fresh, local produce at a lower price than shopping at the grocery store, delivered to their neighborhood.
- Call 345-7819 for more details

For more information on programs and services, call the Community Information and Referral Centre: 211

Produced by the
Thunder Bay Food Action Network
with support from the
Thunder Bay District Health Unit.

To download a copy go to:
http://www.nwofood.com

Where to get Food in Thunder Bay

A List of Food Programs and Food Banks

food action network

N-137 Nov. 2015

Emergency Food Programs

Southward

Thunder Bay Food Bank
129 Miles Street E., 626-9231

- **Open Tuesday and Friday 9:00 - 11:00 a.m.** (except the first Tuesday and Friday of every month)
- Limit once a month, must bring ID for self and children, with current address.

Family Giving Centre c/o St. Thomas Anglican Church
1400 S. Edward Street, 623-3608
Email: stthomasfgc@gmail.com

- Open to Westfort residents and individuals and families living in close proximity of Westfort
- Must show ID
- Please phone ahead before coming
- **Open two Fridays per month 10:30 - 11:30 a.m. with a free community lunch 11:00—12:30 on those days**

Redwood Park Opportunities Centre
532 N. Edward Street, 577-3463

- **Open every Thursday 12:30 - 2:30 p.m.**
- Closed the week of New Year's
- Only Northwood and County Park residents
- I.D. required
- Limit once per month, pick-up only
- Call for more details

St. Vincent de Paul Society South Ward Branch
1019 Brown Street, St. Agnes Church, 577-3464

- Must live in the South Ward
- Limit once every 2 months
- **Hampers distributed from 9:00am—10:30 am Fridays**
- Proper ID with current address must be shown

The Losier Centre
920 Sprague St. Thunder Bay Methodist Church
622-7686

- Food available on an emergency basis only
- **Open Wednesday 9:00 - 11:00 a.m.**
- Closed during July and August and on holidays

The Gathering Place
299 W. Amelia St., 623-8184

- **Hampers available on Tuesdays between 12:30—2:30 p.m.**
- Limit once a month
- Must show ID

Northward

Elevate NWO
574 Memorial Avenue, 345-1516

- For clients only
- **Phone for details.**
- Available on Wednesday's

St. Vincent de Paul Society North Ward Branch
664 Red River Road Corpus Christi Church, 344-4898

- **Wednesday by walk-in from 1:00 p.m. - 3:00 p.m.**
- Available to North Ward families with children only, does not include Current River residents
- Must show ID for entire family with current address
- Limit 6 visits / year

Current River Churches Food Cupboard
360 Blackbay Rd. (Elim Community Church), 344-3391

- **Open every Tuesday from 9:30 a.m. to 11:30 a.m.**
- For residents from Current River Ward, Lakeshore Drive, Pass Lake, and Shuniah Township
- Requires proof of current residence
- Can be used once every two weeks

Salvation Army Community & Family Services
545 N. Cumberland Street, 344-7300

- **Hampers by appointment only**
- Appointments must be made a week in advance
- Limit once a month, must show ID, income and expense information

Students

Lakehead University Food Bank 343-8850 or 343-8259

- **Open Monday - Friday 10:30 a.m. - 4:00 p.m.**
- Reduced hours May-September 2:30-3:30
- For Lakehead University students only; must show ID
- Limit once a month
- If no one at food bank, go to Student Union office
- Contact foodbank@lusu.ca

Confederation College Food Bank, 475-6110 or 475-6226

- **Open Monday - Friday 8:30 a.m.- 4:00 p.m.**
- For Confederation College students only
- Visit SUCCI office or call for further details

Rural

Rural Cupboard Food Bank
Highway 11/17 Kakabeka Falls at Redeemer Lutheran Church, 285-0836
Email: ruralcupboardfoodbank@gmail.com

- For east and south rural residents only; must show ID, SIN card and verification of address.
- **Open every third Wednesday from 11:00 a.m. to 1:30 p.m. (except December is the second Wednesday)**
- Please bring your own bags.

Daily Meals (no charge)

St. Andrew's Dew Drop Inn - 286 Red River Road, 345-0481

- Daily meals from 2:00 - 3:30 p.m., open to the public

Shelter House Soup Kitchen - 420 George Street, 623-8182

- Lunch 1:00 - 2:30 p.m., and Dinner 7:00 - 8:00 p.m., open daily to the public
- Sandwiches available at the door

Salvation Army Soup Van, 344-7300

- 6:00 p.m for Southward residents
- 7:00 p.m for Northward residents
- Call for information and locations

Grace Place - 235 Simpson Street, 473-3538 or 627-9848

- Meals 2x week:
  Tues, Wed. 1:00 p.m. - 4:00 p.m.
- Sunday service; coffee and baking at 2:00 p.m.

Wiisinyog Food Van (ONWA), 623-3442

- Thursdays only
- 12:00-12:30 p.m. in Port Arthur (Cumberland St. by the Hydro building)
- 1:00-1:30 p.m. in Fort William (Corner of Donald & Simpson St.)

Elim Community Church Soup Kitchen
360 Black Bay Rd.

- Tuesdays and Thursdays, 10:00-12:30 p.m.
- Open to the public

Community Food Programs

Our Kids Count

- Kitchens, food cupboards and food vouchers available for participants.
- 704 McKenzie street location call 623-0292

Thunder Bay Indian Friendship Centre
345-5840

- Pre/postnatal program, community kitchen and garden.

NorWest Community Health Centres - Thunder Bay
525 Simpson Street, 622-8235

- Pre/postnatal programs including cooking and food packages for program participants. Call for further details.

Beendigen Inc. - 541 Luci Court, 628-0624

- Pre/postnatal programs for Aboriginal mothers, including community kitchens, hot meals, food packages and food coupons for program participants only.

June Steeve Lendrum Family Resource Centre
283 Pearl Street, 345-0311

- Call for details.

SAM-MISOL 475-6502

- Pre/postnatal programs for teen mothers aged 13-21 looking to complete their high school education. Daycare and breakfast program available for program participants. Call for further details.

Anishnawbe Mushkiki Aboriginal Health Access Centre 343-4843

- Pre/postnatal support. Healthy Kindred Kitchen Program, Healthy choices, Community Kitchens, Fetal Alcohol Syndrome/Fetal Alcohol Effects Project.

Ontario Women's Native Association (ONWA)
380 Ray Boulevard, 623-3442

- Community kitchen last Tuesday of each month-from 12-2pm

Food Banks in the District of Thunder Bay (other than the City of Thunder Bay)

Rural Food Cupboard

115 Clergue Street, Kakabeka Falls, ON; 807-475-4276

Oliver Paipoonge Municipal Office; 4569 Oliver Road, Murillo, ON; 807-935-2613

Oliver Paipoonge Library in Rosslyn Village, 3405 Rosslyn Road; 807-939-2312

Neebing Municipal office, 4766 Highway 61, Neebing, ON; 807-474-5331

Churches in rural areas

Food Bank Third Wed of the month Jan-Nov 11 am-1:30 pm
Second Wed of the month Dec 11 am-1:30 pm

Nipigon

Church of the Annunciation, 26 Second St 807-887-2348

Open 3rd Saturday of the month from 1 – 3. Clients can call anytime.

Schreiber

North Shore Harvest Cupboard, 501 Winnipeg St, 807-824-2018. Open 3rd Wednesday of the month from 2 – 4, clients can call anytime

Terrace Bay

North Shore Harvest Cupboard, 58 Laurier Ave 807-824-2018, Open 3rd Wednesday of the month from 2 – 4, clients can call anytime

Marathon

Marathon Food Bank, 84 Evergreen Drive, 807-229-0514, can be accessed 1/month. Only open Fridays

Manitouwadge

Neighbour to Neighbour Program, 51 Oshweken rd. 807-826-4326

Geraldton

Greenstone Harvest Centre. 401 Main St, 807-854-1100, 2nd and 4th Thursday of each month 6 – 8

Longlac

Longlac Town Office, 105 Hamel Rd, 807-854-3663, 2nd Thursday of each month

Thunder Bay District Health Unit

PROGRAM/ DIVISION	Healthy Living Health Promotion	***REPORT NO.***	60 - 2015
MEETING DATE	November 18, 2015	***MEETING TYPE***	Regular
SUBJECT	Food Security: An Important Public Health Issue		

RECOMMENDATION

FOR INFORMATION ONLY

REPORT SUMMARY

To provide the Board of Health with information relative to food security, its implications for population health and effective interventions to address it at the community level.

BACKGROUND

The Thunder Bay District Health Unit is mandated to reduce the burden of preventable chronic diseases of public health importance. The health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions.

Addressing these determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. A key determinant of health is income and related household food security (Public Health Agency of Canada).

Defining Food Security

Food security exists in a household when all people, at all times, have access to sufficient, safe and nutritious food for an active and healthy life. Food insecurity occurs when food quality and/or quantity are compromised, typically associated with limited financial resources.

To achieve food security, all of these four components must be present:

1. availability of food - the quantity of food available for a population;

2. stability of supply - a reliable food source over time;

3. accessibility of food - the ease with which a population may obtain available food; and

4. utilization of food – the cultural and culinary acceptability of the food, as well as the extent to which people have the skills to properly utilize the food.

Food Insecurity and Health

Food insecurity is recognized as an important determinant of health and an urgent public health problem in Canada, that affected 4 million Canadians in 2012, including 1.15 million children, and is associated with significant health concerns. It affects at least 10.2% of households (95% CI: 7.9-13.0) in the Thunder Bay District Health Unit (Canadian Community Health Survey – CCHS, 2013-2014).

When individuals and families are unable to access safe, nutritious food, their overall health can be negatively impacted. They may skip meals, eat fewer vegetables and fruit, drink less milk, and fill up on non-nutritious foods because they are inexpensive. The result of this unhealthy diet is an increased risk of chronic illness, and poor growth and development in children. Household food insecurity has been associated with a range of poor physical and mental health outcomes, for example, self-assessed poor/fair health, multiple chronic conditions, distress, chronic stress, depression, and overweight and obesity.

As food security is an emerging field and much of the activity has, of necessity, occurred at the local level through involvement of community stakeholders, there is limited scientifically rigorous research available on the clinical significance and causal pathways of food security initiatives with respect to human health. However, there are a number of program evaluations and case studies available, as well as a growing body of theoretical analysis, planning documents and guides prepared by experts in the field which help to inform understanding of the field.

Relationship Between Income and Food Security

Since the mid-1990s, several national population health surveys have demonstrated a clear linkage between income and food security. Consistently these surveys show that the adequacy of household income deteriorates, the likelihood that a household will report some experience of food insecurity increases dramatically to almost 50% in the lowest income group.

The risks for food insecurity vary according to household characteristics. Food insecurity is most prevalent among households with children under the age of 18. The most recent analysis of food security in Canada, using the 2012 CCHS, was carried out by PROOF, an international, interdisciplinary team of researchers. They found that one in six (16%) children in Canada are affected by household food insecurity. Most vulnerable are lone parent families headed by women, those renting rather than owning a home, households whose major source of income is social assistance and those reliant on Employment Insurance or Workers' Compensation. The majority of food insecure households (62.2%) are reliant on wages or salaries from employment. Being Aboriginal (28%) also increases the risk for food insecurity with a rate over two and one-half times that of all Canadian households.

Costs of Poverty and Food Insecurity

The extreme levels of material deprivation associated with household food insecurity have been associated with extensive dietary compromise, higher levels of stress and compromises across a broad spectrum of basic needs, decrease an individuals' abilities to manage health problems and increase the need for health care.

A PROOF study looking at the Canadian Community Health Survey in 2005, 2007/08 or 2009/10 found that total health care costs and mean costs for inpatient hospital care, emergency department visits, physician services, same-day surgeries, home care services and prescription drugs covered by the Ontario Drug Benefit Program rose systematically with increasing severity of household food insecurity. Costs were 23% higher in households with marginal food insecurity, 49% higher in those with moderate food insecurity and as much as 121% higher in those with severe food insecurity compared to those who were food secure.

Achieving Household and Community Food Security

To achieve food security, it is widely understood that communities must address matters that impact both the general population and vulnerable groups. Food security at the individual and household level are imbedded within a larger context of the global food system and the broader community in which individuals live. Community Food Security is both an important process and an outcome for achieving food security for individuals. It exists when all community residents obtain food security through a sustainable food system that maximizes healthy choices, community self-reliance and equal access for everyone.

To identify effective measures for improving access to, and availability of, healthy, culturally appropriate food within communities, the British Columbia Ministry of Health, Population and Public Health Division completed a comprehensive review of evidence and best practice in 2011 and updated it in 2013. This is being used as a basis for program planning in the Healthy Living Team at TBDHU and additional literature from 2013-present is being reviewed to ensure it is current.

SOLUTIONS

It is important that everyone has consistent access to safe, affordable, and nutritious food to promote health and prevent chronic disease. Addressing food insecurity at the individual, household and community levels requires a multifaceted approach; one that calls upon changes to current government public policy and that targets the barriers faced by our most vulnerable populations, as well as addressing the food system as a whole.

The solutions recommended by a high level United Nations task force highlight the need for a unified response to the challenge of global food security requiring a twin-track approach to address immediate needs as well as longer term

structural needs through participation of government, civil society, businesses and researchers. They include land use and agricultural policies that support environmental sustainability, as well as support for “closer-to-home” food production that improves access to healthy foods and builds partnerships and networks to strengthen the social fabric of communities.

Networking and community capacity are key to the successful development of food security initiatives. Public health is uniquely positioned and mandated to engage stakeholders in cross-sectoral partnerships, networks and strategies to share information and best practices, align programs and priorities, and build a broader understanding of food system issues.

Barriers to Accessing Food: The Local Picture

The barriers to consuming nutritious food can be both economic and physical. Studies conducted over the past decade have shown that access to nutritious, affordable food is often better in neighbourhoods with a large proportion of high-income earners and highly educated people. Lower income neighbourhoods have fewer food outlets offering nutritious food compared to higher-income ones; and have a higher proportion of both people who are obese and people with poor health. Community design and planning can significantly affect food access.

Transportation can also impact access to nutritious and affordable food; in both rural and low-income urban neighbourhoods under-served by public transport. This problem is more acute in rural areas, in northern communities and among Aboriginal peoples living on reserves.

Key findings from local research:

Access to healthy food

A Food Access Mapping Project and Surveys implemented in 2014-15 by the Food Strategy Food Access Working Group, identified a number of issues and solutions for increasing food access in Thunder Bay that are consistent with the evidence. Results suggested that:

- People obtain their food from a variety of sources around Thunder Bay; the most common being grocery stores and “other” food sources (such as pharmacies and large discount department stores).

- Accessibility in terms of price and location are major factors that impact where people obtain their food, with transportation being a key issue.

- A considerable percentage of respondents reported accessing alternative food sources on a monthly basis: 48% reported accessing local Food Banks every month; 38% reported using the Good Food Box program monthly; 27% reported accessing various Church food hamper programs throughout the month.

Local food system development

The Strengthening Connections Project led by the City of Thunder Bay with two rounds of Greenbelt funding (2013-15) identified a number of challenges and opportunities that the Food Strategy will be working on over the next few years. The supply of local food in our area is limited by a short growing season and capacity to meet the growing demand. More infrastructure is also required to support increased purchasing i.e. distribution, storage, processing. The seven institutions that were the focus of the project serve nearly 3000 meals and snacks daily with a combined annual food procurement budget of $1.5 million, so the potential for business development are being met enthusiastically by all stakeholders.

Community Response to Food Insecurity

There is considerable, consistent evidence that better access to healthy food corresponds to the likelihood of healthier eating, healthier weights and reduced rates of diabetes. In addition, there is strong evidence that reducing the cost of healthier foods, through subsidies or other mechanisms, increases their purchase.

Regional and municipal governments can incorporate food security initiatives into a variety of community strategies, development plans/permits, land use policies, and community development processes, as well as a range of incentives or restrictions that encourage access to, availability of, healthy food. Although public health does not manage these initiatives directly, we play an important role in advising and supporting regional and local governments in these efforts. Strategies that have been adopted by the District and viewed generally as being helpful in increasing food security in communities include:

- Food policy coalitions/councils to provide advice, leadership, advocacy, coordination, networking, education, and research i.e. the Food Action Network, led by TBDHU has been networking, advising and developing initiatives since 1995, and more recently, have spearheaded the more formal Food Strategy Steering Committee.

- Community assessment and mapping of healthy food sources and food access resources in the community as a basis for identifying and assessing community strengths and weaknesses i.e. annual “Where to Get Food in Thunder Bay” inventory, Community Food Assessment Report (2004), the Healthy School Food Zones Report (2013), Food Access Mapping Focus Group Report (March 2014), Food Access Solutions Report (March 2015)

- Increasing availability of, and access to, healthy foods by facilitating establishment of grocery stores in low-income neighbourhoods, stocking healthy foods in a range of local food outlets, and the use of development permits, zoning by-laws, regulations, subsidized permits and other incentives i.e. advised on Official Plan review 2014, exploring feasibility of

mobile markets, conducted Healthy Food Zones Around Schools research project in 2012-13.

- Policies and guidelines on the provision of healthy foods in public institutions i.e. support City of Thunder Bay's Local Food Procurement project.

- Mechanisms to support farmers markets, farm-to-cafeteria programs and other means of direct food purchase from farms i.e. support Thunder Bay and Area Food Strategy implementation plan.

- Transportation policies to enable people to easily access healthy food outlets i.e. Thunder Bay and Area Food Strategy working with City of Thunder Bay Transit to increase access through the Transportation Master Plan.

Programs and initiatives that have been adopted by the District and viewed generally as being helpful in increasing food security in communities include:

Programs that support immediate/short-term food relief:

- Charitable food programs such as food banks, soup kitchens and meal programs provide short-term relief (although they have many limitations and do not address the root causes of food insecurity) i.e. RFDA serves 38 member food banks and meal programs in Northwestern Ontario.

- Food recovery programs such as gleaning and encouraging donations of perishable food to charitable food programs can increase the availability of healthy food i.e. the TBDHU Gleaning Program organized 8 gleaning trips to 3 area farms in 2015. The 7600 pounds of berries and vegetables gleaned on these trips benefitted at least 1148 people including the 218 participants.

- Nutrition support programs for low-income pregnant women have shown positive health outcomes i.e. cooking with good food box with young mothers and HBHC food skills programming (includes cooking in homes with families and providing food vouchers)

- School meal programs also help to provide healthy food to children and have shown effective outcomes. In Thunder Bay there are 80 school meal and snack programs throughout the District. We support these programs by assisting in providing menu suggestions and safe food handling information with funding administered through the Red Cross.

Programs that support longer term food security:

- Programs to develop food skills, including planning and preparing food and the use of community kitchens, indicate positive outcomes and are generally considered promising practices i.e. TBDHU has a number of food skills programs such as Cooking with the Good Food Box and

Adventures in Cooking, and provide training and support to social service agencies to help them run community kitchens and cooking programs.

- Urban agriculture has demonstrated promise in improving nutrition and strengthening neighbourhoods i.e. TBDHU supports the Community Garden Collective (21 community gardens), Roots to Harvest, and Backyard Chicken By-law development, and provides advice to community groups wishing to establish community gardens across the District.

- Farmers' markets can improve access to healthy foods in the community while also supporting local farmers and the sustainability of local supplies. Subsidies for low income people in the form of coupons and vouchers for use at farmers' markets in combination with knowledge and skill building programs have had a positive impact on participants' food knowledge and healthy eating.

- Farm-to-school programs have, in combination with teacher knowledge, attitudes and behaviours, positively contributed to healthier dietary choices i.e. support 16 School Gardens, Roots to Harvest Farm to Caf program. In 2013, 1123 local food meals were served through a partnership with the Lakehead Public Schools secondary schools Westgate, Superior, Churchill, and Hammarskjold.

- Food boxes of fresh fruits and vegetables and community-supported agriculture (membership fees to a farm for a share of the harvest) are considered to be helpful mechanisms for facilitating access to nutritious foods i.e. support the Thunder Bay Good Food Box program, that provides over 400 boxes of fresh produce a month at a discounted price through 33 hosts sites with over 100 active volunteers, and provided advice to community groups to establish programs in Nipigon and Marathon.

Public Health Role in Food Security

The overall goal of the Thunder Bay District Health Unit's food security program is to increase food security for the population in the Thunder Bay District. To achieve this we are working at various levels in the community to achieve the following objectives:

- To create policies that support food security initiatives on all levels, thereby enhancing access to affordable, high quality foods (using environmentally sustainable production and distribution methods).

- To strengthen community action by increasing community capacity to address local food security.

- To create supportive environments that will increase accessibility to, and the availability of, healthy foods in a sustainable and dignified manner.

- To increase food knowledge and skills by providing information and education resources.

- To facilitate services and resources that communities and individuals require for increasing the accessibility, availability and affordability of healthy foods.

- To partner with other sectors and levels of government in addressing barriers to food security for all communities and citizens in the District.

These objectives provide the context for considering the evidence and a foundation for developing programs and strategies.

FINANCIAL IMPLICATIONS

None

STAFFING IMPLICATIONS

None

CONCLUSION

Food security is an important public health issue. Public health has a role to play in what has become a significant population health issue, and the evidence exists to guide TBDHU's efforts.

LIST OF ATTACHMENTS

Attachment 1 - Cost of Eating in the District of Thunder Bay Report, 2015
(Distributed Separately)

PREPARED BY: Catherine Schwartz Mendez, Public Health Nutritionist

THIS REPORT RESPECTFULLY SUBMITTED BY: ***DATE:***

Lynda Roberts, Director – Health Promotion October 30, 2015

Chief Executive Officer Medical Officer of Health (A)

The Red Cross reports the following schools are currently funded for student nutrition programs in the Thunder Bay District

Agnew H Johnston Public School	Hammarskjold High School	Sam/Misol Program
Armstrong Public School	Holy Angels School	Schreiber Public School
B.A Parker Public School	Holy Cross School	Sir Winston Churchill Collegiate and Vocational Institute
Beardmore Public School	Holy Family School	St. Bernard School
Bernier Stokes Public School	Holy Saviour School	St. Bridgid Catholic School
Bishop E.Q Jennings	Hyde Park Public School	St. Edward Catholic School
Bishop Gallagher Elementary School	Johnny Terriault School	St. Francis Catholic School
Boys and Girls Club (after school programs)	Kakabeka Falls Public School	St. Hilary Catholic School
C.D Howe Public School	Kingsway Park Public School	St. Ignatius High School
College Jump Start Alternate Education	Lake Superior High School	St. James Public School
College Link	Manitouwadge Breakfast Club	St. Joseph School
Connections Alternative Education	Manitouwadge High School	St. Martin School
Crestview Public School	Marathon High School	St. Patrick High School
Dennis Franklin Cromarty High School	Margaret Twomey Public School	St. Paul School
Dorion Public School	Marjorie Mills Public School	St. Thomas Aquinas School
Ecole Catholique Val des Bois	McKellar Park Central School	St. Vincent School
Ecole Gron Morgan Public School	McKenzie Public School	Superior Collegiate and Vocational Institute
Ecole Sec. Cite Superisure	Nakina Public School	Terrace Bay Public School
Ecole Secondaire Chateau Jeunesse	Nipigon Red Rock District High School	Upsala Public School
Ecole St. Joseph	Ogden Community Public School	Valley Central Public School
Edgewater Park Public School	Our Lady of Charity	Westgate Collegiate and Vocational School
Five Mile Public School	Our Lady of Fatima	Westmount Public School
Gateway Alternative Education	Pope John Paul II Sr. Elementary	Whitefish Valley Public School
George O'Neil Public School	Sherbrook Public School	Woodcrest Public School
Gorham and Ware Public School	Red Rock Public School	

The 39 partners in the District of Thunder Bay to whom food supplies are provided by the Regional Food Distribution Association

Elevate NWO	PACE/Efry
Anishnawbe Mushkiki	Redwood Oppunities Food Bank
Beendigan	Rural Cupboard Food Bank
Brain Injury Services of Northern Ontario	Salvation Army-Thunder Bay
Confederation College Food Bank	Shelter House
Current River Churches Food Cupboard	St Andrew's Kitchen Inc - Dew Drop Inn
Faye Peterson House	St. Thomas Anglican Church Food Cupboard
Grace Ministries	St. Vincent De Paul- Corpus Christi Church
Greestone Harvest Centre	St. Vincent De Paul- St. Agnes Church
John Howard Society of Thunder Bay	Teen Challenge
June Steeve-Lendrum Family Resource Centre	Thrift R Us- Marathon Food Bank
Kateri	Gathering Place
Mary Berglund Health Centre	Thunder Bay Counselling Centre
Metis Nation of Ontario	Thunder Bay Food Bank
Neighbourhood Capacity Building Project	Thunder Bay Indian Friendship Centre
New Life Christian Fellowship	The River
Nipigon Food Bank	New Life Ministries Hope House
North Shore Harvest Food Cupboard	Youth Centres Thunder Bay
Our Kids Count	Gaa Mino Bimaadiziwaad Counselling

THE DISTRICT OF THUNDER BAY
SOCIAL SERVICES ADMINISTRATION BOARD

POSITION PAPER:

FOOD SECURITY IN THE DISTRICT OF THUNDER BAY

Jennifer Lible, Manager – Client Services

Saku Pinta, Senior Social Policy Analyst

March 1, 2016

Introduction

That food is one of the paramount necessities of life is an obvious truism. Food is identified, for example, as one of the basic physiological requirements in Maslow's hierarchy of needs, and food security is naturally considered to be one of the cornerstones of individual well-being and social stability. Health Canada, in adopting the United Nations Food and Agricultural Organization definition, defines food security as a condition "when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life." Similarly, food insecurity is defined as "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so."[1]

Recognizing the well-documented social consequences of food insecurity – ranging from negative health outcomes to diminished educational attainment – there is cause for heightened concern with regards to food security issues in Canada in general, and more specifically, in the District of Thunder Bay. As will be shown, the price of food has been steadily climbing over the past decade and food inflation in Canada is again projected to exceed the general inflation rate in 2016. Rising food prices will have a disproportionate impact on low income individuals and families, as is already evident in the increasing number of people relying on food banks in Ontario.

With these factors in mind, it is of critical importance to ensure not only that food security issues in the District of Thunder Bay are being addressed but also that data on food insecurity is accurately tracked as an evidence-based foundation to monitor progress and to assist in further planning or interventions.

The objectives of this position paper are twofold. First, to provide a broad overview of food security issues on the national and regional level as well as summarizing some of the social consequences of food insecurity, with a special focus on children as the most vulnerable group. Second, to offer recommendations that will help to better prepare for, and alleviate, some of the anticipated impacts of food insecurity. Specifically, two recommendations will be proposed. Firstly, that the Board advocate that the Ontario Ministry of Education implement a universal hot meal program in elementary and secondary schools. Secondly, that the Regional Food Distribution Association of Northwestern Ontario (RFDA) – as the central hub for charitable food distribution in the District of Thunder Bay – develop and implement a data collection plan that will, minimally, monitor food bank usage identifying the number of unique individuals served, client demographics, and the amount of food distributed on a monthly basis.

Food Security and the Cost of Food in Canada

The Food Price Report published by the Food Institute of the University of Guelph forecasts that the rate of food inflation across Canada will be anywhere between 2.0%

[1] "Household Food Insecurity in Canada: An Overview" 2012, available at http://www.hc-sc.gc.ca/fn-an/surveill/nutrition/commun/insecurit/index-eng.php#fnb2

to 4.0% in 2016 and will again exceed the general inflation rate. Notably, two of the factors identified in the report that are predicted to affect retail food prices in Canada are climate change and the value of the Canadian dollar.

Climate will be a significant, yet unpredictable, factor influencing food prices. As the report states, "El Nino could be a significant factor in 2016, in fact meteorologists predict next year's El Nino to be one of the strongest on record. This may cause more precipitation in southern and western regions in the United States." While the impacts of El Nino are uncertain at this stage, the primary area of concern is in the production of vegetables and fruits that are grown in these regions "as 81% of all vegetables and fruits consumed in Canada are imported." This intersects with another major driver impacting food prices in Canada, namely, the value of the Canadian dollar. The report predicts "the Canadian dollar to devalue further against the American dollar" perhaps dropping as low as $0.70 or lower. As a consequence, "every cent drop in the dollar over a short period of time, currency-exposed food categories like vegetables, fruits, and nuts are likely to increase by more than 1%."[2]

These forecasted price increases should be placed in the context of a much greater, longitudinal trend towards higher food prices (refer to Figure 1). The price of fresh or frozen beef, for example, increased by more than 117% between the years 2000 to 2015.

These factors have contributed significantly to food insecurity in Canada. Increased food prices, as well as other economic trends since 2008, have a significant and disproportionate impact on low income individuals and families who typically have less discretionary income or a financial buffer to mitigate against rising prices. This is reflected in available food bank usage statistics. The 2015 HungerCount Report, produced by the Food Banks Canada, reported that 825,137 Canadians turned to a food bank in 2015 – a 1.3% increase in food bank use since 2014, but an alarming overall 26% increase since 2008.[3] Low-income is, unsurprisingly, consistently found to be the most reliable predictor of food insecurity, with Aboriginal Canadians, recipients of social assistance, single mothers, and those housed in rental accommodations amongst the groups with the highest rates of food insecurity.[4]

Social Consequences

The social consequences of food insecurity are well-documented through a vast and ever increasing academic literature. The impacts of hunger are well-known.

[2] Sylvain Charlebois et. al, "Food Price Report 2016," available at https://www.uoguelph.ca/foodinstitute/system/files/Food%20Price%20Report%202016%20English.pdf

[3] HungerCount 2015, available at https://www.foodbankscanada.ca/getmedia/01e662ba-f1d7-419d-b40c-bcc71a9f943c/HungerCount2015_singles.pdf.aspx

[4] For a collection of recent, Canadian academic studies on social determinants of food insecurity, refer to the Proof Food Insecurity Policy website, available at http://proof.utoronto.ca/resources/research-publications/social-determinants-of-food-insecurity/

Figure 1

Source: Statistics Canada information, compiled by Global News

Some of the most damaging immediate and long-term effects of hunger are experienced by children. These include reduced learning and productivity, higher rates of mental health disorders and chronic diseases, and increased rates of child obesity. In the context of pregnancy and infancy, iron deficiency has been linked to "poor performance on language comprehension tests and an inability to follow directions over the first five years of a child's life" as well as "delays in socioemotional, cognitive, motor and neurophysiological development." Studies on food insecure school-aged children have found that nutritional deficiencies double the likelihood "persistent symptoms of hyperactivity/inattention," with evidence of improvement "after the introduction of a healthy diet." The adverse impact of food insecurity on the mental health of children is wide-ranging, with evidence of "depression and suicidal ideation" and increased rates of "adolescent mood, behaviour and substance abuse disorders" linked to child hunger. Overall health is also negatively impacted, with a "higher likelihood of chronic conditions and of asthma." Some Canadian and American studies have also found a correlation between food insecurity and childhood obesity, thought to be a result of "more restrictive

and pressuring maternal feeding styles" which "decrease the ability of children to self-regulate eating behaviours."[5]

Given the strong linkages between hunger and reduced cognitive ability in children, on the one hand, and the correlation between educational attainment and socio-economic status, on the other, the likelihood of impoverished children remaining in low income in adulthood is increased.

Local Context

As was demonstrated in the preceding sections, there are several strong indicators that point to a continued increase in food insecurity on the national level, and that the well-researched impact of food insecurity is experienced particularly intensely by children. Turning now to the local context, this section will provide an overview of food insecurity in the District of Thunder Bay.

There are multiple food banks and feeding programs in the District of Thunder Bay (please refer to the Food Bank Information document). Beyond extrapolating from the macro-economic data and larger-scale social indicators, it is somewhat difficult to get an accurate picture of food security in the District of Thunder Bay.

It is known that the RFDA has had a recent, staggering drop in food donations and that rising food prices are having an impact on donations.[6] According to the 2015 Hunger Report, produced by the Ontario Association of Food Banks, the RFDA serves approximately 14,000 individuals per month, however, no statistical breakdown of food bank usage per community or other similar data appears to be publicly available.[7] The Thunder Bay and Area Food Strategy 2015 'Community Food Security Report Card' states that the average number of food bank users per month is 3,447 with 9,000 meals served by emergency programs each month, however, it is unclear if this refers to unique individuals and/or if this information pertains only to the City of Thunder Bay or if it includes other communities.[8]

Another approximate conception of those who are at risk of food insecurity can be extrapolated from the Thunder Bay District Health Unit's 'The Cost of Eating Well in the District of Thunder Bay.' This report provides an income-based analysis combined with

[5] Janice Ke and Elizabeth Lee Ford-Jones, "Food insecurity and hunger: A review of the effects on children's health and behaviour" in *Paediatrics & Child Health* 20:2 March 2015 pp.89-91, available at http://foodsecurecanada.org/sites/default/files/effects.food_.insecurity.hunger.march_.2015_2.pdf

[6] "Food donations to RFDA down a staggering $400,000 in 2015," available at http://www.tbnewswatch.com/News/382796/Food_donations_to_RFDA_down_a_staggering_$400,000_in_2015

[7] See pg.18-19 in the 2015 Hunger Report, available at http://www.oafb.ca/tiny_mce/plugins/filemanager/pics_cms/3/303/FINAL_-_2015_OAFB_Hunger_Report_updated.pdf

[8] Community Food Security Report Card 2015, available at http://tbfoodstrategy.ca/files/7014/5504/9817/FoodStrategy_FoodSecurityReportCard.pdf

an annual survey to determine the average cost of a healthy diet.[9] Singles on Ontario Works are shown to be the most vulnerable with the highest proportion of income devoted to rent and the lowest amount remaining to cover basic expenses.

In terms of school-aged children, a valuable study and social indicator is the Early Development Instrument (EDI) report produced by Communities Together for Children. The EDI is an early child development questionnaire that measures a child's readiness to learn upon entry in Grade 1. The EDI measures 5 domains, including "Physical Health and Well-Being" which features hunger as a risk factor. Although the study only covers the region of Thunder Bay-Atikokan – rather than the District of Thunder Bay – the numbers are revealing. The region "had a vulnerability rate (Vulnerable on One or More Domains) of 31.5% in 2006, which increased to 33.1% in 2012. The Ontario Vulnerability rate was 28.0% in 2012."[10]

Recommendations and Rationale

Given the immediate and long-term impacts of food security on children, it is recommended that the Ontario Ministry of Education implement a universal, hot meal program in elementary and secondary schools. Based on available information, it appears that children in Thunder Bay and surrounding areas are increasingly vulnerable in the domains studied through the EDI. Aside from the nutritional benefits, a universally applied hot meal program would limit stigma associated with means testing or self-identification as low income, and such a program would also help to increase the disposable incomes of families that are on a fixed budget.

