**Board of Health for the**
**Peterborough County-City Health Unit**
**AGENDA**
**Board of Health Meeting**
**Wednesday, December 11, 2013 - 4:45 p.m.**
**General Committee Room, City Hall**
**500 George Street North, Peterborough**

**1. Call to Order**

**2. Confirmation of the Agenda**

**3. Declaration of Pecuniary Interest**

**4. Delegations and Presentations**

4.1. **Day In The Life – Communications Supervisor**
Brittany Cadence, Supervisor, Communications Services

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

5.1. **November 13, 2013**

5.2. **November 28, 2013**

**6. Business Arising From the Minutes**

**7. Correspondence**

**8. New Business**

8.1. **Staff Report: Renewable Energy**
Donna Churipuy, Manager, Environmental Health Programs

8.2. **Staff Report and Presentation: Municipal Alcohol Policies Update**
Monique Beneteau, Health Promoter
***Presentation link***

8.3. **Presentation: Nobody's Perfect - Parent Education and Support Program**
Gail Chislett, Health Promoter

8.4. **Report and Presentation: Oral Health In Peterborough**
Andrew Kurc, Epidemiologist
***Presentation link***

8.5. **Presentation: Social Media Update**
Brittany Cadence, Communications Supervisor

8.6. **Staff Report: 2014 Cost-Shared Budget Approval**
Brent Woodford, Director, Corporate Services

8.7. **Staff Report: One-Time Funding Requests**
Brent Woodford, Director, Corporate Services

8.8. **Staff Report: Estimate of Reserves and Restrictions**
Brent Woodford, Director, Corporate Services

8.9. **Staff Report: CINOT Deficits**
Brent Woodford, Director, Corporate Services

8.10. **Committee Report: Governance**
Mr. Watton, Member, Governance Committee

8.11. **Committee Report: Property**
Deputy Mayor Sharpe, Chair, Property Committee

**9. In Camera to Discuss Confidential Personal and Property Matters**

**10. Date, Time, and Place of the Next Meeting**
January 8, 2014, 4:45 p.m.
Council Chambers, County Court House, County of Peterborough, 470 Water Street

**11. Adjournment**


# Day in the Life *of a* Communications Supervisor

# The Communications Team

- Jane Naylor – graphic design, on hold messages

- Kerri Tojcic – website, HUB, social media

- Brittany Cadence – media relations, communications planning, advertising support

# The IT Team

- Sam Rezai – system administration, security, IT Helpdesk, project support

- Mike Westbrook – IT Helpdesk, network administration, project support

# Role of IT Services

- To plan, implement and maintain the Health Unit's technological infrastructure to enable all staff to perform their public health role
- To ensure data is managed securely and that privacy is optimally protected
- To support special projects that have a technological component, and integrate them into regular IT operations if needed

# Role of Communications

# Role of Communications Services

- **Strategic guidance:** We help develop communications strategies to reach target audiences in ways that promote health literacy.
- **Branding:** We ensure clear language and consistency in the look and feel of PCCHU communications products.
- **Tactical support:** We manage a number of "official" PCCHU communications vehicles to help staff get their message out

# Consultation Process

# Health Literacy…What's That?

Health literacy is the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

*(Healthy People 2010, a U.S. public health initiative)*

# PCCHU Communications Products

- Website – *www.pcchu.ca*
- Twitter account, Facebook page
- Monthly Examiner column by MOH
- Monthly Board of Health meeting summaries
- On hold messages
- Annual Report
- Bi-annual School Health Newsletter *(for elementary teachers)*
- Monthly FYI Newsletter *(for healthcare providers)*
- Fax/email alerts *(for healthcare providers, community partners)*
- Clinic TVs *(in waiting rooms of sexual health and dental clinics)*
- The HUB *(intranet for staff)*
- …and many more!

# Graphic Design

- Brochures, newsletters, handouts, templates
- Campaign materials
- Display materials
- Advertising


# Digital & Multimedia Projects

- Video production
- Facebook advertising
- Smartboard graphics
- Photo shoots

# Media Relations

## PROACTIVE

- News releases
- Audio files
- Pitch stories to local media (e.g. CHEX Healthwatch)
- Media training for staff
- Media monitoring

## REACTIVE

- Handle all inbound calls from reporters and coordinate interviews
- Prepare media contact records and background info, key messages
- Coach spokesperson and assist during interview

**Board of Health for the**
**Peterborough County-City Health Unit**
**MEETING MINUTES**
**Board of Health Meeting**
**Wednesday, November 13, 2013 – 4:45 p.m.**
**General Committee Room, City Hall**
**500 George Street North, Peterborough**

**In Attendance:**

| | |
|---|---|
| **Board Members:** | **Councillor Henry Clarke** |
| | **Mr. Jim Embrey** |
| | **Mayor John Fallis** |
| | **Mr. Scott McDonald** |
| | **Councillor Lesley Parnell** |
| | **Deputy Mayor Andy Sharpe** |
| | **Mayor Mary Smith *(arrived at 5:20 p.m.)*** |
| | **Mr. David Watton, Chair** |
| **Regrets:** | **Mr. Andrew Beamer** |
| | **Councillor Trisha Shearer** |
| | **Chief Phyllis Williams, Vice Chair** |
| **Staff:** | **Ms. Brittany Cadence, Communications Supervisor** |
| | **Mrs. Janet Dawson, Health Promoter** |
| | **Mr. Atul Jain, Manager, Inspection Services** |
| | **Dr. Rosana Pellizzari, Medical Officer of Health** |
| | **Mr. Larry Stinson, Director, Public Health Programs** |
| | **Mrs. Alida Tanna, Administrative Assistant (Recorder)** |
| | **Mrs. Ruth Walker, Public Health Nurse** |
| | **Mr. Brent Woodford, Director, Corporate Services** |
| **Regrets:** | **Ms. Catherine Robinson, Secretary to the Board** |

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## 1. Call to Order

Board Chair Mr. David Watton called the meeting to order at 4:45 p.m.

### 1.1 Motion to Amend Meeting Schedule

MOTION:
*To postpone the October 9, 2013 meeting.*
Moved: Councillor Clarke
Seconded: Mr. Embrey

Motion carried. (M-13-119)

1.2 Announcement of New Provincial Appointee

The Chair introduced Mr. Scott McDonald, incoming Provincial Appointee to the Peterborough County-City Health Unit Board of Health. Mr. McDonald's term of appointment will conclude on November 6, 2016.

1.3 Introduction of Board Secretary, Catherine Robinson

The Chair noted Ms. Robinson had assumed the position of Secretary to the Board, however was unable to attend due to a family emergency.

## 2. Confirmation of the Agenda

The Chair requested the following amendments to the agenda:

- move the In Camera Session prior to Item 4, Delegations and Presentations
- move the Staff Report – Food And Beverage Marketing to Children, to the beginning of New Business.

MOTION:
*To approve the Agenda as amended.*
Moved by: Mayor Fallis
Seconded by: Councillor Parnell
Motion carried. (M-13-120)

## 3. Declaration of Pecuniary Interest

No declaration of pecuniary interest was received.

**In Camera to Discuss Confidential Property and Personal Matters**

MOTION:
*That the Board of Health go In Camera to discuss confidential property and personal matters.*
Moved by: Deputy Mayor Andy Sharpe
Seconded by: Councillor Henry Clarke
Motion carried. (M-13-121)

*MOTION:*
*That the Board of Health rise from In Camera.*
Moved by: Councillor Henry Clarke
Seconded by: Councillor Parnell

Motion carried. (M-13-122)

## 4. Delegations and Presentations

No delegations or presentations were on the agenda for this meeting.

## 5. Confirmation of Minutes of Previous Meeting – September 11, 2013

MOTION:
*That the minutes of the Board of Health meeting held on September 11, 2013 be approved as circulated.*
Moved by: Mayor Fallis
Seconded by: Councillor Clarke
Motion carried. (M-13-124)

## 6. Business Arising from the Minutes

### 6.1. Renewable Energy

Mr. Stinson advised the Board that the following motion, made at the September meeting, was not carried out:

MOTION:
*That the correspondence be received for information, and that the Board of Health express support for the resolution submitted from the Haliburton, Kawartha, and Pine Ridge Districts on renewable energy*.
Moved by: Councillor Clarke
Seconded by: Mayor Fallis
Motion carried. (M-13-100)

It was discovered later that week that the actions in the HKPR motion were no longer feasible as they proposed participation in a provincial consultation process that had already been closed.

## 7. Correspondence

Mayor Smith joined the meeting.

MOTION:
*That the following documents be received for information and acted upon as deemed appropriate.*

1. *Email correspondence dated September 27, 2013 (and prior) with Deputy Mayor Scott McFadden, Township of Cavan-Monaghan regarding wind turbines.*
2. *Letter dated October 25, 2013 from Minister Sousa in response to a letter sent by the Board Chair on April 17, 2013 regarding problem gambling.*
3. *Letter dated October 30, 2013 to Minister Ambrose regarding industry violations of the International Code of Marketing of Breastmilk Substitutes.*
4. *Letter dated November 1, 2013 to Sally Saunders, County Clerk, regarding mandatory and non-mandatory re-inspection of on-site sewage systems.*
5. *Letter dated November 5, 2013 to Rusty Hick and Barbara McMorrow, Directors of Education for KPRDSB and PVNCCDSB respectively, regarding breastfeeding and Family Studies curriculum.*
6. *Resolutions/Letters from other local public health agencies:*
   *<u>Durham</u>*
   - *Air Quality Health Index*
   - *Bill 79, Public Transportation and Highway Improvement Amendment Act, 2013*
   - *Human Papillomavirus (HPV) Immunization*

   *<u>Haliburton, Kawartha, Pine Ridge District</u>*
   - *Sewage Systems*

   *<u>North Bay Parry Sound District</u>*
   - *Healthy Workplace*

   *<u>Northwestern</u>*
   - *Bill 59, Healthy Decisions for Healthy Eating Act*

   *<u>Simcoe Muskoka</u>*
   - *Regulatory Modernization in Ontario's Beverage Alcohol Industry*

   *<u>Sudbury & District</u>*
   - *Transportation and Public Health*

   *<u>Timiskaming</u>*
   - *Oral Care Services*

   *<u>Wellington-Dufferin-Guelph</u>*
   - *Nutritious Food Basket*
   - *Storage and Handling of Vaccines*

Moved by: Councillor Clarke
Seconded by: Mr. Embrey
Motion carried. (M-13-125)

Mr. Embrey commented on the correspondence from Deputy Mayor Scott McFadden, Township of Cavan-Monaghan, regarding wind turbines. He requested further discussion on this item at the next meeting if possible, and expressed concern regarding setbacks. Dr. Pellizzari advised that the Board of Health is awaiting results from two forthcoming research studies: a study by Health Canada (expected to be released in 2014) and a survey conducted by the

University of Waterloo. She noted that once these are published, Public Health Ontario (PHO) would look at the results of the research which would further inform a public health position. Boards of Health and public health units rely on PHO for scientific advice on these matters. Mayor Smith stated that the Board should defer to the Chief Medical Officer of Health's position statement, issued in 2010. A staff report on renewable energy will be presented in December, and although the focus of the report is not on wind turbines, they will be addressed. Dr. Pellizzari encouraged Mr. Embrey to meet with Donna Churipuy, Manager of Environmental Health, to discuss this matter in further detail. Following that discussion, they could determine the best way to report back to the Board with the most relevant details on this issue, and such a meeting could also assist in producing a report on wind turbines for later in 2014.

Councillor Parnell recommended the endorsement of the Durham Region resolution (originally from Simcoe Muskoka), regarding the Highway Improvement Act.

MOTION:
*That the Peterborough County-City Unit Board of Health express support for the Simcoe Muskoka position on Bill 79: The Public Transportation and Highway Improvement Act, as communicated by the Regional Municipality of Durham.*
Moved by: Councillor Parnell
Seconded by: Mayor Smith
Motion carried. (M-13-126)

Councillor Parnell recommended supporting the Durham resolution on the Human Papillomavirus (HPV) Immunization.

MOTION:
*That the Peterborough County-City Unit Board of Health direct staff to review whether the Board has already taken a position on this matter, and if not, to express support of the Durham position*.
Moved by: Councillor Parnell
Seconded by: Mayor Fallis
Motion carried. (M-13-127)

## 8. New Business

**Staff Report on Food and Beverage Marketing to Children**
Carolyn Doris, Public Health Nutritionist

Councillor Clarke declared a pecuniary interest for this item, apologizing for not declaring so at the beginning of the meeting.

Councillor Clarke departed the meeting.

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

- *urge Health Canada, Industry Canada and the Ontario Ministry of Government and Consumer Services to prohibit all commercial advertising of food and beverages to children under the age of thirteen years; and*
- *direct staff to begin discussions with City, County and First Nations staff on the potential to develop guidelines or policies for their respective Councils' consideration that would prevent commercial advertising of food and beverages to children under the age of thirteen years in City/County/First Nation funded or operated services, facilities and venues.*

Moved by: Mayor Fallis
Seconded by: Mayor Smith
Motion carried. (M-13-128)

**8.1. <u>Staff Report and Presentation: Complete Streets Position Statement</u>**
Janet Dawson, Health Promoter

Councillor Parnell departed the meeting.

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

- *receive the staff report, Complete Streets Position Statement, for information;*
- *endorse the enclosed Position Statement on Complete Streets Policies; and*
- *share the report and position statement with local Municipalities, local First Nation Councils and provincial counterparts.*

Moved by: Mr. Embrey
Seconded by: Mayor Smith
Motion carried. (M-13-129)

**8.2. <u>Presentation: A Poverty Perspective on Children and Families</u>**
Ruth Walker, Public Health Nurse

The Board requested that staff investigate the possibility of inviting Senator Hugh Segal to speak in Peterborough on the subject of guaranteed annual incomes.

**8.3. <u>Staff Report on Food and Beverage Marketing to Children</u>**

This item was moved, please refer to item 8.0 for details.

**8.4. Staff Report: Request to Pursue Sewage System Agreements with Municipalities External to Peterborough County**

An amendment to the motion as presented was requested and passed.

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

- *receive the staff report, Request to Pursue Sewage System Agreements with Municipalities External to Peterborough County, for information;*
- *direct staff to investigate sewage system agreements external to Peterborough County; and*
- *direct staff to report back on status of above, on or before the June, 2014 Board of Health meeting.*

Moved by: Mayor Fallis
Seconded by: Mayor Smith
Motion carried. (M-13-130)

**8.5. Staff Report: Delegation of Leasing**
Brent Woodford, Director, Corporate Services

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

- *delegate authority to sign leases with tenants with Health Unit owned premises at lease rates directed by the Board; and*
- *direct staff to offer prospective tenants a rental rate that covers operating costs and is competitive with current market conditions.*

Moved by: Deputy Mayor Sharpe
Seconded by: Mr. McDonald
Motion carried. (M-13-131)

**8.6. Staff Report: Insurance Renewal**
Brent Woodford, Director, Corporate Services

MOTION:
*That the Board of Health for the Peterborough County-City Health Unit renew its automotive, property and liability insurance with the Frank Cowan Insurance Company for 2013-2014, represented by Brokerlink in Peterborough.*

Moved by: Mayor Fallis
Seconded by: Mr. Embrey
Motion carried. (M-13-132)

**8.7. Staff Report: Disposal of Old Equipment**

Brent Woodford, Director, Corporate Services

MOTION:
*That the Board of Health for the Peterborough County-City Health Unit, pending a revision to current policy, authorize the disposal of old equipment and furniture deemed of no use or value.*
Moved by: Mr. Embrey
Seconded by: Mayor Fallis
Motion carried. (M-13-133)

**8.8. Staff Report: Q3 2013 Program Update**

Larry Stinson, Director, Public Health Programs

Mr. Stinson noted that there was no change in compliance since the end of the second quarter. Areas of non-compliance due to lack of capacity are:

- chronic diseases
- reproductive health
- infectious disease prevention; and
- health hazard programs.

Mr. Embrey stated concern about Giant Hogweed. It was noted that both the City and the County have weed inspectors looking after public lands, and they would be qualified to provide direction to private owners to address their concerns. Dr. Pellizzari will follow up on any further actions that the Health Unit can undertake and report back at the next meeting.