While broader social trends indicate the strong likelihood of an increase in food insecurity in the District of Thunder Bay, at present time there is insufficient data with which to adequately determine the needs, monitor the trends, or track progress in the area of addressing food security issues. Given that reliable data is necessary for making good, evidence-based decisions and policies, it is recommended that the Regional Food Distribution Association of Northwestern Ontario (RFDA) – as the central hub for charitable food distribution in the District of Thunder Bay – develop and implement a data collection plan that will, minimally, monitor food bank usage in terms of numbers of unique individuals served, client demographics, and amount of food distributed on a monthly basis. The use of free software for this purpose, such as the Homeless Individuals and Families Information System (HIFIS) – as utilized by a growing number of food banks across Ontario – could be employed to help get a better sense of the needs of those using the food bank system.

[9] The Cost of Eating Well in the District of Thunder Bay 2015, available at http://www.tbdhu.com/NR/rdonlyres/60D58A19-E9EB-464F-86CE-16320D2CA6AF/0/TheCostofEatingWellintheDistrictofThunderBay_website.pdf

[10] Executive Summary, "Thunder Bay-Atikokan Region Early Development Instrument Report (2005-2012)," available at: http://www.ctctbay.org/data_analysis_coordination/documents/Executive_Summary_EDI_Report_Electronic.pdf

June 2, 2016

The Honourable Dr. Jane Philpotts
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9

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

Dear Ministers:

Re: Lyme Disease

On May 27, 2016, the Board of Health for the Grey Bruce Health Unit passed the following resolution.

Resolution No: 2016-52

Moved by: Gary Levine **Seconded by: David Shearman**

WHEREAS, the blacklegged tick, Ixodes scapularis, is expanding into new areas of Ontario, and can carry the bacteria, Borrelia bugdorferi, which causes Lyme disease; and

WHEREAS, people who are infected with Borrelia burgdorferi, may develop Lyme disease which can cause long-term consequences if not treated properly;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Grey Bruce Health Unit requests the Province of Ontario to increase funding to enhance environmental surveillance for the tick;

AND FURTHER THAT the Province of Ontario monitor the pattern of spread of the tick and the rate of tick infection in various areas of the province;

AND FURTHER THAT the Province of Ontario develop control measures for the tick;

AND FURTHER THAT the Province of Ontario increase the education to the population regarding personal protection, property management, testing and treatment.

Carried

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: Hon, Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada
Hon. Jane Philpott, Minister of Health
Hon. Kathleen Wynne, Premier of Ontario
Hon, Madeleine Meilleur, Attorney General for Canada
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
Dr. David Williams, Chief Medical Officer of Health (Interim)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Dr. Catherine Zahn, President and CEO, Centre for Addiction and Mental Health
All Ontario Boards of Health

Encl.

Administration
Office of the Regional Clerk
1815 Sir Isaac Brock Way, PO Box 1042, Thorold, ON L2V 4T7
Telephone: 905-685-4225 Toll-free: 1-800-263-7215 Fax: 905-687-4977
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May 9, 2016

The Honourable Dr. Jane Philpotts
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9

Sent via email:
hon.jane.philpott@canada.ca

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

Sent via email:
ehoskins.mpp@liberal.ola.org

RE: Lyme Disease
Minute Item 9.3, CL 6-2016, April 28, 2016

Dear Ministers:

Regional Council at its meeting held on April 28, 2016, passed the following resolution:

Whereas the number of cases of ticks positive for Lyme disease is increasing throughout Ontario and specifically in Niagara Region;

Whereas the laboratory testing for and diagnosis of Lyme disease is sub-optimal; and

Whereas there are chronic sufferers of long term consequences of this disease.

NOW THEREFORE BE IT RESOLVED:

1. That Niagara Region **REQUEST** the Province of Ontario to increase funding for research aimed to enhance the testing for Lyme disease;

2. That Niagara Region **REQUEST** the Government of Canada to increase funding for research aimed to enhance the testing for Lyme disease and determine better treatment for long term outcomes of Lyme disease;

3. That this resolution **BE FORWARDED** to all Municipalities in Ontario for their endorsement; and

4. That this resolution **BE FORWARDED** to the Premier of Ontario, the Minister of Health and local Members of Provincial Parliament.

…/2

Please do not hesitate to contact me should you have any questions.

Yours truly,

Ralph Walton
Regional Clerk

cc: The Honourable K. Wynne, Premier of Ontario *Sent via email:* kwynne.mpp@liberal.ola.org
W. Gates, MPP (Niagara Falls) *Sent via email:* wgates-co@ndp.on.ca
The Honourable R. Nicholson, MP (Niagara Falls) *Sent via email:* rob.nicholson@parl.gc.ca
T. Hudak, MPP (Niagara West) *Sent via email:* tim.hudakco@pc.ola.org
D. Allison, MP (Niagara West) *Sent via email:* dean.allison@parl.gc.ca
The Honourable J. Bradley, MPP (St. Catharines) *Sent via email:* jbradley.mpp.co@liberal.ola.org
C. Bittle, MP (St. Catharines) *Sent via email:* chris.bittle@parl.gc.ca
C. Forster, MPP (Welland) Sent via email: cforster-op@ndp.on.ca
V. Badawey, MP (Niagara Centre) *Sent via email:* vance.badawey@parl.gc.ca
All Ontario Municipalities *Sent via email*

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Correspondence for Information**

Date: September 14, 2016

Proposed Recommendation:

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

1. Letter dated May 25, 2016 from Minister Monsef to the former Board Chair regarding her original letter dated December 2, 2015, regarding food security and the transformation of social assistance in Ontario. *(Note: Dr. Salvaterra has forwarded the letter from Minister Jaczek as per her request).* p. 93

2. Email received June 10, 2016 from the Association of Local Public Health Agencies (alPHa) regarding the disposition of resolutions from the June 2016 Annual General Meeting (AGM). p. 94

3. Letter dated June 21, 2016 from the Board Chair to Minister Hoskins regarding Community Water Fluoridation. p. 106

4. Email received June 30, 2016 from alPHa regarding conference proceedings from the June 2016 conference and AGM. p. 108

5. E-newsletter dated July 13, 2016 from alPHa. p. 125

6. Letter dated July 22, 2016 from Minister Hoskins to the Board Chair, in response to his original letter dated June 2, 2016, regarding Patients First. p. 128

7. Letter dated August 2, 2016 to Ministers Bennett and Zimmer regarding safe drinking water on reserves. p. 130

8. E-newsletter dated August 15, 2016 from alPHa. p. 132

9. Updates from the Ministry of Health and Long-Term Care regarding the Modernization of the Ontario Public Health Standards:
   a. Organizational Governance Committee (OGC) – Highlights #1 p. 134
   b. Accountability Committee (formerly OGC) – Highlights #2 p. 136
   c. Accountability Committee – Highlights #3 p. 141

d. Executive Steering Committee – Highlights #1 p.142
e. Executive Steering Committee – Highlights #2 p. 152
f. Executive Steering Committee – Highlights #3 p. 153
g. Practice and Evidence Program Standards Advisory Committee – Highlights #1 p. 154

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

Basic Income Guarantee*
a. Haliburton Kawartha Pine Ridge p. 157
b. Simcoe Muskoka p. 164

Cannabis – Legalization/Public Health Approach*
c. Lambton p. 167
d. Wellington Dufferin Guelph p. 172

International Code of Marketing of Breastmilk Substitute*
e. Grey Bruce *(appendices available upon request)* p. 175

Environmental Health Program Funding*
f. Algoma p. 177

Patients First*
g. Lambton *(appendices available upon request)* p. 178

Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act
h. Windsor Essex *(appendices available upon request)* p. 179

*NOTE: *The Board has taken previously taken a position on these items.*

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Maryam Monsef
Member of Parliament
Peterborough—Kawartha

Councillor Lesley Parnell
Chair, Board of Health
Peterborough County-City Health Unit
Jackson Square, 185 King St.
Peterborough, ON
K9J 2R8

May 25, 2016

Dear Councillor Parnell,

I want to thank you for including me in your correspondence on behalf of the Peterborough County-City Health Unit to Minister Jaczek of Community and Social Services.

The statistics for our area presented in your letter are extremely troubling. As the Member of Parliament for Peterborough-Kawartha I am personally concerned with the health and wellbeing of all members of our community, especially those who are most vulnerable.

While many of the social services addressed in your letter to the minister are administered under provincial jurisdiction, I would greatly appreciate an update on the situation, at such a time when you receive one from the minister.

Thank you for your continued efforts to bring an improved quality of life to people living in poverty in our area. I look forward to working with all levels of government to this end.

Truly,

Maryam Monsef, P.C., M.P.
Peterborough-Kawartha

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Maryam.Monsef@parl.gc.ca

alPHa
Association of Local
PUBLIC HEALTH
Agencies

June 2016
DISPOSITON OF RESOLUTIONS

alPHa Resolutions Session, 2016 Annual General Meeting
Monday, June 6, 2016
Champagne Ballroom, 2nd Floor
Novotel Toronto Centre
45 The Esplanade
Toronto, Ontario

RESOLUTIONS CONSIDERED
at June 2016 alPHa Annual General Meeting

Resolution Number	Sponsor	Title	Action from Conference
A16-1	alPHa Board of Directors	Change to Quorum in Constitution	Carried
A16-2	Thunder Bay District Board of Health	Amending alPHa Resolution Submission Guidelines	Carried as amended
A16-3	Council of Ontario Medical Officers of Health	Health-Promoting Federal, Provincial and Municipal Infrastructure Funding	Carried
A16-4	Haliburton, Kawartha, Pine Ridge District Health Unit	Enactment of Legislation to Enforce Infection Prevention and Control Practices Within Invasive Personal Service Settings (PSS) under the *Health Protection and Promotion Act*	Carried as amended
A16-5	Thunder Bay District Board of Health	Healthy Babies Healthy Children 100% Funding	Carried
A16-6	Middlesex-London Board of Health	Advocate for a Comprehensive Province-Wide Healthy Eating Approach Integrating the Recommendations in the Senate's Report on Obesity and the Heart and Stroke Foundation Sugar, Heart Disease and Stroke Position Statement, including Taxation of Sugar-Sweetened Beverages	Carried as amended

alPHa RESOLUTION A16-1

TITLE: **Change to Quorum in Constitution**

SPONSOR: **alPHa Board of Directors**

WHEREAS alPHa's Board of Directors allows for up to 21 voting members; and

WHEREAS alPHa's Constitution defines quorum at Board of Directors meetings as the fixed number twelve (12); and

WHEREAS this fixed number is based on the assumption of a full complement of Directors on the Board; and

WHEREAS alPHa's Board of Directors, at full complement contains seven (7) Board of Health voting representatives, seven (7) Council of Ontario Medical Officers of Health voting representatives, and seven (7) Affiliate Organization voting representatives; and

WHEREAS from time-to-time there are vacancies in voting positions making quorum difficult to achieve; and

WHEREAS the Constitution may be amended at any general meeting of the Association; and

WHEREAS notice of the proposed amendment must be sent to every member at least thirty (30) days prior to the general meeting;

NOW THEREFORE BE IT RESOLVED that the Constitution of the Association of Local Public Health Agencies be revised such that quorum is defined as the simple majority of filled voting positions on the Association's Board of Directors;

AND FURTHER that quorum be additionally defined to include no less than one-third of the filled positions from each of the Board of Health voting representatives; Council of Ontario Medical Officers of Health voting representatives, and Affiliate Organization voting representatives;

AND FURTHER that the members of the Association are asked to approve these constitutional changes at the June 2016 Annual General Meeting.

ACTION FROM CONFERENCE: **Resolution CARRIED**

alPHa RESOLUTION A16-2

TITLE: **Amending alPHa Resolution Submission Guidelines**

SPONSOR: **Thunder Bay District Board of Health**

WHEREAS resolutions facilitate the formation of policy for the Association of Local Public Health Agencies (alPHa); and

WHEREAS resolutions make a substantive and significant contribution to the Association's public profile and agenda for action; and

WHEREAS timelines have been established for the submission of resolutions to alPHa; and

WHEREAS these established timelines provide for the necessary time required for review and categorization of submissions; and

WHEREAS the call for submissions allows for ample time for the members of the Association to format and submit any resolutions; and

WHEREAS resolutions received after the submission cut-off date are not subjected to the same review process by membership;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) undertake to review its Procedural Guidelines for alPHa Resolutions and that recommendations regarding the submission of late resolutions be brought back to the Annual General Meeting.

ACTION FROM CONFERENCE: **Resolution CARRIED AS AMENDED**

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A16-3

TITLE: **Health-Promoting Federal, Provincial and Municipal Infrastructure Funding**

SPONSOR: **Council of Ontario Medical Officers of Health**

WHEREAS the design of communities and transportation systems significantly impacts on the health and health equity of the population; and

WHEREAS these impacts include physical activity, nutrition, obesity, air quality, injuries, and their related health conditions, as well as social and psychological wellbeing; and

WHEREAS alPHa and OPHA have passed resolutions advocating for the Ontario provincial government to apply a *Health In All Policies* framework; and

WHEREAS there are clear, evidence-informed recommendations for the design of communities and transportation systems to improve health and health equity in the population; and

WHEREAS health and health equity-promoting design of communities and transportation systems also achieves economic, environmental and quality of life benefits; and

WHEREAS local public health agencies in Ontario are working with partner agencies and with their communities to achieve health and health equity-promoting community and transportation system design, in keeping with the Ontario Public Health Standards; and

WHEREAS the federal government through Infrastructure Canada is offering substantial funding grants for community and transportation infrastructure; and

WHEREAS these funding grants could serve as a substantial opportunity to achieve health and health equity -promoting design for community and transportation infrastructure; and

WHEREAS the objectives for these funds do not specifically include the improvement of population health; and

WHEREAS the criteria cited for these funds do not include built form features known to improve health and health equity, such as complete and compact design supportive of active transportation and public transit; and

WHEREAS the potential for such grants to achieve health and health equity-promoting community and transportation system design would be increased by including population health as an objective and with health and health equity-promoting design criteria; and

WHEREAS notwithstanding the leadership provided by the provincial government in Ontario in health and health equity-promoting design, it would also be beneficial for Ontario provincial funding sources to require the objective of population-health improvement, and health and health-equity promoting criteria for community and transportation system design;

WHEREAS notwithstanding the leadership provided by the municipal governments in Ontario in health and health equity-promoting design, it would also be beneficial for municipal governments to officially pursue population-health improvement through the design of communities and transportation systems, applying evidence-informed design criteria to this end;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) endorse the pursuit of health and health equity through the design of communities and transportation systems; and

AND FURTHER that alPHa request that the federal Ministers of Infrastructure and Communities, Health, Transportation, Finance, and the Environment and Climate Change include improving population health as an objective, and include evidence informed health and health equity-promoting design criteria for federal community and transportation infrastructure funding;

AND FURTHER that alPHa request that the Ontario Ministers of Economic Development Employment and Infrastructure, Health and Long-Term Care, Associate Minister of Health and Long-Term Care (Long-Term Care and Wellness), Municipal Affairs and Housing, Transportation, Finance, the Poverty Reduction Strategy, and the Environment and Climate Change include improving population health as an objective, and include evidence informed health and health equity-promoting design criteria for provincial community and transportation infrastructure funding;

AND FURTHER that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer of Canada, the Chief Medical Officer of Health for Ontario, the Ontario Professional Planners Institute, the Canadian Institute of Planners, the Association of Municipalities of Ontario, the Federation of Canadian Municipalities, the Ontario Public Health Association and the Canadian Public Health Association be so advised;

AND FURTHER that alPHa advocate for health and health equity through the design of communities and transportation systems as opportunities arise on an ongoing basis.

ACTION FROM CONFERENCE: **Resolution CARRIED**

alPHa RESOLUTION A16-4

TITLE: **Enactment of Legislation to Enforce Infection Prevention and Control Practices Within Invasive Personal Service Settings (PSS) under the *Health Protection and Promotion 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, whichis 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; and

WHEREAS An enforcement program should include set fines to be established for offences that are prosecuted under Part I of the *Provincial Offences Act* that can be settled out of court by payment of the amount written on the offence notice;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies 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 an appropriate inspection frequency of invasive personal services settings be determined and included in the Infection Prevention and Control in Personal Services Settings Protocol, 2015 (or as current) under the Ontario Public Health Standards;

AND FURTHER that the province be asked to provide the necessary funding to accomplish these goals;

AND FURTHER that the Premier of Ontario, the Minister of Health and Long-Term Care, the Chief Medical Officer of Health, the Association of Supervisors of Public Health Inspectors of Ontario, the Canadian Institute of Public Health Inspectors and the Ontario Public Health Association are so advised.

ACTION FROM CONFERENCE: **Resolution CARRIED AS AMENDED**

alPHa RESOLUTION A16-5

TITLE: **Healthy Babies Healthy Children 100% Funding**

SPONSOR: **Thunder Bay District Board of Health**

WHEREAS the Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and

WHEREAS the Healthy Babies Healthy Children program is a mandatory program for Boards of Health; and

WHEREAS in 1997 the province committed to funding the Healthy Babies Healthy Children program at 100% and the HBHC budget has been flat-lined since 2008; and

WHEREAS collective agreement settlements, travel costs, pay increments and accommodation costs have increased the costs of implementing the HBHC program, the management and administration costs of which are already offset by the cost-shared budget for provincially mandated programs; and

WHEREAS the HBHC program has made every effort to mitigate the outcome of the funding shortfall, this has becoming increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) urgently request the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing and administrative costs.

ACTION FROM CONFERENCE: **Resolution CARRIED**

alPHa RESOLUTION A16-6

TITLE: **Advocate for a Comprehensive Province-Wide Healthy Eating Approach Integrating the Recommendations in the Senate's Report on Obesity and the Heart and Stroke Foundation Sugar, Heart Disease and Stroke Position Statement, including Taxation of Sugar-Sweetened Beverages**

SPONSOR: **Middlesex-London Board of Health**

WHEREAS In Ontario, between 1978 and 2004 the prevalence of overweight children aged 12-17 increased from 14% to 29% and obese from 3% to 9% (Shields, 2006) Youth who are overweight and obese are at higher risk of being overweight or obese in adulthood (Singh, Mulder, Twisk, van Mechelen & Chinapaw, 2008); and

WHEREAS The etiology of obesity is complex and involves interactions between genetics, social and environmental factors; and

WHEREAS A comprehensive approach has been found to be most effective to bring about social change in order to improve health and wellbeing and reflected in the five elements of the Ottawa Charter for Health Promotion, World Health Organization(WHO), 1986, building healthy public policy, reorienting the health services, creating supportive environments, strengthening community action, developing personal skill; and

WHEREAS As part of a comprehensive approach, specific policy measures such as taxation can have a measurable impact, particularly when they are large enough to affect consumer behaviour, and revenues are redirected toward prevention efforts (Sturm et al, 2010); and

WHEREAS The Senate's Report on Obesity describes an innovative, whole-of-society approach to address this important issue — and urges bold but practical steps that can and must be taken to help Canadians achieve and maintain healthy weights (2016); and

WHEREAS It is estimated that Canadians consume as much as 13% of their total calorie intake from added sugars (Brisbois et al, 2014); and

WHEREAS In children higher intake of Sugar Sweetened Beverages has been associated with a 55% increased risk of being overweight or obese compared to children with lower intake (Te Morenga, Mallard & Mann, 2012); and

WHEREAS WHO recommends the consumption of free sugar, both added and natural sugars be limited to 10% of total energy intake to reduce the risk of overweight, obesity and tooth decay (2015); and

WHEREAS The position paper, Sugar, Heart Disease and Stroke by the Heart and Stroke Foundation identifies a comprehensive approach to address the overconsumption of sugar, sweetened (energy dense, nutrient poor) beverages which evidence shows is linked to overweight and obese children (2014);

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to develop a province-wide comprehensive strategy to promote healthy eating and the taking into considerations the recommendations in the Senate's Report on Obesity and the Heart and Stroke Foundation Sugar, Heart Disease and Stroke Position Statement, including taxation of sugar-sweetened beverages.

AND FURTHER that alPHa request an update on the progress of the Healthy Kids Panel's recommendations.

ACTION FROM CONFERENCE: Resolution CARRIED AS AMENDED

References:

Brisbois, TD, Marsden SL, Anderson GH, Sievenpiper JL. Estimated intakes and sources of total and added sugars in the Canadian diet. Nutritents 2014:6:1899-1912.

Shields M. Measured Obesity Overweight Canadian children and adolescents, Statistics Canada, 2006.

Senate Report on Obesity - www.parl.gc.ca/content/sen/committee/421/SOCI/Reports/2016-02-25_Revised_report_Obesity_in_Canada_e.pdf.

Singh et al., Estimated Global, Regional, and National Disease Burdens Related to Sugar-Sweetened Beverage Consumption in 2010, available at http://circ.ahajournals.org.

Singh AS, Mulder C, Twisk JWR , van Mechelen W & Chinapaw MJM. Tracking of childhood overweight into adulthood: A systematic review of the literature. 2008 International Association for the Study of Obesity, obesity reviews 9, 474–4882008.

Sturm, R Powell, L Chriqui, J & Chaloupka F. Soda Taxes, Soft Drink Consumption, And Children's Body Mass Index, : http://content.healthaffairs.org/content/early/2010/04/01/hlthaff.2009.0061.full

Te Morenga L, Mallard S, & Mann J, Dietary sugars and body weight: systematic review and meta-analyses of randomised controlled trials and cohort studies. BMJ 2012; 345.

World Health Organization. Guideline: Sugars intake for adults and children. Draft guidelines on free sugars released for public consultation, 5 March 2014.

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
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June 21, 2016

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

Dear Minister Hoskins,

Re: Community Water Fluoridation

At its meeting held on June 8, 2016, the Board of Health for Peterborough Public Health considered correspondence from the Porcupine Health Unit regarding the above noted matter.

The Board echoes the recommendations outlined in their resolution (attached), and appreciates your attention to this important public health issue.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

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

Porcupine
Health Unit • Bureau de santé

May 2, 2016

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

Dear Minister Hoskins,

On April 22, 2016, the Porcupine Health Unit Board of Health passed the following resolution:

WHEREAS, the relationship between poor oral health and poor physical and mental health is clear; and

WHEREAS, the relationship between poor oral health and risks associated with childhood development are known; and

WHEREAS, individuals in the community of lower socio-economic status suffer a more significant burden of poor health; and

WHEREAS, providing fluoride via community water offers the positive benefits equally for everyone in the community; and

WHEREAS, global health experts and evidence support community water fluoridation to prevent tooth decay;

THEREFORE BE IT RESOLVED THAT, the Porcupine Health Unit recommends that the Province of Ontario amend the regulations of the Safe Drinking Water Act to require community water fluoridation for all municipal water systems (when source-water levels are below the Health Canada-recommended level of 0.7 mg/L) to prevent dental caries; and

FURTHER THAT, the Province provide the funding and technical support to municipalities to implement community water fluoridation.

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

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

alPHa Association of Local PUBLIC HEALTH Agencies

30 YEARS 1986-2016

Celebrating 30 Years!

BUILDING A HEALTHIER ONTARIO

2016 Annual Conference

Proceedings

SUNDAY, JUNE 5

Final Meeting of 2015-16 alPHa Board of Directors

Minutes of this meeting will be distributed to Board members once completed.

Opening Reception

Delegates were invited to assemble in the Alsace Room for an introductory reception featuring warm hors d'oeuvres, cheese and spreads and a selection of fruits.

Building a Healthier Ontario. One Fruit Plate at a Time.

MONDAY, JUNE 6

Combined Annual Business Meeting & Resolutions Session. *Dr. Penny Sutcliffe, Chair (Annual Business Meeting), Dr. Robert Kyle, Chair (Resolutions Session)*

The 2016 alPHa Annual General Meeting was held to report on and endorse the activities of the Association and its Board of Directors over the past year. Six resolutions were then debated and passed, two of which were related to alPHa's policies and procedures and four others as positions for advocacy. These included calls for legislation of infection control practices in personal services settings, health promoting infrastructure, 100% funding for Healthy Babies Healthy Children and a comprehensive province-wide healthy eating approach.

[Agenda and reports: Annual General Meeting]

[DRAFT Minutes] *(Final approval will be invited from the membership at the 2017 AGM)*

[alPHa 2015-16 Annual Report]

[Disposition of Resolutions]

Fitness Break featuring alPHa Fitness Challenge Winner, Timiskaming Health Unit

Photos: Dr. Marlene Spruyt & Linda Stewart (l); Timiskaming Fitness Challengers (r).

22 health units took part in this year's alPHa Fitness Challenge. The commitment on display this year was impressive with the high percentage of health unit staff participants. The range of activities was equally impressive, proving that there are many ways to build 30 minutes of physical activity into a busy day. Dog walking, aqua fit, various kinds of sports camps, bocce-ball, relays and beanbag races, cycling tours, Yoga and Pilates classes were organized and many participants built in a healthy eating component as well.

alPHa formally congratulated the Timiskaming Health Unit for successfully completing the 2016 alPHa Fitness Challenge with not only 100% participation but also organizing a Group Photo Scavenger hunt in their community. Honourable mentions were given to Sudbury, Northwestern and Huron County, for achieving 100% participation by their staff members.

In addition to a special plaque, alPHa's Fitness Challenge winner is also given the honour of leading delegates into the break with a helping of physical activity.

Opening Remarks

alPHa Executive Director Linda Stewart welcomed delegates to the conference and gave an overview of the format for the day. Focusing on the relationship between public health and Local Health Integration Networks (LHINs) that has been proposed in the Patients First discussion paper and its related legislation (Bill 210), plenary sessions will provide members with context from other sectors as well as existing local arrangements. Breakout sessions will then provide members with the opportunity to discuss the relationship more deliberately, and the outcome of these will inform strategic discussions at the alPHa Board table, as well as further discussions with and among alPHa's members.

alPHa Past-President Penny Sutcliffe then gave her own words of welcome before remarking that alPHa's 30th Anniversary coincides with 30 years since the First International Conference on Health Promotion, organized by the World Health Organization, which resulted in what is now known as The Ottawa Charter for Health Promotion.

The Charter's five pillars (building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and re-orienting health care services toward prevention of illness and promotion of health) have guided the work of local public health since then, and it is fitting that we are gathering now to discuss a proposal and new legislation by the Ontario government to strengthen that fifth pillar by bringing population health, health equity and health promotion into health services planning.

A population health approach to health care system planning is an emerging paradigm that can contribute to both the equity and sustainability of the health care system. Local public health agencies in Ontario have important information on inequities of health at the local level and can support the envisioned reorientation of the health care system. In public health, we also understand that, although access to a quality health care system is a determinant of individual and population health, it is a relatively minor determinant as compared with social and economic circumstances that create or deny opportunities for health.

Having been invited to play a greater role in health care system planning, the conference sessions have been designed to give us the chance to gather information and to discuss possible ways forward. Delegates were encouraged to participate actively, as these represent important opportunities to influence the process in the coming months.

Plenary Session – Working with LHINs *Facilitator:* **Dr. Chris Mackie**, Medical Officer of Health, Middlesex-London Public Health; *Speaker:* **Kevin Empey**, CEO Lakeridge Health (Retired); *Speaker:* **Nancy Cooper**, Director of Quality & Performance, Ontario Long-Term Care Association.

Click here for biographies.

Dr. Chris Mackie introduced the panel session with a reminder of the importance of maintaining our collective focus outside of the health care system, which is estimated to be responsible for only about a 25% share of health. That said, 25% is not insignificant and cannot be ignored. He referred to the changes that have been proposed as part of the Patients First legislation (Bill 210), urging members to have a look at the alPHa Summary that was prepared on the subject for more detail.

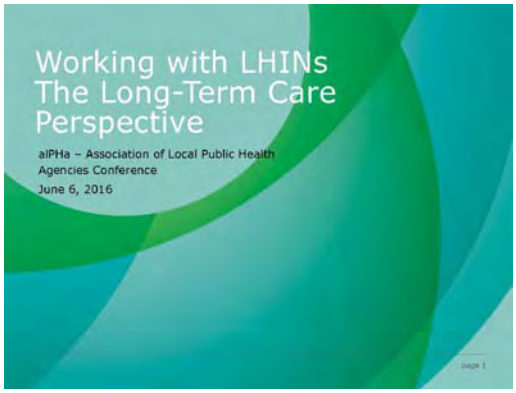
Noting that the original Patients First proposals included a transfer of funding and accountability agreements for local public health to the LHINs, he congratulated the alPHa

leadership for its successful efforts to convince the Ministry that this was not necessary to what they are trying to achieve. With the legislation now introduced (without the contentious transfers), we can now focus on what local public health can contribute to the health care system without worrying about what it might lose in the process.

Kevin Empey gave delegates an idea of what it is like to work with LHINs from the hospital perspective. He acknowledged that hospitals are by far the most visible part of the health care system and also the most complex. In addition to agreements with LHINs, hospitals also have agreements (funding and legal) with agencies including MCYS, MOHLTC, and CCO. He added that even in the absence of formal agreements, LHINs are often looked to for information about coordination of services within the regions. He then noted that the LHIN Act is structured in such a way that LHINs are fulfilling their planning, funding and integration roles in different ways, which underscores the importance of engaging with them.

That said, an eye always needs to be kept on what the Government is doing, because LHINs, despite their flexibility, still need to conform to the Government's vision.

His key piece of advice to alPHa's members was to ensure that LHINs understand who they are and what they do. This will have an important bearing on the degree to which LHINs will be a help or hindrance. Being helpful in areas of alignment is the best strategy for the foundation of the relationship, even if there are disagreements.



Nancy Cooper then gave an overview of the structure of Long Term Care in Ontario (providers, capacity and funding), the characteristics of its residents (increasing mental health issues, multiple chronic conditions), and the parallel accountabilities to LHINs, the Ministry under the Long Term Care Homes Act and Health Quality Ontario, which have resulted in contradictory mandates and obstacles to coordination and

integration.

She noted the irony of the inherent conflicts, given that the goal of LHINs is to enhance access and improve customer experience within the health care system through its coordination roles. She observed that LHINs need to learn how to work with entities that are not hospitals and that Government needs to be more careful about the unintended and sometimes absurd consequences of failing to harmonize different statutes that have common application.

During the ensuing discussion, it was clear that delegates were very interested in exploring the challenges and opportunities further, with a view to making contributions to health system planning where it makes sense to do so while protecting local public health's particular interests.

Responding to a question about formal linkages and data use, Kevin Empey observed that LHINs often have a different set of problems to solve, so while there are gaps and clear opportunities for using epidemiological data for planning in general, it may suffer from hasty and inappropriate application. Similarly, the Government (from which LHINs take their marching orders) may have certain priorities that could draw resources away from non health system activities.

Some delegates reported that they have good relationships with LHINs and are working well together in certain areas. Even then, there appears to be a persistent lack of knowledge about what local public health does and what its central purposes are. This is illustrated by the incompatibility of many local public health activities (WNV monitoring, food premises inspections, drinking water safety etc.) with the idea of integration with LHINs. The panelists agreed with this, and emphasized the importance of educating the new partners, especially given their historical focus on acute care and the fact that very few of the LHIN governors actually come from a health background of any kind.

Bringing the skill sets for population health planning to health services planning may be an important avenue for this kind of education going forward, and both panelists observed that there is a real desire within the LHINs to move away from paying exclusive attention on hospitals. As their coordinating role expands and the direct provision of services is added to their mandate, many of them are realizing that prioritization and strategic use of resources is going to be required. This suggests that they will be receptive to what public health brings to the table and willing to understand the nature of it better.

One member even suggested that local public health should have authority over the LHINs rather than the inverse, observing that public health is far more than a community service agency. With its expertise in the factors unrelated to the health care system that contribute to 75% of health, public health should really be using data to direct LHINs on how to organize services.

Relief that public health would not in fact be integrated into the LHINs was a strong undercurrent of the discussion, but uncertainty about what the formal relationship between the two is going to look like remained. The opportunity to innovate through collaboration is certainly attractive, but there are unanswered questions about prescriptiveness and autonomy, the tension between consistency and local

tailoring, the capacity and resource impacts of the new public health role, the impact on municipalities (as funders of public health), and services to First Nations communities.

There appeared to be cautious optimism that beginning to answer these questions will be an important opportunity to influence the definition of the relationship while raising the required awareness of public health's raison d'être. LHINs have questions of their own, and will be likely be receptive to this as they seek to bring in a culture and mentality that isn't limited to acute care.

Hon. Eric Hoskins, Minister of Health and Long-Term Care
Click here for introductory Bio

After lunch, alPHa Past-President Penny Sutcliffe welcomed the Honourable Dr. Eric Hoskins to briefly address the membership. He opened with words of thanks for everything that our members do to preserve the health of Ontarians and observed that as a public health physician, he considered himself among friends and colleagues.

Referring to elements of his biography that were shared by Dr. Sutcliffe during his introduction, he reiterated that the lenses of health equity and the social determinants of health bring all of the work that he has done into focus.

He acknowledged members' keen interest in the Patients First Act and assured them that he welcomes the opportunity to speak directly to them about how this the legislation is going to elevate their role in health system planning. He characterized public health as critically important to the health of populations, and stated his strong belief that its voice needs to be heard to ensure that health resources are properly allocated.

Citing the "Three Cities Within Toronto" report, he declared a strong interest in breaking the twin cycles of poverty and poor health outcomes, which is going to require a close look at the data underlying the association between the best health outcomes and the greatest access to community health services. Gaps will need to be identified and prioritized for action, and this is one of the goals of the Patients First Action Plan for Health Care. Putting the needs of patients at its centre, the Plan seeks to ensure that how and where services are delivered maximize quality of care.

This, he suggested, is parallel to public health's own actions that prevent poor health outcomes at the community level, and he argued that this perspective is badly needed at the health service provision level. The Plan acknowledges the need for better coordination and distribution, which will ensure a better experience for all users and better access for the neediest ones.

He then observed that the work of public health is largely occurring independently of the other entities within the health system, and as such is an underutilized resource. He acknowledged the importance of ensuring that public health's existing programs and services are strongly protected while providing the opportunity for these entities to start looking at their own services through a health equity lens and to make use of population health expertise and data to inform their planning.

This, he argued, would instil a change in culture by elevating public health to a position where the rest of the system is obliged to listen, and will help us close the gaps that we have told them exist. In short, the intent is a greater role for public health, not a diminished one.

In order to achieve this, an Expert Panel on Public Health Integration will provide advice on how public health expertise, which has been ignored by the health service sector for too long, can be incorporated, strengthened and properly applied so that all 14 million Ontarians can benefit.

Plenary Session – Getting Local: Ontario public health experiences in partnering with LHINs, success factors in developing positive relationships

Facilitator: **Nancy Jacko**, Chair, North Bay Parry Sound BOH *Click here for Bio*
Speaker: **Dr. Paul Roumeliotis**, Medical Officer of Health, Eastern Ontario Health Unit
Speaker: **Dr. Hazel Lynn**, Medical Officer of Health, Grey Bruce Health Unit
Speaker: **Dr. David McKeown**, Medical Officer of Health, Toronto Public Health

Photo l-r: Nancy Jacko, David McKeown, Hazel Lynn, Paul Roumeliotis

Our second panel gave members the opportunity to hear from local public health colleagues about their experiences partnering with LHINs.