Concern regarding Lyme disease was also raised. Dr. Pellizzari noted that the Health Unit does surveillance on ticks and that a timely diagnosis is key to both treatment and prevention. The Health Unit has been working with local healthcare providers to provide more education and information on diagnosing the disease. The process of tick submission for the Peterborough Regional Health Centre was also recently updated.

Mayor Smith requested that staff produce a covering report to precede the quarterly program report, in effect an executive summary for the Board. It would summarize the report and assist the Board in easily identifying areas of concern.

Mayor Fallis requested that staff investigate the impact of advertising bans on alcohol consumption and report back at a future meeting. Dr. Pellizzari advised that she would discuss this with staff, and this would likely be planned for 2014.

A motion for this item was passed later in the agenda, please refer to item 9.10.

**8.9. Staff Report: Q3 Financial Update**

Brent Woodford, Director, Corporate Services

A motion for this item was passed later in the agenda, please refer to item 9.10.

**8.10. Staff Presentation: 2013 Mid-Year Report on Accountability Agreement Indicators**

Larry Stinson, Director, Public Health Programs

Board Members expressed general concern over the fall-related emergency room visits for the 65+ age group.

Questions were raised as to whether the statistics can be further broken down and if the information can be made more widely available. Dr. Pellizzari advised that hospitals provide administrative data to the Ministry of Health and Long-Term Care. Health Units utilize this data locally.

Dr. Pellizzari advised that staff could prepare a report to the Board for a future meeting, addressing the Health Unit's work on falls prevention.

MOTION:
*That the Board of Health for the Peterborough County-City Health Unit receive for information the following reports:*

- *Q3 2013 Program Update;*
- *Q3 2013 Financial Update; and*
- *2013 Mid-Year Report on Accountability Agreement Indicators (Presentation).*

Moved by: Mayor Fallis
Seconded by: Mr. McDonald
Motion carried. (M-13-134)

Dr. Pellizzari advised that a motion was still required from an item considered during the in camera session for open session.

MOTION:
*That the Board of Health for the Peterborough County-City Health Unit approve the closure of the Health Unit at noon on Christmas Eve (December 24, 2013) and New Year's Eve (December 31, 2013), unless there is an emergency declared by the Medical Officer of Health*.

Moved by: Deputy Mayor Sharpe
Seconded by: Mayor Smith
Motion carried. (M-13-135)

**10. Date, Time, and Location of Next Meeting**

December 11, 2013, 4:45 p.m.
General Committee Room, City Hall, 500 George Street North

**11. Adjournment**

MOTION:
*That the meeting be adjourned.*
Moved by: Mr. Embrey
Seconded by: Mr. McDonald
Motion carried. (M-13-136)

The meeting adjourned at 7:20 p.m.

Chairperson

Medical Officer of Health

**Board of Health for the**
**Peterborough County-City Health Unit**
**MINUTES**
**Special Board of Health Meeting**
**12:00 p.m., Thursday, November 28, 2013**
**(City and County Rooms, 150 O'Carroll Avenue)**

**In Attendance:**

| | |
|---|---|
| **Board Members:** | **Mr. Andrew Beamer (*via teleconference)*** |
| | **Councillor Henry Clarke (*via teleconference)*** |
| | **Mr. Jim Embrey** |
| | **Mayor John Fallis** |
| | **Mr. Scott McDonald** |
| | **Councillor Lesley Parnell (*via teleconference)*** |
| | **Deputy Mayor Andy Sharpe** |
| | **Mayor Mary Smith** |
| | **Mr. David Watton, Chair** |
| **Regrets:** | **Councillor Trisha Shearer** |
| | **Chief Phyllis Williams, Vice Chair** |
| **Staff:** | **Dr. Rosana Pellizzari, Medical Officer of Health** |
| | **Ms. Catherine Robinson, Secretary to the Board (Recorder)** |
| | **Mrs. Alida Tanna, Administrative Assistant** |
| | **Mr. Brent Woodford, Director, Corporate Services** |

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**1. Call to Order**

Board Chair Mr. David Watton called the meeting to order at 12:00 p.m.

**2. Roll Call**

The Chair requested a roll call of all attendees participating via teleconference to confirm attendance.

**3. Confirmation of the Agenda**

MOTION:
*To approve the Agenda as circulated.*
Moved by: Councillor Clarke

Seconded by: Mayor Smith
Motion carried. (M-13-137)

**4. In Camera to Discuss Confidential Property Matters**

MOTION:
*That the Board of Health go In Camera to discuss confidential property matters.*
Moved by: Mr. Embrey
Seconded by: Mr. McDonald
Motion carried. (M-13-138)

*MOTION:*
*That the Board of Health rise from In Camera.*
Moved by: Mr. Embrey
Seconded by: Mayor Smith
Motion carried. (M-13-139)

**5. Date, Time, and Place of the Next Meeting**

4:45 p.m., Wednesday, December 11; General Committee Room, City Hall
500 George Street North, Peterborough.

**5. Adjournment**

MOTION:
*That the meeting be adjourned.*
Moved by: Mr. McDonald
Seconded by: Mayor Fallis
Motion carried. (M-13-140)

The meeting adjourned at 1:00 p.m.

Chairperson

Medical Officer of Health

**To:** All Members
Board of Health

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

**Subject:** **Correspondence**

**Date:** December 11, 2013

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**Recommendation:**

That the following documents be received for information and acted upon as deemed appropriate.

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1. Letter dated November 7, 2013 from Minister Jeffrey in response to a letter sent by the Board Chair on August 12, 2013 regarding smoke-free provincial housing.

2. Email dated November 13, 2013 from Gordon Fleming, Manager, Public Health Issues, Association of Local Public Health Agencies (alPHa) regarding proposals for legislated enhancements to the Smoke-Free Ontario Act.

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

   Durham
   - Healthy Smiles Ontario
   - Nutritious Food Basket

   Grey Bruce
   - Breastmilk Substitutes
   - Vaccine Storage and Handling Protocol

   Middlesex London
   - Menu Labelling

   Simcoe Muskoka
   - Oral Health

**Ministry of Municipal Affairs and Housing**

Office of the Minister

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Ontario



13-61007



Mr. David Watton
Chair Board of Health
Peterborough County/City Health Unit
10 Hospital Drive
Peterborough ON K9J 8M1

Dear Mr. Watton:

Thank you for your letter requesting that the Province consider implementing a policy requiring municipal and community recipients of funding for provincial housing be designated smoke-free as a criterion for eligibility.

Our government recognizes the need for affordable housing and its role in supporting the health and growth of communities across Ontario. This is why we developed our Long-Term Affordable Housing Strategy – the first strategy of its kind in Ontario. This initiative supports our Poverty Reduction Strategy and sets a strong foundation for a more efficient, accessible system for those who need safe, affordable housing.

A key feature of this housing strategy and the subsequent *Housing Services Act, 2011* was to create a new balance point between the Province and Service Managers. This led to increased local flexibility in certain areas, subject to prescribed provincial criteria.

The *Housing Services Act, 2011* is silent on smoking-related policies. As you identified in your letter, social-housing providers currently have the authority to enact no-smoking policies – in line with the *Residential Tenancies Act, 2006* and the *Smoke-Free Ontario Act*. The ministry encourages local decision-making on this issue, and continues to monitor emerging perspectives that balance the health benefits of smoking cessation with the legal rights of tenants.

Those housing providers that wish to convert or establish no-smoking units and buildings may wish to make use of the services and information provided by Smoke-Free Ontario Housing. This agency provides specific advice and resources for non-profit housing providers. You can find this information and advice online at: www.smokefreehousingon.ca/sfho/landlords-how-to-guide.html.

.../2

Lastly, the Ontario Non-Profit Housing Association (ONPHA) provides its members with advice and resources on how to establish no-smoking policies in social housing. General information can be found online at: www.onpha.on.ca/AM/Template.cfm?Section=Smoke_Free_Buildings&Template=/CM/HTMLDisplay.cfm&ContentID=13009 .

Once again, thank you for raising this matter with me. Please accept my best wishes.

Sincerely,

Linda Jeffrey
Minister

**From:** allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org] **On Behalf Of** Gordon Fleming
**Sent:** Wednesday, November 13, 2013 2:48 PM
**To:** allhealthunits@lists.alphaweb.org
**Subject:** [allhealthunits] New Smoke Free Ontario Measures

ATTENTION
CHAIRS, BOARDS OF HEALTH
TOBACCO CONTROL STAFF

Hi All,

The Minister of Health and Long-Term Care has announced proposals for legislated enhancements to the SFOA, including

Prohibiting smoking on playgrounds, sport fields, and restaurant and bar patios.
Increasing fines for those who sell tobacco to youth
Banning the sale of flavoured tobacco products
Strengthening enforcement to allow for testing of tobacco in waterpipes in indoor public places

(alPHa will clarify what this means and encourage her instead to ban the indoor use of waterpipes as per alPHa Resolution A13-5)

The full news release is here.

Gordon Fleming, B.A., BASc, CPHI(C)
Manager, Public Health Issues
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto, Ontario
(416) 595-0006, ext 23
(416) 595-0030 Fax

**Note: Documents which are hyperlinked above have been enclosed.

**alPHa RESOLUTION A13-5**

**TITLE:** **Provincial Legislation to Prohibit the Use of Waterpipes in Enclosed Public Places and Enclosed Workplaces**

**SPONSOR:** **Simcoe Muskoka District Health Unit**

WHEREAS the emerging use of waterpipes in enclosed public places and enclosed workplaces has the potential to undermine the success of the Smoke-Free Ontario Act; and

WHEREAS tobacco-free ("herbal") waterpipe smoke has been demonstrated to have concentrations of toxins comparable to tobacco waterpipe smoke[1]; and

WHEREAS the environmental smoke from waterpipe use in indoor public places and workplaces has been demonstrated to contain toxins at harmful concentrations[2]; and

WHEREAS the alleged "herbal" preparations are poorly regulated and often contain tobacco even when they are labelled tobacco free[3]; and

WHEREAS the Tobacco Strategy Advisory Group report recommends an amendment of the Smoke-Free Ontario Act, with "the addition of controls on the indoor use of waterpipes such as hookahs";

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies (alPHa) advocate for provincial legislation to be enacted to prohibit the use of waterpipes (regardless of the substance being smoked) in all enclosed public places and enclosed workplaces.

**ACTION FROM CONFERENCE:** **Resolution CARRIED**

**References**

1 Shidadeh A; Salman R; Jaroud E; Saliba N; Sepetdijian E; Blank M; Does switching to a tobacco-free waterpipe reduce toxicant intake? A crossover study comparing CO, NO, PAH, volatile aldehydes, tar and nicotine yields. Food and Chemical Toxicology Journal Vol. 50, Issue 5, 2012.
2 The Ontario Tobacco Research Unit, OTRU Update, Waterpipe Smoking: A Growing Health Concern, January 31, 2011.
3 The Non-Smokers' Rights Association, Hooked on Hookah: Issue Analysis and Policy Options for Waterpipe Smoking in Ontario, March 2011.

# Taking the Next Steps for a Smoke-Free Ontario

*Ontario Helping to Further Protect Youth from the Harmful Effects of Tobacco*

November 13, 2013 2:00 p.m.

Ontario is taking the next steps to protect youth from the harmful effects of smoking so they can lead healthy, active lives.

The province will introduce legislation and propose regulatory changes that would, if passed, strengthen the Smoke-Free Ontario Act by increasing penalties for selling tobacco to kids and further limiting smoking in public areas.

The proposed measures include:

- Prohibiting smoking on playgrounds, sport fields, and restaurant and bar patios.
- Increasing fines for those who sell tobacco to youth, making Ontario's penalties the highest in Canada.
- Banning the sale of flavoured tobacco products to make smoking less appealing to young people.
- Strengthening enforcement to allow for testing of tobacco in waterpipes in indoor public places.
- Prohibiting tobacco sales on post-secondary education campuses and specified provincial government properties, such as Macdonald Block in Toronto and 1 Stone Road in Guelph.

These measures build on steps the government has already taken, including protecting kids from tobacco exposure in motor vehicles, prohibiting tobacco use in indoor public places and workplaces, and banning the sale of flavoured cigarillos.

Preventing youth from starting to use tobacco and protecting them from the harmful effects of second hand smoke will help to achieve the government's Action Plan for Health Care goal to have the lowest smoking rate in the country. This is part of the Ontario government's plan to build a successful, vital province where everyone has the opportunity to connect, contribute and achieve their goals.

**QUOTES**

" We know that if we can prevent youth from smoking in the first place, fewer people will become addicted to tobacco. These measures will help to achieve our goal of having the lowest smoking rate in the country — because we want to reduce Ontarians' exposure to the harmful effects of tobacco and lessen the burden of tobacco-related diseases our health care system."

- Deb Matthews

Minister of Health and Long-Term Care

## QUICK FACTS

- 66 per cent of people in Ontario want smoking to be prohibited on restaurant and bar patios.
- 58 Ontario municipalities representing 61 per cent of the population already ban smoking on playgrounds.
- Each year, tobacco claims 13,000 lives in Ontario — equivalent to 36 lives every day.
- Tobacco-related disease costs Ontario's health care system an estimated $1.9 billion in direct health care costs and an additional $5.8 billion in indirect costs such as lost productivity.
- Ontario's smoking rate fell from 24.5 per cent in 2000 to 19 per cent in 2012, representing 255,000 fewer smokers.

## LEARN MORE

- Upon introduction of the legislation, a summary of the draft regulatory measures will be posted for public review and comment on Ontario's Regulatory Registry
- Ontario's Smoke Free Ontario Strategy.

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**Available Online**
**Disponible en Français**

November 22, 2013



The Honourable Kathleen Wynne
Premier
Room 281
111 Wellesley Street West
Queen's Park
Toronto ON M7A 1A1

**RE:** MEMORANDUM FROM DR. ROBERT KYLE, COMMISSIONER & MEDICAL OFFICER OF HEALTH, DATED OCTOBER 31, 2013, RE: HEALTHY SMILES ONTARIO (HSO)
OUR FILE: P00-48

Honourable Premier, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on November 20, 2013 Council adopted the following recommendations of the Committee:

"a) THAT the correspondence dated October 22, 2013 from the Timiskaming Board of Health, to all Ontario boards of health, urging the Government of Ontario to increase the household Adjusted Family Net Income of $20,000 or less eligibility criterion of the Healthy Smiles Ontario (HSO) program, be endorsed; and

b) THAT the Premier of Ontario, Ministers of Children and Youth Services, Community and Social Services, Finance and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health, and all Ontario boards of health be so advised."

Deb Bowen

D. Bowen, AMCT
Regional Clerk/Director of Legislative Services

DB/lf

c: The Honourable T. Piruzza, Minister of Children and Youth Services
The Honourable T. McMeekin, Minister of Community and Social Services
The Honourable C. Sousa, Minister of Finance
The Honourable D. Matthews, Minister of Health & Long-Term Care
T. MacCharles, MPP (Pickering/Scarborough East)
C. Elliott, MPP (Whitby/Oshawa)
J. O'Toole, MPP (Durham)
J. Ouellette, MPP (Oshawa)
L. Scott, MPP (Haliburton/Kawartha Lakes/Brock)
J. Dickson, MPP (Ajax/Pickering)
A. King, Chief Medical Officer of Health
L. Stewart, Executive Director, alPHa
Ontario Boards of Health
R.J. Kyle, Commissioner & Medical Officer of Health

DURHAM REGION

**The Regional Municipality of Durham**

Corporate Services Department - Legislative Services

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**Matthew L. Gaskell**
Commissioner of Corporate Services

November 22, 2013

The Honourable Kathleen Wynne
Premier
Room 281
111 Wellesley Street West
Queen's Park
Toronto ON M7A 1A1

**RE:** MEMORANDUM FROM DR. ROBERT KYLE, COMMISSIONER & MEDICAL OFFICER OF HEALTH, DATED OCTOBER 31, 2013, RE: COST OF NUTRITIOUS FOOD BASKET (NFB)
OUR FILE: P00-48

Honourable Premier, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on November 20, 2013 Council adopted the following recommendations of the Committee:

"a) THAT the correspondence dated October 8, 2013 from the Toronto Board of Health, to all interested parties, urging the Premier of Ontario to increase social assistance rates to a level that reflects the true cost of nutritious food and requesting that the Minister of Health and Long-Term Care act on the recommendations of the Healthy Kids Panel, be endorsed; and

b) THAT the Premier of Ontario, Ministers of Children and Youth Services, Community and Social Services, Finance, and Health and Long-Term Care, Durham's MPPs, Chief Medical Officer of Health, and all Ontario boards of health be so advised."