Dr. David McKeown kicked off the presentations, referring to the City of Toronto's relationship with 5 different LHINs and the need to coordinate with them given the broad range of care-focused services that Toronto Public Health (TPH) provides.

A table established to bring representatives of the 5 LHINs and the TPH health services together, one of the main benefits of which turned out to be bringing those 5 LHINs together. It was an opportunity to get to know each other and how LHINs would relate to services being provided. There were differing degrees of interest depending on the relative share of the city contained within LHIN boundaries, and it allowed the Toronto Central LHIN (the one with the largest chunk of the city) to become the connector.

One of the most notable areas of success was coming to grips with the health needs of the urban indigenous population. There was no strategy to address these needs, and the Central Toronto LHIN and TPH joined forces to develop one. Over 2 years, both organizations have assigned staff, funded studies and consulted with the community via an advisory table, which also needed to be established in the absence of an appropriate local indigenous government. The net result of this was Toronto's first Indigenous Health Strategy, launched just last month.

He added that he (as Toronto MOH) and his LHIN CEO counterpart have attended nearly every meeting of the larger table, which speaks to the importance of leadership engagement in yielding a successful strategy to embed mutually beneficial processes in the organizations' respective plans.

Dr. McKeown also observed a change in the relationship following the release of Patients First, in that the LHINs are starting to reach out and ask questions about how public health uses its data and information for planning purposes. They are looking for guidance on how to move into this new area, and he believes that this is a promising sign that public health will be able to ensure a productive role for itself.

Dr. Hazel Lynn then shared her experience, which began with a 2007 request from the Chair of her LHIN Board for a rural voice. Hers was a solitary one among hospital administrators, and she found it interesting that faster surgery was being seriously discussed as a means to reduce wait times. One of her first achievements was to have the area's Chronic Disease management team renamed "prevention and management" in order to expand the focus. This opened the door to a new way of thinking, and led to an important joint effort on falls prevention. Knowing the significant impact that injury due to falls had on hospital populations, the LHIN became very interested in policy development and health promotion, to the point that the concept of age-friendly communities gained traction.

A LHIN grant then laid the foundation for Finding Balance Ontario, a campaign designed to increase awareness of fall risks and strategies to prevent them. The LHIN asked if this Grey Bruce program could be used LHIN-wide, and hospital visits related to falls for 65-74 year olds dropped dramatically. Dr. Lynn cited this as an example of good collaboration and mutual assistance in the development of approaches in areas of mutual interest. Stronger relationships and improved outcomes were welcome consequences.

Dr. Paul Roumeliotis shared his experiences from the perspective of a health unit that is fortunate to be grouped with three others in a single LHIN (Champlain), whose inaugural CEO was a former medical officer of health, which ensured a good relationship from the start. He also referred to the early identification of falls prevention as an area of mutual interest, which evolved to the development of the province-wide Falls Prevention Toolkit. This was the outcome of the Integrated Provincial Falls Prevention Project, which involved LHIN CEOs and MOHs across the entire province, a collaboration that was the first of its kind.

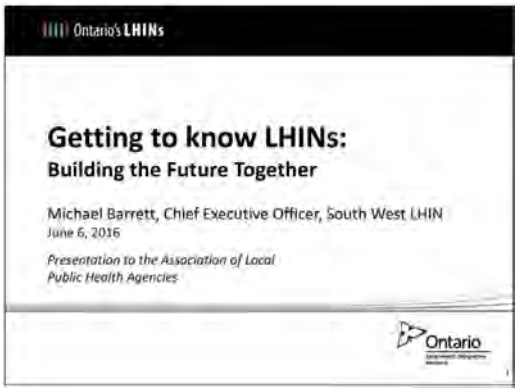
He also referred to the response to the Kashechewan flood, during which evacuees were housed in Eastern Ontario's 500-room NAV Centre. Coordination of health services was imperative over their nine-week stay, and the LHIN delegated this responsibility to the local MOH. Daily meetings were arranged with pharmacies, hospitals, ministry and social services to ensure that communicable diseases, pregnancies, medication distribution and so on could be attended to. His observation here was that the relationships and trust were already in place to do what needed to be done.

Nancy Jacko then described the North East LHIN, which includes 115 health service providers and 25 hospitals. She provided several examples of close collaboration between LHINs and the NBPSDHU, including aging at home / assisted living, falls prevention, health care worker immunization and the North Bay Gateway Hub, a multi-disciplinary approach to address the needs of at-risk youth in order to keep them out of justice and hospital systems.

During the ensuing discussion, panelists were asked to comment on any changes to the relationships following the introduction of the Patients First proposals. The responses from each were very similar, in that the relationships themselves hadn't changed much, but there was certainly increased engagement and increased interest in discussing the proposals and their implications. Some noted that the LHIN counterparts expressed similar reservations about the transfer of funding and accountability. Nancy Jacko observed that there has been an enhanced interest in what public health is all about and that its potential value is beginning to be recognized.

Concurrent Breakout Sessions:
Click here for facilitator biographies.

A: Understanding LHINs, their key roles and functions, legal framework, and operations *Facilitator:* **Michael Barrett**, CEO South West LHIN. *MC:* **Dr. Robert Kyle,** COMOH Rep to alPHa Board for Central East *Recorder / Reporter* **Sandra Laclé**, HPO Rep to alPHa Board



The objective of this session was to describe the role and functions of the Local Health Integration Networks so that the concepts learned from others about working with a LHIN can be applied in a public health context.

Michael Barrett gave an overview of the LHIN role in health care planning and decision making at the local level, which is based on the idea that community health needs are best understood by the people who live and work there (vs centralized government). He then gave a brief history, a description of their funding and accountability relationship with the Ministry.

The LHIN's main aim is to ensure smooth transitions for patients and caregivers through linkages between providers and other partners, making the system easier for patients to navigate, and connecting health service providers to non-health services.

Community engagement is both a core value and a legislative requirement under the Local Health System Integration Act but it is about increasing access and smooth transition to the system. It was noted that stakeholder and client engagement is built into the Ontario Public Health Standards (OPHS) and organizational standards, but the focus is on prevention, promotion and protection of health rather than navigating a system of services.

The involvement of public health in local LHIN decision making as proposed in the Patients First paper was characterized as an opportunity to leverage public health programs, leverage shared data to better understand populations and work together as a system to unify approaches. Better communication between public health and primary care providers is seen as an essential element of improving the health of our communities.

Mr. Barrett suggested that MOHs could sit at the senior management table at the LHINs as part of the as-yet-undefined formalized linkages between the two, but he acknowledged the difficulties where more than one health unit lies within a LHIN boundary and vice versa. Dr. Penny Sutcliffe suggested in response that we need clarity on what we are trying to achieve and define the nature and form of the linkage.

The importance of understanding each other's business and identifying shared priorities was seen as fundamental to defining the parameters of the relationship if it is to achieve its goals.

B: Scenario planning for the local public health sector in a Patients First context *Facilitator:* **Karen Singh**,Consultant, Former Senior Policy Advisor to Minister of Health, *MC:* **Mary Johnson,** BOH Rep to the alPHa Board for the Eastern Region, *Recorder / Reporter*: **Maureen Cava,** Ontario Association of Public Health Nursing Leaders (OAPHNL) rep to alPHa's Board

All of the information from this session is available in the documents linked above. The slide deck may be downloaded to view the speaker's notes, which will give readers a clear view of how the session was conducted. The facilitator also prepared a detailed report from the session based on the recorder's notes.

C. Population health planning – scoping out the possible *Facilitator/ Reporter / Recorder:* **Emma Tucker**, Manager & Senior Epidemiologist Public Health Surveillance & Evaluation, Halton Region and Association of Public Health Epidemiologists in Ontario (APHEO) Rep to alPHa Board, *MC:* **Linda Stewart,** Executive Director, alPHa.

The purpose of this session was to explore potential next steps in bringing the population health planning role to the health system planning table and identify what questions need answering to be able to move forward.

Participants were asked to share examples of PHU and LHIN collaborations related to planning, and the responses were predictably diverse. They illustrated that the 14 LHINs were quite different from each other and engagement occurred in different ways and in different areas. Examples given included: Health Links, a health equity working group, socio-demographic data collection of patients/clients, emergency

preparedness, a joint breastfeeding committee, a chronic disease prevention planning committee, falls prevention planning, aboriginal health planning, tobacco cessation, and electronic health records. Other examples were given of work that PHUs had been asked to deliver but have been unable to, such as neighbourhood-level data/profiles and providing health equity education to service providers.

There was recognition that Population Health Planning needs to be clearly defined and distinguished from population-level health care system planning, as our expertise is in the former and public health should not be expected to lead on the latter.

A key focus of the discussion was the need to identify areas where it makes sense to work together and plan together. Areas of mutual interest may include shared performance indicators (each with separate PHU and LHIN accountability) on treatment of STIs, timely immunization across the lifecycle, breastfeeding, smoking cessation, alcohol intake, and equity targets (well baby visits in KFLA by neighbourhood income was an example given of this).

There was also a consensus that any joint planning needs to be deliberate, as opposed to simply providing data dumps without the interpretation and knowledge translation to inform good decisions. This of course raised the issue of the required additional resources and the opportunity costs of not receiving them.

Questions were then presented as worthy of further exploration, including:

- What data do we have?
- What data does the LHIN have?
- What are the assumptions about what public health epidemiologists can actually do?
- Is this an opportunity to assess our own data sources, comprehensiveness and quality?
- How can other partners assist in the data and planning work, e.g. Public Health Ontario, Institute for Clinical Evaluative Sciences (ICES), Rapid Risk Factor Surveillance System (RRFSS)?"

More broadly, it was felt that there would be value in developing a set of principles for the application of population health planning to health system planning that can be ensure a provincially consistent public health approach that can be applied locally.

Reporting Back, l-r: Linda Stewart, Sandra Laclé, Maureen Cava, Emma Tucker

President's Reception and alPHa Distinguished Service Awards Dinner *sponsored by AVIVA Canada*

Please click on the image to view the entire booklet, which includes profiles of each of the 8 alPHa DSA winners for 2016.

Diane Bewick with presenter Maureen Cava (OAPHNL)

Jo Beyers (r) with presenter Tracy-Allan Koester (OSNPPH)

Kevin Churchill with presenter Ellen Wodchis (HPO)

Pat Hewitt with presenter Don West (AOPHBA)

(l-r) Kevin Churchill, Jo Beyers, David McKeown, Chris Munn, Pat Hewitt, Hazel Stewart, Diane Bewick, Julie Roy.

Julie Roy (c) with presenters Trudi Sachowski and Mark Perrault (BOH)

David McKeown with presenter Rosana Salvaterra (COMOH)

Chris Munn (r) with presenter Bjorn Christensen (ASPHIO)

Hazel Stewart with presenter Paul Sharma (OAPHD)

TUESDAY, JUNE 7, 2016

Ministry Update: **Roselle Martino**, Assistant Deputy Minister, Population and Public Health Division, MOHLTC; **Sharon Lee Smith**, Associate Deputy Minister, Policy and Transformation, MOHLTC; **Dr. David Williams**, Chief Medical Officer of Health

Roselle Martino referred to her detailed slide deck to provide updates on a number of initiatives:

Regulation of E-Cigarettes & Medical Marijuana: She also drew attention to the related Ontario Smoking Cessation Action Plan

Menu Labelling: She acknowledged the enforcement challenges inherent in the specificity of the legislation and will be looking to local public health to help them develop protocols over the summer.

Healthy Kids Strategy: She presented some of the questions she's been getting and reiterated the government's support for the three pillars (healthy start, healthy food and healthy active communities including the HKCC) and the various activities related to them.

Alcohol Policy: She thanked alPHa for its ongoing feedback on provincial alcohol policy and acknowledged the need for a culture of social responsibility to offset the economic drivers involved. A provincial Alcohol Policy was announced in December 2015 and consultations occurred over the winter and recommendations are expected soon.

Healthy Smiles Ontario: She thanked alPHa for its support in implementing what she called one of the most complex initiatives she's ever worked on. Allocations are expected to be revealed by the end of the summer.

Immunization 2020: This is a Cabinet document and will be Ministry policy over the next 5 years. Amendments to ISPA and expansion of HPV coverage were part of this. She noted that family physicians administer 80% of immunizations and acknowledged that record keeping is a problem. The MOHLTC will continue to work with the Ontario Medical Association on this. She also confirmed that extraordinary costs under the expanded HPV program will be considered for reimbursement, and that coverage for the Shingles vaccine is expected to begin in the autumn.

Patients First and OPHS Reviews: she reiterated the plan to strike an Expert Panel on Health Integration to look at the form and function of the formal relationship between PH and LHINs, and noted that a capacity committee is being considered in addition to the Organizational Governance Committee (OGC), Practice and Evidence Program Standards Advisory Committee (PEPSAC), and Executive Steering Committee (ESC). They are also looking at a stream for indigenous people, i.e. how the Standards can be applied within their communities.

Sharon Lee Smith joined the meeting to provide further details on Patients First, which she described as a cornerstone of much of what's going on in the Ministry.

She provided highlights of the public health parts to provide context for its inclusion and integration, and thanked alPHa for the ongoing work that it has done and its leadership on behalf of local public health.

She reiterated that changes are no longer planned for the funding and accountability models, but that there remains strong interest in the enhancement of planning functions at the system level with public health's valuable advice.

She then referred to the Patients First Act as the source of the establishment of the formal linkage required to achieve this, but emphasized that the consultations going forward will inform how it is implemented. She noted that health equity has gained enormous currency in all parts of the system and it has been recognized that public health is where the rest of the system can learn its lessons.

She then stated her intention to have more in-depth conversations with alPHa and local public health when the capacity planning element of this is further along, recognizing the necessity to analyze where resources are going to be needed in the longer term.

Responding to an observation that accountability indicators tend to become organizational priorities and a question about the likelihood of LHIN indicators becoming more population health-based, Ms. Smith stated that she believed that they would, but it would take some time and would be influenced by the public health presence to make them so.

Concerns about the risks that may accompany the integration continued to be expressed by delegates. An enhanced role in the health care delivery system could come at the expense of public health independence and resources, and infringe on the multitude of functions that have nothing to do with health care. In addition, there is a fundamental incongruity between the population health approach (e.g. social marketing, policy development, enforcement) employed by public health and the patient-centred approach of the care system.

Ms. Smith responded that the acute care system is suffering, and she believes that there is strength to be found in the proactive, population health based planning in which local public health specializes. This isn't about pooling resources so much as creating a system that takes full advantage of the individual strengths of each component.

Dr. David Williams greeted delegates and remarked that these are exciting times that will bring equally exciting opportunities for public health in Ontario. He commented that with a public health physician as Minister, a physician as Deputy Minister and passionate ADMs, there will be plenty of openings to promote local public health and its strengths and successes within the Ministry and throughout the system it oversees.

The OPHS reviews and Patients First are the processes that will provide avenues to do this, but he acknowledged that increasing demands on finite resources need to be carefully considered at all times. This, he thinks, speaks to a need to combine the various data sources to better inform decision making while maintaining local flexibility where necessary and consistency where required.

We know where health status is deteriorating and we need to find a way to let local PH address them, especially as it often falls to the acute care system to manage the consequences. The cost drivers of acute care are not changing, and public health's potential role in saving money down the road is finally being understood. It will be important to emphasize public health's central purpose while measuring this value in order to mitigate some of the risks outlined in the discussions above.

He reminded colleagues that the CMOH office is a resource to the entire provincial government, and we need to leverage that voice. He is building a stronger relationship with his local MOH colleagues in order to properly address programmatic issues.

Responding to a question about the Province's intention to address community water fluoridation through legislation and support, Dr. Williams responded that there isn't any at the moment, although he agreed that this is an example of a crisis of trust in information management. Preconceived notions and mistrust of government itself presents ongoing challenges that are very difficult to overcome. He suggested that local public health is in a good position to rebuild the required trust to win these kinds of battles.

Regarding the Ontario Public Health Standards Review, he did confirm that mental health, seniors' health, the partnership with LHINs, vision screening, population health assessments have all been raised as potential new areas and that some clinical services and functions that now reside with PHO are being looked at for possible removal. Nothing has been decided and information will be shared as progress is made.

Concurrent Business Meetings for alPHa Sections (COMOH & BOH); Inaugural Meeting of 2016-17 alPHa Board of Directors

Materials related to these meetings will be distributed directly to participants as appropriate.

alPHa would like to acknowledge the essential contributions of the members of the 2016 Conference Planning Committee!

Oma Boodoo, Health Promotion Specialist, Toronto Public Health; Nancy Jacko, Board of Health Member, North Bay Parry Sound District Health Unit; Barbara Johne, Senior Policy & Strategic Issues Advisor, Toronto Public Health; Stuart Kidd, Board of Health Member, North Bay Parry Sound District Health Unit; Susan Lee, Manager, Administrative & Association Services, alPHa; Gary Levine, Board of Health Member, Grey Bruce Health Unit; Mark Perrault, Chief Executive Officer, Northwestern Health Unit; Sharon Pfaff, Board of Health Member, Chatham-Kent Public Health Unit.

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From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: Wednesday, July 13, 2016 3:47 PM
To: Alida Tanna
Subject: alPHa Information Break - July 13, 2016

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

Information Break

July 13, 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.

2016 Annual Conference Wrap Up

Thank you to everyone who attended alPHa's 2016 annual conference, *Building a Healthier Ontario*, held last month in Toronto. Thanks also to our speakers, sponsors and exhibitors for their participation and support. alPHa has prepared a summary of the breakout sessions and plenary presentations, including remarks by the Minister of Health and Long-Term Care, which can be accessed by visiting alPHa's website and clicking the link below (login and password required).
2016 alPHa Annual Conference Proceedings

New alPHa Executive Committee

Members of the 2016-2017 Executive Committee of the alPHa Board of Directors are:

Dr. Valerie Jaeger (Niagara) - President
Carmen McGregor (Chatham-Kent) - Vice President
Dr. Robert Kyle (Durham) - Treasurer
Mary Johnson (Eastern Ontario) - Boards of Health Section Chair
Dr. Penny Sutcliffe (Sudbury) - COMOH Chair
Bjorn Christensen (Niagara) - Affiliate Representative
Gilles Chartrand (Porcupine) - Member-at-Large

For a full list of the 2016-2017 alPHa Board, click here.

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alPHa Resolutions

Six resolutions were endorsed by the alPHa membership at the June AGM, including calls to government to fully fund the Healthy Babies Healthy Children, and adopt health- and health equity-promoting design criteria in community and transportation infrastructure funding. One resolution also called on the province to develop a healthy eating strategy based on recent health report recommendations that promote reduced consumption of sugar, sugar-sweetened beverages, and processed foods. With support from the Heart & Stroke Foundation, alPHa issued a news release on July 12 on this healthy eating resolution.
View the 2016 alPHa resolutions here
Read the July 12 alPHa news release here

Save the Date - 2017 Annual Conference

The alPHa Board is pleased to announce that the 2017 alPHa Annual General Meeting and Conference will be held from **June 4 to 6, 2017** in Chatham, Ontario. Co-hosting with the association will be Chatham-Kent Health Unit. More details to follow.

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alPHa Group Insurance Offer

alPHa members and all health unit staff are eligible to receive an exclusive group discount of 12.5% on home and auto insurance from Aviva Insurance. Request a quote today by visiting www.alphagroupinsurance.ca or by calling 1-877-787-7021. Other benefits include: additional savings available through other discounts, free access to personal legal, home and health information service (included with home insurance policies), and professional claims handling backed by Claims Service Satisfaction Guarantee.

Upcoming Event

June 4, 5 & 6, 2017 - 2017 alPHa Annual General Meeting and Conference, Chatham, Ontario. Details TBA.

Ministry of Health
and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel. 416 327-4300
Fax 416 326-1571
www.ontario.ca/health

Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

Édifice Hepburn, 10e étage
80, rue Grosvenor
Toronto ON M7A 2C4
Tél. 416 327-4300
Téléc. 416 326-1571
www.ontario.ca/sante

Ontario

HLTC2966MC-2016-5778

JUL 22 2016

Scott MacDonald, Chair
Board of Health
Rosana (Pellizzari) Salvaterra,
MD, Msc, CCFP, FRCPC
Medical Officer of Health
Peterborough Public Health
Jackson Square, 185 King Street
Peterborough ON K9J 2R8

Dear Mr. MacDonald and Dr. Salvaterra:

Thank you for providing feedback on the Patients First proposals including your support for an approach that ensures that population and public health priorities and expertise inform health planning, funding and delivery at the local level, and concerns related to funding and accountability for public health activities and local boards of health.

On June 2, 2016, the Ministry of Health and Long-Term Care introduced the Patients First Act. If passed by the Ontario Legislature, the Act will introduce specific requirements to delineate the formal linkages for ongoing engagement between Medical Officers of Health and LHIN Chief Executive Officers, as well as the active involvement of boards of health in the development of Integrated Health Service Plans. The Act would not change the current mechanisms for funding public health or the accountability agreements with boards of health at this time, nor the current roles of the LHINs or the ministry with respect to overseeing public health across the province.

I recognize the complexities involved with funding and accountability for public health.

The Expert Panel on Public Health Integration, to be implemented shortly, will advise on opportunities for further integration of public health with the broader health sector and to deepen the partnership between LHINs and public health.

...2

I look forward to your continued input and collaboration as the ministry moves forward together with health system reform.

Yours sincerely,

Dr. Eric Hoskins
Minister

c: Jeff Leal, MPP
Laurie Scott, MPP

Peterborough Public Health

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

August 2, 2016

Hon. Carolyn Bennett
Minister of Indigenous and Northern Affairs
Room 173, East Block
House of Commons
Ottawa, ON K1A 0A6
carolyn.bennett@parl.gc.ca

Hon. David Zimmer
Minister of Indigenous Relations and Reconciliation
160 Bloor Street East, Suite 400
Toronto, ON M7A 2E6
dzimmer.mpp@liberal.ola.org

Dear Honourable Ministers:

Re: Safe Drinking Water on Reserves

The board of health for Peterborough Public Health is concerned about the lack of safe drinking water that continues to exist in one of our two First Nations.

Curve Lake First Nation (CLFN) currently has a small treatment plant that services 56 homes, however it has been flagged by Aboriginal and Northern Development Canada (AANDC) as being over capacity. In addition to the homes that are serviced, there are 588 homes on private wells that continually experience boil water advisories (BWAs), with an average of one-and-a-half (1.5) BWAs per month for E.coli and coliform bacteria.

Our Public Health Inspectors conduct weekly beach water sampling at the two CLFN beaches and since 2014, we have had to close one of the beaches between 5 to 8 days per season because of the high counts of E. Coli in the water. We are concerned that the surface water surrounding this community is poor, potentially putting residents at risk.

The Physical Environment is recognized by the Public Health Agency of Canada as a determinant of health. The underlying premise of this determinant of health is that, at certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments.

Given the current federal and provincial commitments to address drinking water on First Nations by ending boil water advisories on reserves within the next five years, we are advocating that CLFN be considered a priority.

The leadership at CLFN has undertaken several studies and invested in the planning for a new water treatment facility. We are all counting on the federal and provincial levels of government to provide the funding and support required to ensure that safe drinking water is available for its residents now and in the future.

Thank you for your consideration.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at

cc: Chief Phyllis Williams, Curve Lake First Nation
Trilateral Working Group on Drinking Water, c/o Indra Prashad, Director, Indigenous Drinking Water Projects Office, Ministry of the Environment and Climate Change
Hon. Maryam Monsef, MP Peterborough-Kawartha
Hon. Jeff Leal, MPP, Peterborough

From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: Monday, August 15, 2016 4:04 PM
To: Alida Tanna
Subject: alPHa Information Break - August 15, 2016

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

Information Break

August 15, 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.

New Dates for 2017 Annual Conference

In a previous edition, we announced that the 2017 alPHa Annual General Meeting and Conference would take place June 4 to 6 in Chatham, Ontario. However, we have had to change the date (but not the location) and will now be holding the conference from **June 11 to 13**. It appears that the original dates would have conflicted with another national public health association's event that is attended by more than a few alPHa members. We look forward to co-hosting alPHa's 2017 AGM and Conference with Chatham-Kent Health Unit at the new Chatham-Kent John D. Bradley Convention Centre. We'll have more conference details in the coming months, so stay tuned.

Upcoming Risk Management Webinar: August 25, 2016

alPHa will be holding a risk management webinar for health unit staff on August 25 from 10:00 to 11:30 AM. Corinne Berinstein, Senior Audit Manager with the Health Audit Team, will lead the webinar which will cover the basics of risk management as it applies to health units. **Pre-registration to participate is required**.

Register here for the August 25 Risk Management Webinar

To join the webinar click on the appropriate Adobe Connect URL below. It is recommended that you connect 5 to 10 minutes prior to the start of the webinar at 10:00 AM. Please log in as a guest and provide your name and health unit in the guest log in box.

August 25 - https://ali.health.gov.on.ca/r271rj4myhg/

To connect to the audio portion of either webinar, participants are asked to call **1-866-633-1033 or 416-212-8013** and enter Participant code: **5850435#**

If you are unable to attend the August 25 webinar, the next one will be held on September 14. Details to come.

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alPHa Online Risk Management Resources

Online resources for health unit risk management are now available on alPHa's website. Created by the alPHa Risk Management Working Group, the resource area allows viewers to access information about risk management, including the implementation approach. Health unit staff also have the opportunity to share their own risk management resources by posting these to the alPHa website. For information on how to post, please click the second link below.
Visit the alPHa Risk Management Resources page here
Instructions for sharing risk management resources

Breastfeeding Supports for Ontarians

On August 1 during World Breastfeeding Week, the government reminded Ontario mothers about provincial supports available to help them breastfeed. Support programs include a telephone hotline and an online list of services. To learn more, click the link below.
View the Ontario government news release here

Upcoming Events - Mark your calendars!

November 24 & 25, 2016 - alPHa Fall Symposium. Toronto, Ontario.

February 23 & 24, 2017 - alPHa Winter Symposium. Toronto, Ontario.

June 11, 12 & 13, 2017 - alPHa Annual General Meeting and Conference, Chatham-Kent John D. Bradley Convention Centre, Chatham, Ontario.

Organizational Governance Committee for Standards Modernization
June 2016
Highlights #1

Health system transformation is underway in Ontario, with a focus on access, quality and value for money. The foundation for an accountable, transparent, integrated, and evidence-informed system that provides the right care at the right time in the right place and promotes healthy living has been established through Action Plan for Health Care, 2012. The person-centred framework established in the Patients First: Action Plan for Health Care, 2015 aims to: provide faster access to the right care; deliver better coordinated and integrated care in the community, closer to home, provide the education, information and transparency people need to make the right decisions about their health, and protect the universal public health care system by making decisions based on value and quality.

Public health has a key role to play in achieving the aims of the person-centred framework for strategic action. As part of the broader health system transformation efforts underway in Ontario, the Ministry of Health and Long-Term Care (MOHLTC) has embarked on a process to modernize the 2008 Ontario Public Health Standards (OPHS) and the 2011 Ontario Public Health Organizational Standards (Organizational Standards) ("Standards Modernization"). The Standards Modernization process will provide the opportunity to review and clearly define public health's role and contributions within the broader health system transformation process.

As part of the Standards Modernization process, the ministry has established the Organizational Governance Committee (OGC) to recommend an accountability framework for public health. The OGC will report to the ministry through the Executive Steering Committee (ESC).

The OGC is chaired by **Ms. Roselle Martino**, Assistant Deputy Minister, Population and Public Health Division, MOHLTC. Members of the Committee include:

Ms. Karen Jones
Senior Corporate Management and
Policy Consultant
City of Toronto
(City of Toronto representative)

Mr. Brian Laundry
Senior Director
Central East Local Health Integration
Network (LHIN representative)

Dr. Chris Mackie
Medical Officer of Health
Middlesex London Health Unit
(COMOH representative)

Ms. Anne Schlorff
Director, Central Resources
Region of Waterloo Public Health
and Emergency Services
(AOPHBA representative)

Ms. Janette Smith
Commissioner
Health Services Region of Peel
(AMO representative)

Ms. Linda Stewart
President
Association of Local Public Health
Agencies (alPHa representative)

Mr. Larry Stinson
Director of Operations
Peterborough Public Health
(OPHA representative)

Ms. Cynthia St. John
Executive Director
Elgin St. Thomas Public Health
(AOPHBA representative)

Mr. Don West
Chief Administrative Officer
Porcupine Health Unit
(AOPHBA representative)

Update

The first meeting of the OGC was held on the afternoon of May 13, 2016. The members discussed the Committee's Terms of Reference and its relationships to ESC and the other committees within the Standards Modernization process.

The Committee will focus its workplan on an overall approach to accountability. Specifically, the Committee will deliberate on a proposed accountability framework, focusing on board of health accountability for the use of ministry funding for the delivery of public health programs and services. The Committee will also consider how the framework will be operationalized, and what tools and resources are required to support boards of health in fulfilling accountability requirements within their respective organizations and to the ministry.

The Committee began by considering historical accountability frameworks in relation to the need for increased transparency and the ability to demonstrate value for money. Members spent time discussing the need for an approach to accountability within the public health sector which takes into account the anticipated transformation of the health care system. The important role of governance in accountability was also noted.

Members were asked to consider whether the name of the committee should be changed to reflect the committee's mandate to focus on accountability. The OGC is expected to provide recommendations to ESC in support of the December 2016 submission to the ministry of revised standards for public health.

The next meeting of the OGC will focus on performance measurement – the first pillar within the proposed accountability framework.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Accountability Committee for Standards Modernization July 2016 Highlights #2

The Organizational Governance Committee (OGC) has been renamed the Accountability Committee (AC) to better reflect the committee's mandate and focus on accountability. The AC reports to the Executive Steering Committee for the Standards Modernization process and is continuing with its review of accountability within the context of the relationship of boards of health to the ministry.

There has been one change in the committee's membership: Mary Johnson has replaced Florence Campbell as the alPHa Board of Health Section representative. Mary is a member of the board and the past chair of the Board of Health for Eastern Ontario. The AC Terms of Reference are included in Appendix 1.

The AC held its second meeting on June 17, 2016 and discussed the fundamental components of performance measurement and quality improvement. The main goal for the committee is to articulate an accountability framework for the public health sector and recommend operational tools which will support the ministry in holding boards of health accountable for both complying with standards and achieving outcomes.

The articulation of a performance measurement strategy will be explored further once the scope of all of the core components of the accountability framework has been considered. Committee members discussed the importance of quality improvement (QI). This could be supported through the use of standardized approaches to quality improvement, which would enhance the sector's capacity to undertake QI processes.

Future committee meetings will focus on continuing the discussion regarding the scope of the accountability framework, including consideration of how to address accountability for programs and services, governance and funding.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Standards Modernization
Accountability Committee
TERMS OF REFERENCE

BACKGROUND

As part of the public health renewal agenda, the ministry released the Ontario Public Health Standards (OPHS) in 2008 and the Ontario Public Health Organizational Standards (Organizational Standards) in 2011. The OPHS and incorporated protocols are guidelines issued by the Minister under the *Health Protection and Promotion Act* (HPPA). These establish the minimum requirements for fundamental public health programs and services to be delivered by Ontario's 36 boards of health. The Organizational Standards establish the minimum management and governance requirements for all boards of health and public health units and are operationalized via the Public Health Funding and Accountability Agreement.

CONTEXT

Health care system transformation is underway in Ontario, with a focus on access, quality and value for money. The foundation for an accountable, transparent, integrated, and evidence-informed system that provides the right care at the right time in the right place and promotes healthy living has been established through Action Plan for Health Care, 2012. The person-centred framework established in the Patients First: Action Plan for Health Care, 2015 aims to provide faster access to the right care, deliver better coordinated and integrated care in the community, closer to home, provide the education, information and transparency people need to make the right decisions about their health, and protect the universal public health care system by making decisions based on value and quality.

As part of the broader health system transformation efforts underway in Ontario, the Ministry of Health and Long-Term Care (MOHLTC) is conducting a review of the OPHS and Organizational Standards (Standards Modernization). Demonstrating an accountable, efficient and transparent system are key objectives of Ontario's health care transformation agenda and public health can play a key role in achieving these aims through the Standards Modernization process. The Standards Modernization process will provide an opportunity to clearly define public health's role and contributions within the broader health system transformation process.

MANDATE

The Accountability Committee (AC) is being convened to recommend an accountability framework for the public health sector in Ontario to support enhanced transparency and the demonstration of value for money. This will include a review of the tools and processes currently in place to support the ministry's accountability for public funds.

RESPONSIBILITIES

The Accountability Committee is charged with providing the Executive Steering Committee (ESC) with recommendations on an accountability framework and a revised set of accountability tools and processes.

To complete this task, the Accountability Committee will:

- Receive direction from ESC and respond to requests from ESC for input and advice;
- Provide recommendations on a draft accountability framework that is specific to public health and include recommendations on the processes and mechanisms that are needed to support implementation;
- Ensure the scope of the accountability framework covers the full scope of the accountabilities of boards of health in their relationship to the ministry.
- Consider how to achieve a balance between ensuring compliance with service delivery expectations and supporting the achievement of intended outcomes;
- Consider how accountability can be implemented without creating excess burden on resources;
- Develop recommendations regarding transparency, value for money, efficiency, effectiveness, risk management and standardization in practices can be achieved;
- Provide recommendations on the infrastructural elements that are needed to support the implementation of an accountability framework;

DELIVERABLES

The Accountability Committee will conclude its mandate following submission of a recommended accountability framework with tools and processes to the Executive Steering Committee for review.

The Accountability Committee will contribute to the key messages and process updates for the sector, which will form part of a broader ESC and MOHLTC communication strategy.

MEMBERSHIP

The Accountability Committee will be chaired by Roselle Martino, Assistant Deputy Minister, Population and Public Health Division. Membership on the Committee will represent a balance of representatives from public health units, boards of health, as well as other individuals, stakeholder organizations and government representatives.

Members will sign confidentiality agreements due to the sensitive nature of some of the items discussed and brought for the committee's review and consideration.

In order to sustain the momentum of committee work, there will be no delegates permitted for meetings. Members who miss more than two meetings may be asked to reconsider their commitment to membership on the Committee.

Meetings may occur as frequently as every 4 weeks. Meetings will occur in-person in Toronto, with teleconference access available upon request. The ministry will cover eligible travel expenses to Toronto when accompanied by receipts.

See Appendix for a list of members.

ACCOUNTABILITY

Through the chair, the Accountability Committee will be accountable to the Executive Steering Committee, which in turn is accountable to the Ministry of Health and Long-Term Care.

RELATED WORKING GROUPS

The Accountability Committee will function as one of several sub-committees within the overall standards modernization process. By reporting to the Executive Steering Committee, appropriate linkages between the sub-committees will be ensured. In addition to the Accountability Committee, the following sub-committees will provide support to the Executive Steering Committee:

- Practice and Evidence Program Standards Advisory Committee;
- Intra-ministerial Committee;
- Capacity and Public Health Disciplines Committee; and
- Systems & Infrastructure Committee

There will also be ongoing communication between the Executive Steering Committee, the Inter-ministerial Liaison, and processes for the engagement of Indigenous Communities.

TIME FRAME

The committee will be convened for a specific period of time, which is expected to be from May, 2016 – December, 2016.

SECRETATIAT

Population and Public Health Division, Ministry of Health and Long-Term Care.

APPENDIX:
Membership of the Accountability Committee

Chair

Ms. Roselle Martino	Assistant Deputy Minister, Population and Public Health Division, MOHLTC

Members

Ms. Mary Johnson	Board of Health Member, Eastern Ontario Health Unit, (alPHa representative)
Ms. Karen Jones	Senior Corporate Management and Policy Consultant (City of Toronto representative)
Mr. Brian Laundry	Senior Director, Central East Local Health Integration Network (LHIN representative)
Dr. Chris Mackie	Medical Officer of Health, Middlesex London Health Unit, (COMOH representative)
Ms. Anne Schlorff	Director, Central Resources, Region of Waterloo Public Health and Emergency Services (AOPHBA representative)
Ms. Janette Smith	Commissioner, Health Services Region of Peel, (AMO representative)
Ms. Linda Stewart	President, Association of Local Public Health Agencies (alPHa representative)
Mr. Larry Stinson	Director of Operations, Peterborough Public Health, (OPHA representative)
Ms. Cynthia St. John	Executive Director, Elgin St. Thomas Public Health (AOPHBA representative)
Mr. Don West	Chief Administrative Officer, Porcupine Health Unit (AOPHBA representative)

Committee Support (MOHLTC)

Mr. Brent Feeney	Manager, Public Health Standards, Practice and Accountability Branch, Population and Public Health Division, MOHLTC
Ms. Laura Pisko	Director, Health Promotion Implementation Branch, Population and Public Health Division, MOHLTC
Ms. Jane Sager	A/Director, LHIN Liaison Branch, Health System Accountability and Performance Division, MOHLTC
Ms. Paulina Salamo	A/Director, Public Health Standards, Practice and Accountability Branch, Population and Public Health Division, MOHLTC

Accountability Committee for Standards Modernization August 2016 Highlights #3

The Accountability Committee (AC) held its third meeting on July 8, 2016 to continue its review of accountability within the context of the relationship of boards of health to the ministry.

The AC began its meeting by discussing the key information which the ministry provides on public health to the central agencies of the government. It was acknowledged that the lack of data presents a challenge as it limits the ability to demonstrate the scope of program delivery and the value for money that is achieved through the government's investment in public health.

The remainder of the meeting was devoted to presentations by Committee members on how health units demonstrate accountability to their boards of health and municipalities. Some of the commonly identified practices and themes included:

- Use of internal program level dashboards,
- Use of locally developed indicators to report to boards,
- Aligning achievements with health unit strategic plans,
- Use of health status reports to identify local priorities,
- Use of local data to bring together the financial and performance streams to understand value for money, and
- The work involved in developing and maintaining relationship with municipalities.

The Committee considered the possibility of identifying and developing a core set of population health measures which all or most health units are currently using for provincial reporting purposes.
Creating a common set of process and outcome indicators which meet the needs of both boards and the ministry would be a positive step forward in the development of a new accountability framework.

The next Committee meeting will include additional reports from Committee members on local accountability practices.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Standards Modernization Executive Steering Committee May 2016 Highlights #1

Health system transformation is underway in Ontario, with a focus on access, quality and value for money. The foundation for an accountable, transparent, integrated, and evidence-informed system that provides the right care at the right time in the right place and promotes healthy living has been established through Action Plan for Health Care, 2012. The person-centred framework established in the Patients First: Action Plan for Health Care, 2015 aims to: provide faster access to the right care; deliver better coordinated and integrated care in the community, closer to home, provide the education, information and transparency people need to make the right decisions about their health, and protect the universal public health care system by making decisions based on value and quality.

Public health has a key role to play in achieving the aims of the person-centred framework for strategic action. As part of the broader health system transformation efforts underway in Ontario, the Ministry of Health and Long-Term Care (MOHLTC) has embarked on a process to modernize the 2008 Ontario Public Health Standards (OPHS) and the 2011 Ontario Public Health Organizational Standards (Organizational Standards) ("Standards Modernization"). The Standards Modernization process will provide the opportunity to review and clearly define public health's role and contributions within the broader health system transformation process.

Executive Steering Committee:

An Executive Steering Committee for the Standards Modernization (the "ESC"), which reports to the MOHLTC, has been established to provide overall strategic leadership and guidance on the review of the Standards Modernization with a goal to strengthen and enhance accountability and transparency within the public health system. The ESC Terms of Reference are included in Appendix I.

The ESC is chaired by **Dr. David Jones**, former Chief Public Health Officer of Canada, and is executively sponsored by **Ms. Roselle Martino**, Assistant Deputy Minister of Population and Public Health Division, MOHLTC and **Dr. David Williams**, Chief Medical Officer of Health of Ontario. Members of the Committee include:

Mr. Michael Barrett
Chief Executive Officer,
South West Local Health Integration Network (LHIN representative)

Mr. Bjorn Christensen
Director, Environmental Health,
Niagara Regional Public Health Department (alPHa representative)

Dr. Robert Cushman
Former City of Ottawa Medical Officer of Health and Chief Executive Officer,
Champlain Local Health Integration Network

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

Ms. Kaiyan Fu
Provincial Chief Nursing Officer,
MOHLTC

Ms. Jessica Hill
Chief Executive Officer,
Ontario College of Family Physicians

Mr. Michael Jacek
Senior Advisor,
Association of Municipalities of Ontario

Dr. Robert Kyle
Commissioner and Medical Officer of Health, Regional Municipality of Durham (COMOH representative)

Mr. Darryl Sturtevant
Assistant Deputy Minister, Strategic Policy and Planning Division, Ministry of Children and Youth Services (MCYS)

Ms. Kate Manson-Smith
Assistant Deputy Minister, Local Government and Planning Policy Division, Ministry of Municipal Affairs and Housing (MMAH)

Dr. Ruta Valaitis
Associate Professor, School of Nursing, McMaster University

Dr. David McKeown
Medical Officer of Health, Toronto Public Health (City of Toronto representative)

Update

The ESC's first meeting was held on December 18, 2015. In their opening remarks the Committee's Executive Sponsors, Dr. David Williams and Ms. Roselle Martino, emphasized the need for the work to be strategic, system-focused and innovative. The objective is to build on existing strengths and explore opportunities for a strengthened system whereby:

- public health service providers work in a coordinated, integrated way that facilitates optimal delivery of public health functions across the full continuum of health;
- a set of modernized standards for public health programs and services support local flexibility, maintaining the ability to adapt to shifting evidence and science; and,
- the linkages that exist between public health and primary care are strengthened in order to maximize the contribution of public health within the broader system.

The ESC reviewed its Terms of Reference and the mandate for the Standards Modernization Process. The ESC examined the overall structure of the province's current OPHS and began considering the challenges and opportunities facing the sector and broader system. These included challenges and opportunities related to system integration; new and emerging issues of public health importance; establishing outcome measures to inform and validate interventions; generating collective approaches through shared accountability; and the use of evidence to support decision-making. The Practice and Evidence Program Standards Advisory Committee ("PEPSAC") reporting to the ESC has been established to address these areas in detail to inform on-going discussions and decisions.

Dr. David Jones led a discussion on the topic of tension between flexibility and consistency, which the Committee is responsible for addressing through the standards.

The ESC also began to review the scope of its work in the context of the release of the discussion paper Patient's First: A Proposal to Strengthen Patient-Centred Health Care in Ontario. The ESC discussed opportunities for strategic alignment with the paper's vision and its work to establish a set of standards that can emphasize public health as an important input and influence into the broader health system. Specifically, the ESC agreed that public health should strengthen and support system capacity for epidemiology, program planning and evaluation to help primary health fill those gaps.

A commitment was made to discuss the broader engagement plan across the sector as it was acknowledged that the success of the Standards Modernization process very much depends on involvement, consultation and engagement.

The ESC met again on February 23, 2016 and April 19, 2016. In February, the ESC discussed health disparity and equity and considered approaches to revise the OPHS to ensure greater emphasis on

population health assessment to inform planning of programs and services. The ESC also had a preliminary discussion on the scope of the OPHS. In April, the ESC had a detailed discussion on the scope of the OPHS and began considering opportunities for greater efficiency, taking into consideration the work of other sectors.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Standards Modernization Process
Executive Steering Committee
TERMS OF REFERENCE

BACKGROUND

As part of the public health renewal agenda, the ministry released the Ontario Public Health Standards (OPHS) in 2008 and the Ontario Public Health Organizational Standards (the "Organizational Standards") in 2011. The OPHS and 27 incorporated protocols are guidelines issued by the Minister under the *Health Protection and Promotion Act* (HPPA); which establish the minimum requirements for fundamental public health programs and services to be delivered by Ontario's 36 boards of health. The Organizational Standards establish the minimum management and governance requirements for all boards of health and public health units and are operationalized via the Public Health Funding and Accountability Agreement.

CONTEXT

Health care system transformation is underway in Ontario, with a focus on access, quality and value for money. The foundation for an accountable, transparent, integrated, and evidence-informed system that provides the right care at the right time in the right place and promotes healthy living has been established through Action Plan for Health Care, 2012. The person-centred framework established in the Patients First: Action Plan for Health Care, 2015 aims to: provide faster access to the right care; deliver better coordinated and integrated care in the community, closer to home, provide the education, information and transparency people need to make the right decisions about their health, and protect the universal public health care system by making decisions based on value and quality.

As part of the broader health system transformation efforts underway in Ontario, the Ministry of Health and Long-Term Care (MOHLTC) is conducting a review of the OPHS and Organizational Standards (Standards Modernization). Demonstrating an accountable, efficient and transparent system are key objectives of Ontario's health care transformation agenda and public health can play a key role in achieving these aims through the Standards Modernization process. The Standards Modernization process will provide an opportunity to clearly define public health's role and contributions within the broader health system transformation process.

MANDATE

The Executive Steering Committee (ESC) will provide overall strategic leadership and guidance for the OPHS and Organizational Standards modernization process (Standards Modernization) by identifying a focused scope of practice for public health units; how public health units should deliver and integrate services; and the structure and capacity required to deliver efficient and effective services. The modernized OPHS will reflect the scope of programs and services that the government will expect to be provided by public health units.

The objectives of the Standards Modernization process are to develop programmatic and organizational standards that are informed by evidence and best practice, responsive to priority issues in public health, and are aligned with the government's strategic vision and priorities for public health within a transformed health system; and to develop recommendations for implementation of a renewed set of standards that address capacity and infrastructure needs. The Standards Modernization will result in standards being revised, with activities being added and removed. Where recommendations identify that public health units discontinue activities, ESC may recommend who is best placed to provide the activities across the health system.

The ESC will ensure broad engagement with public health stakeholders throughout the Standards Modernization.

The OPHS and Organizational Standards Modernization placemats can be found in Appendix A.

RESPONSIBILITIES

The ESC is charged with the task of providing strategic leadership, oversight and guidance on the review of the OPHS and Organizational Standards. Specifically, the ESC will:

- Make recommendations on the scope of the OPHS and Organizational Standards;
- Make recommendations on how to improve coordination of services across the health continuum;
- Make recommendations on how to ensure accountability and transparency for the modernized OPHS and Organizational Standards;
- Identify how to optimize and best demonstrate value for money in the delivery of public health standards;
- Establish a consultation strategy, and where appropriate, participate in processes for consulting and validating the program and organizational standards with the public health community and others;
- Provide advice regarding the impact of any changes to the OPHS and Organizational Standards and recommendations for system implementation in terms of capacity and infrastructure of a renewed set of program and organizational standards;
- Provide recommendations on a roll-out strategy for the program and organizational standards to support their implementation and uptake, including the development of accompanying tools; and
- Provide direction on a continuous improvement process and structure for ongoing review and refinement of the program and organizational standards.

The ESC will carry out these responsibilities by:

- Providing strategic direction to the sub-committees as established for the governance structure for the Standards Modernization;
- Providing direction to relevant sub-committees on the work required from them to inform recommendations the scope of the OPHS and Organizational Standards;

- Making decisions based on input from relevant sub-committees and expert advice where required;
- Reviewing relevant evidence and input from experts and/or sub-committees to identify how a structure of standards can improve accountability and transparency within the public health system;
- Establishing a framework, based on evidence, to capture public health sector contribution to population health outcomes; and
- Providing advice and guidance on issues identified by the sub-committees.

If necessary, the ESC will commission specific work or research to support its activities.

DELIVERABLES

The ESC will submit a:

- recommended set of renewed program and organizational standards to the MOHLTC for review and decision-making.
- set of recommendations for system implementation of the renewed set of standards that address capacity and infrastructure needs.

The ESC will communicate key messages and process updates with constituent groups and other stakeholders on a regular basis. Key messages will form part of a broader MOHLTC communication strategy.

MEMBERSHIP

The ESC will be chaired by Dr. David Jones, former Chief Public Health Officer of Canada. Membership on the Committee will represent a balance of strategic leaders and government representatives (from MOHLTC, Ministry of Children and Youth Services, and Ministry of Municipal Affairs and Housing). See Appendix B for a list of members.

Members will sign confidentiality agreements due to the sensitive nature of some of the items discussed and brought for the Committee's review and consideration.

In order to sustain the momentum of Committee work, there will be no delegates permitted to attend meetings. Members who miss more than two meetings may be asked to reconsider their commitment to membership on the Committee.

ACCOUNTABILITY

Through the chair, the ESC will be accountable to the MOHLTC. Linkages and strategic direction arising from other concurrent MOHLTC processes which impact the work of the ESC will be brought forward by the Executive Sponsors and/or Secretariat as appropriate.

RELATED WORKING GROUPS

The ESC will be supported by several sub-committees to help inform the overall Standards Modernization. The ESC will ensure appropriate linkages between the sub-committees are provided. The sub-committees that provide support to the Executive Steering Committee include:

- Practice and Evidence Program Standards Advisory Committee
- Organizational Governance Committee
- Intra-ministerial Committee
- Capacity and Public Health Disciplines Committee
- Systems & Infrastructure Committee

There will also be ongoing communication between the ESC, the Inter-ministerial Liaison, and processes for the engagement of Indigenous Communities.

TIME FRAME

The ESC will be convened for a specific period of time, which is expected to be from December, 2015 – June, 2017.

Meetings may occur as frequently as every 3-4 weeks. Meetings will occur in-person in Toronto, with potential for teleconference. The MOHLTC will cover eligible travel expenses to Toronto when accompanied by receipts.

SECRETARIAT

Population and Public Health Division, MOHLTC.

Goals of Review

1. **To develop programmatic standards that are responsive to emerging evidence and priority issues in public health and are aligned with the government's strategic vision and priorities for public health within a transformed health system.**
2. **To develop recommendations that address capacity and infrastructure needs for implementation of modernized standards.**

Drivers for Change

- **System Integration**
- **Accountability**
- **Transparency**
- **Organizational Capacity**
- **Efficiency/Value for Money**
- **Expert Advice**
- **Evidence based**
- **Service gaps (First Nations, Mental Health etc.)**

Objectives

Identify what public health should deliver	Identify how public health should deliver services	Identify capacity to deliver public health services	Identify the systems and structures required to deliver effective and efficient public health services

Activities

Identify what public health should deliver

- Identify evidence to support requirements for public health programs and services based on core public health functions.
- Reduce variation in service delivery through increased standardization, taking into consideration the parallel need to foster flexibility to respond to local needs and priorities.
- Identify service gaps and areas of duplication to improve coordination of services across the continuum of care and other sectors.
- Enhance the role of public health in addressing determinants of health and decreasing health inequities.
- Identify opportunities for public health to increase its role in addressing the needs of priority populations.

Identify how public health should deliver services

Through:

- Strengthening and enhancing accountability and transparency.
- Improving efficiency of public health program & services.
- Establishing collaborative partnerships to support system efficiency across the continuum of care.
- Establishing a performance measurement and management framework to capture public health sector contribution to population health outcomes (value for money).

Identify capacity to deliver public health services

- Identify public health capacity needs to ensure the effective and efficient delivery of public health services.
- Identify roles and responsibilities for public health disciplines that improve efficiency and effectiveness of public health service delivery.
- Identify processes to ensure a sector with qualified professionals to provide required services.

Identify the systems and structures required to deliver effective and efficient public health services

- Identify required IM & IT and infrastructure to support effective and efficient delivery of public health programs and services.
- Identify opportunities for integration of public health IM & IT systems with EMRs and the broader system, where appropriate.
- Identify how current systems support transparency across the public health sector.
- Identify current and required systems to support performance measurement across the public health sector.

Inputs

- **Jurisdictional Scans**
- **Literature Reviews**
- **Technical Reviews (PHO and others)**
- **Expert Advice**
- **Stakeholder Consultation and Engagement**

Outputs

- A recommended set of evidence based program standards reflective of current accepted practice in the areas of health protection and health promotion that support key government priorities, address service gaps, and the needs of priority populations.
- A recommended approach to performance measurement at all system levels to ensure accountability, support transparency, and demonstrate value for money.
- Recommendations to address capacity requirements for the effective and efficient delivery of public health services.
- Recommendations for systems and structures which support the effective and efficient delivery of public health services.

Timelines

PHASE 1: Development of modernized program standards for public health (Fall 2015 to December 2016)

PHASE 2: Recommendations for system implementation in terms of capacity and infrastructure to support modernized standards (January 2016 to June 2017)

Result

Recommendations for modernized standards and practice guidance, in alignment with the vision and principles of Health System Transformation, that facilitate optimal delivery of public health functions and support co-ordinated delivery of public health programs and services across the full continuum of health.

Goals of Review	**1. To establish the ministry's expectations for effective governance which are reflective of emerging evidence on public sector governance and administration practices.** **2. To strengthen effective governance by boards of health by developing recommendations that address the governance and administrative capacity and infrastructure needs of boards of health.**		**Drivers for Change:** • Accountability • Transparency • Due Diligence • Evidence • Efficiency/Value for Money • Organizational Capacity
Objectives	Integrate best practices in standards for effective governance and administration of boards of health in Ontario	Strengthen and enhance accountability and transparency of boards of health for governance and administrative practices	Identify the capacity and infrastructure needed to support effective and efficient governance and transparency
Activities	• Review evidence and best practices in public sector governance and administration. • Determine areas where increased standardization can enhance effective governance and administrative practices of boards of health. • Identify gaps in current Organizational Standards. • Ensure alignment with government policy on governance and administration requirements for transfer payment partners.	• Identify accountability mechanisms related to governance and administrative practices. • Identify options for enhanced transparency.	• Identify the organizational capacity required within boards of health to provide effective leadership. • Identify the range of expertise, skills and advice required to support effective governance. • Identify required IM & IT and infrastructure for effective and efficient governance and transparency across the public health sector.
Inputs	**Jurisdictional Scans**	**Literature Reviews**	**Expert Advice**	**Stakeholder Consultation and Engagement**
Outputs	A set of evidence based organizational standards grounded in current accepted best practices in public sector governance and administration.	An approach to performance measurement of governance and administrative practices to ensure accountability, support transparency, and demonstrate due diligence.	Recommendations to address capacity requirements and systems and infrastructural needs which support effective governance of boards of health.
Timelines	PHASE 1: Development of renewed organizational standards for public health (Fall 2015 to December 2016)		
		PHASE 2: Recommendations for implementation supports (January 2016 to June 2017)	
Result	Recommendations for modernized organizational standards and infrastructure supports that facilitate effective governance and administration of boards of health, in alignment with government's Transfer Payment Accountability Directive, and the vision and principles of Health System Transformation.		

Membership of the Executive Steering Committee

Chair

Dr. David Jones	Former Chief Public Health Officer of Canada

Executive Sponsors

Ms. Roselle Martino	Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams	Chief Medical Officer of Health of Ontario

Members from Health Units and Other Organizations

Mr. Michael Barrett	Chief Executive Officer, South West Local Health Integration Network (LHIN nominee)
Mr. Bjorn Christensen	Director, Environmental Health, Niagara Regional Public Health Department (alPHa nominee)
Dr. Robert Cushman	Former City of Ottawa Medical Officer of Health and Chief Executive Officer, Champlain Local Health Integration Network
Dr. Peter Donnelly	President and Chief Executive Officer, Public Health Ontario
Ms. Jessica Hill	Chief Executive Officer, Ontario College of Family Physicians
Mr. Michael Jacek	Senior Advisor, Association of Municipalities of Ontario
Dr. Robert Kyle	Commissioner and Medical Officer of Health, Regional Municipality of Durham (COMOH nominee)
Dr. David McKeown	Medical Officer of Health, Toronto Public Health (City of Toronto nominee)
Dr. Ruta Valaitis	Associate Professor, School of Nursing, McMaster University

Members from the Ontario Government (MOHLTC, MCYS, MMAH)

Ms. Kaiyan Fu	Provincial Chief Nursing Officer, MOHLTC
Ms. Kate Manson-Smith	Assistant Deputy Minister, Local Government and Planning Policy Division, MMAH
Mr. Darryl Sturtevant	Assistant Deputy Minister, Strategic Policy and Planning Division, MCYS

Executive Steering Committee Support (MOHLTC, MCYS)

Ms. Nina Arron	Director, Public Health Policy and Programs Branch, Population and Public Health Division, MOHLTC
Mr. Clint Shingler	A/Director, Emergency Management Branch, Population and Public Health Division, MOHLTC
Ms. Stacey Weber	A/Director, Early Child Development Branch, MCYS
Ms. Laura Pisko	Director, Health Promotion Implementation Branch, Population and Public Health Division, MOHLTC
Ms. Paulina Salamo	A/Director, Public Health Standards, Practice and Accountability Branch, Population and Public Health Division, MOHLTC
Ms. Elizabeth Walker	Director, Public Health Planning and Liaison Branch, Population and Public Health Division, MOHLTC
Ms. Jackie Wood	A/Director, Strategic Initiatives Branch, Population and Public Health Division, MOHLTC

Standards Modernization Executive Steering Committee June 2016 Highlights #2

The Executive Steering Committee for the Standards Modernization (the "ESC"), which reports to the MOHLTC, continues the review of the Ontario Public Health Standards (OPHS) with a goal to strengthen and enhance accountability and transparency within the public health system.

The ESC has met five times from December 2015 to May 2016. ESC discussions in the first few meetings focused on opportunities related to system integration, new and emerging issues of public health importance, approaches to revise the OPHS to ensure greater emphasis on population health assessment to inform planning of programs and services, and a preliminary discussion on the scope of the OPHS.

In April and May the ESC had detailed discussions on the scope of the OPHS and began considering opportunities for greater efficiency, taking into consideration the work of other sectors. At its meeting on May 20, 2016, the ESC completed its first detailed review of each of the standards in the OPHS. The Committee agreed that a second review of the OPHS to further refine the scope is required. The ESC's meeting on May 27, 2016 focused on opportunities for flexibility within the OPHS to address local needs. There was also a strategic level discussion on the approach to the OPHS in terms of structure, considering the Principles and the Logic Models.

Future meetings will focus on continuing the discussion on scope of the OPHS, opportunities for flexibility, equity, and accountability.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Standards Modernization Executive Steering Committee July 2016 Highlights #3

The Executive Steering Committee for the Standards Modernization (the "ESC") continues the review of the Ontario Public Health Standards (OPHS) with a goal to strengthen and enhance accountability and transparency within the public health system.

The ESC has met six times from December 2015 to June 2016. ESC discussions have focused on opportunities related to system integration, new and emerging issues of public health importance, approaches to revise the OPHS to ensure greater emphasis on population health assessment to inform planning of programs and services, the scope of the OPHS, and opportunities for flexibility within the OPHS to address local needs.

On June 13, 2016, ESC members had the opportunity to hear from Dr. Cory Neudorf, Chief Medical Health Officer, Saskatoon Health Region, who shared his experiences and successes in addressing health disparity in Saskatoon. ESC members were very engaged in the discussion which focused on the role that public health plays in influencing decisions and program planning in an integrated system through measurement, sharing information and data, partnerships, and collaboration.

At its last meeting on June 27, 2016, the ESC was provided with an update on the ongoing discussions with Indigenous Organizations to identify opportunities to address Indigenous Communities' needs in the OPHS. ESC members also provided input and suggestions on where further work could be undertaken in revising the Principles of the OPHS, as well as potential opportunities for culturally appropriate requirements. The ESC also discussed the mandate of the Organizational Governance Committee, which has been re-named the Accountability Committee, and was provided with a high level summary of its work to date. The afternoon focused on a detailed discussion on incorporating a greater focus on equity, taking into consideration the presentation from Dr. Cory Neudorf. ESC also reviewed decisions to date to identify outstanding issues and future discussion items.

Future meetings will focus on discussing recommendations on changes to the Standards from the Practice and Evidence Program Standards Advisory Committee (PEPSAC), value-for-money, and transparency.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Standards Modernization
Practice and Evidence Program Standards Advisory Committee
May 2016
Highlights #1

Health system transformation is underway in Ontario, with a focus on access, quality and value for money. The foundation for an accountable, transparent, integrated, and evidence-informed system that provides the right care at the right time in the right place and promotes healthy living has been established through Action Plan for Health Care, 2012. The person-centred framework established in the Patients First: Action Plan for Health Care, 2015 aims to: provide faster access to the right care; deliver better coordinated and integrated care in the community, closer to home, provide the education, information and transparency people need to make the right decisions about their health, and protect the universal public health care system by making decisions based on value and quality.

Public health has a key role to play in achieving the aims of the person-centred framework for strategic action. As part of the broader health system transformation efforts underway in Ontario, the Ministry of Health and Long-Term Care (MOHLTC) has embarked on a process to modernize the 2008 Ontario Public Health Standards (OPHS) and the 2011 Ontario Public Health Organizational Standards (Organizational Standards) ("Standards Modernization"). The Standards Modernization process will provide the opportunity to review and clearly define public health's role and contributions within the broader health system transformation process. The OPHS Modernization placemat is included in Appendix A.

An Executive Steering Committee for the Standards Modernization (the "ESC"), which reports to the MOHLTC, has been established to provide overall strategic leadership and guidance on the review of the Standards Modernization with a goal to strengthen and enhance accountability and transparency within the public health system.

Practice and Evidence Program Standards Advisory Committee (PEPSAC):

The PEPSAC has been established to recommend a set of program standards that are informed by evidence and best practice.

The PEPSAC is chaired by **Dr. David Williams**, Chief Medical Officer of Health of Ontario. Members of the Committee include:

Mr. John Barbaro
Epidemiologist,
Simcoe Muskoka District Health Unit
(APHEO nominee)

Ms. Maureen Cava
Manager Professional Development & Education, Toronto Public Health
(OAPHNL nominee)

Dr. Ray Copes
Chief, Environmental and Occupational Health, Public Health Ontario

Ms. Kelly Farrugia
Chief Nursing Officer, Chatham-Kent Public Health Unit (OAPHNL nominee)

Mr. Atul Jain
Manager, Inspection Services,
Peterborough County-City Health Unit
(ASPHIO nominee)

Dr. Isra Levy
Medical Officer of Health,
Ottawa Public Health
(COMOH nominee)

Dr. Heather Manson
Chief, Health Promotion, Chronic Disease and Injury Prevention, Public Health Ontario

Dr. Liana Nolan
Medical Officer of Health, Region of Waterloo Public Health (COMOH nominee)

Dr. George Pasut
Vice-President, Science and Public Health, Public Health Ontario

Dr. Brian Schwartz
Chief, Communicable Diseases, Emergency Preparedness and Response, Public Health Ontario

Mr. Eric Serwotka
Director, Environmental Health, Leeds, Grenville & Lanark District Health Unit (ASPHIO nominee)

Dr. Paula Stewart
Medical Officer of Health, Leeds, Grenville & Lanark District Health Unit (COMOH nominee)

Dr. Penny Sutcliffe
Medical Officer of Health, Sudbury & District Health Unit (Health Equity and Population Health Policy representative)

Ms. Emma Tucker
Manager and Senior Epidemiologist, Halton Region Public Health (APHEO nominee)

Update

At its first meeting on January 18, 2016, members discussed the Committee's Terms of Reference and relationships to ESC and the various committees to be struck as part of the Standards Modernization process. Members spent time discussing the current OPHS and thoughts about opportunities for modernization. Members recognized the use of the core functions and the principles of the OPHS. The PEPSAC discussed the discussion paper Patient's First: A Proposal to Strengthen Patient-Centred Health Care in Ontario and linkages to the Standards Modernization process. The PEPSAC met again on March 21, 2016 and May 9, 2016. In March, the PEPSAC had a detailed discussion on the Foundational Standard, taking into consideration ESC's comments regarding approaches to revise the OPHS to ensure greater emphasis on population health assessment to inform planning of programs and services. In May, the PEPSAC continued the discussion on the Foundational Standard. The PEPSAC agreed that further work and discussions are required on the Foundational Standard, which will continue in future meetings. The PEPSAC also began a preliminary review of the Infectious Diseases Prevention and Control Program Standard and discussed next steps for continuing the review of each of the Program Standards.

For information, contact: Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Ministry of Health and Long-Term Care at Paulina.Salamo@ontario.ca or (416) 327-7423.

Goals of Review

1. **To develop programmatic standards that are responsive to emerging evidence and priority issues in public health and are aligned with the government's strategic vision and priorities for public health within a transformed health system.**
2. **To develop recommendations that address capacity and infrastructure needs for implementation of modernized standards.**

Drivers for Change

- **System Integration**
- **Accountability**
- **Transparency**
- **Organizational Capacity**
- **Efficiency/Value for Money**
- **Expert Advice**
- **Evidence based**
- **Service gaps (First Nations, Mental Health etc.)**

Objectives

Identify what public health should deliver	Identify how public health should deliver services	Identify capacity to deliver public health services	Identify the systems and structures required to deliver effective and efficient public health services

Activities

Identify what public health should deliver

- Identify evidence to support requirements for public health programs and services based on core public health functions.
- Reduce variation in service delivery through increased standardization, taking into consideration the parallel need to foster flexibility to respond to local needs and priorities.
- Identify service gaps and areas of duplication to improve coordination of services across the continuum of care and other sectors.
- Enhance the role of public health in addressing determinants of health and decreasing health inequities.
- Identify opportunities for public health to increase its role in addressing the needs of priority populations.

Identify how public health should deliver services

Through:

- Strengthening and enhancing accountability and transparency.
- Improving efficiency of public health program & services.
- Establishing collaborative partnerships to support system efficiency across the continuum of care.
- Establishing a performance measurement and management framework to capture public health sector contribution to population health outcomes (value for money).

Identify capacity to deliver public health services

- Identify public health capacity needs to ensure the effective and efficient delivery of public health services.
- Identify roles and responsibilities for public health disciplines that improve efficiency and effectiveness of public health service delivery.
- Identify processes to ensure a sector with qualified professionals to provide required services.

Identify the systems and structures required to deliver effective and efficient public health services

- Identify required IM & IT and infrastructure to support effective and efficient delivery of public health programs and services.
- Identify opportunities for integration of public health IM & IT systems with EMRs and the broader system, where appropriate.
- Identify how current systems support transparency across the public health sector.
- Identify current and required systems to support performance measurement across the public health sector.

Inputs

- **Jurisdictional Scans**
- **Literature Reviews**
- **Technical Reviews (PHO and others)**
- **Expert Advice**
- **Stakeholder Consultation and Engagement**

Outputs

- A recommended set of evidence based program standards reflective of current accepted practice in the areas of health protection and health promotion that support key government priorities, address service gaps, and the needs of priority populations.
- A recommended approach to performance measurement at all system levels to ensure accountability, support transparency, and demonstrate value for money.
- Recommendations to address capacity requirements for the effective and efficient delivery of public health services.
- Recommendations for systems and structures which support the effective and efficient delivery of public health services.

Timelines

PHASE 1: Development of modernized program standards for public health (Fall 2015 to December 2016)

PHASE 2: Recommendations for system implementation in terms of capacity and infrastructure to support modernized standards (January 2016 to June 2017)

Result

Recommendations for modernized standards and practice guidance, in alignment with the vision and principles of Health System Transformation, that facilitate optimal delivery of public health functions and support co-ordinated delivery of public health programs and services across the full continuum of health.

HALIBURTON KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT
BASIC INCOME GUARANTEE

Position Statement

It is the position of the Haliburton Kawartha Pine Ridge District Health Unit that eliminating poverty is an urgent health, human rights and social justice issue that requires action on the part of the municipal, provincial and federal governments. Basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, is an essential component of a strategy to effectively eliminate poverty, ensure all Canadians have a sufficient income to meet their basic needs, and live with dignity and to eliminate health inequities.

Backgrounder

Income has been identified as the most important determinant of health as it influences living conditions, physical and mental health and health-related behaviours including the quality of one's diet, extent of physical activity and tobacco use[1]. People living in poverty are more likely to experience poorer health, have two or more chronic conditions, have more injuries, be more likely to have a disability, use health care services more frequently and live shorter lives.

Based on the Low-Income After Tax (LIM-AT), the incidence of low-income in 2013 was 13.5% for the Canadian population.[2] More specifically, 16.5% of children aged 17 and under lived in low income families and for children living in lone-parent families headed by a woman, the incidence rose to 42.6%.

Locally in the Haliburton Kawartha Pine Ridge District Health Unit, in 2010, 12.7% of the population lived in low-income situations based on LIM-AT.[3] In terms of children under the age of 6 years, 21.8 % lived in low income families. [4]

Currently, households that rely on Ontario Works or Ontario Disability Support Programs as their primary source of income have income levels that are inadequate to meet core basic needs such as housing and food. According to a report on household food insecurity in Canada

[1] In Focus The Social Determinants of Health, Epidemiology and Evaluation Services, Fall 2014 available from http://www.hkpr.on.ca/Portals/0/PDF%20Files/PDF%20-%20Epi/InFocus14-Web.pdf
[2] Statistics Canada Canadian Income Survey 2013 available from http://www.statcan.gc.ca/daily-quotidien/150708/dq150708b-eng.htm
[3] 2011 National Household Survey, Statistics Canada available from https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=HR&Code1=3535&Data=Count&SearchText=Haliburton,%20Kawartha,%20Pine%20Ridge%20District%20Health%20Unit&SearchType=Begins&SearchPR=01&A1=All&B1=All&GeoLevel=PR&GeoCode=3535&TABID=1
[4] Ibid

in 2012, 70% of households whose primary source of income was social assistance were food insecure.[5]

Over the past 20 years there have been tremendous changes in technology and globalization, which impacts job stability and security. Almost half of working adults are employed in precarious employment, which is part-time, seasonal or contract work that has little or no benefits and often pays low wages. Research shows that 70% of Canadians living in poverty are considered to be the working poor, which means they are employed but do not earn enough to make ends meet. [6]

Basic Income Guarantee

The causes of poverty are complex and a multipronged approach is required to eliminate poverty and to improve health and social equity for all. One component of a poverty reduction strategy is to provide a basic income guarantee (BIG). It is an unconditional income transfer from the government to individuals and families that is not tied to labour market participation. [7] The objective of a basic income guarantee is to provide a minimum annual income at a level that is sufficient to meet basic needs and allows individuals and families to live with dignity, regardless of work status.[8] Since research shows that basic income guarantee could have health promoting effects and reduce health and social inequities, it is considered to have merits as an effective policy option.