D. Bowen, AMCT
Regional Clerk/Director of Legislative Services

DB/lf

c: The Honourable T. Piruzza, Minister of Children and Youth Services
The Honourable T. McMeekin, Minister of Community and Social Services
The Honourable C. Sousa, Minister of Finance
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**Matthew L. Gaskell**
Commissioner of Corporate Services

November 20, 2013

David Watton
Board of Health for Peterborough County-City Health Unit
10 Hospital Drive
Peterborough ON  K9J 8M1

Dear Mr. Watton:

**Re:  International Code of Marketing of Breastmilk Substitute**

On November 15, 2013 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached recommendations by your Board urging the province to advocate for legislation of the International Code of Marketing of Breastmilk Substitutes.

The following motion was passed:

Motion No:  2013-75

Moved by:  Bob Pringle  Seconded by:  Arlene Wright

**"That the Board of Health for the Grey Bruce Health Unit supports Peterborough County-City Health Unit's position to urge the province to enact legislation to ensure that the International Code of Marketing of Breastmilk Substitutes be honoured."**

Carried.

Sincerely,

*Original Signed by*

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc:  Health Canada
All Ontario Boards of Health

Encl.

November 20, 2013

Amanda Rayburn
Board of Health for Wellington-Dufferin-Guelph Public Health
474 Wellington Road 18, Suite 100
RR 1 Fergus ON  N1M 2W3

Dear Ms. Rayburn:

**Re:  MOHLTC Protocol for the Storage and Handling of Vaccines**

On October 18, 2013 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached recommendations by your Board regarding changes to the current Vaccine Storage and Handling Protocol (2010) to increase the requirements for cold chain equipment for the storage of publicly funded vaccine to include:

- Purpose-built refrigerator, pharmacy grade
- Glycol-encased Min/Max Thermometer
- Data loggers
- Generator or battery back-up

The following motion was passed:

Motion No:  2013-67

Moved by:  Arlene Wright  Seconded by:  Kevin Eccles

**"That the Board of Health for the Grey Bruce Health Unit supports the letter from Wellington-Dufferin-Guelph Health Unit requesting changes to the Ministry of Health and Long Term Care Protocol for the storage and handling of vaccines."**

Carried.

Sincerely,

*Original signed by*

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc:  Ministry of Health and Long-Term Care
All Ontario Boards of Health

Encl.

Public Health

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October 2, 2013

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

**Re: MOHLTC protocol for the Storage and Handling of Vaccines**

Dear Minister Matthews,

The maintenance and storage of vaccine is vital to the continued success of immunization programs. The Ministry of Health and Long-Term Care (MOHLTC) defines the "cold chain" as the system of all equipment and procedures used to maintain optimal conditions during the transport, storage and handling of vaccines, starting at the manufacturer and ending with the administration of the vaccine to the client.[1] Failure to adhere to cold chain requirements reduces vaccine potency, resulting in an inadequate immune response to vaccine preventable diseases and/or increased local reactions after administration of vaccine.[2]

The current MOHLTC protocol for the Storage and Handling of Vaccines (2010) requires community partners storing publicly funded vaccine to have a fridge that maintains temperatures of +2 °C to +8 °C, minimum/maximum thermometer and a log book to record temperatures. The standard of such equipment needs to be improved to provide optimum vaccine. The Centres of Disease Control and Prevention (CDC) and the World Health Organization (WHO) supports this direction based on research and evidence-based practice.

The Board of Health for the Wellington-Dufferin-Guelph Health Unit are requesting a change to the current Vaccine Storage and Handling Protocol (2010) to increase the requirements for cold chain equipment for the storage of publicly funded vaccine to include:

- Purpose-built refrigerator, pharmacy grade
- Glycol-encased Min/Max Thermometer
- Data loggers
- Generator or battery back-up

The MOHLTC has recommended some of the equipment mentioned above however has never mandated the usage of glycol-encased probe thermometers, data loggers, purpose-built fridges or the

use of power back-up. This makes it difficult for public health to enforce an optimum standard of the storage of vaccines. Recognizing the cost of the purposed equipment may be significant to healthcare providers and may be a barrier for some to offer publicly funded vaccine; such equipment standards are required to ensure vaccine is being stored in the most optimum manner. The decrease in cold chain incidences would save vaccine dollars over the long-term. In addition cold chain incidents often make vaccines unavailable to clients during the investigation therefore the opportunity to vaccinate clients is missed. Missed opportunities attribute to incomplete immunization records. Cold chain incidents compromise the potency of the vaccine therefore affecting the immune response of the client. Decreased immune response and under-immunized clients put the community at-risk for vaccine preventable diseases and may decrease the confidence in vaccines.

We look forward to your attention to address the requirements outlined in the current Vaccine Storage and Handling Protocol (2010).

Sincerely,

Amanda Rayburn
Chair, Board of Health
Wellington-Dufferin-Guelph Public Health

cc:

Randy Pettapiece, MPP
Honourable Liz Sandals, MPP, Minister of Education
Ted Arnott, MPP
Sylvia Jones, MPP
Ontario Public Health Units
Dr. Nicola Mercer, MOH & CEO, Wellington-Dufferin-Guelph Public Health

REFERENCES


1. McColloster, P J. (2010). US vaccine refrigeration guidelines: loose links in the cold chain. Human Vaccines 7(5): 574-575.
2. Ministry of Health and Long-term Care (2010). *Vaccine Storage and Handling Guidance Documents*

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 120-13

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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# MENU LABELLING: IMPROVING THE FOOD ENVIRONMENT

## *Recommendations*

***It is recommended that the Board of Health:***

1. *Endorse the recommendation that clear, prominent labelling of calorie and sodium content on menus, including reference values, be required through provincial legislation as proposed by the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) **Position Statement** (Appendix A), "Serving Up Nutrition Information in Ontario Restaurants" and **Toronto Public Health** (Appendix B).*

2. *Communicate its support for provincial menu labelling legislation by sending a letter to the Premier of Ontario, the Minister of Health and Long-Term Care, local members of parliament, the Ontario Public Health Association and the Association of Local Public Health Agencies (alPHa).*

3. *Endorse the OSNPPH **Position Paper** (Appendix A) in its entirety and forward this Report to all Boards of Health across Ontario to communicate its support for the implementation of local, evidence-based complementary menu labelling initiatives.*

**Key Points**

- Addressing unhealthy diets high in calories and sodium would result in a major increase in life expectancy – likely greater than two more years for every per person in Ontario.
- Food environments, particularly restaurants, can affect people's food choices in ways that are difficult to overcome through individual knowledge, skills, and good intentions.
- Menu labelling interventions may have a more substantial effect on higher-calorie consumers, influencing higher-risk, priority populations.
- Menu labelling legislation should emphasize clear, prominent labelling of calorie and sodium content on menus and include reference values and nutrient profiles to be optimally effective.

## The Issue

Increasingly, the food environment has been implicated in rising rates of overweight and obesity, even more than individual knowledge, skills and intentions. It has been estimated that obesity costs Ontario billions of dollars annually. Addressing unhealthy diets high in calories and sodium would result in a major increase in life expectancy – likely greater than two more years for every per person in Ontario. There is strong evidence that consuming excessive calories and sodium has long-term negative health implications.

Over 60% of Canadians eat out at least once per week, and multiple studies have associated increased consumption of restaurant meals with excessive intakes of calories, sodium and fat. It is difficult for consumers to estimate the calorie and sodium content of restaurant meals. For nearly a decade, the World Health Organization has been recommending that governments include food labelling in strategies to prevent non-communicable diseases in hopes that such interventions will enable consumers to make informed decisions. In October, the Ontario government revealed plans to re-introduce legislation to implement

mandatory menu labelling in the province through consultations with key stakeholders from the health and food industry sectors.

Nutrition labelling on menus is seen by more consumers than other methods of nutrition communication (e.g., on-premise brochures, restaurant's website). When menu labelling is provided, one study found that 34% of people used the information to make purchasing decisions, compared to as few as 0.1% of consumers when nutrition information is provided somewhere other than the menu.

Menu labelling may have a larger effect on individuals consuming higher calories compared to those consuming fewer. A study of consumers at Starbucks® locations in three American states found that overall, consumers reduced the calorie content of their orders 6% upon implementation of menu labelling. However, consumers in the Starbucks® study whose orders had been over 250 calories reduced the calorie content of their meals by 26%. This indicates potential for menu labelling interventions to target consumers at increased risk. Although small, such an effect is significant on a population level. If only 10% of customers reduced their order by 100 calories, menu labelling could prevent 40% of the average annual weight gain in consumers five years of age and older.

The type and amount of information provided at point of sale also seems to impact the effectiveness of menu labelling campaigns. Research shows that providing too much information may be counterproductive, as over 70% of consumers faced with only calorie content remembered the information whereas only 49% remembered the information when 4 nutrients were provided. As such, it is recommended that only calories and sodium content be provided on menus to prevent information overload.

## Need for Legislation

Voluntary menu labelling measures have proven ineffective; without strong legislation, nutrition information tends not to be provided clearly or consistently, leading to consumer confusion. As well, mandatory menu labelling has the potential to reach beyond the individuals who read and understand nutrition information to everyone who eats at restaurants. If menu labelling is implemented through legislation, provision of genuinely healthier foods may become a competitive advantage, stimulating restaurants to voluntarily lower their calorie and sodium content.

## Conclusion and Next Steps

Recent surveys have shown that 70-73% of Canadians feel it is important for restaurants to display calorie and sodium content in their menu items. The adoption of U.S. federal legislation for menu labelling means that US outlets of large chain restaurants, many that operate in Canada, are preparing to display nutrient content. Several public health units and organizations such as Canada's Sodium Reduction Task Force, the OSNPPH, Cancer Care Ontario, and the Healthy Kids Panel have endorsed menu labelling as an improvement strategy targeting the food environment.

The Ministry of Health and Long-Term Care (MOHLTC) hosted a series of consultations with key stakeholders from the food, beverage and advertising industries, the health sector and families. alPHA is preparing a submission to MOHLTC to speak to the need for provincial menu labelling legislation and marketing restrictions to children and youth based on the latest evidence. Health Unit staff will support alPHA's submission to MOHLTC by forwarding recommendations for consideration.

This report was prepared by Ms. Lisa Doerr, Dietetic Intern; Dr. Heather Thomas RD, Public Health Dietitian, and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Chronic Disease and Injuries Program Standards: 4, 5, 6, 7, 11, 12.

simcoe muskoka
DISTRICT HEALTH UNIT

November 20, 2013

The Honourable Deb Matthews
Minister – Minister's Office
Ministry of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor St
Toronto, ON M7A 2C4

Dear Minister Matthews:

**Re: Oral Health Care for Low Income People**

Despite provincially mandated public health programs, many people of low income have no affordable access to dental care. The Board of Health is concerned that funding for oral health care announced as part of Ontario's Poverty Reduction Strategy in 2008 was reduced from the original $45 million to $34 million by 2011/2012. Therefore, the Board urges the Ontario government to fully utilize all the funds annually as originally allocated to oral health services for low income individuals and families in 2008.

While the Healthy Smiles Ontario program has provided relief for those living in poverty who receive it, the current income eligibility cutoff is very low, resulting in the program being underutilized provincially and in the exclusion of many who need the program. To address this, the Board recommends changing the entry level criteria for Healthy Smiles Ontario from $20,000 net family income or less, to be for any family that receives the Ontario Child Tax Benefit. This is in keeping with the Association of Local Public Health Agencies Resolution A13-2 entitled "The Healthy Smiles Ontario and the Overall Inequality within the Oral Health Care System" (Appended). The Board also recommends that the province take action on all of the recommendations within the resolution.

Oral health is essential for general health and well-being, and access to dental care that provides even the most basic dental care is especially important for low income individuals and families. People living in poverty bear a disproportionate amount of oral health problems compared to the rest of the population. Local public health dental services are essential to meeting these needs.

Sincerely,

**ORIGINAL SIGNED BY**
Barry Ward
Chair, Board of Health

Att. (1)

c Chief Medical Officer of Health of Ontario
Ontario Boards of Health
Association of Local Public Health Agencies
Ontario Public Health Association
Local Members of Parliament in Simcoe Muskoka
North Simcoe and Central Local Health Integration Network

alPHa
Association of Local PUBLIC HEALTH Agencies

**alPHa RESOLUTION A13-2**

**TITLE:** **The Healthy Smiles Ontario Program and the Overall Inequity within the Oral Health Care System**

**SPONSOR:** **Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit**

WHEREAS OHIP pays to provide medical care to every part of the body except the mouth and one in four Ontarians do not visit a dentist because of cost; and

WHEREAS working adults and seniors on fixed incomes do not have a government program to assist them with any dental care expenses; and

WHEREAS there are four provincial dental programs for children aged 0-17 each with a different set of eligibility criteria and fee guide, making access to them confusing to dental offices, administrators and families; and

WHEREAS children from families with partial insurance that cannot afford to pay the uninsured portion of their dental treatment do not qualify for these programs; and

WHEREAS Healthy Smiles Ontario, the preventive and early dental treatment program, is underutilized provincially and locally; and

WHEREAS there are different models of assisting in the delivery of provincially funded oral health programs including Community Health Centres; and

WHEREAS a number of recent provincial reports and initiatives have indicated the urgent need to move forward to transform the current oral care health system;

**NOW THEREFORE BE IT RESOLVED** that the Association of Local Public Health Agencies request the Government of Ontario to:

1. Increase the Healthy Smiles Ontario (HSO) income cut-off threshold, which is currently adjusted family net income of $20,000 or less;
2. Remove the 'no dental insurance' eligibility criterion from the HSO program;
3. Streamline children's dental treatment programs to make them more efficient, effective and equitable as recommended in *Oral Health – More Than Just Cavities. A Report by Ontario's Chief Medical Officer of Health, April 2012;*
4. Extend provincial programs to include adults who need and cannot afford emergency dental care.
5. Continue to facilitate the partnerships between local health units and community health centres to assist with the delivery of provincially funded oral health programs;
6. Continue ongoing, stable and indexed 100% provincial funding of the HSO program beyond the sunset date originally announced (Fall 2013);

**AND FURTHER** that the Premier of Ontario, the Minister of Health and Long-Term Care, Chief Medical Officer of Health, the Association of Municipalities of Ontario and Ontario boards of health are so advised.

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

# Staff Report

## Renewable Energy

| | |
|---|---|
| **Date:** | December 11, 2013 |
| **To:** | Board of Health |
| **From:** | Dr. Rosana Pellizzari, Medical Officer of Health |

| ***Original approved by*** | ***Original approved by*** |
|---|---|
| Rosana Pellizzari, M.D. | Donna Churipuy, Manager of Environmental Health programs |

**Recommendations**

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

- receive this report for information;
- support the Council of Ontario Medical Officers of Health input to the Environmental Review of Ontario's Long Term Energy Plan; and
- direct staff to develop an organizational position statement supporting renewable energy sources that aligns with the Council of Medical Officers of Health recommendations and this staff report.

**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. On September 11, 2013, the Board of Health requested that staff prepare letters to local municipalities recommending that they provide input into the review of Ontario's Long-Term Energy Plan. The period for review through the Environmental Review Board had closed by the time the request was received by staff so this request was not completed.

On March 14, 2012, the Board of Health for the Peterborough County-City Health Unit requested membership in the Sustainable Peterborough Partnership as a "Champion".

**Background**

According to the Intergovernmental Panel on Climate Change (IPCC), "warming of the climate system is unequivocal, and since the 1950s, many of the observed changes are unprecedented over decades to millennia. The atmosphere and ocean have warmed, the amounts of snow and ice have diminished, sea level has risen, and the concentrations of greenhouse gases (GHGs) have increased."