A basic income guarantee was piloted in Dauphin Manitoba from 1974-1979 to study the impact of a guaranteed income supplement. Research showed a number of substantial benefits including a decrease in hospitalization rates, which were 8.5% less when compared to the control group. There were fewer incidents of work-related injuries, fewer visits to the emergency department from motor vehicle accidents and domestic violence and there was a reduction in the rates of psychiatric hospitalizations and the number of mental illness consultations with health care professionals. The research also showed that teenagers and new mothers were the only populations to significantly work less. The study showed that more teenagers completed high school and new mothers extended their maternity leaves. Once the

[5] Tarasuk, V., Mitchell, A., Dachner, N.,(2014) Household food insecurity in Canada, 2012 available from http://nutritionalsciences.lamp.utoronto.ca/wp-content/uploads/2014/05/Household_Food_Insecurity_in_Canada-2012_ENG.pdf

[6] Lewchuk, W. et al. It's More than Poverty: Employment Precarity and Household Well-being United Way Toronto-McMaster University Social Sciences, 2013. www.pepso.ca

[7] Pasma, C., and Mulvale, J. Income Security for all Canadians Understanding Guaranteed Income. Ottawa: Basic Income Earth Network Canada; 2009. Available from http://www.cpj.ca/files/docs/Income_Security_for_All_Canadians.pdf

[8] Ibid

pilot finished and the cash transfers stopped, the number of teens not graduating from high school rose, returning to the previous rate that existed before the pilot.[9]

Currently in Canada, Old Age Security (OAS) and Guaranteed Income Supplements (GIS) are forms of guaranteed income supplement programs, which are income tested cash transfers for seniors at age 65 and older. Since their implementation, the incidence of poverty in seniors dropped substantially from 21.4% in 1980 to 5.2% in 2011. As a result, Canada has one of the lowest rates of seniors living in poverty in the world and the incidence of food insecurity is 50% less for those age 65 to 69 than for those age 60-64.[10]Similarly, other programs such as the Canadian Child Tax Benefit and National Child Benefit Supplement (which are tax free monthly payments for eligible families with children) have shown benefits in terms of improved math and reading skills and improved mental and physical health measures.[11]

Cost Considerations for a Basic Income Guarantee Program

It is widely agreed upon that the costs of poverty are very high. The total cost of poverty in Ontario is approximately $32.2-$38.3 billion dollars.[12] It is estimated that between $10.1 billion and $13.1 billion is spent on the social costs of poverty related to social assistance, housing and justice programs and health care costs associated with the effects of poverty. Lost opportunities for income tax revenue are estimated to be $4- $6.1 billion dollars and an additional $21.8-25.2 billion is attributed to lost productivity and revenue and intergenerational poverty low-income cycles.

Given the magnitude of the social and economic costs of poverty and the resources being spent on countering the negative effects of poverty, it is more prudent to spend those resources on prevention.

The costs of a basic income guarantee program in contrast to the costs of social and private costs of poverty have yet to be extensively researched. Estimates from Queen's University and the University of Manitoba identify that the amount for a basic income guarantee program for all of Canada would cost between $40 and $58 billion. Considering the total costs of poverty for just Ontario, a basic income guarantee would be very achievable.[13]

[9] Forget, E. **The Town with No Poverty: Using Health Administration Data to Revisit Outcomes of a Canadian Guaranteed Annual Income Field Experiment 2011** available from http://nccdh.ca/images/uploads/comments/forget-cea_(2).pdf

[10] Hyndman, B., and Simon, l., Basic Income Guarantee Backgrounder October 2015 alPHA and OPHA available from ww.opha.on.ca/getmedia/bf22640d-120c-46db-ac69-315fb9aa3c7c/alPHa-OPHA-HEWG-Basic-Income-Backgrounder-Final-Oct-2015.pdf.aspx?ext=.pdf

[11] Ibid

[12] Laurie, N. **The cost of poverty: an analysis of the economic cost of poverty in Ontario.** Toronto Ontario Association of Food Banks, 2008. http://www.oafb.ca/assets/pdfs/CostofPoverty.pdf

[13] Roos, N., and Forget, E. **"The time for a guaranteed annual income might finally have come."** The Globe and Mail, August 4, 2015. Available at http://www.theglobeandmail.com/report-on-business/rob-commentary/the-time-for-a-guaranteed-annual-income-might-finally-have-come/article25819266/

Provincial and National Support for a Basic Income Guarantee Program

Support for the basic income guarantee program exists across the political spectrum including politicians from several provinces and municipalities, economists and the health and social service sectors. Many large associations have given formal expressions of support such as The Canadian Medical Association, the Association of Local Public Health Agencies and the Ontario Public Health Association, the Ontario Society of Nutrition Professionals in Public Health, the Canadian Association of Mental Health, the Canadian Association of Social Workers and many health units in Ontario. Citizen groups in communities across Canada have also been forming to express their support for this initiative.

This past winter the Ontario provincial government embraced the opportunity to engage in the needed research to provide a clearer understanding of the implications and outcomes of the basic income guarantee program. By conducting a pilot study of the program, evidence will be gathered to determine if this is a more efficient manner of delivering income support, if it strengthens engagement in the labour force and if savings are achieved in areas such as the health care and justice systems. In 2016, the Ontario provincial government will work with researchers, communities and stakeholders to develop and implement a basic income guarantee pilot study.

HALIBURTON KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT
RESOLUTION ON BASIC INCOME GUARANTEE

WHEREAS addressing the social determinants of health and reducing health inequities are fundamental to the work of public health in Ontario; and

WHEREAS the Haliburton Kawartha Pine Ridge District Health Unit's strategic direction is to address the social determinants of health and health equity; and

WHEREAS income is recognized as the most important determinant of health and health inequities; and

WHEREAS 12.7% of the population in the Haliburton Kawartha Pine Ridge District live in low income circumstances based on the Low-Income After-Tax (2011 National Household Survey, Statistics Canada); and

WHEREAS low income and income inequality have well-established, strong relationships with a wide range of adverse health and social outcomes as well as lower life expectancy; and

WHEREAS income insecurity continues to rise in Ontario and Canada as a result of an increase in precarious employment and an increasing number of working-age adults who rely on employment that pays low wages; and

WHEREAS existing federal and provincial income security programs are insufficient to ensure that all Canadians have adequate and equitable access to the social determinants of health (e.g., food, shelter, education); and

WHEREAS a basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, has the potential to ensure all Canadians have a sufficient income to meet basic needs and to live with dignity; and

WHEREAS a basic income guarantee resembles existing income security supplements currently in place for Canadian seniors and children, which have contributed to improved health status and quality of life in these age groups; and

WHEREAS a pilot project of basic income for working age adults conducted in Dauphin Manitoba in the 1970s, indicates that the provision of a basic income guarantee can reduce poverty and income insecurity, improve physical and mental health and educational outcomes, and enable people to pursue educational and occupational opportunities relevant to them and their families; and

WHEREAS the concept of a basic income guarantee has received support from the health and social sectors including the Canadian Public Health Association (CPHA), the Canadian Medical Association (CMA), the Canadian Association of Social Workers, the Association of Local Public Health Agencies (alPHa) and the Ontario Association of Public Health Agencies (OPHA), the Ontario Society of Nutritional Professionals in Public Health and the Ontario Mental Health and Addictions Alliance as a means to alleviate poverty and improve health outcomes of low income Canadians; and

WHEREAS there is growing support from economists, political affiliations and other sectors across Canada for a basic income guarantee;

NOW THEREFORE BE IT RESOLVED THAT the Haliburton Kawartha Pine Ridge District Health Unit Board of Health endorse a position statement of a basic income guarantee;

AND FURTHER that the Haliburton Kawartha Pine Ridge District Health Unit Board of Health join alPHA and OPHA in requesting that the federal Ministers of Employment, Workforce Development and Labour, Families, Children and Social Development, Finance and Health, as well as the Ontario Ministers Responsible for the Poverty Reduction Strategy, Community and Social Services, Children and Youth Services, Finance and Health and Long-Term Care, prioritize joint federal-provincial consideration and investigation into a basic income guarantee as a policy option for reducing poverty and income insecurity;

AND FURTHER that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer, the Chief Medical Officer of Health for Ontario, the Canadian Public Health Association, the

Association of Local Public Health Agencies, the Ontario Boards of Health, the Federation of Canadian Municipalities, the Association of Municipalities of Ontario, MP Kim Rudd, MP Jamie Schmale, MPP Lou Rinaldi and MPP Laurie Scott as well as the City of Kawartha Lakes, the County of Haliburton and Northumberland County be so advised.

simcoe muskoka
DISTRICT HEALTH UNIT

June 15, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Room 281, Legislative Building
Queen's Park
Toronto, Ontario M7A 1A1

Dear Premier Wynne:

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I would like to commend you for the inclusion of a basic income pilot in the 2016 provincial budget. We appreciate that the voices of public health and many other stakeholders have been heard on this issue. We are very pleased to see that your government is examining the potential role of basic income in addressing key issues such as poverty reduction, the changing labour market, and cost savings in health care and elsewhere. We were also encouraged to read your government's plans to work with communities, researchers and other stakeholders in 2016 to design and implement a basic income pilot.

The health rationale for a basic income is strong, given the powerful impact of poverty and income inequality on a wide range of population health outcomes. We'd like to draw attention, in particular, to the clear evidence of a direct link between poverty, poor health and food insecurity. Children and youth who experience hunger at any time in their lives are more likely to have poorer mental and physical health, including likelihood of chronic conditions. Food insecure adults are more likely to have poorer physical and mental health, and social well-being, and suffer from multiple chronic conditions including depression, diabetes, heart disease and hypertension. Inadequate income is the most significant barrier to a nutritious diet, and the lower the household income the greater the prevalence of food insecurity.

Like other health units across the Province, the Simcoe Muskoka District Health Unit has been conducting the Nutritious Food Basket survey (NFB) for many years. Annually, the local cost of the NFB plus rent are compared with household income from social assistance or minimum wage work to assess whether income from these sources is adequate to cover the cost of these basic necessities. Unfortunately, year after year NFB survey results indicate that a healthy diet is beyond the reach of many individuals and families of low income. For example, a reference family of two adults and two children with income from one full-time minimum wage job ($11.00/hour) would require 68% (Muskoka) or 72% (Simcoe) of their total income to pay for food and rent alone (NFB, 2015). If this same family of four was receiving Ontario Works, almost their entire income (89% for Muskoka, 94% for Simcoe) would be needed for food and rent alone. It should be noted that, as grim as these income/expense scenarios are, they do not factor in the cost of other essentials such as transportation, phone, clothing, and household

. . . 2

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❑ **Midland:** B-865 Hugel Ave., Midland, ON, L4R 1X8, 705-526-9324, FAX: 705-526-1513
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and personal care products. It is also troubling that the cost of the Nutritious Food Basket in Simcoe Muskoka has risen substantially over the last five years. The cost for a family of four was $170.86 more per month in May 2015 than in May 2010, which would amount to $2,050.00 more per year than five years ago. Under these circumstances, low income households may have no choice but to look at food dollars as “flexible” and redirect this money to pay for rent, utilities and other necessities.

Recognizing the troubling nature of such circumstances and the strong link between poverty and food insecurity, the Board of Health for the Simcoe Muskoka District Health Unit, at its meeting on June 15, 2016, endorsed the Ontario Society of Nutrition Professionals in Public Health Position Statement on Responses to Food Insecurity (attached). This position statement urges the provincial and federal governments to jointly prioritize and investigate a basic income guarantee as a policy option for reducing poverty and food insecurity among people of low income. The Simcoe Muskoka District Health Unit Board of Health urges the Province of Ontario, in collaboration with the Government of Canada, to move forward on the recommendations contained in the OSNPPH Position Statement. Specifically, we encourage you to act without delay on the design and implementation of the basic income pilot your government committed to in the 2016 budget.

In May of 2015, the SMDHU Board of Health sent the attached letter to several of your Ministers, requesting an investigation into this promising policy approach. We also had the opportunity to meet with Minister Jaczek regarding basic income at a 2015 meeting of the Association of Municipalities of Ontario. A request for exploration of basic income was subsequently made by the Association of Local Public Health Agencies and the Ontario Public Health Association. The current version of the 2015 backgrounder on basic income prepared for these public health organizations is linked here for your information and use as a resource: http://www.opha.on.ca/Advocacy-and-Policy/Position-Paper,-Resolutions-and-Motions.aspx.

We look forward to hearing more from your government on engagement opportunities surrounding the pilot. Once again, our congratulations for your government’s inspiring leadership on this issue and for your courage to consider a different path forward. Combined with continued investment in other key aspects of poverty reduction such as early childhood development and affordable housing, a basic income guarantee may well be necessary to address some of the most complex, impactful and largely preventable health and social issues facing Ontarians.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward
Chair, Board of Health

Attachments (2):
- OSNPPH Position Statement on Responses to Food Insecurity
- May 28, 2015 Letter from SMDHU Board of Health to Minister Poilievre, Minister Leitch, Minister Ambrose, Minister Flynn, Minister Hoskins, Minister MacCharles, and Minister Mathews

c. Ontario Boards of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Evelyn Vaccari, Chair, Ontario Society of Nutrition Professionals in Public Health
Simcoe Muskoka Members of Provincial Parliament
Simcoe Muskoka Members of Parliament
Simcoe Muskoka Upper and Lower Tier Municipalities
North Simcoe Muskoka and Central Local Health Integration Networks
Chair, Child, Youth and Family Services Coalition of Simcoe County
Chair, Poverty Reduction of Muskoka Planning Table (PROMPT)
Chair, Simcoe County Alliance to End Homelessness

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Wyoming, ON N0N 1T0

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July 14, 2016

The Right Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

Dear Prime Minister:

Re: A Public Health Approach to the Legalization of Cannabis in Canada

At its meeting of June 1, 2016, the County of Lambton Board of Health considered the attached correspondence from Barry Ward, Board of Health Chair, Simcoe Muskoka District Health Unit dated April 20, 2016 regarding a public health approach to the legalization of cannabis in Canada.

The County of Lambton Board of Health passed the following motion:

> *#3: McGugan/Gillis: That correspondence PH 06-06-16 be supported by the Board of Health.*
>
> *Carried.*

Substance misuse is an important public health issue that has a profound effect on many local individuals, families and our health system. In 2011/12, 43% of Lambton County residents, ages 15 years and older, reported using cannabis at least once in their lifetime. Approximately 12% reported using cannabis in the past year. Marijuana use was highest among those between 15 and 29 years of age, with 31% of Lambton residents within this age group reporting cannabis use in the past year. This was higher than the provincial percentage (23%).

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in its field. CAMH recommends that legalization of cannabis can only be effective within a comprehensive system that considers the following factors:

- Establishment of a minimum age for cannabis purchase and consumption to protect youth.
- Development of a framework to address and prevent cannabis-impaired driving.
- Investment in education and prevention, and expanded access to treatment options.

The County of Lambton Board of Health supports a comprehensive public health approach to the regulation and legalization of cannabis in Canada. In the event the government proceeds with cannabis legislation, we encourage you to adopt this approach.

Thank you for your consideration. Please do not hesitate to contact me should you wish to discuss further.

Sincerely,

Warden Bev MacDougall
Chair, County of Lambton Board of Health

cc: Marilyn Gladu, M.P., Sarnia-Lambton
Bev Shipley, M.P., Lambton-Kent-Middlesex
Bob Bailey, M.P.P., Sarnia-Lambton
Monte McNaughton, M.P.P., Lambton-Kent-Middlesex
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Dr. Sudit Ranade, Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services Division

simcoe muskoka
DISTRICT HEALTH UNIT

April 20, 2016

The Right Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

Dear Prime Minister:

Re: A Public Health Approach to the Legalization of Cannabis in Canada

The Simcoe Muskoka District Health Unit (SMDHU) is mandated by the Ministry of Health and Long-Term Care (MOHLTC) under the Ontario Public Health Standards (2008) to address the prevention of the "adverse health outcomes associated with substance use". Prevention efforts include the delayed use of substances, such as cannabis, as well as incorporating harm reduction strategies in the delivery of health unit services. We are pleased that you are aware of the need for a well-regulated system for cannabis access which promotes public health and safety, reduces the harms associated with the use of marijuana, and helps to restrict access to youth.

In May of 2014, The Canadian Public Health Association (CPHA) identified the need for a public health approach in the management of psychoactive substances that is "based on the principles of social justice, attention to human rights and equity, evidenced informed policy and practice, and addressing the underlying determinants of health". [5] The SMDHU Board of Health has similarly passed a resolution today strongly urging you to adopt a public health approach regarding the legalizing of cannabis, with strict regulation of its use, production, distribution, product promotion, and sale.

Despite prohibition, cannabis is the most commonly used illegal drug in Canada, with youth and young adults having the highest rates of use. Research shows that cannabis use is associated with adverse health consequences, most notably for those who begin use at an early age and use it frequently. The evidence suggests that cannabis use — particularly chronic use — can have negative impacts on mental and physical health, brain function (memory, attention and thinking), driving performance and dependence. In addition, women who use cannabis during pregnancy can negatively affect the development and behaviour of their future children. [1, 2, 3, 4]

While cannabis use has the potential for many health harms, it is also important to consider the disproportionate social harms stemming from its prohibition. In addition to being ineffective and costly, prohibition has led to a series of harmful consequences including the criminalization and marginalization of users while hindering the ability of health and education professionals to effectively prevent and address problematic use. [1, 5] We are aware that you are familiar with the

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❑ **Huntsville:** 34 Chaffey St, Huntsville, ON, P1H 1K1, 705-789-8813, FAX: 705-789-7245
❑ **Midland:** B-865 Hugel Ave, Midland, ON, L4R 1X8, 705-526-9324, FAX: 705-526-1513
❑ **Orillia:** 120-169 Front St. S, Orillia, ON, L3V 4S8, 705-325-9565, FAX: 705-325-2091

Centre for Addiction and Mental Health (CAMH) Cannabis Policy Framework (October 2015) and strongly recommend that a public health approach to legalizing cannabis should include some or all of the following evidence informed guidelines for a regulatory framework as proposed by CAMH:

- **Establish a government monopoly on sales.** Control board entities with a social responsibility mandate provide an effective means of controlling consumption and reducing harm.
- **Set a minimum age for cannabis purchase and consumption.** Sales or supply of cannabis products to underage individuals should be penalized.
- **Limit availability.** Place caps on retail density and limits on hours of sale.
- **Curb demand through pricing.** Pricing policy should curb demand for cannabis while minimizing the opportunity for continuation of lucrative black markets. It should also encourage use of lower-harm products over higher-harm products.
- **Curtail higher-risk products and formulations.** This would include higher-potency formulations and products designed to appeal to youth.
- **Prohibit marketing, advertising, and sponsorship.** Products should be sold in plain packaging with warnings about risks of use.
- **Clearly display product information**. In particular, products should be tested and labelled for Tetrahydrocannabinol (THC) and Cannabidiol (CBD) content.
- **Develop a comprehensive framework to address and prevent cannabis-impaired driving.** Such a framework should include prevention, education, and enforcement.
- **Enhance access to treatment and expand treatment options.** Include a spectrum of options from brief interventions for at-risk users to more intensive interventions.
- **Invest in education and prevention.** Both general (e.g. to promote lower-risk cannabis use guidelines) and targeted (e.g. to raise awareness of the risks to specific groups, such as adolescents or people with a personal or family history of mental illness) initiatives are needed. (1)

When implementing these critical policy changes we strongly encourage your government to take sufficient time to develop and build capacity to implement these regulations and to ensure systems are in place to monitor patterns of use and health outcomes. In addition, we recommend that you develop evidence based prevention and harm reduction messaging for broad dissemination across the country. (1)

Thank you for considering a comprehensive public health approach to cannabis policy in Canada. Please do not hesitate to contact me should you wish to discuss further.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward, Board of Health Chair
Simcoe Muskoka District Health Unit

c. Bill Blair, MP (Scarborough Southwest)
Dr. Kellie Leitch, MP (Simcoe-Grey)
The Honourable Tony Clement, MP (Parry Sound–Muskoka)
Patrick Brown, MPP (Simcoe North)
Ann Hoggarth, MPP (Barrie)
Norm Miller, MPP (Parry Sound-Muskoka)
Julia Munro, MPP (York-Simcoe)
Jim Wilson, MPP (Simcoe-Grey)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Boards of Health in Ontario

References:

1. Crépault J-F. Cannabis Policy Framework. [Report online]. Toronto: Centre for Addiction and Mental Health; 2014 [Last accessed 2016/03/03]. Available from: http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf

2. Canadian Centre on Substance Abuse. Substance Abuse in Canada: The Effects of Cannabis Use during Adolescence. [Report online]. Ottawa: Canadian Centre on Substance Abuse, 2015 [Last accessed 2016/03/03]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Effects-of-Cannabis-Use-during-Adolescence-Report-2015-en.pdf

3. Porath-Waller AJ, Beirness, DJ, Diplock J, Kalant H. Clearing the Smoke on Cannabis: Highlights [Report online]. Canadian Centre on Substance Abuse (CCSA), 2015 [Last accessed 2016/03/03]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Clearing-Smoke-on-Cannabis-Highlights-2015-en.pdf

4. Beirness D, Porath-Waller A. Clearing the Smoke on Cannabis: Cannabis Use and Driving-An Update. [Report online]. Ottawa: Canadian Centre on Substance Abuse; 2015 [Last accessed 2016/03/03]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Cannabis-Use-and-Driving-Report-2015-en.pdf

5. Canadian Public Health Association. A New Approach to Managing Illegal Psychoactive Substances in Canada. [Discussion paper online]. Ottawa: Canadian Public Health Association, 2014 [Last accessed 2016/03/03]. Available from: http://www.cpha.ca/uploads/policy/ips_2014-05-15_e.pdf

June 1, 2016

The Right Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6

Dear Prime Minister,

Re: Proposed Introduction of Cannabis Legislation in Canada – Spring 2017

The Board of Health (BOH) for Wellington-Dufferin-Guelph Public Health (WDGPH) recognizes that cannabis is a commonly used illicit drug that can have significant health and social harms. The recent announcement by Jane Philpott, Federal Health Minister, stated that Canada would introduce cannabis legislation in the spring of 2017. If the federal government is in fact proposing cannabis legalization, the WDGPH BOH strongly urges the government to take a public health approach. This would include educating the public on the potential health effects of cannabis use and highlighting the need for a public health policy approach that includes strict regulations to ensure that the new regulatory system promotes health and safety, reduces harms, and prevents youth uptake.

Cannabis is the most widely used illicit drug in Canada, with approximately 11% of Canadians and 14% of Ontarians reporting past year use. The Wellington Dufferin Guelph Youth Survey indicates that 22% of grade 10 students reported past year cannabis use, and there are no significant differences between genders or geographic areas.

Research has shown that cannabis use is associated with adverse health effects including impairments in learning, attention, memory, and psychomotor function, and mental, respiratory, and reproductive health issues. While the health effects of cannabis use are mostly concentrated among heavy (daily or near daily) users and individuals that initiate use during adolescence, there are also risks associated with short-term use.

Recognizing the potential health and social harms of cannabis use, the Centre for Addiction and Mental Health released a *Cannabis Policy Framework* document, which proposes ten (10) evidence-informed guidelines for a regulatory framework, as follows:

1. Establish a government monopoly on sales.
2. Set a minimum age for cannabis purchase and consumption.
3. Limit availability.

…/2

4. Curb demand through pricing.
5. Curtail higher risk products and formulations.
6. Prohibit marketing, advertising and sponsorship.
7. Clearly display product information.
8. Develop a comprehensive framework to address and prevent cannabis impaired driving.
9. Enhance access to treatment and expand treatment options.
10. Invest in education and prevention.

The WDGPH BOH discussed this important issue at its meeting of June 1, 2016 and, in the event the government proceeds with the cannabis legislation, the WDGPH BOH urges the government to consider the points outlined in its Board motion attached hereto as Appendix "A".

Thank you for your consideration to a comprehensive public health approach to cannabis policy in Canada.

Please do not hesitate to contact me should you wish to discuss further.

Sincerely,

Doug Auld,
Chair, WDGPH Board of Health

cc:
The Honourable Jane Philpott, P.C., M.P. Minister of Health
Mr. Bill Blair, M.P. Parliamentary Secretary to the Minister of Justice and Attorney General of Canada (Scarborough Southwest)
The Honourable Michael Chong, P.C., M.P. (Wellington – Halton Hills)
Mr. John Nater, M.P. (Perth – Wellington)
Mr. Lloyd Longfield, M.P. (Guelph)
Mr. David Tilson, M.P. (Dufferin – Caledon)
The Honourable Kathleen Wynne, M.P.P., Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care – via e-mail
Ian Culbert, Executive Director, Canadian Public Health Association
Pegeen Walsh, Executive Director, Ontario Public Health Association
Linda Stewart, Executive Director, Association of Local Public Health Agencies – via e-mail
All Ontario Boards of Health – via e-mail

APPENDIX "A"

On June 1, 2016, the Board of Health for Wellington-Dufferin-Guelph Public Health passed the following Motion:

That the Board of Health send a letter to the federal government requesting consideration of the following recommendations, in the event that the federal government moves forward with the proposed introduction of cannabis legalization/legislation:

(i) To adopt a public health approach to the proposed legalization of non-medical cannabis that includes strict regulations around production, distribution, promotion and sale;
(ii) To allow sufficient time to develop and build capacity to implement a policy that includes strict regulation;
(iii) To establish baseline data and mechanisms to monitor the local use of cannabis and related health and societal outcomes; and
(iv) To develop evidence-based prevention and harm reduction messaging for broad and continuous dissemination across the country."

June 7, 2016

The Hon. Jane Philpott
70 Colombine Driveway,
Tunney's Pasture
Postal Location: 0906C
Ottawa, ON K1A 0K9
Hon.Jane.Philpott@Canada.ca

Dear Minister Philpott:

Re: Legislation for the International Code of Marketing of Breastmilk Substitute

On May 27, 2016 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached letter from the Peterborough County-City Health Unit regarding the International Code of Marketing of Breastmilk Substitute (The Code) and requesting your government to advocate for legislation for the Code in Canada. The following motion was passed:

Motion No: 2016-51

Moved by: David Shearman **Seconded by: Mike Smith**

"That, the Board of Health does endorse the correspondence from Peterborough County-City Health Unit regarding legislation for the International Code of Marketing of Breastmilk Substitute."

Carried.

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: The Right Hon. Justin Trudeau, Prime Minister of Canada
Dr. Gregory W. Taylor, Chief Public Health Officer, Public Health Agency of Canada
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
Association of Local Public Health Agencies
Ontario Boards of Health

Encl.

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May 26, 2016

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

Dear Minister Hoskins,

Re: Environmental Health Program Funding

At its meeting held on May 25, 2016, the Board of Health for the District of Algoma Public Health Unit considered correspondence from the North Bay Parry Sound District Health Unit and the Board of Health for the Grey Bruce Health Unit regarding the above noted matter.

We agree unequivocally with our colleagues that there are significant challenges in implementing new environmental health policy and legislation as our current Environmental Health program staff is already working at full capacity and without additional resources it will be extremely difficult to meet the demands resulting from new regulations.

We strongly support the recommendations outlined in North Bay Parry Sound resolution (attached), and appreciate your attention to this important public health issue.

Sincerely,

Lee Mason
Board of Health Chair
Algoma Public Health

Attachment

cc: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, MOHLTC
Roselle Martino, Executive Director, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Hon. David Orazietti, MPP Sault Ste. Marie
Linda Stewart, Executive Director, Association of Local Public Health Agencies
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Ontario Boards of Health
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July 14, 2016

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

Dear Minister Hoskins:

Re: Patients First Discussion Paper

At its meeting of June 1, 2016, the County of Lambton Board of Health considered the attached correspondence from Dr. Valerie Jaeger, President, Association of Local Public Health Agencies (alPHa) dated February 29, 2016, a response from Dr. Eric Hoskins dated April 20, 2016 and a further response from Dr. Valerie Jaeger dated April 28, 2016 regarding *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*.

The County of Lambton Board of Health passed the following motion:

> *#3: McGugan/Gillis: That correspondence PH 06-14-16 be supported by the Board of Health.*
>
> *Carried.*

The Board of Health supports the recommendations from alPHa as outlined in the attached letter dated February 29, 2016. The Board requests the Ministry of Health and Long-Term Care to include the alPHa recommendations in any implementation of the *Patients First* proposal.

Thank you for your consideration.

Sincerely,

Warden Bev MacDougall
Chair, County of Lambton Board of Health

cc: Bob Bailey, MPP, Sarnia-Lambton
Monte McNaughton, MPP, Lambton-Kent-Middlesex
Linda Stewart, Executive Direction, Association of Local Public Health Agencies
Ontario Boards of Health
Dr. Sudit Ranade, Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services Division

WINDSOR-ESSEX COUNTY HEALTH UNIT
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Leamington 33 Princess Street, Leamington, ON N8H 5C5

June 23, 2016

The Honourable Peggy Sattler
Main Legislative Building, Room 359
Queen's Park, Toronto, ON
M7A 1A5

Dear Ms. Sattler:

Re: Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act

At its June 16, 2016 meeting, the Windsor-Essex County Board of Health reviewed correspondence from the Middlesex-London Board of Health and Toronto Public Health, passing the following motion.

It was moved that the Windsor-Essex County Board of Health support letters from Middlesex-London Board of Health and Toronto Public Health re: the proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act and, furthermore, that a similar letter of support be sent on behalf of the Windsor-Essex County Board of Health.

The Windsor-Essex County Board of Health supports legislation that assists victims of domestic and sexual violence in the workplace.

Sincerely,

Gary McNamara
Chair, Windsor-Essex County Board of Health

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cc: Dr. Gary Kirk, Medical Officer of Health, Windsor-Essex County Health Unit
Cheryl Hardcastle, MP Windsor-Tecumseh
Brian Masse, MP Windsor-West
Tracy Ramsey, MP Essex
Dave Van Kesteren, MP Chatham-Kent — Leamington
Hon. Kathleen Wynne, Premier of Ontario

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Rick Nicholls, MPP, Chatham-Kent-Essex
Lisa Gretzky, MPP, Windsor-West
Percy Hatfield, MPP, Windsor-Tecumseh
Taras Natyshak, MPP, Essex
Monika Turner, Director of Policy, AMO
Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Kevin Daniel Flynn, Ministry of Labour
Hon. Tracy MacCharles, Minister Responsible for Women's Issues
Hon Michael Coteau, Minister for Children and Youth Services
Dr. David Williams, Chief Medical Officer of Health
Pegeen Walsh, Executive Director, Ontario Public Health Association
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Erie-St. Clair LHIN
Ontario Women's Directorate
Canadian Women's Foundation
Dr. Catherine Zahn, President and CEO, Centre for Addiction and Mental Health
Claudia Den Boer Grima, CEO, Canadian Mental Health Association, Windsor
Dr. Glenn Bartlett, Executive Director, Windsor-Essex Community Health Centre
Mark Ferrari, Windsor Family Health Team
David Musyj, CEO, Windsor Regional Hospital
Terry Shields, CEO, Leamington District Memorial Hospital
Al Frederick, Chief, Windsor Police Services
Ontario Boards of Health
All Windsor-Essex municipalities

Quarter 2 2016 Status Report
(April 1 – June 30, 2016)

Overall Compliance Status

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

ME: Meeting Expectations PME: Partially Meeting Expectations

Program Compliance Details

Chronic Disease Prevention
Hallie Atter, Manager, Community Health;

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

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

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

Rabies Prevention and Control
Atul Jain, Manager, Environmental Health

Program Compliance:
Due to a technical error in the virtual fax system, nine animal bite reports were not received by Peterborough Public Health within 24 hours. Our IT department concluded there was an issue with the software. This has been remedied and procedures put in place to ensure this type of error does not occur again. All nine reports mentioned above received follow-up the next business day.

Quarter 2 2016 Status Report
(April 1 – June 30, 2016)

Communications

Brittany Cadence, Manager, Communications & IT Services

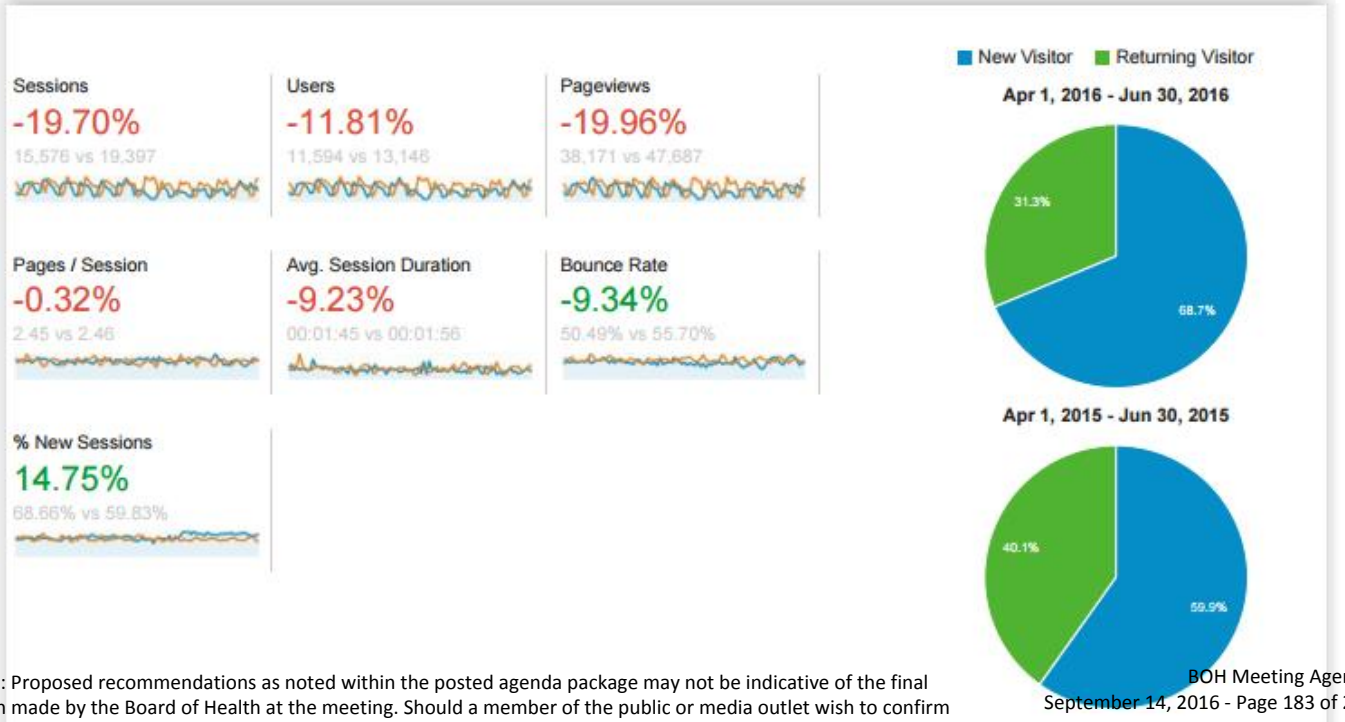
Media Relations

Activity	Q2 comparison	
	2016	2015
Press releases (accompanied by 21 audio files), letters to the editor, Medical Officer of Health (MOH) Examiner columns, Board of Health (BOH) meeting summaries issued	51	50
Media interviews	36	15
Number of media stories directly covering Peterborough Public Health (PPH) activities (print and TV only, and some radio when stories posted online)	118	154

Top Stories:

- Launch of new name/brand Peterborough Public Health, Myrtle's Kitchen completion and Community Open House event on June 10.
- Hepatitis A outbreak.
- Rabid bat identified.
- Beach testing/closures/swimmer's itch.