Climate change is expected to alter the range and transmission of infectious diseases such as Lyme disease, cause food insecurity, and reduce access to safe water. Poor air quality and extreme heat events are already causing health issues for residents. Ongoing emissions of greenhouse gases will cause further warming and changes in all components of the climate system. Limiting climate change will require substantial and sustained reductions of greenhouse gas emissions.

To avoid additional adverse impacts of climate change on water resources, ecosystems, food security, and human health with possibly irreversible abrupt changes in the climate system, climate experts call for limiting global average temperature rises to no more than 2°C above preindustrial values. In order to be confident of achieving an equilibrium temperature increase of only 2°C to 2.4°C, GHG concentrations would need to be stabilized in the range of 445 to 490ppm $CO_2$eq in the atmosphere. In 2013, measurements of $CO_2$eq reached 400ppm.

According to the Fourth Assessment Report completed by the IPCC fossil fuels provided 85% of the total primary energy in 2004 and 2008. In 2004, the combustion of fossil fuels accounted for 56.6% of all anthropogenic GHG emissions. In 2008, the top carbon dioxide ($CO_2$) emitters were China, the United States, the European Union, India, the Russian Federation, Japan, and Canada. The continued use of fossil fuels poses a threat to human health. Fossil fuels contribute to global climate change because their combustion releases climate-altering pollutants such as carbon dioxide ($CO_2$), methane and ozone.

In Canada, 80 % of the GHGs produced are associated with the production or use of fossil fuels for energy purposes. About 44 % comes from sources such as electricity generation, space heating, fossil fuel industries, manufacturing, construction, and mining. The transportation of goods and people accounts for 27%. The left over nine percent come from fugitive sources such as venting and flaring of waste fuel gases or releases from mine openings.

Energy generation and use is essential to human existence and to our global civilization. The unprecedented growth of our global population is a direct result of modern society's ability to obtain and utilize energy to meet our needs. Consequently, demographic changes are a factor in the amount of energy consumption by-products we can expect to encounter in the future with a growing global population requiring larger reserves of energy. The ways that we

currently generate and use energy impact our health with foreseeable impending impacts on the health of human (and other species) populations in the future. For these reasons, energy generation and utilization is a public health issue.

Each source of energy entails some health risks with some having major implications for the burden of disease globally. Each stage of energy generation, from collection to production to waste disposal has the potential for adverse health effects. Globally, the biggest health impacts are due to the harvesting and burning of solid fuels, coal and biomass, mainly presenting in the form of occupational health risks and household and general ambient air pollution.

Coal is an example of one fossil fuel used to generate electricity. Its use in Ontario has been declining in favour of renewable energy sources and natural gas which produces less $CO_2$ than coal. Combustion is the stage of the coal life cycle with the heaviest health burden. Primary pollutants, produced directly from coal combustion, include $CO_2$, carbon monoxide (CO), sulfur oxides, nitrogen oxides, particulate matter (PM), mercury, and other metals. Secondary pollutants, produced when primary products react with other chemicals, include ozone, particulate matter, and organic vapours. The effects of these can be experienced downwind, often hundreds of kilometers away from the source.

Many of the other pollutants released in coal combustion, such as PM, also have the potential to exert direct health effects. With respect to exposures that the general public experiences, air pollutants such as nitrogen oxides, sulphur dioxide and particulate matter contribute to millions of premature deaths and acute cardio-respiratory distress visits to hospitals each year worldwide, particularly among those who have debilitating health conditions that make them vulnerable.

Coal is not the only fossil fuel with negative impacts on the environment and health of people. There are also human health and substantial environmental impacts from the bitumen extraction process. There are aquifer impacts that can occur with natural gas hydraulic fracturing (fracking). In addition, the use of fossil fuels for the transportation of goods and people contributes significantly to the release of GHGs.

GHG emissions are of primary concern for their ability to contribute to potentially disastrous climate change events. The uncertainty in attributing climate change and greenhouse gas emissions as the causes of past extreme heat events (such as seen in 1995 in Chicago and 2003 in Europe) has led to inaction and indecisiveness around mitigation strategies, yet the global scientific community has developed a greater appreciation for these relationships with the advent of stronger and consistent research.

*Nuclear Energy*

About half of Ontario's electricity is currently and projected to continue being generated by *nuclear energy*. With respect to contribution to climate change, the extraction process for nuclear fuel does result in both greenhouse gas and air pollution emissions. However, overall

the carbon footprint for this is very low compared to that of fossil fuels. Similarly nuclear energy in Ontario has resulted in very low air pollution emissions. Of greater concern is the potential for environment release and transport of radioactive by-products and precursors for energy generation, and the environmental and human health risks and costs associated with long term storage of radioactive waste. It is important to compare the potential for such incidents occurring in Ontario with the climate changes measured and anticipated and the ongoing measured and documented mortality from air pollution occurring annually from cruder sources of energy.

*Renewable Energy*

There are multiple means for lowering GHG emissions from the energy system, while still providing desired energy services. Clearly, energy conservation measures are essential to reducing GHGs. Utilization of renewable energy (RE) technologies also greatly reduces or in some cases eliminates the production of GHGs. Renewable energy (RE) technologies are diverse and can serve the full range of energy service needs. Various types of RE can supply electricity, thermal energy and mechanical energy, as well as produce fuels that are able to satisfy multiple energy service needs. RE is any form of energy from solar, geophysical or biological sources that is replenished by natural processes at a rate that equals or exceeds its rate of use. Unlike fossil fuels, most forms of RE produce little or no $CO_2$ emissions.

In addition, wind and solar energy require essentially no water to operate and thus do not pollute water resources or strain supply by competing with agriculture, drinking water systems, or other important water needs. In contrast, fossil fuels can have a significant impact on water resources. For example, both coal mining and natural gas drilling can pollute sources of drinking water. Natural gas extraction by hydraulic fracturing (fracking) also requires large amounts of water.

Currently, there is 36,013 MW of installed generation in Ontario's electricity market. This is comprised of: nuclear (12,998 MW or 36.2%); gas (9,987 MW or 27.9%); coal (3,293 MW or 9.1%); hydro (7,939 MW or 22%); wind (1,725 MW or 4.8%) and other (122 MW or 0.3%). The amount of generation actually available at any one time is dependent on outages and the capacity factor of certain forms of supply.

The replacement of coal with natural gas as a means of generating electricity (to be completed in Ontario by 2014) will result in some reductions in harmful air pollutants with an improvement in air quality and a reduction in the associated illness and mortality for Ontarians. Although the extraction of natural gas imparts its own hazards and ecological threats, it should be noted that natural gas results in approximately half the carbon dioxide release into the atmosphere per unit of electricity produced compared with coal, thus contributing in part to climate change mitigation.

No energy source is free from health and environmental impacts and renewable energy is not without its challenges, limitations and concerns. However, renewable energy sources offer

several potential advantages and play a role in providing energy services in a sustainable manner and, in particular, in mitigating climate change. They do not irreversibly deplete finite resources, and most have a lower climate footprint than do fossil fuels. If managed well, they pose minimal health risks.

*Solar energy* has been deployed in both small scale (rooftop) and large scale electrical production. The major health concern from solar power relates to the life cycle of photovoltaic (PV) cells. PV manufacturing may entail exposure to toxic metals and gases with the cells typically being made from crystalline silicon. Silica mining is associated with the risk of silicosis, although this is completely preventable with personal protective equipment. Available data suggests that environmental emissions are generally low, although waste management and product disposal remain a challenge. Overall the health impact of solar power is likely to be far less than with any of the fossil fuels.

*Biofuels* are produced from landfill waste (methane), or from plant, animal or algae materials grown and harvested to produce fuels to be burned for transportation, heating or the generation of electricity. Health concerns related to biofuels include air pollution emissions (such as particulates and ground-level ozone from biodiesel), and the diversion of land from food crop production (resulting in increased food prices and thus impacts on food security). Furthermore, the energy efficiency profile of some biofuels (such as corn ethanol) has been demonstrated to be poor.

*Hydroelectric power* is produced when falling or flowing water strikes the blades of turbines, which in turn, generate electricity. It represents 16% of the world's total electric supply. Larger hydroelectric plants typically feature dams that form reservoirs. These dams often provide other benefits including flood control; water storage for household, industrial and agricultural use; irrigation; and recreational opportunities. Hydroelectric generation is considered a clean source of energy because it does not involve combustion. Environmental impacts in river systems, including altered water flow, temperature and sedimentation; disruption of wetlands; disruption of fish migration; and reduced water quality can be significant. In addition, direct health impacts may occur as the result of population displacement, infectious diseases, and dam failures.

*Geothermal energy* uses thermal energy from the Earth's interior. Heat is extracted from geothermal reservoirs using wells or other ways. Once at the surface, fluids of various temperatures can be used to generate electricity or more directly for applications that require thermal energy, including district heating or the use of lower-temperature heat from shallow wells for geothermal heat pumps used in heating or cooling applications.

*Wind turbines* (WTs) are becoming an increasingly common power generation option across North America and in many parts of the world. In 2008, more wind power capacity was installed in the European Union and the United States, than any other form of electricity generating technology. This source of energy is viewed as a viable and environmentally friendly alternative to fossil fuels. It is a sustainable, clean form of energy. Wind capacity in Canada is

currently surpassing 5.4 Gigawatts (GW) - enough to power over 1.2 million homes. By 2015, wind capacity is expected to reach 10 GW, which is a 20-fold increase over 2000 levels. By 2025, it is envisioned that 20% of Canada's electricity will be wind power generated.

The placement of wind turbines has met with local opposition on the basis of perceived health concerns, as well as issues such as aesthetics, property value, electricity supply and demand levels, and autonomy disputes between municipal government, home owners and the province.

The 2010 review by Ontario's Chief Medical Officer of Health concluded "that while some people living near wind turbines report symptoms such as dizziness, headaches, and sleep disturbance, the scientific evidence available to date does not demonstrate a direct causal link between wind turbine noise and adverse health effects". Some peer-reviewed literature shows an association of consistent symptoms in a minority of people living close to wind turbines; however the level of evidence is low and caution should be employed in drawing firm conclusions regarding causation. The current setback requirements for wind turbines in Ontario (550 meters) are intended to address noise intensity (maximum of 40 dB – consistent with WHO European recommendations) and other health and safety issues. Overall, the population health impacts appear to be far lower than for equivalent energy generation by fossil fuel combustion.

*Ocean energy* comes from the potential, kinetic, thermal and chemical energy of seawater, which can be transformed to electricity, thermal energy, or potable water. As this source of energy is not accessible in Ontario it will not be addressed in this report.

It is recognized that there are many challenges associated with integrating renewable energy sources into existing power grids in ways that do not result in base load surpluses or the increase of GHG emissions. The complexity of these issues and their solutions must be addressed by the appropriate ministries and professions so that GHG-free and renewable energy is available and affordable. Currently, the University of Waterloo is completing research to address the technological, health, and safety aspects of renewable energy conversion.

According to the IPCC, as infrastructure and energy systems develop, in spite of the complexities, there are few, if any, fundamental technological limits to integrating renewable energy technologies to meet a majority share of total energy demand in locations where suitable renewable energy resources exist or can be supplied. The rate of integration will be influenced by factors such as costs, policies, environmental issues and social aspects.

Renewable energy technologies have low fatality rates. Accident risks of RE technologies are not negligible, but their often decentralized structure strongly limits the potential for disastrous consequences in terms of fatalities. However, hydropower projects may create a specific risk depending on site-specific factors.

As well as having a large potential to mitigate climate change, renewable energy has the potential to provide additional benefits. If implemented properly, it can contribute to social and

economic development, energy access, a secure energy supply, and reducing negative impacts on the environment and health.

RE systems do pose challenges if not managed carefully. The production of energy from solar and wind sources cannot be induced at all times (dependent on weather conditions, and the season and time of day), and thus methods for the storage of the energy produced need to be developed. To date, the cost of renewable energy sources is greater than fossil fuels. However technological advancement is very rapid in this field, with an exponential rise in the level of investment, as well as similar exponential decline in the cost per unit of energy produced. This compares favorably with gasoline and coal which will increase as their reserves are depleted over time.

An ideal vision for the future of Ontario's energy systems should include a strong reliance on and promotion of conservation and reduced demand followed by a plethora of safe and widely available renewable energy options taking center stage ahead of non-renewables, with nuclear energy having less relevance over time.

**Rationale**

The longer-term impacts of energy use are associated with climate change. Wide arrays of environmental changes that have the potential to severely impact human health have been documented and are projected to increase greatly over time. These include heat-related deaths, injuries and illnesses from adverse weather events, food and water shortages, expanded niches for contracting vector borne diseases, population displacements with drought and flooding, and possible increases in human conflict secondary to these stressors. Individual studies indicate that if RE deployment is limited, the costs of mitigation increase and low GHG concentration stabilizations may not be achieved.

The present and ongoing shorter-term health impacts of energy generation include, among other problems, illness and mortality attributable to reduced air quality. The Ontario Medical Association (OMA) has estimated some 5,800 smog-related deaths occur annually, along with thousands of hospital visits and admissions. The estimated costs associated with lost productivity, healthcare costs, pain and suffering and loss of life have been estimated to be over $7.8 billion dollars, and projected to increase to nearly $13 billion dollars in 2026. These impacts can be dramatically reduced with a transition to energy sources that have reduced or no emissions of harmful air pollutants.

Air emissions can also be reduced with conservation methods. Conservation can help reduce the need for electricity generation (thus reducing the emissions associated with it) and should therefore play a key role in the development of a forward-thinking energy plan. However, conservation should also apply more broadly to the design of entire communities, resulting in reduced emissions from automobiles and residential buildings. Efficient, compact and complete communities, with reduced automobile dependency, and with complete multimodal transportation systems have the potential not only to reduce energy demands, but also to

achieve improved health by facilitating increased physical activity and walkability, reduced automobile related injuries, increased health equity (with mixed-income residential neighbourhoods), and increased general quality of life.

Presently, the province of Ontario is conducting a review of its long-term energy plan. The Built Environment Working Group of the Council of Ontario Medical Officers of Health (COMOH) recently formulated a review of energy policy as a means of improving the health of the population. The review took considered primary research as well as publicly available reports on topics related to energy generation and use and its impacts on human health. COMOH supports energy policy as a means of improving population health through improved air quality, mitigation of climate change, and energy conservation and thus provided input to the Environmental Review of Ontario's long-term energy plan.

COMOH requested that the province consider the following:

1. That the goals of the long-term energy plan include the improvement of the health and the health equity of Ontarians;
2. That the province continue to pursue an 80% or greater reduction in greenhouse gas emissions by 2050 compared to 1990;
3. That the province continue to aggressively pursue the replacement of fossil fuels as an energy source with renewable energy sources that are proven to be energy efficient and with low air pollution emissions;
4. That the province push for improved and affordable commercial and end-user energy efficiency;
5. And that the energy efficient, health-promoting and complete community design be aggressively pursued as an inter-ministerial objective.

It is important to note that nuclear energy has the advantage over some forms of renewable energy (wind and solar, specifically) of being reliably available when needed at peak hours. Therefore any movement to limit and reduce nuclear energy needs to be taken with caution to ensure a stable and reliable energy grid. COMOH supports the continuation, but not the expansion of nuclear power in Ontario until the near elimination of fossil fuel emissions has been achieved with the development and widespread adoption of renewable energy sources and the optimization of energy conservation.

**Strategic Direction**

Peak demands for energy consumption combined with inefficient structural design may pose a threat to the ability for energy grids supplying the province. It is vital that the most vulnerable members of our society have affordable access to energy demanding resources, such as cool environments, when needed. In this way, this staff report supports the Board's strategic direction of *Determinants of Health and Health Equity.*

Other core functions of public health, such as maintenance of cold chain for vaccines or food safety initiatives to prevent contamination and spoilage are also threatened by peak demands for energy consumption. Although energy efficiencies may not be directly linked to these outcomes, upstream efforts to improve energy efficiency will mitigate the risk of downstream shortages and improve surge capacity.

The safe level of carbon dioxide ($CO_2$) in the atmosphere is 350ppm. Monitoring has shown that we are now at 395.47ppm, the highest levels found on earth in millions of years. The IPCC has identified that moving the global economy away from fossil fuels and into RE, energy efficiency and sustainable farming practices will help decrease this level. According to the IPCC, RE supply sources can lower $CO_2$ emissions because they have low carbon intensity with emissions per unit of energy output typically 1 to 10% that of fossil fuels.

In addition to adding its voice to the demand for GHG mitigation, the World Health Organization envisions public health playing a significant role in **adaptation** to climate change through assessment of the interactions of climate change with determinants of health, the impact on immediate and indirect health outcomes, the effectiveness of short-term interventions, the impact on non-health sectors with evidence for joint benefits and the methods that can be used to strengthen health systems to address health effects. Several health units in Ontario, including PCCHU, have already taken on climate change adaptation activities through surveillance of related health problems, preparing for extreme heat events and heat-related illness, identifying those at risk and assessing their vulnerability, participating in emergency response planning and collaborating with municipal and federal partners on adaptation plans.

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# Staff Report

## Municipal Alcohol Policies Update

| | |
|---|---|
| **Date:** | December 11, 2013 |
| **To:** | Board of Health |
| **From:** | Dr. Rosana Pellizzari, Medical Officer of Health |

| ***Original approved by*** | ***Original approved by*** |
|---|---|
| Rosana Pellizzari, M.D. | Monique Beneteau, Health Promoter |

**Recommendations**

That the Board of Health for the Peterborough County-City Health Unit receive the staff report, *Municipal Alcohol Policies Update*, for information.

**Financial Implications and Impact**

There are no financial implications arising from this report.

**Decision History**

At the October, 2011 Board of Health meeting, Suzanne Galloway, Health Promoter in the Substance Misuse Prevention Program provided a staff report and presentation on the *Report on Alcohol Use in Peterborough City and County: Recommendations for a Healthier and Safer Community*. One of the recommendations endorsed by the Board of Health at that time was:

***The Board of Health request local Councils (elected representatives) to:***

- *update and revise their Municipal Alcohol Policies or First Nations Council resolutions, and*
- *develop consultation mechanism with public health on applications for liquor licence permits, as required by recent changes to the Liquor Licence Act.*

In October, 2012, an update on this work was provided to the Board. At that meeting, the Board requested a progress report from staff in one year's time.

**Background**

To quote from the staff report submitted in October 2011, "[a]lcohol-related chronic disease can be minimized through low risking drinking. Unfortunately, over a third of Peterborough adults drank in excess of established low risk drinking guidelines. Peterborough drinkers also engage in binge drinking at rates 9% higher than the provincial average, ranking 9th highest in the province (amongst 36 health units). Since 2001, the prevalence of heavy drinking amongst adults has been steadily increasing in Peterborough and at a slightly faster rate than provincial estimates. In a recent high school study, 79% of Peterborough students report binge drinking at least once in the previous year. Of these, 18% report binge drinking weekly.

While alcohol consumption has been increasing in Ontario and Peterborough County and City over the past fifteen years, alcohol controls have been eroded. Alcohol marketing has become increasingly sophisticated and ubiquitous. There exists a high societal tolerance for high risk drinking. Recent changes to Ontario's liquor laws will likely further integrate alcohol use into many more social settings, as tobacco was years ago.

To stem the rising tide of alcohol harm, a multi-dimensional and comprehensive approach is required. Action aimed to address population-level health harm from alcohol use and high risk drinking as well as specific populations, contexts, or risk behavior is recommended."

Part of the multi-dimensional approach is to work with municipal and First Nation partners in the development of comprehensive municipal alcohol policies in an effort to mitigate the risks of alcohol use and to create healthy communities. In an effort to support this, the Substance Misuse Prevention Program incorporated a variety of actions into the 2012 and 2013 operational plans. Attachment A provides a summary of the activities that were planned, including an update on the progress to date. It should be noted that the progress made was, in no small measure, due to the support from the Board of Health.

Prior to the November 21, 2013 municipal alcohol policy (MAP) session, three townships received one-on-one support from the Health Unit in developing their MAPs. Through this process, it became clear that a template that would guide the development of these policies would be very helpful. The other townships were asked to hold off, if possible, until such a template was designed. Other health unit jurisdictions had already initiated collaborative work with their townships and we elected to model our process based on their experiences.

The November session was our first conversation about moving in this direction. The group agreed to set aside time in a future meeting to share each other's MAPs in order to identify commonalities that could be outlined in a "master" policy. Such a policy would ensure consistency, equity and fairness across the County. Some of the Clerks and Recreation Managers involved with the development of the Access to Recreation Policy suggested that a

similar model be used for this issue. This approach will enable the Health Unit to channel our limited resources effectively.

Health Unit staff will encourage the creation of a MAP template that is broad in scope, like a strategic plan for alcohol management in their communities. Some of the key components that will be emphasized by public health will include alcohol density (i.e., locations where alcohol is available), proximity to vulnerable populations and alcohol advertising. It is possible that some components of the MAP may eventually become by-laws.

It should be noted that due to the alcohol management presentations delivered to Township Councils by Suzanne Galloway throughout 2012, numerous townships have reviewed and updated their MAPs. With the exception of the Township of Trent Lakes which does not have a policy as of yet, all other townships do. Some of the policies have not been reviewed since the Liquor License Act changes in 2011, and the session in November gave them the impetus to do so soon.

**Rationale**

Health promotion involves a number of strategies from awareness/education to policy development. The chart included as Attachment B provides a snapshot of the various strategies undertaken to manage alcohol at the community level. The strength of the research shows that addressing public policy-level strategies that restrict accessibility to alcohol are effective and low-cost options. Many of these strategies require support at the provincial level. However, there are certain strategies that can be achieved at the local level such as restricting access to outlets and ensuring proper training of servers—strategies that can easily be captured in a municipal alcohol policy.

**Strategic Direction**

This report supports the PCCHU strategic direction of *Community-Centred Focus.*

**Contact:**

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mbeneteau@pcchu.ca

**Attachments:**

Attachment A - Status of MAPs in Peterborough County and City (as of November 30, 2013)
Attachment B – Ratings of Alcohol Policy-Relevant Strategies & Interventions

**ATTACHMENT A - Status of MAPs in Peterborough County and City (as of November 30, 2013)**

| **2012** | |
|---|---|
| **Activity** | **Update** |
| Assess the scope and possibilities for MAPs and other actions municipalities can take on alcohol. | Hosted a webinar on municipal alcohol policies for community partners (Q1)<br><br>Developed a briefing document to help municipalities understand their roles and powers under recent changes to the LLA (in collaboration with other health units) (Q1)<br><br>Convened interested professionals from across the province into an Alcohol Management In Municipalities Working Group and hosted a teleconference to share information effectively supporting MAPs/local alcohol policy and action (Q3) |
| Assess current existing MAPs within Peterborough County. | Supported 3 townships in the development/updating of their MAP (Q3)<br><br>Liaised with the City of Peterborough about updating their MAP (Q3) |
| Present to City & County Councils. Liaise with City and Townships to support update of their MAPs. | Presented to County Council (Q1)<br>Presented to 7 Township Councils (Q3) |
| **2013** | |
| **Activity** | **Update** |
| Support review/development of Municipal Alcohol Policies in City & 5 Townships. | Supported the Townships of Selwyn, Otonabee-South-Monaghan and Asphodel-Norwood in developing/updating their Municipal Alcohol Policies (MAPs). (Q1 and Q2) ➔ County of Peterborough finalized MAP in May 2013; Asphodel-Norwood finalized MAP in June 2013; Selwyn finalized MAP in summer. |
| Explore alcohol management mechanisms on First Nation communities. | Representatives from both Curve Lake and Hiawatha First Nations attended the MAP session on November 21, 2013. |
| **2013 Cont'd.** | |

| Activity | Update |
|---|---|
| Organize 1 day session with all with AGCO & insurance provider representative. | MAP session on November 21, 2013:<br>▪ Occupied a large portion of the agenda for the monthly Managers, Clerks and Treasurers Association meeting<br>▪ Over 20 people attended including clerks, deputy clerks, CAOs, NNADAP workers, Curve Lake First Nation councillor and recreation managers and staff; every township (but not the City) were in attendance<br>▪ Presentations were delivered by the AGCO (local liquor inspector and public affairs coordinator), the manager of risk management for the Frank Cowan Company, John Ewart, local lawyer specializing in municipal law, and the Health Unit representative.<br>▪ Following the presentations, the group discussed how to proceed. |

**Attachment B - Ratings of Alcohol Policy-Relevant Strategies & Interventions**

| Policy – Strategy | Effectiveness | Breadth of Research | Cross-cultural Testing | Cost to Implement |
|---|---|---|---|---|
| **Retail Monopoly** | +++ | +++ | ++ | Low |
| **Restrict outlet density** | ++ | +++ | ++ | Low |
| **Increase alcohol taxes** | +++ | +++ | +++ | Low |
| **No service to intoxicated** | + | +++ | ++ | Moderate |
| **Server liability** | +++ | + | + | Low |
| **School programs** | 0 | +++ | ++ | High |
| **Warning labels** | 0 | + | + | Low |
| **Minimum legal purchase age** | +++ | +++ | ++ | Low |
| **Drivers <21 'zero tolerance'** | +++ | +++ | ++ | Low |
| **Brief intervention – at risk** | ++ | +++ | +++ | Moderate |

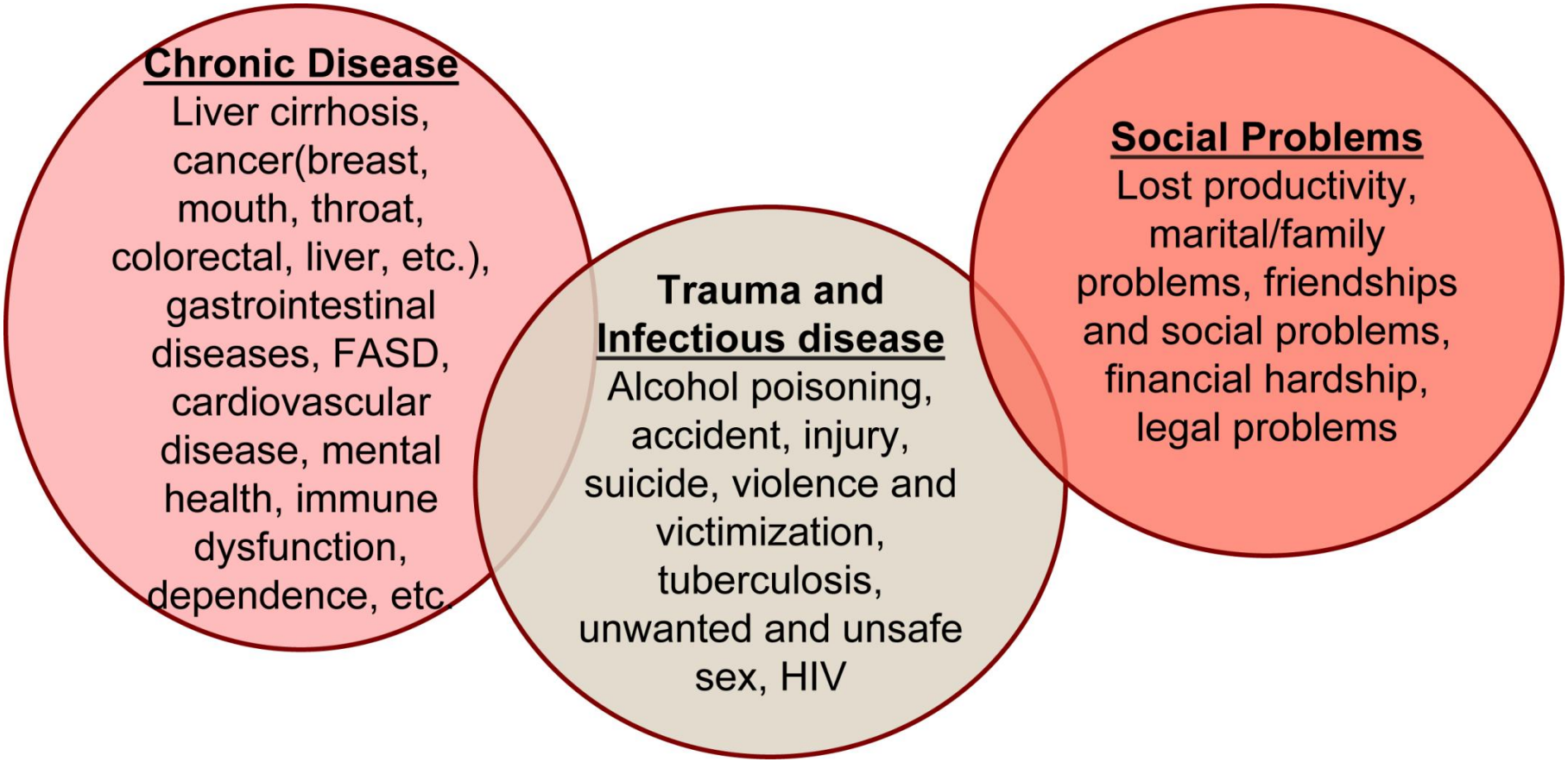
Source: Adapted from T. Babor et al, *Alcohol: No Ordinary Commodity* (Table 16.1), 2003, by T. Greenfield, et al, 2007.

# Municipalities and Alcohol

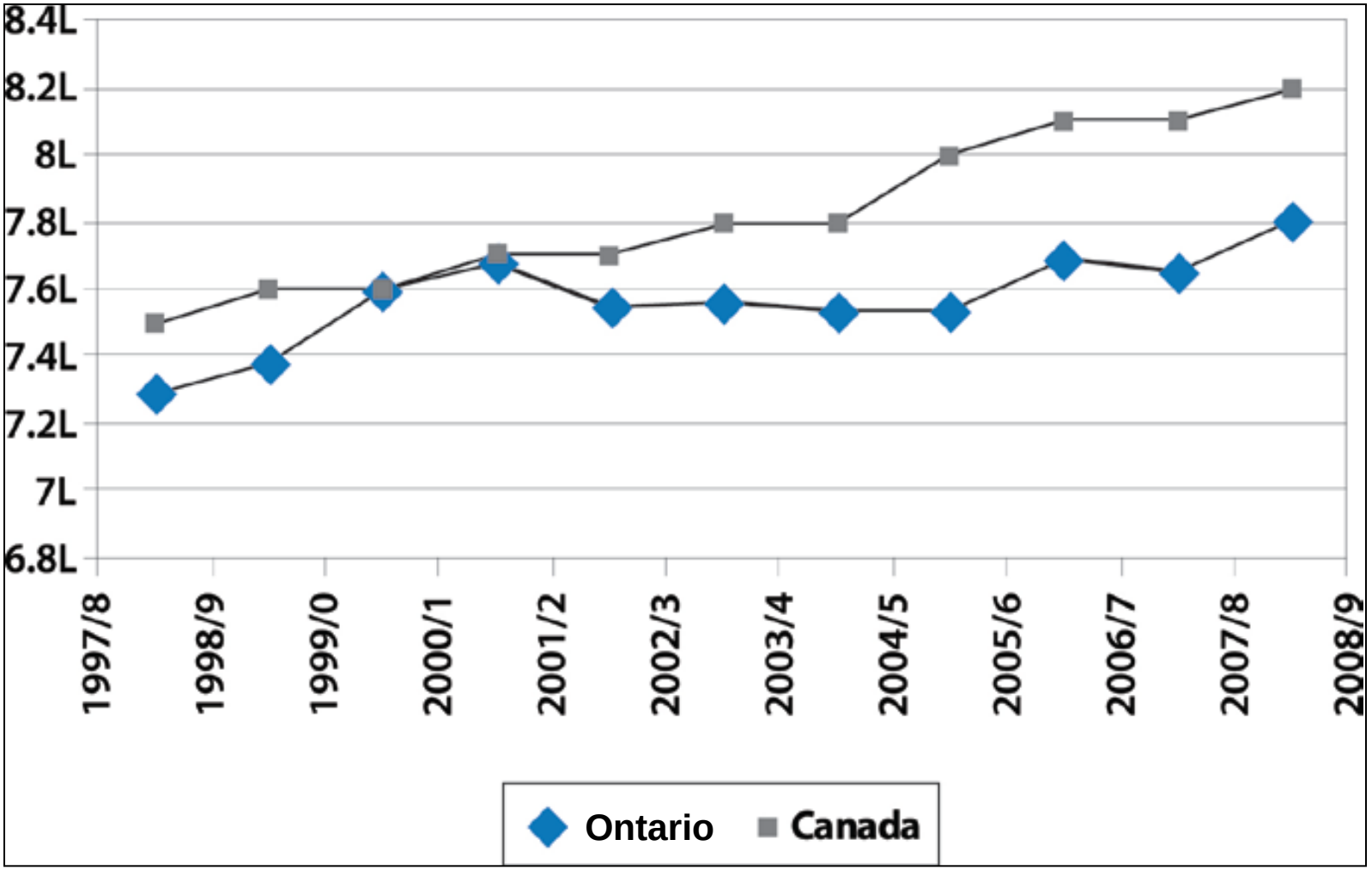
## Reducing alcohol related harms and liability: An update

Presentation to: PCCHU Board of Health
Presentation by: Monique Beneteau, Health Promoter, Community Health Team
Date: December 11, 2013

# Impact of Alcohol on the Community's Health



# Alcohol Consumption is Increasing



# Why Are We Seeing this Increase?

- Increasing Access to Alcohol - longer hours; higher density; prices lagging behind cost of living
- Extensive Integration of Alcohol into Social Contexts - more diverse venues and less restricted
- More and Diversified Marketing - increasingly ubiquitous and inadequately regulated

# How Do We Reduce Harms?

## Multi-pronged approach

- **First tier strategies**
  - Population-level strategies (e.g. limiting availability of alcohol, restricting alcohol advertising)

- **Second tier strategies**
  - Specific populations, contexts, or risk behaviours (e.g. , countering impaired driving, social marketing to youth about low risk drinking, increasing alcohol screening by medical care providers.)