Website Statistics – Q2 2016



Top Pages (# of page views)

Homepage	8036
Employment	2052
Contact Us	1758
Food Handler Course	1582
Rabies Clinics	1199
Beach Testing Results	1092
Sexual Health Clinic	1077
Food Handler Course Dates	773
Food Handler Course Exam Dates	680
About Us	594
News and Alerts	532

Peterborough Public Health Social Media

The highlight of social media was the rebranding of all of our platforms. This was done seamlessly without any downtime or loss of followers. All platforms are consistent utilizing the handle @Ptbohealth (Twitter, Facebook and new to Peterborough Public Health, Instagram)

Engagement in Social Media:

Social media is all about engagement. Engagement is a type of action beyond just exposure and involves interactions with the audience. The actions noted below, for example: re-tweets, mentions, link clicks, favourites, replies, etc. demonstrate that the audience has participated with versus simply viewed the message.

Activity	**Q2 2016**	**Q2 2015**
Twitter (@Ptbohealth)		
Tweets	118	156
New Followers	93	92
Total followers as of the end of this quarter	1609	1270
Engagement Summary: (new analytics for 2015)		
Impressions *(number of times PPH info appeared on a screen)*	77300	65900
Mentions	260	212
Re-tweets	167	171
Profile Visits	1486	1584
Link Clicks	179	231
Favourites	160	98
Replies	128	22
Facebook (search: Peterborough Public Health or previous name)		
Total Likes	503	--
New Likes	26	62
Events Promoted	5	3
Posts	86	72
Most Viewed post – “Eyes on Your Child not Your Phone”	1196	269
Ad Campaigns	1	1

Highest Engagement Tweets:

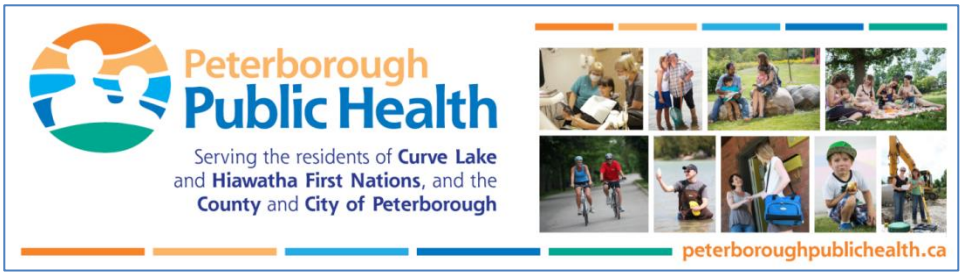
NOTE: the engagement rate below is the number of engagements (clicks, retweets, replies, follows and favourites) divided by the number of impressions

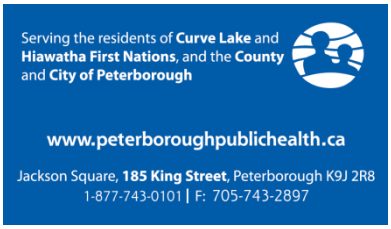
Social Media Content:

ITDP Day	Small Butts Big Problem
Blue Green Algae	Healthy Families Workshops
Mrytle's Kitchen	Tobacco Wise
World No Tobacco Day	Emergency Preparedness Week
Branding of PPH	World Maternal Health Day
Open House	Hepatitis A case
Cycling	Rabies Clinics
HPV Vaccine	Car Free Wednesdays

Graphic Design Projects

Community Open House, Myrtle's Kitchen Launch and the start of our rebranding (including letterhead, envelopes, banners, business card, etc.)





Information Technology - 2016 Q1

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

System Status This Quarter:

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

Project Highlights

- Migrate emails from @pcchu.ca to @peterboroughpublichealth.
- Migrate PPH website to new domain www.peterboroughpublichealth.ca.
- Created facilities helpdesk system.
- Replaced old Digium phone server with new. Restored backups.

Total Number of Helpdesk Tickets Served:
373 tickets from April 1 – June 30, 2015

Finance

Dale Bolton, Manager, Financial Services

Financial Implications and Impact
This report provides a pre-provincial budget approval look at the status of budgets and results for the second quarter financial operations of 2016.

At this time, we have not received provincial budget approvals. Budgets were approved by the Board of Health and submitted to the province in accordance with provincial funding rules. Some early indications from the Province suggest that we should not anticipate any funding increases for cost-shared or 100% funded program. If the Board of Health receives no increase in base budgets, as suggested by the province, year to date operations indicate there are sufficient savings to date to maintain program operations until the end of the year at existing levels. Until provincial budget approvals are known, the actual status of the Board's financial operations for 2016 cannot be determined with certainty.

The 2016 cost shared budget submission included a 1% increase in funding which would fund cost shared one-time initiatives within approved municipal budget contributions. If the board receives 0%, current operations would need to be assessed to determine if we could proceed with provincially-approved one-time initiatives.

On the whole, most programs have operated within Board approved and Provincial submitted budgets. Within the report some financial issues are highlighted to draw attention to aspects that have a potential financial impact.

As soon as provincial approvals are received, management will update the Board on the status of operations.

Background

Current year to date savings in public health programs is due to the some of the organization's operational resources being focused on establishing the new building during the first three months of the year and therefore covered out of moving budgets. As a result, these savings will allow operations to be maintained at existing levels until the end of the year.

As previously reported, there is a level of uncertainty regarding the Healthy Smiles Ontario program operations as the Province transitions to an integrated dental system. Effective January 1, 2016, the Ontario government integrated six (6) existing publicly-funded dental programs and/or benefits including the Healthy Smiles Ontario (HSO) and Children In Need Of Treatment (CINOT) Program. The ministry goal is to create one (1) seamless program for children and youth aged 17 and under from low-income families. The new program will provide eligible children with a simplified enrolment and renewal process and access to a full range of oral health services. The new program will also streamline administration and delivery of services. Peterborough Public Health will continue to play a significant role in the delivery of these programs. The Province has not requested a budget to be submitted for 2016 nor has it indicated directly what to expect for approved budgets. The program is currently being cash flowed at a higher amount than the previous year, however without further direction regarding budgets it can't be projected that this will continue.

The Needle Exchange Initiative program continues to operate above the 2015 Provincial approval of $34,100. The board requested an increase of 31.9% in 2016. Based on current operations, additional funding will be required to balance by the end of the year. If an increase is not approved by the province, the board will need to request one-time funding, if available, or utilize existing deferred funds. Further communication will be required in 2017 with the province to secure funding required to meet program needs.

Attachments

Attachment A - Financial Update June 30, 2016

Financial Update Q2 2016 (Finance: Dale Bolton)

Programs funded January 1 to December 31, 2016	Type	2016	Approved By board	Approved By Province	Expenditures to June 30	% of Budget	Funding	Comments
Mandatory Public Health Programs	Cost Shared	7,488,050	09-Dec-15	submitted 29-Feb	3,531,833	47.2%	MOHLTC	Operating within budget. Board approved $8,174,982 which includes Small Drinking Water ($90,800), Vector Borne Disease ($76,133) and Occupancy Cost ($520,000) - See lines below.
Mandatory Public Health Programs - Occupancy costs	Cost Shared	520,000	09-Dec-15	submitted 29-Feb	224,617	43.2%	MOHLTC	Operating within budget.
Small Drinking Water Systems	Cost Shared	90,800	09-Dec-15	submitted 29-Feb	45,582	50.2%	MOHLTC	Operating within budget.
Vector- Borne Disease (West Nile Virus)	Cost Shared	76,133	09-Dec-15	submitted 29-Feb	17,688	23.2%	MOHLTC	West Nile Virus measures and students started in May.
Infectious Disease Control	100%	247,300	10-Feb-16	submitted 29-Feb	114,938	46.5%	MOHLTC	Operating within budget based on budget request.
Infection Prevention and Control Nurses	100%	91,867	10-Feb-16	submitted 29-Feb	45,634	49.7%	MOHLTC	Operating within budget based on budget request.
Healthy Smiles Ontario	100%				227,710		MOHLTC	Ministry has not provided direction on budget for 2016. Currently operating within prior year approval of $427,300. **Given the increased responsibilites for the program under program standards, the issue of not having a budget is significant.**
Enhanced Food Safety	100%	25,000	10-Feb-16	submitted 29-Feb	12,608	50.4%	MOHLTC	Operating within budget.
Enhanced Safe Water	100%	15,500	10-Feb-16	submitted 29-Feb	4,127	26.6%	MOHLTC	Operating below budget. Student position started in May. Anticipate being within budget by end of year.
Needle Exchange Initiative	**100%**	**45,000**	**10-Feb-16**	**submitted 29-Feb**	**26,891**	**59.8%**	**MOHLTC**	**Operating above budget based on request. Budget request was increased 31.9% over prior year approval of $34,100. Year to date expenditures are $4,300 over current year budget request. Action will be required to balance or additional funding will be sought.**
Nurses Commitment	100%	185,530	10-Feb-16	submitted 29-Feb	92,747	50.0%	MOHLTC	Operating within budget based on budget request.
Chief Nursing Officer Initiative	100%	128,923	10-Feb-16	submitted 28-Feb	63,400	49.2%	MOHLTC	Operating within budget based on budget request.

Programs funded January 1 to December 31, 2016	Type	2016	Approved By board	Approved By Province	Expenditures to June 30	% of Budget	Funding	Comments
Smoke Free Ontario - Control	100%	100,000	10-Feb-16	submitted 27-Feb	48,584	48.6%	MOHLTC	Operating within budget.
Smoke Free Ontario - Enforcement	100%	202,100	10-Feb-16	submitted 27-Feb	96,192	47.6%	MOHLTC	Operating within budget.
Smoke Free Ontario - Youth Prevention	100%	80,000	10-Feb-16	submitted 27-Feb	37,881	47.4%	MOHLTC	Operating within budget.
Smoke Free Ontario - Prosecution	100%	6,700	10-Feb-16	submitted 27-Feb	0	0.0%	MOHLTC	Operating within budget.
Smoke Free Ontario - One Time Electronic Cigarettes Act - Protection & Enforcement	100%	29,300	10-Feb-16	submitted 27-Feb	14,801	50.5%	MOHLTC	Operating within budget.
Healthy Babies, Healthy Children	100%	928,413	09-Mar-16	submitted 23-Mar	441,395	47.5%	MCYS	Program savings due to gapping in beginning of year. Anticipate operating within budget by year end.

One Time Programs funded January 1 to December 31, 2016	Type	2016	Approved By Board	Approved By Province	Expenditures to June 30	% of Budget	Funding	Comments
Enhanced Tobacco Cessation	100%	30,000		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Public Health Inspector Practicum Project	100%	20,000		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Pharmacist Integration into UIIP	100%	17,081		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Enforcement of the Immunization of School Pupils Act	100%	22,500		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Enhanced Mobility of Food Premises	Cost Shared	37,500		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Health and Safety Risk Assessment	Cost Shared	7,910		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Program Resource Support	Cost Shared	30,000		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Workplace Mental Health Leadership Training	Cost Shared	22,000		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Creating a Healthy, Complete Outdoor Play Spaces Toolkit	Cost Shared	30,000		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Precarity Employment Survey	Cost Shared	22,500		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
Rapid Risk Factor Surveillance System	Cost Shared	40,000		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.
WiFi Implementation	Cost Shared	44,000		submitted 27-Feb	0	0.0%	MOHLTC	Expenditures waiting for provincial approval.

Programs funded April 1, 2016 to March 31, 2017	Type	2016-2017	Approved By Board	Approved By Province	Expenditures to June 30	% of Budget	Funding	Comments
Infant Toddler and Development Program	100%	245,220	March 9/16	Approved Aug 16/16	59,827	24.4%	MCSS	Operated within budget.
Medical Officer of Health Compensation	100%	51,100	NA	Funds being cashflowed at 2014/15 approval	12,775	25.0%	MOHLTC	Operating at budget. Still waiting for 2016/2017 approval from Province.
Speech	100%	12,670	Annual Approval	NA	3,168	25.0%	FCCC	Operating at budget.
Healthy Communities Challenge Fund		74,300	NA		20,728	27.9%		Second year of program commenced April 1/16 to March 31/17.
Locally Driven Collaborative Project	100%	17,433	NA	February 2014	17,433	100.0%	Public Health Ontario	Operated at budget. Program expenditures cover April 1 through July 31/16. Program now complete.

Funded Entirely by User Fees January 1 to December 31, 2016	Type	2016	Approved By Board	Approved By Province	Expenditures to June 30	% of Budget	Funding	Comments
Safe Sewage Program		382,389	12-Nov-14	NA	188,227	49.2%	FEES	Expenditures are within budget. Revenue from User Fees are below budget resulting in a deficit of $35,777. Building activity has increased in second quarter and anticipate increase in revenues as season progresses to offset deficit.
Mandatory and Non-Mandatory Re-inspection Program		81,000	12-Nov-14	NA	32,355	39.9%	FEES	Expenditures are within budget. Revenue from User Fees are operating within budget resulting in a surplus of $9,500.
Programs funded through donations and other revenue sources January 1 to December 31, 2016	**Type**	**2016**	**Approved By Board**	**Approved By Province**	**Expenditures to June 30**	**% of Budget**	**Funding**	**Comments**
Food For Kids, Breakfast Program & Collective Kitchens		49,200	NA	NA	27,341	55.6%	Donations	Budget based 2015 actuals. Additional costs incurred to date due to specific funding provided for programs. Anticipate being within budget by end of year.
Other Programs and workshops		6,765	NA	NA	1,929	28.5%		Operating within budgets, including Breaking Down Barriers and Love My Life.

Peterborough Public Health

Staff Report

Toward the Legalization, Regulation and Restriction of Access to Marijuana: Submission to Federal Task Force

Date:	September 14, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Hallie Atter, Manager

Proposed Recommendations

That the Board of Health for Peterborough Public Health receive the staff report, *Toward the Legalization, Regulation and Restriction of Access to Marijuana: Submission to Federal Task Force,* for information.

Financial Implications and Impact

There are no financial implications arising from this report.

Decision History

The Board of Health has not previously made a decision with regards to this matter.

Background

Despite the fact that Marijuana has been prohibited in Canada since the 1920s, it remains the most commonly used illicit substance in Canada. It is the second most used recreational drug in Canada after alcohol, especially among youth.

The Canadian Community Health Survey found that 61.3% of Peterborough men and 42.9% of Peterborough women reported trying marijuana at least once compared to 46.1% of Ontario

men and one third (35.0%) of Ontario women. By comparison, a similar proportion of Peterborough residents (both male and female) reported using marijuana in the past 12 months compared to Ontario.[1]

The Canadian Student Tobacco and Drug Survey found that among the 1,358 students sampled at six different schools across Peterborough during the 2014/2015 school year, 36.9% had used or tried marijuana. The survey also found that experimentation with marijuana increased as students aged. Among those students who had used or tried marijuana in the past 12 months, nearly one third (31.3%) used marijuana at least once a week or more (males: 23.4%; females: 40.5%). Frequent use also increased with each grade.[2]

In general, health risks associated with marijuana use can be acute or chronic. However, the risks are significantly lower than they are for alcohol or tobacco.[3] The potential for harm may increase significantly depending on a number of factors[4], including:

- age at which use begins;
- frequency of use;
- duration of use;
- amount used and potency of the product;
- a user's actions while intoxicated, such as driving or consuming other substances or medications; and,
- a user's health status and medical, personal, and family health history.

Despite increased risks for adolescents who use marijuana, the 2015 Ontario Student Drug Use and Health Survey[5] reported that, among adolescents, the perceived risk of harm associated with marijuana use is actually decreasing.

The Government of Canada has made a commitment to legalize, strictly regulate and restrict access to marijuana. They believe that the new regime for legal access to marijuana must achieve the following objectives[6]:

- Protect young Canadians by keeping marijuana out of the hands of children and youth.
- Keep profits out of the hands of criminals, particularly organized crime.
- Reduce the burdens on police and the justice system associated with simple possession of marijuana offences.
- Prevent Canadians from entering the criminal justice system and receiving criminal records for simple marijuana possession offences.
- Protect public health and safety by strengthening, where appropriate, laws and enforcement measures that deter and punish more serious marijuana offences, particularly selling and distributing to children and youth, selling outside of the regulatory framework, and operating a motor vehicle while under the influence of marijuana.
- Ensure Canadians are well-informed through sustained and appropriate public health campaigns, and for youth in particular, ensure that risks are understood.

- Establish and enforce a system of strict production, distribution and sales, taking a public health approach, with regulation of quality and safety (e.g., child-proof packaging, warning labels), restriction of access, and application of taxes, with programmatic support for addiction treatment, mental health support and education programs.
- Continue to provide access to quality-controlled marijuana for medical purposes consistent with federal policy and Court decisions.
- Conduct ongoing data collection, including gathering baseline data, to monitor the impact of the new framework

The Government of Canada has created a task force to make recommendations on the design and implementation of a new system. The Task Force (see Attachment B for Task Force members) is seeking the views of experts, stakeholders and individual Canadians on issues that are key to the design of a new system. They will then provide the federal government with a final report. These key areas are:

1. Minimizing harms of use.
2. Establishing a safe and responsible production system
3. Designing an appropriate distribution system.
4. Enforcing public safety and protection.
5. Accessing marijuana for medical purposes.

The Provincial Marijuana Collaborative is a group of substance misuse professionals from public health agencies across Ontario who have joined together to promote a comprehensive public health approach to legalizing marijuana.

A recent Toronto Public Health Report[7], describes a public health approach to the legalization of non-medical marijuana to include the following elements:

- Availability and accessibility;
- Minimum age;
- Density of sales outlets;
- Marketing and promotion;
- Pricing and taxation;
- Impaired driving laws;
- Health promotion and education;
- Use in public spaces; and
- Supply and production regulations.

The attached submission was developed by a working group of the Collaborative to respond to the Government of Canada's five areas of consideration. This submission was based on the elements of a public health approach and was reviewed and approved by representatives of each of the listed public health agencies.

Strategic Direction

Reference the strategic direction(s) the report applies to:

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

Contact:

Hallie Atter
Manager, Community Health and Foundational Standards
(705) 743-1000, ext. 380
hatter@peterboroughpublichealth.ca

Attachments:

Attachment A – Toward the Legalization, Regulation and Restriction of Access to Marijuana: Submission to Federal Task Force
Attachment B – Task Force on Marijuana Legalization and Regulation ***(web hyperlink)***
http://healthycanadians.gc.ca/task-force-marijuana-groupe-etude/task-force-bios-groupe-de-travail-eng.php

References:

[1] Canadian Community Health Survey (CCHS) 2011-2012, Statistics Canada, Share File, Ministry of Health and Long-Term Care

[2] Propel Centre for Population Health Impact. (2015) Canadian Student Tobacco and Drug Survey, University of Waterloo. Waterloo, ON.

[3] Centre for Addiction and Mental Health. (2014). Cannabis Policy Framework. Toronto, ON.

[4] Government of Canada. (2016). Toward the Legalization, Regulation and Restriction of Access to Marijuana. Discussion Paper.

[5] Boak, A., Hamilton, H. A., Adlaf, E. M., & Mann, R. E., (2015). Drug use among Ontario students, 1977-2015: Detailed OSDUHS findings (CAMH Research Document Series No. 41). Toronto, ON: Centre for Addiction and Mental Health.

[6] Government of Canada. (2016). Toward the Legalization, Regulation and Restriction of Access to Marijuana. Discussion Paper.

[7] Toronto Public Health. (2016). Staff Report: Legalization and Regulation of Non-Medical Cannabis.

Toward the Legalization, Regulation and Restriction of Access to Marijuana: Submission to Federal Task Force

Ontario Public Health Unit Collaboration on Cannabis

The Ontario Public Health Unit Collaboration on Cannabis is a group of substance misuse professionals from 27 public health units who have joined together to promote a comprehensive public health approach to marijuana legalization.

This feedback was developed by a working group of the Collaborative:

Algoma Public Health, Durham Public Health, Elgin St. Thomas Public Health, Grey Bruce Health Unit, Haliburton, Kawartha, Pine Ridge District Health Unit, Huron County Health Unit, KFL&A Public Health, Middlesex-London Health Unit, Niagara Region Public Health, Northwestern Health Unit, Ottawa Public Health, Perth District Health Unit, Peterborough Public Health, Peel Public Health, Sudbury & District Health Unit, Thunder Bay District Health Unit, Timiskaming Health Unit, Wellington-Dufferin-Guelph Public Health Unit, York Region Public Health

Discussion Issues: Elements of a New System
Section One: Minimizing harms of use

1(a). Do you believe that these measures are appropriate to achieve the overarching objectives to minimize harms, and in particular to protect children and youth?

(1) Minimum age for legal purchase.

Recommendation:

- **The minimum age for purchasing and possessing marijuana should be 21.**
- **The minimum age for purchasing and possessing marijuana should be consistent across Canada in order to provide clear policy direction and eliminate cross-border variations which limit the effectiveness of minimum legal age regulations to protect young people.**
- **Regulations must be coupled with rigorous enforcement and penalties for violations in order to be effective.**

See responses to question 2 (a) and (b) for further detail.

(2) Advertising and marketing restrictions.

Recommendation:

- **Prohibit all forms of marijuana advertising, marketing, and sponsorship through federal legislation, similar to that of the Tobacco Act and include language that addresses volume and content restrictions**
- **Adopt plain packaging regulations that restrict or prohibit the use of logos, colors, brand images, or other promotional information on packaging other than brand and product names displayed in a standard color and font style. Also require that packaging include health warnings.**
- **In the case that marketing, advertising and promotion of marijuana is made allowable within strict limitations, it is crucial that an effective advertising regulatory system be put in place. This system must apply to all forms of marketing and have the flexibility to adjust restrictions as needed.**

- **Given that there is strong evidence from tobacco research that promotion at the point of sale, increases the likelihood that children and adolescents will start to smoke, it is recommended that federal legislation is enacted to prohibit youth under the minimum age for purchase of marijuana from entering marijuana retail outlets.**
- **Develop a supporting infrastructure to ensure accountability for these restrictions.**

Rationale:

There is strong evidence from tobacco research that advertising and promotion, including promotion at the point of sale, increases the likelihood that children and adolescents will start to smoke. (1) Furthermore a growing body of research identifies that exposure to alcohol advertising and marketing increases the likelihood of underage drinking. (2)

Given that lessons learned from tobacco and alcohol show partial restrictions on marketing, advertising and promotion are ineffective, and difficult to enforce, it is strongly recommended that a comprehensive ban on all forms of marijuana marketing be put in place. A substantial opportunity exists currently as a ban would likely appear very restrictive if put in place retrospectively but would be lessened for a new product, such as marijuana, because of its first chance to be legally traded. (3) A comprehensive ban should address all forms of advertising (e.g., print, television, radio, transit, billboards, point-of-sale including retail displays, Internet, and social media outlets), promotion (e.g., price discounting, coupons, free sample distribution), sponsorships, and other indirect forms of marketing (e.g., brand stretching, branded merchandise). (4) Such a ban would be in keeping with the Government of Canada's intention to legalize marijuana for the purposes of reducing its social and health harms, and not for the purpose of promoting its use.

In light of the fact that Health Canada recognizes that tobacco packages have become powerful promotional vehicles for the tobacco industry and has stated that it is committed to introducing plain packaging as part of its continued efforts to protect Canadians against the dangers of tobacco use, it is prudent the same regulations be put in place for marijuana products. (5)

Plain packaging of marijuana will be a useful tool for minimizing harms from use for this new product in an emerging industry, as there are no standards set as yet, and the government has the advantage in setting these standards. The 2013 Guidelines for

Implementation of the WHO Framework Convention on Tobacco Control recommends plain packaging measures that restrict or prohibit the use of logos, colors, brand images, or other promotional information on packaging other than brand and product names displayed in a standard color and font style. [4] Plain packaging of tobacco products has been adopted in Australia and has been shown to reduce the appeal of tobacco products among youth, increase the effectiveness of health warnings, and reduces the ability of the packaging to mislead the consumer. [6, 7]

If, as proposed by the discussion paper, marketing, advertising and promotion of marijuana was to be allowed within strict limitations, it would be crucial that an effective advertising regulatory system be put in place. Best practice evidence from Canadian alcohol advertising research identifies that an effective advertising regulatory system must include content restrictions, volume restrictions and an overall supporting infrastructure. This requires a supporting legal context, a commitment of all stakeholders, transparency of the decision-making process, a mandatory pre-screening system, an effective complaint system, an independent advertising committee, effective sanctions, and a monitoring system. This infrastructure should apply to all forms of marketing and have the flexibility to adjust restrictions as needed. [8]

The State of Washington has adopted some specific advertising content and volume restrictions in order to reduce expose to young people. For example, Washington State Legislature prohibits advertising through any medium within 1,000 feet (300 metres) of the perimeter of a school, playground, recreation center or facility; child care center, public park or library; or any game arcade, admission to which is not restricted to people over 21. State law also prohibits marijuana advertising from including any depiction designed in any manner to be especially appealing to children or other persons under legal age to consume marijuana. [9]

Colorado has placed strict requirements on advertising, including outright bans on Internet pop-up advertisements and any type of advertisement that targets minors. Advertising is only allowed via television, radio, print, Internet, or event sponsorship when it can be documented that less than 30% of the audience is younger than 21 years. Outdoor advertising is prohibited other than signs that identify the location of a licensed retail marijuana store. Additionally, Colorado's Marijuana Enforcement Division rules ban the presence of anyone younger than 21 years in marijuana retail stores. [10]

(3) Taxation and pricing

Recommendations:

- **Index marijuana prices to inflation to ensure prices do not decrease relative to other goods over time.**
- **Further regulate marijuana prices through tax increases, while giving consideration to the level at which minimum prices should be set to curb demand and reduce consumption (especially among youth) , while minimizing the opportunity for continuation of lucrative illicit markets.**
- **Base prices (including minimum prices) on THC content so that higher strength products are more expensive than lower strength products in order to create incentives for the production and consumption of safer, lower strength products.**

Rationale:

As identified in the Centre for Addiction and Mental Health's 2014 Cannabis Policy Framework document, it is important that marijuana pricing policy be designed to curb demand while minimizing the opportunity for continuation of lucrative illicit markets. In addition, it is strongly recommended that pricing encourage use of lower-harm products over higher-harm products. (11)

Alcohol research has shown that it is important to index prices to inflation to ensure prices do not decrease relative to other goods over time. The same research identifies that young people are particularly price-sensitive because of lower average disposable incomes as well as the fact that regular heavy drinking is most common among this age group. In order to reduce harm associated with the use of products with higher alcohol content, research recommends that prices (including minimum prices) need to be based on alcohol content as this creates price incentives for lower strength, less hazardous products and price disincentives for higher strength products. (12)

With regards to tobacco, there is strong and unequivocal evidence that increases in the price of cigarettes result in decreased demand and consumption as well as increased intentions to quit smoking. (13) Research also shows that higher taxes are an effective way to prevent young people from progressing from experimentation with tobacco to regular use. (14)

There is also some evidence that pricing strategies can reduce health-related inequities from tobacco use as well as having a greater impact on reducing tobacco use rates among individuals with lower incomes. The evidence highlights that while low income smokers are more likely to quit smoking in response to tax rate increases those who do not quit pay higher prices and bear a greater cost burden associated with price

increases. It is recommended that these distributional concerns be addressed by coupling tax increases with publically financed smoking cessation initiatives that are structured to particularly target low-income populations. [13]

(4) Limits of allowable THC potency in marijuana

Recommendation:

- **Determine maximum THC limit, which balances the risk for harm against the need to minimize the attractiveness of illegal production and trafficking of higher potency products.**
- **Set regulations that mandate clear and visible labelling of THC content in products, accompanied by evidence-based health warnings.**
- **Establish government right to impose regulations related to marijuana from the beginning, since lessons from tobacco demonstrate how challenging it can be to expand regulatory scope after the fact. As research reveals better evidence about the harms and therapeutic uses related to marijuana, regulations should be adjusted.**
- **Conduct further research into the short and long term health effects associated with the use of higher potency marijuana products.**

Rationale:

Young people are at a higher level of risk for experiencing negative impacts from marijuana use and evidence from Washington and Colorado shows that there are indications that youth are more likely to use products in concentrated format with higher levels of THC. [15] While further research is needed to confirm these issues, consumption of higher THC levels may be associated with a greater chance of a harmful reaction and explain the rise in emergency room visits involving marijuana use. Additionally, regular exposure to higher THC levels may be associated with an increased risk for addiction. [16]

(5) Restrictions on marijuana products:

Recommendation:

- **Set a maximum THC limit for all marijuana products, including specifying what constitutes a single serving size of edible product (e.g. 10 milligrams of THC) regulating the maximum number of serving to be allowed in a single packaged food item.**

- **Require that edible products have clearly marked serving sizes that are appropriate to the food being consumed. (For example a cookie should be one or two servings not ten)**
- **Prohibit production and sale of products that are attractive to youth (e.g., products which mimic popular brand-name snacks and candies (such as gummy bears), additives, flavorings and combinations with other substances (e.g., nicotine, caffeine, alcohol).**
- **Require that marijuana products be sold a child-resistant container that conform to federal consumer product safety regulations and include specific warning statements (e.g., Keep all marijuana products away from children.)**
- **Require that products be sold in plain packaging and be marked with a universal symbol indicating the container holds marijuana.**
- **Require that edible products be labeled with all ingredients, if refrigeration is required, standard serving limit and expiration date (for edibles).**
- **Offer producers of edible products access to its food safety training to help reduce the risk of foodborne illness.**
- **Ensure that a reliable system is put in place for product monitoring and testing to ensure production consistency and consumer safety.**

Rationale:

With regards to marijuana derivative products, such as edibles, salves and creams, it is agreed that regulations be put in place in order to limit the appeal to children and youth as well as to reduce the risk of unintended consumption. Edibles pose a particular risk of accidental expose and overdose, especially to children. Colorado experienced an increase incidence of childhood exposure to marijuana infused edibles following the legalization of medical marijuana in the state in 2000. Following legalization, Colorado also made national news related to residents' and tourists' overconsumption of edible marijuana products. Although initial regulations for edible marijuana sold on the recreational market specified a single serving size of 10 milligrams of THC and a maximum of 100 milligrams of THC per single packaged food item, it was sometimes difficult for consumers to identify serving size portions in a single edible or drinkable product. For example, early regulations allowed up to 10 servings in a single cookie. The resulting fact that 1 serving could only be one tenth of a product that would normally be consumed in one sitting, combined with the delayed onset of the effects of THC after eating, contributed to overconsumption. [(10)]

(6) Limitations on quantities for personal possession.

Recommendation:

- **Set limitations on quantities for personal possession that align with current practice in other jurisdictions, and with current definitions of quantities for personal possession under the criminal law in Canada.**
- **Limitations should include all types of marijuana products, including edibles.**
- **Consideration should be given to having lower limits for products containing higher levels of THC.**

Rationale:

Given that setting limits on quantities of marijuana may serve to minimize opportunities for resale on the illicit market, particularly to youth, it makes good sense that restrictions be put in place. Given that there is currently a lack of evidence to support specific best-practice limitations, restrictions for dried product should minimally align what is currently considered possession for personal use under Canada's current criminal law (30 grams), as possession of more than 30 grams is considered possession for the purpose of trafficking. However, at the outset it would be wise to have tighter limits and to study its impact over time prior to increasing allowable amounts.

Since products such as edibles and concentrates have a much higher level of THC in relation to marijuana in flower form, consideration should be given to having lower limits for these products. For example, in August 2015 the Marijuana Enforcement Division (MED) in Colorado conducted a study to determine the THC equivalent of concentrates and edibles as compared to marijuana in flower form. [(17)] As a result of this study, the MED has issued 'Marijuana Equivalency' guidelines and have updated their recreational marijuana purchasing laws accordingly. These new regulations will take effect as of October 1, 2016. [(18)]

(7) Limitation on where marijuana can be sold.

See comments on "Designing an Appropriate Distribution System."

1(b): Are there other actions which the Government should consider enacting alongside these measures?

We urge the task force to consider the following recommendations:

1) Develop a comprehensive strategy to clearly communicate the risks and harms associated with marijuana use, particularly for youth as well as conveying details of the regulations prior to implementation, so that the public and other stakeholders understand what is permitted, and so that individuals can make informed choices. (15)

2) Invest in evidence-based health promotion, prevention, awareness and education, targeted at both youth and parents, (15) with a secondary focus on other vulnerable groups (pregnant and lactating women, people with personal or family history of mental illness, and individuals experiencing issues with substance abuse) as well as harm-reduction messaging for those who choose to use marijuana.

3) Invest proactively in a collaborative public health approach that prioritizes investment in a continuum of evidence-informed prevention and treatment services to prevent and respond to problematic use. (15)

4) Invest in research to address gaps in knowledge in order to better understand short and longer-term health impacts of both non-therapeutic and medical marijuana use and to guide best-practice policy development. (15) The criminal status of marijuana has limited research opportunities up until now, leaving many gaps in knowledge, such as the full range of risks and therapeutic uses. Many recommendations for a regulatory framework have been made based on evidence borrowed from alcohol and tobacco research, and these should be substantiated by ongoing research specific to marijuana.