# Ratings of Alcohol Policy-Relevant Strategies & Interventions

| Policy – Strategy | Effectiveness | Breadth of Research | Cross-cultural Testing | Cost to Implement |
|---|---|---|---|---|
| **Retail Monopoly** | +++ | +++ | ++ | Low |
| **Restrict outlet density** | ++ | +++ | ++ | Low |
| **Increase alcohol taxes** | +++ | +++ | +++ | Low |
| **No service to intoxicated** | + | +++ | ++ | Moderate |
| **Server liability** | +++ | + | + | Low |
| **School programs** | 0 | +++ | ++ | High |
| **Warning labels** | 0 | + | + | Low |
| **Minimum legal purchase age** | +++ | +++ | ++ | Low |
| **Drivers <21 'zero tolerance'** | +++ | +++ | ++ | Low |
| **Brief intervention – at risk** | ++ | +++ | +++ | Moderate |

Source: Adapted from T. Babor et al, *Alcohol: No Ordinary Commodity* (Table 16.1), 2003, by T. Greenfield, et al, 2007.

# Recommendation endorsed by Board of Health on October 12, 2011

***The Board of Health request local Councils (elected representatives) to:***

- update and revise their Municipal Alcohol Policies (MAPs) or First Nations Council resolutions, and
- develop consultation mechanism with public health on applications for liquor licence permits, as required by recent changes to the Liquor Licence Act.

# Update on MAP Work: 2012

**Activity 1:** Assess the scope and possibilities for MAPs and other actions municipalities can take on alcohol.

- Hosted a webinar for community partners
- Developed a briefing document
- Convened Alcohol Management In Municipalities Working Group

# Update on MAP Work: 2012

**Activity 2:** Assess current existing MAPs within Peterborough County.

- Supported 3 townships in the development/updating of their MAPs
- Liaised with the City of Peterborough about updating their MAP

# Update on MAP Work: 2012

**Activity 3:** Present to City & County Councils. Liaise with City and Townships to support update of their MAPs.

- Presented to County Council
- Presented to 7 Township Councils

# Update on MAP Work: 2013

**Activity 1:** Support review/development of Municipal Alcohol Policies in City & 5 Townships.

- Supported 3 townships (Selwyn, Otonabee-South-Monaghan and Asphodel-Norwood)
- MAPs finalized: County of Peterborough (May 2013); Asphodel-Norwood (June 2013); Selwyn (summer?)

# Update on MAP Work: 2013

**Activity 2:** Explore alcohol management mechanisms on First Nation communities.

- Representatives from both Curve Lake and Hiawatha First Nations attended the MAP session on November 21, 2013.

# Update on MAP Work: 2013

**Activity 3:** Organize one day session with all with AGCO & insurance provider representative.

- MAP session on November 21, 2013

# About the MAP Session

- 23 people from all 8 townships and both First Nations communities including CAOs, Clerks, Deputy Clerks, Rec Managers, and NNADAP Workers.
- Presentations from health, inspection and enforcement, insurance, and law.
- Positioned MAPs as a strategic plan for community-based alcohol management.

# Outcome of Session and Next Steps

Discussion and agreement to meet again as a group in 2014 to create County-wide fundamental components that each municipality agrees to incorporate into their policies.

# Thank you

Any Questions?

# Nobody's Perfect

## Parent Education and Support Program


Presentation to: PCCHU Board of Health
Presentation by: Gail Chislett, Health Promoter
Date: December 11, 2013

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

# NOBODY'S PERFECT (NBP):

- is a parenting education and support program for parents of children from birth to age five.
- is designed for parents who are young, single, socially or geographically isolated, or have low income or limited formal education.
- is voluntary and free of charge.
- informs parents about the "when's," "what's" and "why's" of the first five years of childhood.

# NOBODY'S PERFECT (NBP):

- was developed by Health Canada and introduced nationally.
- was adopted locally in 1986.
- is overseen by local, provincial and federal Advisory Committees.
- is provided in collaboration with community partners and volunteers.
- is coordinated locally by Peterborough County-City Health Unit.
- is offered in the City and County.

# LOCAL DELIVERY


- Groups of 8 – 12 parents meet weekly for a series of eight two-hour sessions.
- NBP may be offered one-to-one.
- Trained NBP co-facilitators (agency staff or volunteers) lead sessions.
- Books, snacks, transportation and child care are provided.
- Parents who do not have custody of their children may attend.
- Parents may attend more than once.

# NOBODY'S PERFECT SERVICE PROVISION

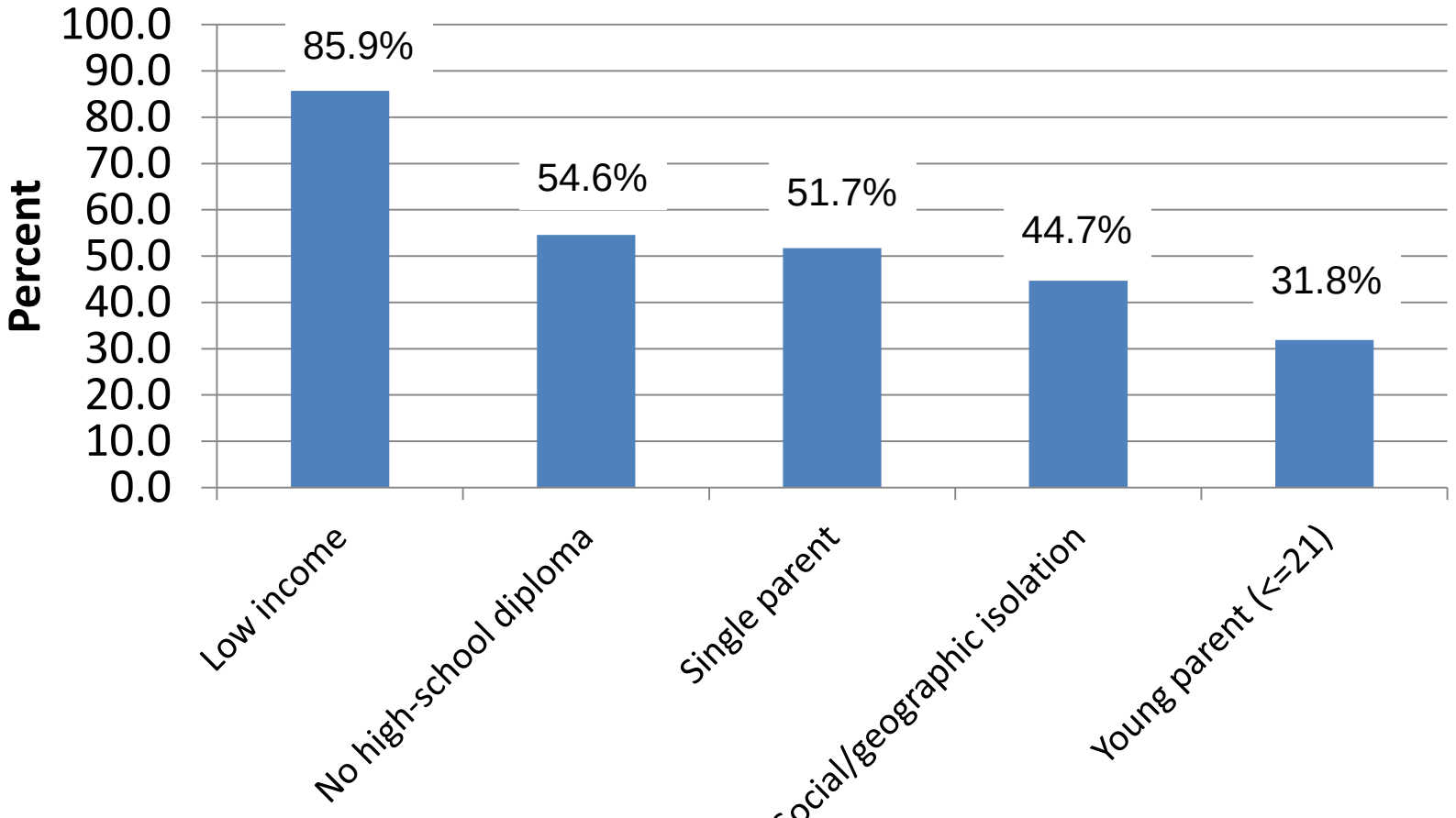
January 1, 2003 to December 31, 2012:

- 170 series (1,187 sessions) provided
- 863 clients attended
- 1,372 children affiliated with clients
- 6,384 facilitator volunteer hours contributed
- 4,331 childcare provider volunteer hours contributed

# WHO ATTENDED, 2003- 2012?


- 75% of clients were female
- 20% were in their teens
- 32% were between the ages of 20 and 24 years
- males were older than females (28.9 and 25.5)
- over 50% of clients' children were under 2 years of age (25% were 0 – 1)
- 75% of clients' children were in their care

# SOCIAL DETERMINANTS OF HEALTH (SDOH): ATTENDEES




Challenges facing NBP clients; 2003-2012

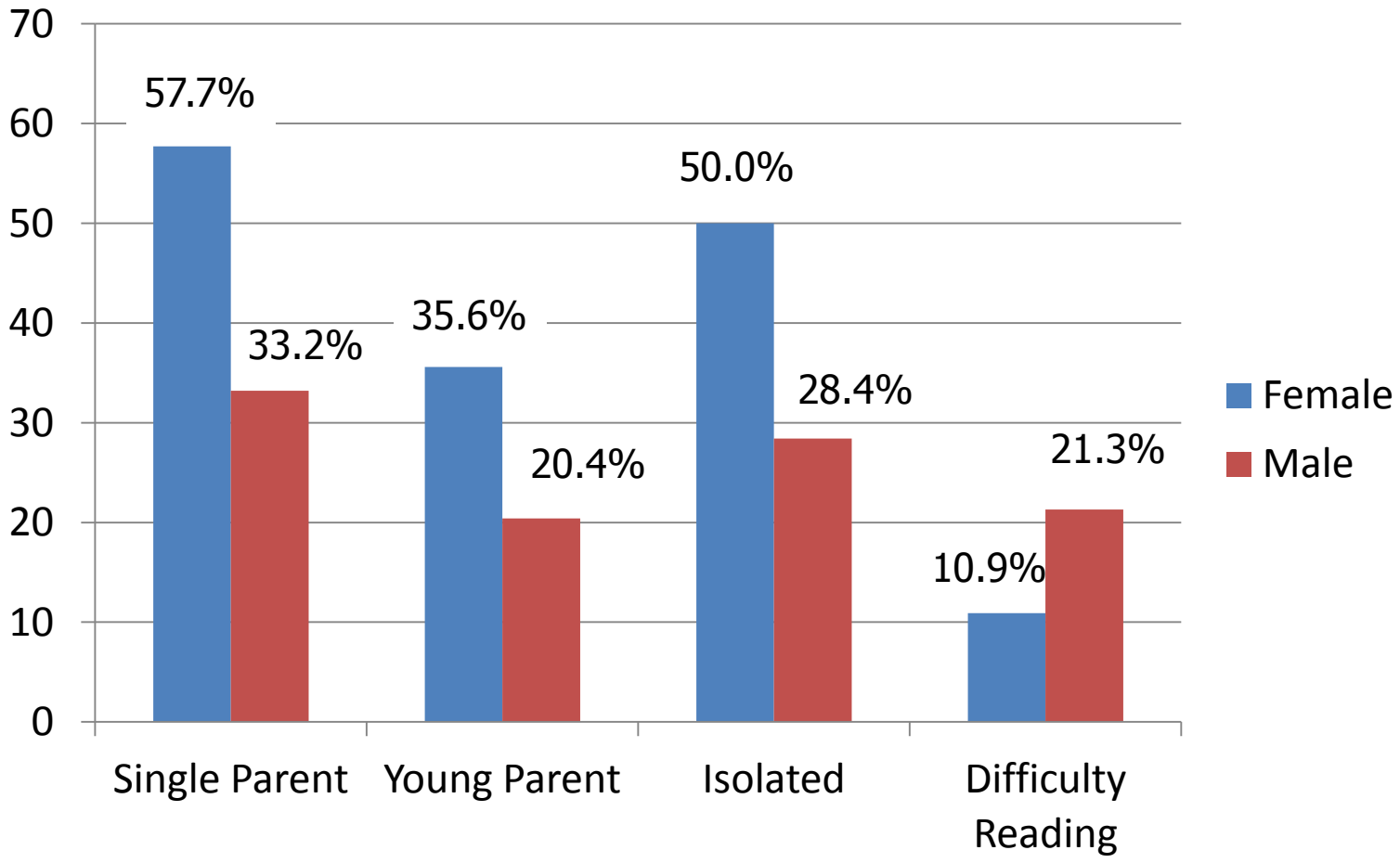
# SDOH: ATTENDEES

Most clients face multiple challenges.

Compared to attendees who were *not* low income, attendees in low income are more likely to:

- be single parents;
- be young parents;
- be without a high-school diploma; and
- have difficulty reading.

# ATTENDEE DIFFERENCES BY GENDER




Differences among NBP clients by gender; 2003-2012

# NBP: COMPLETION


Parents who have attended at least two-thirds of the sessions receive a NBP certificate of completion.

Predictors of completing a NBP series may be:

- having completed high-school;
- having a parenting partner; and
- being female.

# ATTENDANCE FREQUENCY: 2003 - 2012

- 71.6% of clients attended one series only
- 17.6% of clients attended two series
- 7.1% of clients attended three series
- 3.7% of clients attended four or more series

Why attend more than once?

- learn more (topics, as child develops, repetition)
- refresher with subsequent children
- network of social support
- parents like NBP!

# NBP CLIENT FINAL EVALUATION

***2012 Final Evaluations***
*(7 series compiled, N = 52)*

How did you like Nobody's Perfect?

**Very Much** ***76%***

Good ***24%***

**What new things did you learn?**

- Development charts
- Ways to communicate with your child
- The benefits and importance of routines
- Ways to deal with child's behaviour
- How to handle tantrums
- Potty training
- How to manage my money
- How to cope with stress better
- CPR
- First aid

# NBP CLIENT FINAL EVALUATION

**What do you do differently for you or your child since you started this group?**

- Give more attention to child
- Coach my child in different areas of development and learning skills
- Play more games
- Bedtime routine
- Try the problem solving wheel
- Use books when not sure
- I'm more patient
- **Positive parenting**


# Questions?

# Oral Health In Peterborough

## December 2013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Peterborough County-City HEALTH UNIT
...because health matters!

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## Reference

Peterborough County-City Health Unit. *Oral Health In Peterborough.* December 2013.

## Reviewers

Dr. Rosana Pellizzari, Medical Officer of Health; *Peterborough County-City Health Unit*

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The authors also wish to acknowledge the Ontario Ministry of Health and Long-Term Care and Statistics Canada for making data available to support public health.

## Distribution

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## Table of Contents

# Report Overview

## Introduction

Oral health is an integral part of overall health and well-being and it has been shown that poor oral health may be associated with some major systematic disease such as diabetes, heart disease or poor overall health. In addition, dental diseases can severely affect one's quality of life by causing considerable pain and discomfort as well as interfering with normal activities such as social interactions, work and school tasks. Children who experience dental decay early in life are shown to lag behind others in terms of growth and learning abilities.

Oral diseases are mostly preventable. However, once such conditions develop, they impose significant direct and indirect costs on individuals as well as the society. For instance, it has been estimated that in 2009 approximately 40 million hours of school and work were lost due to dental conditions in Canada.

Unfortunately and despite the above evidence, dental services are not publicly covered for the most part. Public Health Units are required to monitor the oral health of children through screenings which take place in schools, and to offer preventive services, and financial assistance through the Children in Need of Treatment program. The data from these assessments are made available at a provincial level, to inform planning and service delivery programs. The Healthy Smiles Ontario program was introduced in 2011 and provides additional funds and coverage for both preventive and treatment dental services to low income children below the age of 18 years.

The purpose of this report is to describe the dental health of people living in Peterborough County and City and First Nation communities (Peterborough residents) and demonstrate the scope and impact of the Oral Health programs at the Peterborough County-City Health Unit (PCCHU). Having this information should help inform decision-makers on the nature and distribution of dental challenges and opportunities in the community. The report utilizes several key databases, accessible to the public health system, to complement direct patient observation to provide a more robust assessment of local oral health.

The information contained in the report can be used to:

- Identify and explain current local public health dental services
- Identify health inequalities and community needs
- Plan and secure future service delivery for priority populations
- Set priorities for local health promotion and disease prevention activities

## Data Sources

Multiple data sources were used in this report:

*Section 1.*

*Oral health screening* data were collected in accordance with the Ontario Public Health Standards (OPHS): *Oral Health Assessment and Surveillance Protocol*. The mandatory information was collected and uploaded into Ministry of Health and Long-term Care's Oral Health Information Support System (OHISS) as aggregate data in accordance with Personal Health Information Protection Act (PHIPA). In this report, OHISS analysis tools were used to retrieve information on number of children screened, percentage of Children with Urgent Care needs (CUC), percentage of caries-free children, average number of decayed, missing, filled teeth (deft/DMFT) and percentage of high-risk schools (see definition pg. 7). These variables were extracted for 2011-12 and 2012-13 school years.

ClearDent™ is a paperless dental office management software system which integrates patient information, digital imaging, electronic charting, treatment plans and recall, management reports and billings, lab tracking and scheduling. This software is used at both Peterborough County-City Health Unit dental clinics to manage and plan all clinical activities, events, and client flow. At the time of writing, ClearDent™ was not set up to run surveillance or population health reports. Administrative data, such as billing and scheduling appear in this report. Data was extracted on the number of clients and the procedures performed at the clinics for the time period April 2012 to March 2013.

*Section 2.*

Data regarding the utilization of *oral health services and oral health status*, such as insurance coverage, visiting a dentist, and sociodemographic indicators are derived from the Canadian Community Health Survey (CCHS) 2009-2010 Share File. The CCHS collects health determinants, health status and health system utilization data from people aged 12 years or older living in households across Canada. The CCHS has several limitations, notably: sample sizes for Peterborough are small and as a result there is large degree of variability associated with some of the estimates provided, particularly in groups which there is low representation (e.g. youth) and for those variables where positive responses are relatively rare (e.g. presence of a specific oral health issue). In addition, people living in First Nations communities are not included in the sample for the CCHS. Estimates from the CCHS have been presented with 95% confidence intervals.

*Section 3.*

*Emergency department (ED) data* were obtained from the National Ambulatory Care Reporting System (NACRS). Emergency departments in Ontario are required to submit data to NACRS. Variables contained in NACRS include: demographic information about the patient (e.g., age, sex, region of residence); and information about the ED visit admission (e.g., date of visit, unscheduled emergency).
Records from NACRS are classified according to the International Classification of Diseases, 10th Revision (ICD-10) and data were retrieved using ICD-10 main problem code block *K00-14 – Diseases of oral cavity, salivary glands and jaws*. This code block includes the following diagnoses:

- K00: Disorders of tooth development and eruption
- K01: Embedded and impacted teeth
- K02: Dental caries

- K03: Other diseases of hard tissues of teeth
- K04: Diseases of pulp and periapical tissues
- K05: Gingivitis and periodontal diseases
- K06: Other disorders of gingival and edentulous alveaolar ridge
- K07: Dentofacial anomalies [including malocclusion]
- K08: Other disorders of teeth and supporting structures
- K09: Cysts of oral region, not elsewhere classified
- K10: Other diseases of jaws
- K11: Diseases of salivary glands
- K12: Stomatitis and related lesions
- K13: Other diseases of lip and oral mucosa
- K14: Diseases of tongue

*Population data* are provided by two sources, Statistics Canada and the Ontario Ministry of Finance. Population estimates are final inter-censal (i.e. between census) estimates that are interpolated using the adjusted census counts around the year that the estimates are for. Data are retrieved using intelliHEALTH, an Ontario Ministry of Health and Long-Term Care data portal.

*Cancer data* are provided by Cancer Care Ontario (CCO) from the Ontario Cancer Registry. Cancer Care Ontario monitors cancer incidence, mortality, survival patterns and trends over time. The Ontario Cancer Registry includes data on all newly diagnosed cases of cancer in Ontario since 1964 and includes approximately 97% of all cancer cases in Ontario. Records of new cancer diagnoses and deaths in Ontario are based on hospital discharge summaries, pathology reports, records from regional cancer centres and death records. This data is disseminated using SEER*Stat software, Release 8 - OCRIS (May 2010) released February 2011.

## Definitions & Notes

A *95%CI*, or 95% confidence interval, is a range of values within which 19 times out of 20 the *true* estimate will lie. Confidence intervals provide an indication of the reliability of the estimate. In some cases reliable estimates could not be obtained and therefore data are suppressed.

An *age-specific rate* is total number of events (e.g. new cases of cancer, deaths) that occur in a specified age group divided by the total population of that age group in that given year. Often these figures are very small and are therefore multiplied by a factor of 100,000 to make them more meaningful.

$$\text{age specific rate} = \frac{\text{number of ED visits in 2012 in Peterborough residents aged 20 to 24}}{\text{total Peterborough population aged 20 to 24 in 2012}} \times 100{,}000$$

The *avg DMFT/deft* is the average number of decayed, missing, filled tooth per child. Lower case letters refer to counts of primary teeth and upper case letters refer to counts of permanent teeth.

*Caries free* refers to children with no present or past experience of cavities.

The *crude rate* is the total number of events (e.g. new cases of cancer, deaths) that occur in a population in a given year divided by the total population in that given year. Often these figures are very small and are therefore multiplied by a factor of 100,000 to make them more meaningful.

$$\text{crude rate} = \frac{\text{number of oral cancer cases in 2007 in Peterborough}}{\text{total Peterborough population in 2007}} \times 100{,}000$$

A *high- risk school* is a school that has received oral health screening and has more than 14% of their Grade 2 students with an average DMFT/deft of equal or greater than 2.

*High and low educational* attainment categories indicate the self-reported highest level of education acquired by the CCHS respondent and are broken down as follows:

- low education: less than high school graduation OR high school graduation, no post-secondary education
- high education: some post-secondary education OR post-secondary degree/diploma

*High and low income* categories are derived from the CCHS using a combination of total household income from all sources and the number of people residing in the household. For this report, *low income* refers to the 'lowest' and 'lower middle' income categories as defined in Table I; *high income* refers to the 'upper middle' and 'highest' categories.

**Table I.** Income categories used in Social Determinants of Health (SDOH) analysis

| Household size | Total Household Income - Categories | | | |
|---|---|---|---|---|
| | Lowest | Lower middle | Upper middle | Highest |
| 1 or 2 | < $15,000 | $15,000 - $29,999 | $30,000 - $59,999 | >= $60,000 |
| 3 or 4 | < $20,000 | $20,000 - $39,999 | $40,000 - $79,999 | >= $80,000 |
| 5+ | < $30,000 | $30,000 - $59,999 | $60,000 - $79,999 | >= $80,000 |

*Peterborough* refers to Peterborough County, the City of Peterborough, Curve Lake and Hiawatha First Nations.

*Peterborough resident* refers to a person whose place of residence at the time of data collection was Peterborough County, the City of Peterborough, Curve Lake or Hiawatha First Nations (with the exception of CCHS data).

*Standardization* removes the effects of differences in the age and gender structure of populations among areas and over time. These rates show the number of events per 100,000 population that would have occurred in a given area if the age structure of the population of that area was the same as the age structure of a specified standard population. To ensure consistency and comparability of age-adjusted rates, it is suggested that the 1991 Total Canadian Population (Version 2) be used as the standard.

The *urban/rural* variable identifies whether the respondent lives in an urban or rural area. Urban areas are those continuously built-up areas having a population concentration of 1,000 or more and a population density of 400 or more per square kilometre based on current census population counts. This variable is grouped into two categories based on the composition of the blocks within the dissemination areas and is a pre-defined variable in the CCHS.

## Executive Summary

Oral health is an integral part of overall health. Poor oral health has been associated chronic diseases such as diabetes and heart disease. In addition, oral diseases are largely preventable. The Peterborough County-City Health Unit's (PCCHU) approach to oral health is holistic in nature. Its goals are to re-orient health services to achieve a balance between disease prevention and treatment, to foster development of healthy public policy, and to achieve positive and equitable oral health outcomes.

Ontario boards of health are mandated to offer a range of oral health services including school screenings, administration of oral health public assistance, supporting policies for community water fluoridation, and reducing barriers to access including operating a community dental health centre and a mobile dental health centre.

Highlights from this report include:

- Approximately three-quarters of JK students are caries free
- Treatment plans for 3,323 people were approved between April 2012 and April 2013
- In 2009/2010, three quarters of Peterborough residents reported that they had visited the dentist in the past 12 months
- The most common reason for not visiting a dentist in the past three years was cost
- Two-thirds of Peterborough residents have dental insurance
- One-quarter of people in Peterborough do not brush their teeth twice or more daily
- On average, there are over 1,000 visits per year to the emergency department (ED) for oral care
- Young adults between the ages of 20 and 39 make up over half the ED visits
- Abscesses and toothaches were the most common reason for visits to the ED

Based on the data presented in this report, PCCHU has identified the following priority populations for oral health programs and services:

- low income families and individuals;
- those without dental insurance;
- older adults, young children and young adults.

Given the findings of this report, the following actions are recommended as priorities for the Peterborough County-City Board of Health and its partners:

- Promote and support policies and provisions for continued access to optimally fluoridated community drinking water;
- Maintain, and expand where possible, the current level of data collection concerning oral health;
- Continue to remove barriers to accessing dental services including operating the community dental health centre and the mobile dental health centre; and
- Work in partnership with community champions to maintain the emergency dental fund, and develop health promotional materials and increase the profile of oral health importance in Peterborough.

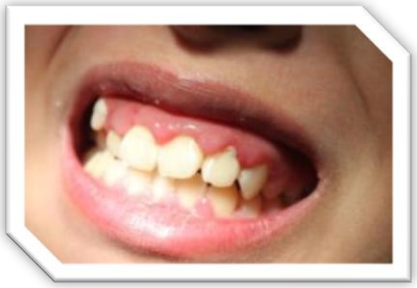
## List of Tables



## List of Figures

## Section 1: Oral Health Services Offered by Public Health

The Public Health model is holistic in approach, promoting broad awareness of the key role of oral health in good overall health and a wide range of health outcomes. Its goals are to re-orient health services to achieve a balance between disease prevention and treatment, to foster development of healthy public policy, to achieve positive and equitable oral health outcomes, and to use innovative approaches to services for those clients who need them most.



### 1.1 School Screening

Oral health screening has been conducted in local elementary schools by the Board of Health since 1979. Since the inception of the Children in Need of Treatment (CINOT) financial assistance program in 1986, the screening program has proven extremely successful in ensuring that children with unmet urgent treatment needs are able to access care. All Boards of Health in the province are mandated under the Ontario Public Health Standards to provide oral health screening in elementary schools.

The screening team offers oral health screening in 48 elementary schools in Peterborough – including Curve Lake First Nation, public, separate, and private schools. Schools screenings, operated by a registered dental hygienist and a dental assistant, are scheduled each month and parents/guardians are notified of the screening by a letter. A secure laptop is used to collect the data from the screenings which is then uploaded to the provincial database (OHISS). Following the visual assessment, the findings are entered into the OHISS application and a screening report card is sent home. Notification letters, advising on the need for treatment, are issued, and mailed to parent/guardian for children with urgent dental care needs.

Through screening, children with urgent treatment needs are identified, as well as children who need care and are not yet in crisis, and other students who require preventive services such as cleaning, fluoride treatments, and pit and fissure sealants. In addition, Board of Health staff encounters many students with various physical and mental disabilities and school screening provides an excellent opportunity for these children to have a positive, non-invasive, dental experience which builds confidence.

The proportion of students in Grade 2 with two or more decayed teeth, determines the screening intensity level of a school. The intensity level, corresponding proportion of Grade 2 students with two or more decayed teeth, and the grades screened are presented in Table 1.

**Table 1.** School screening intensity level, decayed teeth, and grades screened by public health

| Intensity Level | Proportion with 2+ Decayed Teeth | Grades Screened |
|---|---|---|
| High | 14% or more | JK, SK, 2, 4, 6, 8 |
| Medium | 9.5-13.9% | JK, SK, 2, 8 |
| Low | <9.5% | JK, SK, 8 |

Student data are recorded using a provincial database as required by the Ontario Public Health Standards (OPHS). These data are analyzed at a provincial level, to assist in the planning and development of community dental programs.

During the 2012-2013 school year, PCCHU oral health staff screened 4,116 children in grades JK through 8, with most (56.3%) enrolled in JK and SK (Table 2). There were slightly fewer children screened in the 2012-2013 school year compared to the previous year (4,824) though the distribution of students across grades was similar. Overall, more than half of students screened in either year were caries-free or had never experienced dental decay (59% and 60%, respectively). The proportion of caries-free children was the highest among JK students at approximately 73%; Grade 4 had the smallest proportion of caries-free children at approximately 38.5%.

As defined under the CINOT program, urgent treatment needs refer to conditions such as pain, infection, hemorrhage, trauma, large open caries in permanent teeth or in crucial primary teeth, pathology requiring further investigation, or non-reversible periodontal disease may be considered urgent. As shown in Table 2, the overall proportion of children with urgent treatment needs declined slightly from 8.1% in 2011-12 to 7.3 % in 2012-13. This trend is consistent among students of all grades except Grade 6 students where there was increase in the number of children with urgent needs. The average DMFT/deft (decayed/missing/filled teeth) was consistent between 2011-12 and 2012-13 at around 1.5. However, similar to the increase in the proportion of children with urgent treatment needs in Grade 6, DMFT/deft increased from 1.2 to 2.0 between 2011-12 and 2012-13 among Grade 6 students. Finally, the proportion of high-risk schools has increased during the reported school years, from 9.3% to 13.6%.