5) Conduct ongoing surveillance and monitoring on the patterns and trends associated with use, including the collection of baseline data prior to legalization. Stakeholders from Colorado and Washington expressed that they encountered challenges in monitoring impacts because no baseline data existed, particularly because marijuana was not reported separately from other illegal substances in many data systems. (15) Canada is in a position whereby we can put systems in place beforehand to confidently measure impact moving forward. This data will be extremely valuable in making evidence based decisions, regarding the impact of this new legislation and in making adjustments of this new system in years to come.

6) Restrict the sale of drug paraphernalia (e.g., pipes, bongs) in places where children and youth frequent and prohibit the sale of these products to minors. As experience with tobacco shows that the presence and availability of these products can

undermine other regulations by serving to normalize or increase the social acceptability of marijuana use among youth.

2(a): What are your views on the minimum age for purchasing and possessing marijuana?

Recommendation:

- **The minimum age for purchasing and possessing marijuana should be 21.**
- **Regulations must be coupled with penalties for violations and be strictly and consistently enforced in all situations in order to be effective.**

Rationale:

A wealth of evidence exists to support the importance of delaying onset of drug use, including marijuana use, among youth. Current evidence confirms brain development is not complete until approximately age 25. [(19)] And further evidence demonstrates that both early and frequent marijuana use can alter the structure of the developing brain, and that some of these adverse effects may be irreversible, with the potential to seriously limit a young person's educational, occupational and social development. [(20)]

With regards to setting a minimum age for purchasing and possessing marijuana, a precedent has been set given that the legal age for tobacco consumption is 18 and varies between 18 and 19 across the provinces for alcohol. Given that both alcohol and tobacco are dependence–inducing substances that are legal for adults but subject to legal and social constraints on underage use, lessons can be learned for marijuana policy from the Canadian and U.S. experience with regards to the public health impact associated with enacting and raising the minimum age of legal access to tobacco products as well as the minimum legal drinking age.

The U.S. Institute of Medicine recently conducted a comprehensive review of the public health impact of raising the minimum age for purchasing tobacco products. A committee of public health, medical and other experts reviewed the, U.S. and international experience with enacting and raising the minimum age of legal access to tobacco products as well as the minimum legal drinking age. Results of the review were released in the 2015 report, Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products. [(21)]

With regards to alcohol, the review found that that raising the minimum legal drinking age to 21, together with strict enforcement and penalties for violations, has been associated with lowered rates of alcohol consumption among adolescents and adults as

well as with reduced rates of alcohol-related adverse events (e.g., traffic crashes and hospitalizations). [21]

In terms of tobacco, the review concluded that increasing the minimum age of legal access to tobacco products will likely prevent or delay initiation of tobacco use by adolescents and young adults. The review also noted that while these legislative changes would directly pertain to individuals who are age 18 and older, the greatest impact would be on adolescents 15-17 years old. Furthermore, the report states that "The impact on initiation of tobacco use of raising the minimum age of legal access to tobacco products to 21 will likely be substantially higher than raising it to 19, but the added effect of raising the MLA beyond age 21 to age 25 will likely be considerably smaller" (p. 202). [21]

In Canada, an expert panel of scientists and researchers recently compared the effectiveness of provincial strategies to reduce alcohol related harms and costs in Canada. The resulting report, Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Comparison of Provincial Policies (2013), also highlights that a higher minimum legal drinking age is more effective in decreasing alcohol consumption and related harms among youth with a minimum legal drinking age of 21 years representing the best practice. [22]

The Canadian report also recommended that the legal drinking age be supported by legislation that prohibits not only the purchase of alcohol by those below the minimum legal drinking age but also prohibits the sale of alcohol to these individuals. In doing so, the drinker and alcohol retailers share the responsibility of upholding the legal drinking age. Finally, it is important to consider policies that permit individuals under the legal drinking age to drink under specific circumstances (i.e. social hosting policies) due to the permissive attitude towards alcohol they may promote. [22]

2(b): Should the minimum age be consistent across Canada, or is it acceptable that there be variation amongst provinces and territories?

Recommendation:

- **The minimum age for purchasing and possessing marijuana should be consistent across Canada in order to provide clear policy direction and eliminate cross-border variations which limit the effectiveness of minimum legal age regulations to protect young people.**

Rationale:

Both experience from Ontario communities located near inter-provincial borders with Quebec and evidence from Canadian alcohol research demonstrate that cross-border variations in legal drinking age limit the effectiveness of a minimum age to protect young people.

The 2007 National Alcohol-Related Harm in Canada: Toward a Culture of Moderation report proposed that harmonizing minimum purchase ages across jurisdictions would help to reduce certain risky drinking behaviours. An example of this is where youth cross provincial/ territorial borders to take advantage of less restrictive regulations in neighbouring jurisdictions. [23]

Given alcohol, tobacco and marijuana are all clearly linked with varying levels of youth related harm, our recommendation ideally would be that tobacco, alcohol and marijuana all have a legal access age of 21. Given however the complexities involved in altering the legal access age for alcohol and tobacco in order to attain consistency, we are addressing our recommendation from the context of marijuana access only. Consistent age restrictions will provide clear policy direction and eliminate cross-border variations which limit the effectiveness of a legal drinking age to protect young people.

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Section Two: Establishing a safe and responsible Production system

1. ***What are your views on the most appropriate production model? Which production model would best meet consumer demand while ensuring that***

public health and safety objectives are achievable? What level and type of regulation is needed for producers?

Recommendation:

- **A government controlled monopoly on marijuana production.**
- **Marijuana should not be regulated or treated as a food product in the context of the agricultural industry**. This is especially important because it will likely be included as an ingredient in various types of food products (edibles), however marijuana is a psychoactive drug and not an ordinary commodity. This concern stems from the current representation of beer and wine as 'local food' and a 'farming crop' in Ontario's agricultural industry. This representation has been very detrimental to societal perceptions about alcohol and has contributed to its normalization. As lessons learned from alcohol show that normalization results in increased use and associated harms, (3) it is important that this recommendation be followed from the outset of legalization of recreational marijuana.

Rationale:

A government controlled monopoly has been used in different parts of the world on the production of various regulated substances to limit the influence of for-profit businesses. [(1)] Considerable evidence from alcohol literature indicates that government monopolies are better for public health than less regulated options. [(1, 2)] A government controlled monopoly on marijuana production controls diversion, eludes advertising, slows product innovation, maximizes tax revenue, decreases market competition and increases retail price. [(1)] Product innovation is projected to be slower within a government controlled monopoly. This is important from a public health perspective as product innovation will likely decrease production costs, which leads to decreased retail pricing in a competitive market. [(1)] While decreased pricing may appear to benefit consumers, strong evidence from alcohol literature suggests that a decrease in price is associated with an increase in consumption and harm. [(3, 4)] Higher pricing strategies are particularly effective in reducing consumption, especially among high-risk populations, such as youth. [(3)]

A government controlled monopoly also has the benefit of reversibility. [(1)] The health, social and economic implications of legalization are largely unknown. Following legalization, if a government monopoly on marijuana production proves to be the most effective model for reducing consumption and harms, this model will be easiest to retain from the outset. If governments initially choose a commercialized market, change to a more restrictive model will be difficult.

Having said this, a commercialized model (similar to that of alcohol regulation) is **not** recommended. Commercialization aims to "maximize the efficiency of production, the appeal of products to consumers, and the size, scale and scope of the market" (Caulkins et al., 2015, p. 53). While the trajectory of a commercialized model is far from certain, some potential outcomes include:

- decreased production costs resulting from increased production scales, a shift in cultivation from indoor to greenhouse or outdoor spaces, and an increase in production of extract-based products. [1] This has negative health implications as evidence from alcohol literature suggests that a decrease in price is associated with an increase in consumption and harm; [3, 4]
- increased product innovation toward concentrates, edibles and high potency products, and alarmingly, new and unknown products from extraction and blending of psychoactive chemicals in the marijuana plant;
- increased marketing; and
- increased competition and therefore decreased costs. [1]

The following chart was adapted from Caulkins et al. (2015) and highlights the attributes of government monopoly and commercial models.

Attributes	Strategy	
	Government monopoly	Commercial model
Production costs (without fees, taxes, regulation)	Low or medium	Very low
Product quality assurance and labelling	Very good	Good
Incentive for producers to promote use that is harmful to public health	Low	Very high
Government's ability to restrain suppliers promotion of harmful use	Very good	Low
Likelihood of promoting harmful use	Low or medium	Very high
Cost or effort for government control efforts	High	Low
Ability to generate government revenue	Very high	Fair

It is clear that a government monopoly on production is the best model for public health and safety.

2. *To what extent, if any, should home cultivation be allowed in a legalized system? What if any government oversight should be put in place?*

Recommendation:

- **Home cultivation is not recommended.**

Rationale:

From a public health perspective, home cultivation presents the following challenges:

- potential for increased access among children and youth;
- significant challenges in regulating potency, quality and labelling; [1]
- high cost and effort for governments to control and regulate marijuana production; [1]
- increased challenges in regulating commercial production and preventing diversion; [5]
- inability to generate government revenue to support health promotion initiatives.
- lack of authority to inspect homes to ensure safe production; and
- potential health impacts in the surrounding environment and risks to property from home growth, including fire and mould.

3. *Should a system of licensing or other fees be introduced?*

Recommendation:

- **Licensing should be required and a licensing fee enacted to increase revenue to enhance public health and safety through increased producer compliance with regulatory standards, and to** offset t**he health and social costs associated with legalization.**

Rationale:

Licensing will ensure all producers meet standards of regulations for ongoing safe production and storage to protect public health and safety. Licensing also enables governments to geographically track the number of producers to determine community trends and density.

If a commercialized model is considered, incentives are required to ensure production companies comply with regulations rather than opting to violate regulations and take the

chance of being caught. Restricting the number and size of licensed producers and establishing strict penalties to discourage violations creates a sense of value to the license and is a possible strategy to increase compliance. Producers would have a strong incentive to follow regulations. Without restrictions, the value of a license decreases, as does the fear of losing a license for a violation.

In addition, monitoring regulatory compliance is more efficient and less costly within a limited number of firms. [(1)]

4. *The MMPR* (ACMPR as of Aug. 24, 2016) *sets out rigorous requirements over the production, packaging, storage and distribution of marijuana. Are these types of requirements appropriate for the new system? Are there features that you would add or remove?*

Production

Recommendation:

- **Strengthen requirements set out in the ACMPR to develop a more comprehensive regulatory system, including: Development of national standards for production, packaging, storage, distribution and testing of marijuana products. This is an important strategy for public health and safety.**
- **Expansion to include regulation of a wider variety of marijuana products (e.g., edibles, concentrates, and tinctures).**
- **Provision of government resources for inspection and other accountability functions.**
- **Mandating food safety training for producers of edible marijuana products.**
- **Aligning marijuana production with public policy goals related to climate change.**

Rationale:

- The ACMPR sets out strict conditions for the production of medical marijuana in Canada, including batch testing for contaminants. These requirements form a good basis for the new regulatory system for non-medical marijuana.

- Other jurisdictions have measures in place that can inform Canada's system. In Colorado, one department provides key monitoring and accountability functions, including:
    - inspecting all growers, infused product manufacturers and retail outlets; and
    - inspecting and certifying marijuana testing facilities that perform potency and contamination testing on plants, concentrates and edibles. [(6)]

- In other jurisdictions, governments offer producers of edible marijuana products access to its food safety training to reduce the risk of food-borne illness (e.g., risk of contamination with certain viruses and bacteria). [(6)]

- There is an opportunity to align marijuana production with public policy goals related to climate change. The indoor production of marijuana has been shown to have a significant carbon footprint. Indoor cultivation uses significant energy resources, including intensive lighting and climate control. For example, one marijuana 'cigarette' represents 1.5 kg of CO2 emissions. This is equal to driving a hybrid car 35 kilometres. [(7)] Regulation and licensing options worth considering include mandating carbon-free electricity generation. Boulder, Colorado requires marijuana businesses to offset 100% of their electricity consumption with renewable energy. [(8)]

Product Packaging

Recommendations:

- **Develop and enforce product design requirements, including plain and standardized packaging regulations that prohibit branding and promotion of all marijuana products.**
- **Develop and enforce labelling requirements, including marijuana strain, dosage, and THC levels. Lessons can be learned from regulating product packaging of tobacco and alcohol and from other jurisdictions that have legalized marijuana.**
- **Commission research on the effectiveness of health warning labels on marijuana products and update labelling requirements as necessary.**

Rationale:

- Colorado has rules on packaging, labelling and product safety equal to or exceeding those for tobacco that should be considered in the development of Canadian standards. These include:
    - prohibiting appeal to children or youth under age 21;

- restricting use of cartoon characters in the design;
- mandating child-resistant packaging. [6]

- Strategies that prevent the promotion and marketing of marijuana will help reduce consumption and related harms. Health experts recommend the use of plain packaging as a means of reducing promotion and marketing of marijuana. [9, 10] The World Health Organization also recommends plain packaging as one measure to decrease tobacco smoking initiation and cessation. [11]

- There is limited research on the effectiveness of health warning labels on marijuana products to reduce marijuana-related harm. While further research is currently underway to evaluate the effectiveness of warning labels on alcohol products, there is evidence to suggest that consumers support the inclusion of more health/nutrition information on alcohol products. [12] Where evidence supports, health warning labels on marijuana products should advise against frequent use, use prior to age 25, use in combination with alcohol or other drugs, use prior to driving or operating heavy machinery, use during pregnancy, use with a family history of psychosis or with cardiovascular problems, use above recommended dosage, and about the risk for respiratory issues and of second hand smoke.

Distribution

Recommendations for regulations related to the distribution of marijuana are provided in section 3.

5. What role, if any, should existing licensed producers under the MMPR (ACMPR) have in the new system (either in the interim or the long-term)?

- *Out of public health scope. No response.*

Section Two References:

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9. Centre for Addiction and Mental Health (CAMH). *Cannabis Policy Framework.* [Report online]. Toronto: CAMH; 2014 [Last accessed 2016 Aug 18]. Available from: https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf

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11. World Health Organization. Evidence Brief - Plain packaging of tobacco products: measures to decrease smoking. [Report online].Geneva, Switzerland: World Health Organization; 2014 [Last accessed 2016 Aug 18]. Available from: http://www.euro.who.int/en/health-topics/disease-prevention/tobacco/publications/2015/evidence-brief-plain-packaging-of-tobacco-products-measures-to-decrease-smoking-initiation-and-increase-cessation

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Section 3: Designing an appropriate distribution system

1. Which distribution model makes the most sense and why?

Recommendation:

A government owned and controlled store front system is the best model to emphasize health and safety over customer and profit generation and to prevent youth access, through:

- **controlling availability and accessibility of marijuana;**
- **providing adequate staff training;**
- **providing evidence-based information on the potential health effects of using cannabis to consumers;**
- **restricting and enforcing limitations on marketing and advertising;**
- **establishing and maintaining a minimum price; and**
- **ensuring marijuana is not sold alongside other products that can have synergistic effects when combined with marijuana (e.g., alcohol and tobacco).**

Rationale:

Experience from alcohol demonstrates that government ownership of alcohol outlets can regulate alcohol availability in a comprehensive way. There is strong evidence that off-premise monopoly systems limit alcohol consumption and alcohol-related problems if alcohol control is a central goal, and that elimination of those monopolies can increase total alcohol consumption, especially when privatization leads to increased outlets, expanded hours of sale and reductions in the enforcement of policies such as not selling to underage customers. (1)

We can infer that government ownership is the most effective way to achieve the overall government goals of reducing harm related to marijuana consumption. Research on state run alcohol monopolies have shown that monopolies help keep the price of a product higher through reduced competition and help reduce access to alcohol by youth and overall levels of use. (2)

It is difficult to change a policy to make it more restrictive once the use of a substance and its regulations have been socially embedded and accepted. Policies and regulations regarding recreational marijuana should be more restrictive rather than less restrictive in the beginning. The policies and regulations could be loosened if the evidence and experience collected over time is evaluated and supports changes.

Retail outlets

There are several safeguards that protect the health and safety of the public. Some of these regulations include:

- Limiting the number and type of retail outlets
- Restricting hours and days of operation
- Restricting locations of retail outlets
- Restricting density of retail outlets (geographic density or population density)
- Allowing for broad Zoning powers at the municipal level
- Restricting the type of products that can be sold through outlets along with cannabis
- Restricting marketing, promotion and displays
- Training of staff/education of consumers at point of sale
- Training of staff/promotion of health risks through educational material at point of sale

This is supported by evidence:

- The widespread availability of tobacco and alcohol products for purchase helps to normalize their use and to undermine health risk messaging. Contextual cues play a significant role in shaping understanding of the magnitude of a hazard. There is a discord between the risk information provided by health authorities and the contextual cues that tobacco (and alcohol are) commonplace. (3)
- Easy access to tobacco reduces the total cost (price plus time, distance and transportation) to use. Frequent cues (i.e. seeing products in many outlets) prompts impulse buys among experimental and occasional smokers and smokers trying to quit. For former smokers receiving cues to smoke in places where they regularly shop also contributes to high levels of recidivism. (3)
- More than one third of smokers and a higher proportion of young smokers said they would smoke less if they had to travel further to buy cigarettes. (3)

Free Enterprise (Business) Market

There are several public health and safety concerns regarding a free enterprise market for cannabis distribution, including**:**

- Commercial interest and profits take priority over public health interests.
- Lack of control over staff training to prevent youth access to marijuana.
- Decreased accountability to provide health education regarding potential risks of using cannabis for consumers.
- Economic burden on the government to prevent or delay use by youth. More costly and less efficient enforcement of regulations.

These concerns are supported by evidence:

- Research strongly indicates that as alcohol becomes more available through commercial or social sources, consumption and alcohol-related problems rise. Conversely, when availability is restricted, alcohol use and associated problems

decrease. The best evidence comes from studies of changes in retail availability, including reductions in the hours and days of sale, limits on the number of alcohol outlets and restrictions on retail access to alcohol. (1)

- Evidence from privatization experiments in the USA and abroad has shown that privatization leads to more outlets, longer hours of operation, increased promotions and increased sales and use. (4)
- Research suggests that roughly 80% of marijuana purchases in the USA are made by 20% of the users (heavy users who use daily or near daily). (5) To maximize profits, companies would benefit from creating and maintaining heavy users.

2. To what extent is variation across provinces in terms of distribution models acceptable?

Recommendation:

- **A uniform distribution model consistent across Canada is important for public health.**

Rationale:

Cross border variations can present many complexities and challenges, as is seen now between Ontario bordering Quebec and Manitoba, where the legal age to drink alcohol is different.

When it is left to each province to add additional policies and regulations, local health units and our partners are burdened with the challenging task of demonstrating the need for additional safeguards at the local level.

Even within a strict health-focused federal regulatory system, provinces and municipalities will require the jurisdiction to strengthen the regulations and policies in order to further safeguard the health and safety of their residents. For example, municipalities should be able to use zoning bylaws when determining locations of outlets.

3. Are there other models worthy of consideration?

Recommendation:

- **A government monopoly with cross-border consistency is the preferred model for Ontario health units.**

Section Three References

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Section 4: Enforcing public safety and protection

1. *How should governments approach designing laws that will reduce, eliminate and punish those who operate outside the boundaries of the new legal system for marijuana?*

Recommendation:

- **A federal legislative framework that sets out clear minimum standards that all provinces and territories must follow, including a minimum age for sale or provision, restrictions on labelling and promotion, and clear enforcement infrastructure**, will result in a strong foundation upon which more restrictive provincial and municipal laws can be built, if required.

- **Youth possession of marijuana should not be considered a criminal offense.** The onus of compliance with the laws should be placed on the commercial supplier with increasing penalty with each infraction, and include prohibition of any sale or storage of product. This recommendation, however, should not preclude criminal charges of youth related to impaired-driving. Offences regarding youth access should be aligned with those in alcohol and tobacco control.

- **Develop an enforcement infrastructure that prevents the diversion of marijuana products from the legal supply chain**. This will require collaboration at all levels of government and enforcement bodies.

- **Provide mandatory labelling or markings that easily identify permitted products thereby facilitating the removal of prohibited products from the supply chain. Ensure penalties are aligned with alcohol and tobacco contraband offences.**

- **Creating a new role of 'marijuana control officer' (similar to tobacco control officers) to help enforce regulations.**

Rationale:

It is important that the federal government take a public health approach that focuses on preventing youth access to marijuana through the legal and illegal supply chains. Existing alcohol and tobacco control policies provide structures that could support marijuana legislation.

The commercial model of marijuana legalization adopted in Washington, Colorado, Alaska and Oregon State performs well in terms of consumer access and reducing street level illicit marijuana trade. However, like alcohol, tobacco, and gambling, the goal of the commercial for-profit model is to attract new customers, keep existing customers and convert moderate users into consistent users. The preferred approach from a public health standpoint is a regulatory approach similar to alcohol that makes the sale of marijuana a provincially controlled state monopoly similar to the LCBO. This approach, provides an effective means of controlling the quality, cost and availability of the product, promotes responsible use amongst adults while restricting access to minors. [(1)]

Evidence suggests that a regulatory approach can reduce the burden on the criminal justice system and provide a platform for government or health care professionals to effectively address and help prevent problematic use. [(1)] If a regulatory controlled system for the legal purchase and use of marijuana is adopted, criminal sanctions should be strengthened for those who sell to minors or act outside the boundaries of the new regulatory system and civil violations punishable by a small fine to enforce regulatory non-compliance.

For example, a federal regulated legal system for marijuana should set out clear minimum standards that all provinces and territories should follow. At a minimum all provinces and territories should be required to ensure:

- That all sales of marijuana are done through provincially controlled outlets/dispensaries.
- No criminal sanctions for anyone who is the minimum age for purchasing and possessing marijuana or over and in possession of what is deemed to be within the limit for persona possession.
- Provincially appointed enforcement staff (non-criminal) should be given the option to issue Provincial Offences Act (POA) tickets plus tax assessment penalties similar to the taxation powers given to enforcement staff under the Ontario Tobacco Tax Act for all marijuana possession that exceeds the limit for personal possession and/or that was not purchased from a state or provincially controlled outlet/dispensary.
- Criminal charges under the Control Drug and Substances Act should be laid for all sales to persons less than the minimum age for purchasing and possessing marijuana and for distribution or sales without federal or provincial marijuana sales permit.

2. What specific tools, training and guidelines will be most effective in supporting enforcement measures to protect public health and safety, particularly for impaired driving?

Recommendation:

- **Develop a comprehensive framework which includes prevention, education, and enforcement to address and prevent marijuana-impaired driving with a focus on groups at higher risk of harm, such as youth.**
- **Continue with public health support for local law enforcement activities through education and awareness raising efforts on the dangers of marijuana-impaired driving.**
- **Direct provincial education ministries to work with public health to update and provide supports for health and physical education curriculums, embedding key evidence-based messages about risky use.**
- **Additional provincial funding to allow for the expansion of the role of public health inspectors by creating 'marijuana control officer positions (similar to tobacco control officers) to help enforce regulations.**

Rationale:

As highlighted in the discussion paper, it will be important to develop a comprehensive framework to address and prevent marijuana-impaired driving. Such a framework should include prevention, education, and enforcement. [(1)] This strategy should focus on groups at higher risk of harm, such as youth, and should emphasize the risk associated with marijuana use and drug-impaired driving. Targeted campaigns via the use of radio ads, news outlets, TV commercials, or movie stills could be an effective method used to inform the public of the new legislative requirements.

There is a recognized need for research on and the development of reliable technologies that can be used at road-side check points to detect impairment due to marijuana use. The use of these technologies, including training and guidelines, would fall to local, provincial and federal law enforcement agencies, depending upon the jurisdiction. Additional training opportunities could assist enforcement staff to further enhance their ability to combat difficult situations such as dealing with drug-impaired driver or managing conflict with individuals who may be impaired due to the use of marijuana.

Public health can play a role in supporting local police agencies through education and awareness raising efforts. Traditional public health communication channels could be used to help make the public aware of the dangers of marijuana-impaired driving, similar to efforts currently being done around drinking and driving.

Public health staff currently partner with school boards as well as school staff, school councils and students of elementary, secondary and post-secondary educational settings

to raise awareness of the health and safety risks to youth posed by alcohol, tobacco and marijuana use. [2] These efforts can be expanded to include greater emphasis on marijuana and youth-related health effects as well as marijuana-impaired driving. The communication of risk to the wider population can be undertaken using existing social media channels and providing support to relevant local partners, as needed.

3. Should consumption of marijuana be allowed in any publicly-accessible spaces outside the home? Under what conditions and circumstances?

Recommendation:

- **A comprehensive ban of the consumption of marijuana in workplaces and in shared indoor and outdoor spaces at the federal level would prevent a patchwork approach similar to what is observed in tobacco control across Canada. A federal level ban positions marijuana use as having risk, and provides a minimum standard upon which provinces and municipalities can build. Enforcement of these regulations must be jointly shared at the federal, provincial and local levels.**

Rationale:

The prohibition of alcohol consumption in public spaces has its roots in federal and provincial temperance laws and the prohibition movement with the misdirected aim to maintain social order. Currently, alcohol consumption is limited for the most part to private residences or licensed premises. On the other hand, the prohibition of smoking in workplaces, public indoor and outdoor spaces have been implemented to varying degrees across Canada over the last 30 years. The implementation of these policies was in response to the body of evidence that identified the link between tobacco use and chronic diseases. [3]

According to the World Health Organization, 100% smoke-free environments are the only effective way to protect the population from the harmful effects of second hand smoke (SHS). SHS can disperse quickly through a building traveling between adjacent units through cracks in walls and ceiling, windows, heating and ventilations systems. According to the American Society of Heating, Refrigerating & Air-Conditioning Engineers (ASHRAE) there is currently no available or reasonably anticipated ventilation or air cleaning system that can adequately control or significantly reduce the health risks of SHS. ASHRAE also says the only effective means of eliminating the health risk associated with indoor exposure to SHS is to ban smoking altogether. [4]

Studies have shown that smoke-free policies can reduce smoking rates, youth initiation rates and increase quit attempts. Smoking bans have also been associated with improved health outcomes, such as reductions in heart disease and respiratory illness. [4] Tobacco and other combustible smoking products should be the highest priority for no-smoking provisions. Exposure to all smoke, including tobacco, marijuana and herbal products such as shisha water pipe smoke, can trigger cardiovascular events, severe asthma attacks and can aggravate existing chronic obstructive pulmonary disease and other respiratory conditions. [5, 6, 7]

In March 2016, the Ontario government announced plans to further strengthen the smoking and vaping laws by proposing six additional changes to the regulations made under the Smoke-Free Ontario Act (SFOA) and ECA. The Province tabled Bill 178 that would amend the SFOA to prohibit the smoking of any substance or product prescribed by regulation. Bill 178 was carried on third reading in June. The Government would next promulgate the regulations that would stipulate what products/substances (other than tobacco) are not to be smoked in the same places where smoking of tobacco is prohibited. The Province to date has only formally proposed that medical marijuana be prescribed under the regulations but it is recommended that they extend this to recreational use of marijuana as well.

It is evident that the Task Force on Marijuana Legalization and Regulations seeks to protect young Canadians and protect the health of all. In the case of smoking or vaping of marijuana, a prohibition of its consumption in workplaces and public spaces, both indoor and outdoor, ensures the same reasonable and precautionary safeguards to employees, customers and bystanders from exposure to second-hand smoke. Further still, lessons from tobacco control suggest that a prohibition of consumption in public spaces, in conjunction with sufficient taxation and banning advertising, promotion and sponsorship, would prevent the normalization of consumption among youth. [1]

Section Four References:

1. Centre for Addiction and Mental Health (CAMH). *Cannabis Policy Framework.* [Report online]. Toronto: CAMH; 2014 [Last accessed 2016 Aug 18]. Available from: https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf

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Section Five: Accessing marijuana for medical purposes

1. ***What factors should the government consider in determining if appropriate access to medically authorized persons is provided once a system for legal access to marijuana is in place?***

   Recommendation:

   - **Utilizing a health equity lens, the government needs to provide regulations including price and accessibility to suit the needs of all Canadians who require medical marijuana while maintaining effective controls to reduce potential harm.**

   Rationale:

   Ontario public health units focus on the issue of health equity.

   The legalization of marijuana will impact the current system of medical marijuana. If it is anticipated that there will be a continuation of access to marijuana for medical reasons, the proper measures need to be put in place to allow for enforcement.

   Affordability and accessibility have been identified as reasons for the commercial medical marijuana system not meeting the needs of all. Utilizing a health equity lens, the government needs to provide regulations including price and accessibility to suit the needs of all Canadians who require medical marijuana while maintaining effective controls to reduce potential harm. Regardless if the marijuana is medical or recreational, there is a need for strong regulation and control the methods by which people are accessing it.

To: All Members
Board of Health

From: Dr. Rosana Salvaterra
on behalf of Chief Phyllis Williams, Chair, First Nations Committee

Subject: **Committee Report: First Nations**

Date: September 14, 2016

The First Nations Committee met last on June 14, 2016. At that meeting, the Committee requested that the following items come forward to the Board of Health:

1. Meeting Notes

Proposed Recommendation:

That the Board of Health for Peterborough Public Health receive for information, meeting notes from January 8, 2016 of the First Nations Working Group, and April 14, 2016, of the First Nations Committee.

The Committee was established by the Board on February 10, 2016, however given that the Committee did not have quorum on April 14, 2016, official minutes were not taken.

2. Appointment of Volunteers

Proposed Recommendation:

That the Board of Health for Peterborough Public Health appoint Liz Stone and Lori Flynn as volunteer members of the First Nations Committee.

As part of their Terms of Reference, the Committee was tasked with assisting the Board in seeking volunteer community members representing the broader indigenous stakeholder community.

The Committee has been able to recruit Liz Stone, Executive Director, Niijkiwendidaa Anishnaabekwewag Services Circle; and, Lori Flynn, Executive Director, Nogojiwanong Friendship Centre.

Attachments:
Attachment A – Meeting Notes - January 8, 2016
Attachment B – Meeting Notes – April 14, 2016

FIRST NATIONS WORKING GROUP
MEETING NOTES

Date:	**Friday, January 8, 2016**
Time:	**1:00 – 2:30 p.m.**
Location:	**Mississagua Lake Room, 2nd Floor, Jackson Square, 185 King Street**
Attendees:	**Hallie Atter, Brittany Cadence, Greg Connolley (Chair), Deputy Mayor John Fallis, Dr. Rosana Salvaterra (Recorder), Sarah Tanner, Councillor Art Vowles, Chief Phyllis Williams.**

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1. Opening Statement
   We would like to acknowledge that we are meeting on the traditional territory of the Mississauga First Nations.

1. Approval of the Agenda
   The Agenda was approved as circulated.

2. Approval of the Notes from the Previous Meeting
   The notes from July 16, 2015 were approved as circulated.

3. Business Arising From the Notes
   3.1. Pilot of dedicated PCCHU staff and one-time funding request
   This idea was discussed further. Boards of Health (BOHs) usually are requested to submit one-time funding requests with their cost-shared budget submissions. These grants are usually made at the same time as the cost-shared provincial grants are received, which could be summer or fall, so it is unlikely that there would be more than a six-month pilot possible. Chief Williams likes this idea as it would help coordinate work between the health and family services manager and PCCHU staff. Councillor Vowles agreed that as a board member, he does not have hands on experience and this staffing position would ensure that there is good liaison between the organization and the two First Nations (FNs). Having more up-to-date information and knowledge might help us to be more strategic in the future. Brittany suggested that there may be other models to be considered, and part of the work of the pilot could include identifying the most appropriate model for PCCHU to advance public health needs with its FN partners. Some boards of health have used their social determinants of health (SDOH) Public Health Nurses to do this work. Whatever model is implemented, it will require an evaluation component. **ACTION: Staff (Dr. Salvaterra, Patti, Hallie) to take this away and consider options.**

   3.2. On and off reserve PH strategy for Indigenous People living in the Peterborough area:
   TRC Calls to action and local implications: Brittany has scanned the 94 calls to action and said they are broken down into categories – she found some that relate to public health, such as surveillance, cultural competency training, sports and recreation

programming that is more inclusive for indigenous children. Chief Williams stressed the importance of referring to the outcomes of the TRC as "calls to action". The SDOH nurse could be a very good link to develop the strategies on the relevant calls to action. Deputy Mayor Fallis asked that the link to the TRC calls to action be shared. Sarah wondered if PCCHU could play a role in bringing people together – would we be seen as the most appropriate broker for this collaborative work? This could become a key objective in the work plan of the staff person assigned to be in a liaison role with our two FN communities. Chief Williams referred to a statement from the Ontario Regional Chief which implied a renewed relationship with the provincial government and equal access to provincial services as fundamental. She felt that there are many positive signs of change. Brittany asked about other documents and materials that would be helpful to us. Chief Williams shared that there is a forum where health is being discussed and she will keep her eye open for documents that may be relevant to us. **ACTION: Link to the TRC will be included in the notes. Patti, Hallie and Dr. Salvaterra to discuss this further and report back to this committee.**

3.3. Cultural Competency Modules Update:

Chiefs of Ontario have been given additional funding to complete the set of modules for boards of health and their staff to use. The modules are now ready to be tested and this will be done by Fort Williams FN and Thunder Bay public health. There had been an expression of interest to have CLFN and PCCHU also pilot the modules but this will not be required. Chief Williams reported that PRHC is developing a cultural competency strategic directions and have sought input from both Curve Lake and Hiawatha. **ACTION: Dr. Salvaterra to update this group on the readiness of the modules when they are available.**

3.4. 185 King Street and FN heritage:

Sarah reported that she has discussed with AON about the shared condominium space and they are open at looking at designing something for the concrete banner that surrounds the exterior of the building. Inside, in the atrium, they were open to suggestions in the common space. AON mentioned the possibility of having Brand Health as potential consultants to assist us.

Regarding PCCHU's own space, Sarah has been unable to connect with the suggested people over the summer. The Art Gallery is not offering an art leasing program at the moment. Mr. Connolley reported that Gail McIntyre and Sandra Depret were the names of people recommended to him by Tony Tilly at Fleming College. Chief Williams suggested approaching Mike Whetung and his daughter to come in and see the building and make recommendations. Sarah suggested that it may help if we identify priority areas such as the multipurpose rooms, the clinic reception waiting area, and the 3rd customer service area and start with those. Chief Williams reminded us that art should include other media, such as fabric and birch bark. **ACTION: Councillor Vowles will send photos and information from the fire station. Brittany and Dr. Salvaterra will**

meet to plan a process soon so that any existing funds for art can be used prior to the fiscal year end.

3.5. Update on Branding:
Brittany shared that the stakeholder engagement component has been completed and will be shared with the board of health next week. The present name of the organization does not reflect our FN partners so it is hoped that the future name and visual identity is more inclusive. Anne Taylor from Curve Lake will join the process. Brittany is seeking to invite artists from Hiawatha as well.

3.6. BOH Opening Statement (implemented in December 2015):
Mr. Connolley expressed his content with it so far. We will encourage the board and all of its committees to use this opening statement at the start of all meetings.

4. New Business

4.1. Terms of Reference
Draft Terms of Reference for a Board Committee were circulated, Dr. Salvaterra recorded input from attendees and will recirculate an updated version.

There were discussions committee membership and staffing. The BOH can appoint community members to its committees as volunteers and this could be discussed in February with the terms of reference. Executive and Management teams will determine who best should assist with this committee. Potentially that could include front line staff who are involved in the work that is prioritized here and then incorporated into work plans.

4.2. Curve Lake Water Treatment follow-up for BOH?
Chief Williams reported that her staff will let us know if there is any advocacy required by either the board or PCCHU staff.

4.3. Caledon Policy Paper - FYI
The policy paper, *Ensuring Real Accountability on First Nation Reserves (January 2016),* was circulated to the group for their information.

5. Next Steps / Review of Items for BOH:
- Dr. Salvaterra to draft and circulate TOR to everyone and we will try to prepare February BOH meeting.
- Dr. Salvaterra to prepare a business arising summary to go to next week's BOH meeting.

6. Next Meeting Date:
To be determined.

7. Adjournment
The meeting was adjourned at 2:30 p.m.

Board of Health for the
Peterborough County-City Health Unit
NOTES
First Nations Committee Meeting
Thursday, April 14, 2016 – 4:30 p.m.
Mississauga Lake Room, 185 King Street, Peterborough

Present:	**Chief Phyllis Williams** **Deputy Mayor John Fallis**
Regrets:	**Councillor Art Vowles** **Ms. Kerri Davies**
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health** **Ms. Patti Fitzgerald, Assistant Director, Chief Nursing and Privacy Officer** **Ms. Natalie Garnett, Recorder** (4:36 p.m.)

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1. Call to Order

Dr. Salvaterra called the First Nations Committee meeting to order at 4:35 p.m. and noted that the meeting did not have quorum. As a result the members present met informally and made recommendations for consideration at a future meeting.

2. Elections

2.1 Chairperson

Councillor Fallis recommended that Chief Williams be Chair of this Committee.

2.2 Vice Chairperson

Councillor Fallis recommended that Councillor Vowles be Vice Chair of this Committee.

2.3 Review Committee Terms of Reference

This item was deferred to a future Committee meeting.

3. Confirmation of the Agenda

4. Declaration of Pecuniary Interest

5. Delegations and Presentations

6. Confirmation of the Minutes of the Previous Meeting

MOTION:
That the notes of the First Nations Committee Meeting held January 8, 2016 be approved as circulated and provided to the Board of Health at its next meeting for information.
Moved: Chief Williams
Seconded: Deputy Mayor Fallis
Motion carried. (M-2016-00 -FN)

7. Business Arising from the Minutes

7.1 Dedicated Staff

It was agreed that staff will meet with contacts at Curve Lake (Angela Gillies, Health and Family Services Manager) and Hiawatha (to be determined) to establish what their needs are.

7.2 Truth and Reconciliation Commission of Canada: Calls to Action

Dr. Salvaterra reviewed the following items of the *Truth and Reconciliation Commission of Canada: Calls to Action* report which relate to Health issues:

- 5 - Culturally appropriate parenting programs for Aboriginal families
- 8 - Elimination of discrepancy in federal funding for First Nations children being educated on and off reserves
- 18 - Federal, provincial, territorial and Aboriginal governments to implement the health-care rights of Aboriginal people.
- 19 - Establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities
- 20 - Address jurisdictional disputes concerning Aboriginal people who do not reside on reserves
- 21 - Sustainable funding for Aboriginal Health Centres
- 22 - Recognize the value of Aboriginal healing practices
- 23 - Ensure cultural competency training for all health-care professionals and increase the number of Aboriginal professionals in this field
- 24 - Medical and nursing schools in Canada require students to take a course in Aboriginal Health Issues
- 77 - Ensure all records relevant to the history of residential school system be provided to the National Centre for Truth and Reconciliation.

- 89 - Amend the federal Physical Activity and Sport Act to ensure it is inclusive of Aboriginal peoples.

7.3 **Chiefs of Ontario Modules Update**

Dr. Salvaterra advised that work is underway on this item.

7.4 **185 King Street Art Update**

Discussion was held on what types of Aboriginal art items should be included in the planned art for the office.

8. Consent Items

9. New Business

9.1 **Recommendations for Volunteer Community Members for Committee Appointment**

Following Discussion it was decided that Chief Williams will approach the two women agreed upon to see if they would be interested in becoming members of this Committee.

9.2 **Develop Committee Work Plan for 2016**

This item will be deferred to a future meeting of this Committee.

10. In Camera to Discuss Confidential Matters

11. Motions from In Camera for Open Session

12. Date, Time and Place of Next Meeting

Tuesday, June 14, 2016 at 4:30 p.m. in the Board Room, Peterborough County-City Health Unit, 185 King Street, Peterborough.

13. Adjournment

The meeting adjourned at 5:12 p.m.

To: All Members
Board of Health

From: Kerri Davies, Chair, Fundraising Committee

Subject: **Committee Report: Fundraising**

Date: September 14, 2016

The Fundraising Committee met last on July 19, 2016. At that meeting, the Committee requested that the following items come forward to the Board of Health:

1. **Meeting Minutes – April 13, 2016**

   Proposed Recommendation:

   That the Board of Health for Peterborough Public Health receive for information, meeting minutes of the Fundraising Committee for April 13, 2016

2. **Dissolution of the Fundraising Committee**

   Proposed Recommendation:

   That the Board of Health for the Peterborough Public Health dissolve the Fundraising Committee.

   Over the course of the last few meetings of the Committee, members were presented with various options to continue fundraising efforts for PPH.

   Given capacity constraints, members felt that if there were project-specific initiatives that arose in the future, an ad-hoc group (consisting of either Board Members only or Board Members and staff) could be formed in order to address a specific need.

Attachments:
Attachment A - Meeting Minutes – April 13, 2016

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Fundraising Committee Meeting
Wednesday, April 13, 2016 – 4:00 p.m.
Peterborough County-City Health Unit, 185 King Street

Present:	**Ms. Kerri Davies, Chair**
	Mr. Scott McDonald
	Mr. Andy Sharpe
	Councillor Baldwin
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health (Recorder)**

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1. Call to Order

Ms. Davies, Chair called the meeting to order at 4:00 p.m.

2. Confirmation of the Agenda

MOTION:
That the Agenda be approved as circulated.
Moved: Mr. McDonald
Seconded: Councillor Baldwin
Motion carried. (M-2016-015-FC)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

5.1 March 7, 2016

MOTION:
That the minutes of the Fundraising Committee Meeting held March 7, 2016 be approved as circulated and provided to the Board of Health at its next meeting for information.

Moved: Councillor Baldwin
Seconded: Mr. Sharpe
Motion carried. (M-2016-016-FC)

6. Business Arising from the Minutes

6.1. Draft Recognition Policy

Dr. Salvaterra provided an overview of the Draft Recognition Policy.

MOTION:
That the Draft Recognition Policy be approved as amended.
Moved: Mr. McDonald
Seconded: Mr. Sharpe
Motion carried. (M-2016-017-FC)

6.2. Community Kitchen Donor Recognition Wall

Dr. Salvaterra provided an overview of the plan for the Community Kitchen Donor Recognition Wall. It was noted that Ms. Beatty will provide a presentation to the Board at the meeting this evening.

MOTION:
That the presentation from Dr. Salvaterra be received, and

That notice be provided to the Community Kitchen donors indicating that the Official Opening has been changed to June 10, 2016.
Moved: Councillor Baldwin
Seconded: Mr. Sharpe
Motion carried. (M-2016-018-FC)

6.3. Ongoing Fundraising Infrastructure for the Board

Discussion was held regarding the future of fundraising activities for the Board.

MOTION:
That staff investigate the possible establishment of a Public Health Fund with the Community Foundation of Greater Peterborough, and report back to the Committee in June 2016.
Moved: Councillor Baldwin
Seconded: Mr. Sharpe
Motion carried. (M-2016-019-FC)

MOTION:
That Kerri Davies, Chair, be thanked for her efforts and leadership on fundraising activities for the Board.
Moved: Councillor Baldwin
Seconded: Mr. Sharpe
Motion carried. (M-2016-020-FC)

7. Staff Reports

8. Consent Items

9. New Business

10. In Camera to Discuss Confidential Matters

11. Motions from In Camera for Open Session

12. Date, Time and Place of Next Meeting

The Fundraising Committee established a tentative date for the next meeting – June 15, 2016 at 4:00 p.m. at the Peterborough County-City Health Unit, 185 King Street.

13. Adjournment

MOTION:
That the Fundraising Committee meeting be adjourned.
Moved by: Councillor Baldwin
Seconded by: Mr. McDonald
Motion carried. (M-2016-021-FC)

The meeting was adjourned at 4:45 p.m.

Chairperson

Medical Officer of Health

To: All Members
Board of Health

From: Greg Connolley, Chair, Governance Committee

Subject: **Committee Report: Governance**

Date: September 14, 2016

The Governance Committee met last on August 2, 2016. At that meeting, the Committee requested that the following items come forward to the Board of Health:

1. **Meeting Minutes – May 3, 2016**

   Proposed Recommendation:

   That the Board of Health for Peterborough Public Health receive for information, meeting minutes of the Governance Committee for May 3, 2016.

2. **Stewardship Committee**

   Proposed Recommendation:

   That the Board of Health for Peterborough Public Health:
   - *receive for information, the staff report Stewardship Committee; and,*
   - *approve 2-354, Terms of Reference, Stewardship Committee.*

3. **By-Laws/Policies**

   Proposed Recommendation:

   That the Board of Health for Peterborough Public Health approve the following:
   - *2-140 By-Law #5, Powers, Duties and Terms of Office of the Chairperson and Vice-Chairperson of the Board of Health (revised);*
   - *Position Description, Medical Officer of Health (revised);*
   - *2-200 Duties and Responsibilities of Board Members (no changes); and,*
   - *2-284 Correspondence (no changes).*

Attachments:
Attachment A - Meeting Minutes – May 3, 2016
Attachment B – Staff Report, Stewardship Committee
Attachment C – Draft Terms of Reference, Stewardship Committee

Attachment D - 2-140 By-Law #5, Powers, Duties and Terms of Office of the Chairperson and Vice-Chairperson of the Board of Health
Attachment E - Position Description, Medical Officer of Health
Attachment F – 2-200 Duties and Responsibilities of Board Members ***(web hyperlink)***
Attachment G – 2-284 Correspondence ***(web hyperlink)***

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Governance Committee Meeting
Tuesday, May 3, 2016 – 4:30 p.m.
Dr. J. K. Edwards Board Room, 185 King Street, Peterborough

Present:	**Mayor Mary Smith** **Mr. Scott McDonald** **Mr. Greg Connolley, Chair** **Mayor Rick Woodcock**
Regrets:	**Deputy Mayor John Fallis**
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health** **Mr. Larry Stinson, Director of Operations** **Ms. Natalie Garnett, Recorder** (4:35 p.m.)

---

1. Call to Order

Mr. Connolley called the Governance Committee meeting to order at 4:30 p.m.

2. Confirmation of the Agenda

MOTION:
That the Agenda be accepted as circulated.
Moved: Mayor Smith
Seconded: Mr. McDonald
Motion carried. (M-2016-009-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 March 15, 2016 be approved as circulated and provided to the Board of Health at its next meeting for information.
Moved: Mr. McDonald
Seconded: Mayor Woodcock
Motion carried. (M-2016-010-GV)

6. Business Arising from the Minutes

7. Staff Reports

7.1 Staff Report: Risk Management

Mr. Stinson, Director of Operations provided an overview of the staff report "Risk Management".

MOTION:
That the Governance Committee for the Board of Health for the Peterborough County-City Health Unit:
- *Receive the staff report, "Risk Management", for information; and*
- *Approve the recommended action plan for implementation.*

Moved: Mr. McDonald
Seconded: Mayor Smith
Motion carried. (M-2016-011-GV)

MOTION:
That staff undertake additional research on how similar Board of Health are addressing the Risk Management issue and bring a report to the Committee meeting of August 2, 2016 along with a Draft Terms of Reference.
Moved: Mayor Smith
Seconded: Mayor Woodcock
Motion carried. (M-2016-012-GV)

8. Consent Items

8.1 Correspondence

8.2 Staff Reports and Presentations

a. Board By-laws and Policies for Review

MOTION:
That the Governance Committee for the Board of Health for the Peterborough County-City Health Unit advise the Board of Health at its next meeting that the Committee reviewed the following by-law and recommends:

- *2-160, By-law 7, Execution of Documents – be amended as recommended.*

Moved: Mayor Woodcock
Seconded: Mr. McDonald
Motion carried. (M-2016-013-GV)

MOTION:
That the Governance Committee for the Board of Health for the Peterborough County-City Health Unit advise the Board of Health at its next meeting that the Committee reviewed the following and recommends:
- *2-211, Delegation of Authority – be amended as revised.*

Moved: Mayor Smith
Seconded: Mr. McDonald
Motion carried. (M-2016-014-GV)

MOTION:
That the Governance Committee for the Board of Health for the Peterborough County-City Health Unit advise the Board of Health at its next meeting that the Committee reviewed the following and recommends:
- *2-20, Authority and Jurisdiction – no revisions.*

Moved: Mayor Woodcock
Seconded: Mr. McDonald
Motion carried. (M-2016-015-GV)

MOTION:
That the Governance Committee for the Board of Health for the Peterborough County-City Health Unit advise the Board of Health at its next meeting that the Committee reviewed the following and recommends:
- *By-law 4, Appointment of Auditor – be revised as recommended.*

Moved: Mayor Woodcock
Seconded: Mayor Smith
Motion carried. (M-2016-016-GV)

b. <u>Skills Matrix</u>

MOTION:
That the Governance Committee for the Board of Health for the Peterborough County-City Health Unit request staff to draft a skills matrix tool that could be used to search for new Board Members when required.

Moved: Mr. McDonald
Seconded: Mayor Woodcock
Motion carried. (M-2016-017-GV)

8.3 **Committee Reports**

9. New Business

9.1 **Review Committee Terms of Reference**

The Chair provided an overview of the Governance Committee Terms of Reference.

MOTION:
That the Governance Committee advise the Board of Health for the Peterborough County-City Health Unit at its next meeting that the Committee reviewed the following and recommends:

- *2-348, Governance Committee Terms of Reference – be revised as recommended.*

Moved: Mr. McDonald
Seconded: Mayor Woodcock
Motion carried. (M-2016-018-GV)

10. In Camera to Discuss Confidential Matters

11. Motions from In Camera for Open Session

12. Date, Time and Place of Next Meeting

Tuesday, August 2, 2016 at 4:30 p.m. in the Board Room, Peterborough County-City Health Unit, 185 King Street, Peterborough.

13. Adjournment

MOTION:
That the Governance Committee meeting be adjourned.
Moved by: Mayor Smith
Seconded by: Mr. McDonald
Motion carried. (M-2016-019-GV)

The meeting was adjourned at 6:05 p.m.

Chairperson

Medical Officer of Health

Staff Report

Stewardship Committee

Date:	September 14, 2016
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Larry Stinson, Director of Operations

Proposed Recommendations

That the Board of Health for Peterborough Public Health:
- receive for information, the staff report Stewardship Committee; and,
- approve 2-354, Terms of Reference, Stewardship Committee.

Financial Implications and Impact

Risk Management includes the assessment, management and mitigation of financial risk. An effective structure and process for management of financial risk as well as risk in other domains will support the future effectiveness and sustainability of the organization and prevent inappropriate use of resources.

Decision History

At the May 3, 2016 meeting of the Governance Committee, a staff report recommended the establishment of Audit and Risk Management Committee and a proposed timeline for implementation. At the August 2, 2016 meeting of the Governance Committee, draft Terms of Reference, developed by the Governance Committee Chair and Director of Operations, were approved with a recommendation to seek Board approval.

Background

On February 24, 2016 Board Member, Mary Smith and Director of Operations, Larry Stinson attended a Risk Management Workshop hosted by the Association of Local Public Health Agencies (alPHa) and the Association of Ontario Public Health Business Administrators (AOPHBA). The purpose of the event was to provide a broad understanding of risk management and discuss applications within a public health environment.

Among the information shared at the workshop was the Risk Management Strategy and Process Toolkit, a framework used by the Ontario Internal Audit Division to support provincial government staff in developing risk management strategies. The tool lays out 14 different risk categories and proposes a five step process to manage these risks through control and mitigation strategies. One step in the management process is risk prioritization which involves assessing the likelihood and potential impact of each identified risk.

In the presentation provided at the workshop by Graham Scott, the issues of Risk and Governance were shared, with specific attention to Boards of Health. Among his recommendations was that each Board of Health have a minimum of two subcommittees: Governance and Finance. Since the Board of Health for the Peterborough County-City Health Unit has a governance committee, the immediate need to meet this recommendation is the creation of a committee for finance oversight.

Rationale

Based on the above background there is an immediate need for the Board of Health to consider the establishment of a committee for finance oversight and to establish a mechanism to be kept informed of existing and emerging risks and the control mechanisms that are in place and to be able to recommended strategies to prevent and mitigate risks identified as high priority.

The initial proposal introduced at the Governance Committee was the establishment of an Audit and Risk Management Committee. This was to emphasize the role of the committee to provide oversight on financial matters and organizational risks that are relevant to the Board of Health. Based on feedback, examples were compiled of Terms of Reference for comparable committees across health units and similar organizations. The Governance Committee Chair and Director of Operations reviewed these and prepared Terms of Reference that would meet the needs of Peterborough Public Health.

The Terms of Reference highlight the fact that financial risk is the most important area of risk for the Board to monitor. The Stewardship Committee will, therefore, ensure there is accountability for effective and efficient use of financial resources and that it is reported in a transparent manner. They will also take the lead on the formal audit process. The responsibilities extend to include oversight for other significant risks to the organization and the Committee will receive staff reports on the risk domains outlined in the Ontario

Governments Risk Management framework to ensure appropriate prevention and mitigation strategies are in place.

Strategic Direction

The proposed recommendations will assist the Board and staff to achieve the strategic direction of *Quality and Performance*.

Contact:

Larry Stinson
Director of Operations
(705) 743-1000, ext. 255
lstinson@peterboroughpublichealth.ca

Attachments:
Attachment A – Policy 2-354: Stewardship Committee Terms of Reference

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-354	**Title:** Stewardship Committee
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**:**
Signature:		**Author:** Governance Committee
Date (YYYY-MM-DD)**:**		
Reference:		

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Goal

1. To ensure that the Board of Health fulfils its due diligence responsibilities for accountable, effective and efficient management of public resources.

2. To fulfill obligations and oversight responsibilities relating to financial planning, the audit process and financial reporting.

3. To promote and provide oversight for effective risk management practices.

Duties and Responsibilities:

1. *Financial Planning:*
   The Committee will review and make recommendations to the Board in respect of:
   a. Annual budgets for all funding agreements greater than $100,000;
   b. Consistency of planned budget allocations with strategic plans and other identified priorities.

2. *Financial Reporting:*
   The Committee will review and recommend approval to the Board:
   a. financial management by-laws and polices;
   b. quarterly financial statements; and
   c. annual audited financial statements.

3. *External Audit:*
   The Committee will:

a. Meet with the External Auditor to review the terms of engagement and approve the audit plan.
b. Discuss with the External Auditor any problems experienced in conducting the audit, including any issues with management's cooperation or disagreements regarding financial statements or disclosure.
c. Meet with Auditor to discuss significant findings and recommendations.
d. Recommend to the Board the approval of the annual Audited Financial Statement and the appointment of the External Auditor.

4. *Internal Controls:*
The Committee will:
a. Review on an annual basis the control measures in place to manage financial risk.
b. Review legal matters that have potential to impact financial statements in a material way and where deemed appropriate advise and/or seek direction from the Board.
c. Review any recommendations from External Auditors for improved financial management practices together with management.

5. *Risk Management:*
The Committee will:
a. Review on a quarterly basis management`s assessment of any material changes to risk categories as identified in the Province of Ontario's Integrated Risk Management Quick Reference Guide (attached).
b. Request management reports on risk management status for categories deemed most relevant to the Board of Health, including but not limited to: strategy, service delivery, human resources, information and privacy, infrastructure, legislative compliance, technology, security and equity.

Membership

The Committee will be composed of a minimum of three Board members with maximum of one representative from the City, County, Provincial Representatives, or First Nation representatives, in addition to the Chair of the Board.

The Committee will elect its own Chair and Vice-Chair at the first meeting of each calendar year.

Internal staff resources will be provided for the Committee through the Medical Officer of Health and the Director of Operations.

Quorum

A majority of Committee members constitute a quorum.

Reporting

The Committee will provide its minutes, once approved, to the Board of Health at the next scheduled meeting.

The Chair will take motions and/or recommendations deemed appropriate by the Committee forward to the Board of Health at the next scheduled meeting.

Meetings

The Committee will meet a minimum of quarterly and may meet more frequently

Extraordinary meetings to address specific items may be held at the call of the Chair of the Stewardship. Time-limited sub-committees may be formed to address specific issues.

The Stewardship Committee will meet with other Board Committees as required.

Minutes

The Executive Assistant to the Board of Health, or designate, will record the proceedings at meetings and provide secretarial support to the Committee.

The minutes are circulated in draft to Committee members prior to the next Committee meeting. Minutes are corrected and approved at the next meeting of the Committee.

The approved minutes are signed by the recorder and the Chairperson. Original copies of the approved minutes are kept in a binder in the Administration office.

Agendas

Agendas will be prepared and distributed according to the format set forth in Section 4 – Agenda and Order of Business, as written in Board of Health By-Law #3, Calling of and Proceedings at Meetings.

Terms of Reference

The Terms of Reference of the Board of Health's Stewardship Committee will be reviewed and updated at the first meeting of each year, or more often as needed.

Attachment:
Integrated Risk Management Quick Reference Guide

Review/Revisions
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**
On (YYYY-MM-DD)**:**

Board of Health
POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-140	**Title:**	By-Law Number 5 Powers, Duties and Term of Office of the Chairperson and Vice-Chairperson of the Board of Health
Approved by: Medical Officer of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**:** 1989-10-25	
Signature:		**Author:**	
Date (YYYY-MM-DD)**:** 2013-09-11			
Reference: Health Protection and Promotion Act, R.S.O. 1990, c. H.7, Section 48 to and including Section 51, and R.R.O. 1990, Regional 559			

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By-Law Number 5
Powers, Duties and Term of Office of the Chairperson and Vice-Chairperson of the Board of Health

1. In this By-law:

   1.1. "Board" means the Board of Health for the Peterborough County-City Health Unit, also referred to as Peterborough Public Health;

   1.2. "Chairperson of the Board" means the Chairperson elected under the Act;

   1.3. "Vice-Chairperson of the Board" means the Vice-Chairperson elected under the Act;

   1.4. "Committee" means an assembly of two or more members appointed by the Board of Health;

   1.5. "Council" means the municipal councils of the Corporations of the County of Peterborough and the City of Peterborough; and the Councils of Curve Lake First Nation and Hiawatha First Nation;

   1.6. "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.

2. The officers of the Board shall be:

   2.1. the Chairperson of the Board; and

   2.2. the Vice-Chairperson of the Board.

3. The Chairperson of the Board shall:

   3.1. preside at all meetings of the Board;

   3.2. represent the Board at public or official functions or designate the Vice-Chairperson or another Board member to do so;

   3.3. be ex-officio, a member of all committees to which he/she has not been appointed a member; and

   3.4. perform such other duties as may be determined from time to time by the Board.

   As an ex-officio member to all committees, the Chairperson retains the rights and privileges afforded to other committee members, such as the right to vote, however they are not counted when determining the number required for a quorum of the Committee.

4. The Vice-Chairperson shall have all the powers and performs all the duties of the Chairperson of the Board in the absence or disability of the Chairperson of the Board together with such powers and duties, if any, as may be assigned from time to time by the Board.

5. The terms of all officers of the Board shall expire when their successors are elected and no later than immediately preceding the first meeting as set out in section 3 of By-law Number 3.

Review/Revisions:

On (YYYY-MM-DD)**:** 2015-12-09 (review)
On (YYYY-MM-DD)**:** 2013-09-11
On (YYYY-MM-DD)**:** 2010-10-13
On (YYYY-MM-DD)**:** 2007-10-11
On (YYYY-MM-DD)**:** 2006-03-06
On (YYYY-MM-DD)**:** 2005-01-12
On (YYYY-MM-DD)**:** 1998-10-28

Peterborough Public Health ~~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~~s~~ of Operations Chief Nursing Officer Executive Assistant to the Medical Officer of Health
Provides functional direction and guidance to:	~~Administrative Assistant to the Medical Officer of Health~~ Manager, Communications Services ~~Supervisor~~

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 agency ~~Health Unit~~.

Duties and Responsibilities

~~1. Recommends Health Unit structure to the Board of Health.~~ Establishes and ensures appropriate organizational structure.

2. Ensures a process is in place for the development and communication of the Board of Health's ~~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, including recruitment and dismissal of staff.

10. ~~Recruits and s~~Supervises senior management and any other relevant positions ~~Directors.~~

11. Oversees the organization and preparation of board of health meetings, including the contents of each agenda and the orientation of any new members ~~Prepares reports.~~

12. Ensures the appropriate management of property.

13. ~~Attends and participates in meetings.~~

14. Establishes and maintains effective communication with external partners and stakeholders.

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 community health.~~

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

19. Provides and ensures 24-7 coverage for public health urgent and emergency response. ~~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.

22. Provides physician oversight for all clinical programs (Sexual Health, Travel Medicine and Routine Immunization).

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.~~
Reputational risk of the organization.

Briefing Note

Public Health

Date:	Wednesday, August 24, 2016
To:	MPP John Frazer, Parliamentary Assistant for MOHLTC
From:	County of Peterborough Delegation, on behalf of the Board of Health for Peterborough Public Health

Issue:

There are three issues that the delegation would like to address:

1. **Express our thanks to Minister Hoskins, and acknowledge the efforts of our MPP Jeff Leal, in supporting the recent relocation of our public health agency to a downtown Peterborough site**.
2. **Discuss the roles and contributions of local boards of health towards the Minister's vision of a transformed health care system, as expressed in "Patients First"; and**
3. **Discuss concerns about the funding of public health.**

"Patients First":

In December, the Minister of Health, Dr. Eric Hoskins, released a discussion paper, entitled "Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario" which signaled his intent to address gaps and inequities in health care. Included were recommendations that would have changed the funding and accountability relationships between boards of health and the Province, shifting this to LHINs instead. Peterborough's municipalities and First Nations were strongly opposed to this and we made our concerns known to Minister Hoskins.

Gratefully the Minister has responded by postponing decisions about the funding and accountability of public health until after the Expert Panel has been able to review the evidence. We thank Minister Hoskins for listening to our local Peterborough municipalities and First Nations who wrote to him on this matter. Meetings like this one today demonstrate how the Province and local governments can work together to ensure that Ontario's public health system remains strong and effective. Our goal is to preserve and protect the independent voice of boards of health to advocate for healthy public policy change.

The work of public health focuses on healthy **people** first, long before they ever become patients. Public health actually works much more closely with partners **OUTSIDE** of the health care system, such as municipal governments, boards of education and community agencies.

The current direct relationship between provinces and municipalities for public health ensures that provincial principles and standards are upheld by all boards, further ensuring that all Ontarians benefit equitably from the public health system.

Public health in Ontario is currently governed by local boards that are composed of both municipal and provincial appointees. Here in Peterborough, we also have representation from our two First Nations, Curve Lake and Hiawatha. The Health Protection and Promotion Act makes boards of health directly accountable to the Minister of Health for the delivery of public health services. In addition, in their role as healthy public policy advocates, the board is able to speak independently to all levels of government, depending on the issue and jurisdiction. For example, our board advocated provincially for the funding of the Herpes Zoster vaccine. We have advocated federally for the regulation of sodium in foods, and the enforcement of the World Health Organization's International Code of Marketing of Breastmilk Substitutes. We recently advocated on behalf of Curve Lake for funding to build a new water treatment plant as part of the federal and provincial commitment to end all boiled water advisories in First Nation communities. We have requested that both levels of government make the construction of smoke free multi-unit dwellings a requirement for any new funding for housing. Because of our strong connection with municipal governments, we can use venues such as this Association of Municipalities of Ontario conference to speak directly to the Province regarding public health funding. We are not dependent on a Local Health Integration Network (LHIN) to do so on our behalf.

Direct relationships between municipalities and provinces mitigate against the threat of resource reallocation, which has been experienced in other parts of the country and even the world, where public health has been integrated into regional health authorities. The evidence is that when regional health authorities, like Ontario's LHINs are given a public health role, public health attention gets diverted and consumed by other parts of the health care system and public health funding, and impact, inevitably erodes.

The municipal and First Nations councils in Peterborough are unanimous on this point: **boards of health sign accountability and funding agreements directly with the Province and we see no benefit in getting a third party, such as the LHIN, involved.** We are strong advocates for the public health of our communities and residents. The recent acquisition of a new facility for public health in the city of Peterborough demonstrates how important local advocacy can be. In our case, local funding and support was secured first and was leveraged to access provincial support and funding, for which we remain very grateful. We are doubtful whether that would have happened had our funding and accountability been transferred to the LHIN, as first recommended in Patients First.

Public health in Ontario originated as health departments in the municipal sector. Together with the Province, we have done great work, whether it has been the disinfection of water, the pasteurization of milk, the treatment of waste, or the elimination of tobacco smoke in our public places. Municipalities have worked with public health and often lead the way on healthy public policy, with the Province following once public support has been secured. Two recent examples have been the Smoke-Free Ontario Act and the ban on cosmetic use of pesticides. Changes to the provincial Safe Drinking Water Act to transfer the oversight of small and seasonal drinking operations to public health were as a result of public confidence in and preference for public health's leadership. Similarly, together, we need to ensure that any provincial "fix" to the health care system does not

unintentionally break the public health system!

Please relay our thanks to Minister Hoskins for allowing the proposed Expert Panel on public health to make its recommendations before moving ahead with changes to funding and accountability that may inadvertently do more harm than good.

Public Health Funding:

A new funding formula for local boards of health that was adopted in 2015 requires **ongoing evaluation and possible revision based on feedback from the field.**

In 2013, a Funding Review Working Group submitted its recommendations for the creation of a funding model that would incorporate the socio-economic determinants of health for each public health unit to identify an appropriate funding share that reflects local needs in relation to all other public health units in the province. The model takes into accounts "drivers" of service costs, like geography and language of populations, as well as drivers of need for utilization of public health services, such as the Ontario Marginalization Index, the Preventable Mortality Rate for the population, and the percentage of the population that identified itself as aboriginal.

This formula was thoughtfully derived but was based on the application of an untested "equity formula" that has determined that 28 out of 36 boards of health are adequately funded, as a proportion of the provincial funding envelope. Although the theory behind the new formula has appeal, it has never been validated and was applied despite the lack of any evidence to support it. In addition, in the way the formula has been adopted, its current implementation will result with zero increases from the Province for the next 5 to 6 years for the 28 boards of health deemed to be adequately funded. Although Peterborough is one of the boards of health that can expect a minimal adjustment, the application of this formula will result in significant cuts to programs and staff for many boards of health, including the board for Peterborough Public Health.

In the application of the new funding formula, the Province has estimated that it will take up to 5 or 6 years to get everyone up to baseline. This may actually be longer if the provincial economy does not improve. For Peterborough and 28 others, we have been advised to expect 0% increases for years to come. This will most definitely impact service delivery and push us into making decisions between paying fair wages or reducing positions. In the broader context of health system transformation, curtailing investments in demonstrably cost-effective upstream health promotion and protection interventions is short-sighted. The Commission on the Reform of Ontario's Public Services (chaired by Don Drummond), recommended a heightened focus on public health's role in preventing health problems, having observed a correlation between health outcomes and the amount provinces spend on public health. The Commission also recommended avoiding applying the same degree of fiscal restraint to all parts of the health system.

The authors of the report recommended that the Ministry:

- Consult with the sector on implementation strategy prior to implementation. (This was not done.)
- Communicate regularly with the sector throughout its impact assessment to mitigate any unforeseen disruptions to the delivery of public health services. (This has not been done.)

In addition, the Association of Local Public Health Agencies (alPHa), which represents Ontario boards of health, wrote to Minister Hoskins in November 2015 to express its concerns on the funding model and its application. In addition to concerns about the impact of what amounts to a "freeze" on public health funding, alPHa reminded the Minister that the new model will require evaluation, revisions and improvements and offered to work closely with the Province to ensure that this be done. To date there has not been a response or any articulated commitment to do this essential work.

Conclusion and Recommendations:

On Patients First:

- We wish to maintain our direct relationship with the Province on the funding and accountability of public health delivery for our communities.

On Funding for Public Health:

- The untested and invalidated Public Health Funding Model for Mandatory Programs lacks objective evidence that it works as a tool to provide more equitable funding and requires more study and research. At minimum, the Province should be carrying out an impact assessment and sharing the findings with the public health sector.
- alPHa has requested that the public health field be included in the evaluation, revision and improvements to the model.

References:

Patients First – A Proposal to Strengthen Patient-Centred Health Care in Ontario
Public Health Funding Model for Mandatory Programs

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Board Member Skills Matrix**

Date: September 14, 2016

Arising out of the August 2, 2016 Governance Committee meeting, the Committee requested that Dr. Salvaterra lead a discussion on the completion of a Board Member skills matrix form.

Completion of the skills matrix form by individual members allows the Board to maintain an up-to-date inventory of its members and their skill sets. Results can be aggregated on to a master list to identify potential areas for training and recruitment.

The inventory can also be revisited each time the Board approves its Strategic Plan to ensure that the Board has the needed competencies to accomplish its goals.

Attachments:
Attachment A – Board Member Skills Matrix

NOTE: A hard copy of the attachment will be distributed at the meeting for completion.

Board Member Skills Matrix and Inventory

Date: _____

Name: _____

# of Years on Board: _____

Please indicate your competency level and/or interest in the various areas identified below using the following legend:

T – Training (formal training and/or schooling)
E – Experience (work/lived experience)
I – Interest (general interest, no previous training or experience)

Board & Governance		Labour Relations	
Business Acumen		Legal	
Equity and Diversity		Political Acumen & Advocacy	
Finance/Accounting		Project Management	
Fundraising		Public Affairs & Communications	
Government Relations		Public Health	
Health Administration & Policy		Quality & Performance	
Human Resources Management		Risk Management	
Information Technology		Strategic Planning	