**Table 2.** School screening data, 2011-2013

| Indicator | School Year | Grade | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | JK | SK | G2 | G4 | G6 | G8 | Total |
| Children Screened (n) | 11-12 | 1,366 | 1,243 | 1,245 | 147 | 142 | 647 | 4,824 |
| | 12-13 | 1,185 | 1,131 | 1,121 | 93 | 105 | 480 | 4,116 |
| Caries-free Children (%) | 11-12 | 72 | 65 | 48 | 38 | 56 | 50 | 59 |
| | 12-13 | 74 | 68 | 46 | 39 | 40 | 50 | 60 |
| Children with Urgent Treatment Needs (%) | 11-12 | 8.2 | 8.5 | 9.3 | 10.2 | 2.1 | 5.7 | 8.1 |
| | 12-13 | 7.9 | 6.8 | 8.1 | 8.6 | 7.6 | 5.6 | 7.3 |
| Avg. DMFT/deft | 11-12 | 1.0 | 1.4 | 2.1 | 2.3 | 1.2 | 1.4 | 1.5 |
| | 12-13 | 0.9 | 1.0 | 2.2 | 2.5 | 2.0 | 1.4 | 1.4 |
| High-risk Schools (%) | 11-12 | **9.3** | | | | | | |
| | 12-13 | **13.6** | | | | | | |

## 1.2 Administration of Publically Funded Dental Programs

Public health also has a role in the administration of a range of services for eligible children, youth and adults. Healthy Smiles Ontario (HSO), CINOT and Ontario Works Mandatory Basic Dental Care are programs that target children and youth under the age of 18 whose families may face financial difficulties. PCCHU's main role is to administer these programs and if needed, review children's eligibility according to each program.

In addition, PCCHU on behalf of the City of Peterborough, administers the Ontario Works Discretionary Benefit (OWDB) program for adults. Under this program, rules and conditions of any treatment plan that exceeds $400 per calendar year must be reviewed and adjudicated by the PCCHU Dental Consultant. Between April 2012 and April 2013, PCCHU reviewed and approved the treatment plans of:

- 262 CINOT applicants;
- 277 HSO applicants;
- 898 children covered under Ontario Works (OW); and
- 1,886 individual adults' OWDB treatment plans

### 1.2.2. Dental Treatment Assistance Fund

The Dental Treatment Assistance Fund (DTAF) originally commenced in 2007 by the former Oral Health Coalition of Peterborough to meet the emergency needs of uninsured adults and seniors in our community. The Oral Health Coalition was created by the Peterborough Social Planning Council, the United Way, the Victorian Order of Nurses (VON), City of Peterborough Social Services, the Multiple Sclerosis Society, the PCCHU and community members. Originally the VON administered the fund.

Now, DTAF is overseen by the Basic Needs Committee of the Peterborough Poverty Reduction Network. PCCHU provides the administrative support (at no cost to the fund). DTAF is funded strictly by donations, and provides a maximum of $200 per calendar year to individuals, 18 and older, who are not covered by any form of dental insurance and who require but unable to afford, emergency dental assessment and/or treatment. Clients are referred from partner organizations as well as by themselves.

DTAF supported 115 individuals in 2012 between 18 and 82 years of age. The average cost of emergency treatment from the fund was $122 per person. It is estimated that $25,000 a year is needed; to fully meet the needs of the community.

## 1.3 Community Dental Health Services

In 2010 PCCHU submitted a proposal to HSO to establish a clinic in downtown Peterborough and to provide outreach to the County of Peterborough from a fully-equipped mobile dental treatment unit. This proposal was successful and in an effort to address the current gaps and barriers in dental service provision, PCCHU provides dental services in the centrally-located Community Dental Health Centre (CDHC) in downtown Peterborough as well as a mobile dental health centre (MDHC).

The CDHC opened to the public in May 2011 and transitioned to a fully operational dental health centre by April 2012. It provides high quality, accessible and comprehensive oral health treatment and preventive services which meet the needs of eligible children and families. Services are offered six days a week by a team of oral health professionals including a dentist, a registered dental hygienist, certified dental assistants and a secretary. Contract and relief staff work on occasion to help manage demand.

The vast majority of health and social services are located in the City of Peterborough. Transportation to dental services from outside the city can be a challenge for many individuals, especially for those without a private car and those with mobility issues. In January 2012 PCCHU began offering mobile dental health services across Peterborough County via the MDHC. The fully accessible mobile clinic features two treatment areas and carries equipment to provide 360 degree diagnostic x-rays, cleaning, filling and other preventive and treatment services.

The MDHC operates two days per week on a rotating basis and sees clients in Apsley, Buckhorn, Curve Lake First Nation, Havelock, Hiawatha First Nation, Keene, Lakefield, Millbrook, Norwood, and Warsaw. County residents, who otherwise cannot access dental care, have been provided professional dental services on board the MDHC. Starting in 2013, the PCCHU also began offering services within the City - targeting priority populations including low-income youth.

In total, there are 2,769 registered clients at the CDHC and MDHC, just over half of whom (1,478 or 53.4%) were female and 898 (32.4%) were under the age of 18. Between April 2012 and March 2013, there were 2,518 completed appointments which consisted of 1,271 patient visits. Most of the services provided were diagnostic in nature (41.7%). This includes dental examinations and x-rays. Roughly one-quarter (28.0%) of procedures performed were restorative (i.e. filling and restoring teeth). The remainder of the services were either surgical (17.1%; removal of teeth), preventative (10.9%; cleaning) or endodontic (2.3%; root canal therapies and treatments of the pulp of the teeth). Coverage for dental health services are paid for by publically-funded programs administered by PCCHU.

### 1.3.2 Denture Pilot

As previously mentioned, poor oral health and untreated oral diseases can have a significant impact on a person's quality of life. Missing and broken teeth are not only painful, but can mean that a person has difficulty eating and sleeping. Sometimes people will avoid certain foods and

this can impact the ability to maintain a nutritiously balanced diet. Therefore, dentures can be essential for health and wellbeing. They can help people with speech, affect nutrition, support people in finding and keeping employment and play a role in self esteem and social interactions.

In Peterborough, adults receiving OW have limited access to the provision of dentures (partial and complete) with approval from their OW case manager. In November 2012, the CDHC initiated a pilot program assessing readiness of the new CDHC team and financial viability, to offer denture service to clients alongside the other preventive and treatment services available. Clients were assessed by the dentist and recommendations were made to the client's OW case manager for approval of treatment. Between November 2012 and March 2012, 40 dentures were provided for clients. A survey was sent to clients who had received dentures to capture their comments and suggestions in order to evaluate the project; one third (30.0%) responded to the survey.

Feedback from clients was positive:

- 100% reported they felt better about the way they looked following receiving dentures
- 100% felt more confident around people.
- 90% felt more confident to find or keep work.

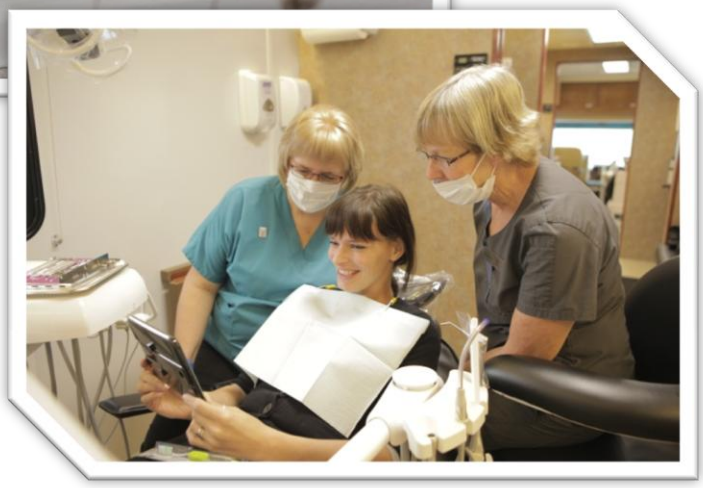
## 1.4 Community Water Fluoridation (CWF)

Fluoride is a natural element that can be found in rocks, soil, and water. For more than half a century, fluoride has been added to public drinking water supplies around the world in order to prevent dental decay and promote oral health. The fluoridation of drinking water is a well-accepted public health measure which protects all members of a community regardless of age, socioeconomic status, education, employment, or dental coverage. It is endorsed by Health Canada and by more than 90 national and international professional health organizations. Fluoridating municipal water supplies remains an especially vital public health intervention for our most vulnerable populations, including seniors, and is considered one of the ten greatest public health achievements in the twentieth century. Studies confirm that water fluoridation can reduce caries in children's primary teeth by up to 60 percent and in their permanent teeth by up to 35 percent. Adults experience a 20 to 40 percent reduction in tooth decay from lifelong exposure to water fluoridation.

The City of Peterborough began fluoridation of municipal drinking water in 1973. As part of its health promotion, PCCHU is committed to the continuation and expansion of community water fluoridation. This is achieved by ongoing review and analysis of the highest quality studies and guidelines. Additionally, levels of fluoride in Peterborough's drinking water system are measured on a daily basis and reports are provided to the PCCHU's Medical Officer of Health and Oral Health department. This is to ensure that the levels of fluoride are within the recommended and safe range.

**Key Points:**

- PCCHU consistently provides more oral health services than required by the OPHS
- Approximately three-quarters of JK students are caries-free
- The Dental Consultant reviewed and approved treatment plans for 3,323 people between April 2012 and April 2013
- DTAF is the only local fund dedicated to providing funds for emergency dental treatment to people who have no form of dental insurance
- Nearly half of the services at the CDHC and MDHC were diagnostic and just over a quarter were restorative
- PCCHU supports and promotes CWF for the benefits of all residents in the City of Peterborough

## Section 2: Utilization of Oral Health Services & Oral Health Status

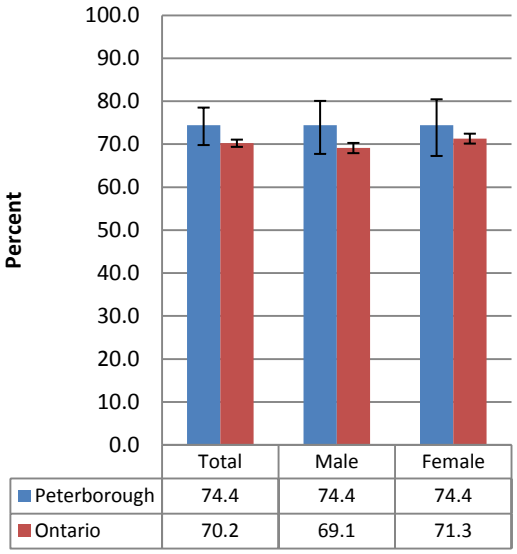
As oral diseases are largely preventable, appropriate access and regular utilization of dental services are crucial in achieving optimum oral health. Large-scale studies have shown that regular dental visits can result in fewer decayed teeth and better oral health. Better access to preventive dental care may also result in cost-savings in future dental treatments.

Those who do not make regular visits to a dental professional demonstrate poor oral health. For instance, while not causal, the results of the Canadian Health Measure Survey 2007-09 (CHMS) illustrate that those who did not visit a dental professional in the last year were almost two times more likely to report their oral health as fair or poor compared to those who made dental visits in the last 12 months. These people also had significantly higher numbers of untreated decayed teeth at all ages. Canadian adults who did not visit a dentist in the past year were more also likely to show worse gingival and periodontal measure scores, report more soft tissue oral lesions and have more treatment needs.

### 2.1 Utilization of Oral Health Services

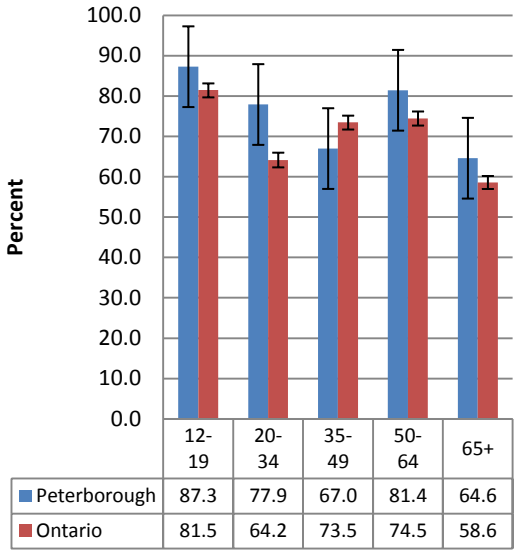
In 2009/10 three-quarters (74.4%) of Peterborough residents and 70.2% of Ontario residents had visited the dentist in the past 12 months; similar proportions of men and women had visited a dentist in the past 12 months (Figure 1). There were significant differences in the proportion of people who had visited a dentist in the past 12 months by age group: in Peterborough, 87.3% of youth aged 12 to 19 reported having seen a dentist in the past 12 months compared to only 64.6% of older adults aged 65 and older (Figure 2). Similarly, only 67.0% of adults aged 35 to 49 had reported visiting a dentist in the past 12 months.

In Ontario, a significantly greater proportion of youth aged 12 to 19 had seen a dentist in the past 12 months compared to any other age group at 81.5%; three-quarters of those aged 35 to 49 years of age and only 58.6% of older adults reported visiting a dentist in the past 12 months. A significantly greater proportion of young adults aged 20 to 34 in Peterborough reported visiting a dentist in the past 12 months compared to Ontario (77.9% and 64.2%, respectively).




| | Total | Male | Female |
|---|---|---|---|
| Peterborough | 74.4 | 74.4 | 74.4 |
| Ontario | 70.2 | 69.1 | 71.3 |

**Figure 1.** Proportion of Peterborough and Ontario residents who have visited the dentist in the past 12 months by gender; 2009/10




| | 12-19 | 20-34 | 35-49 | 50-64 | 65+ |
|---|---|---|---|---|---|
| Peterborough | 87.3 | 77.9 | 67.0 | 81.4 | 64.6 |
| Ontario | 81.5 | 64.2 | 73.5 | 74.5 | 58.6 |

**Figure 2.** Proportion of Peterborough and Ontario residents who have visited the dentist in the past 12 months by age group; 2009/10

Among Peterborough residents *who had not* visited a dentist in the past three years, the most common reasons cited were: cost; not thinking it was necessary; fear; not yet having gotten around to it; and, while more prominent among older age groups, wearing dentures (Table 3). The distribution of reasons was similar in Ontario, though not significantly statistically different. Despite this, it is important to note cost is indicated by two out of five (43.0%) Peterborough residents who have not visited a dentist in the past three years. A greater proportion of Ontario men reported not visiting the dentist because they did not think it necessary compared to women (40.9% and 28.4%, respectively).

**Table 3.** Reasons for not visiting the dentist in the past three years, Peterborough and Ontario; 2009/10

| Reason | Peterborough % (95%CI) | Ontario % (95%CI) |
|---|---|---|
| **Cost** | 43.0 (26.3-61.3) | 29.0 (26.8-31.2) |
| **Did not think it necessary** | 33.0 (18.1-52.2) | 34.8 (32.4-37.3) |
| **Fear** | ‡ | 5.5 (4.4-6.7) |
| **Had not gotten around to it** | ‡ | 9.6 (8.4-11.0) |
| **Wears dentures** | 26.8 (17.5-38.9) | 23.7 (22.1-25.5) |

‡ these data do not meet Statistics Canada's quality standards; conclusions based on these data will be unreliable and most likely invalid and are therefore not included

Being insured for dental care is an important factor that can influence whether or not an individual visits a dentist. In 2009/10, 64.8% of Peterborough residents and 63.6% of Ontarians reported having insurance for dental expenses with males and females reporting similar dental insurance coverage rates (Figure 3). There were significantly different levels of dental insurance coverage based on age, however, with older adults aged 65 and older reporting the lowest rates in Peterborough at 48.1% (Figure 4). However, dental insurance coverage was significantly lower among older adults in Ontario at 34.8%.

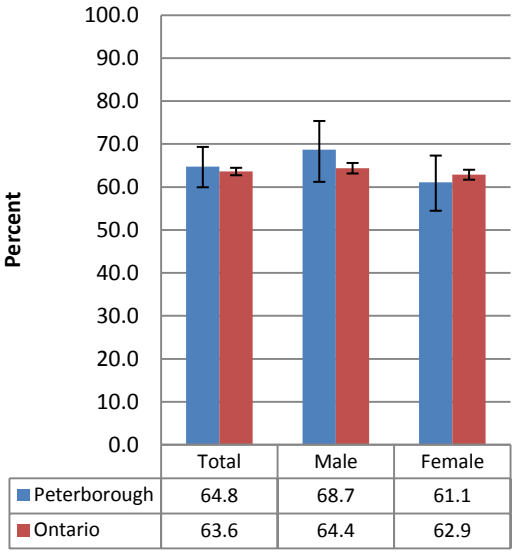



**Figure 3.** Proportion of Peterborough and Ontario residents who have dental insurance by gender; 2009/10

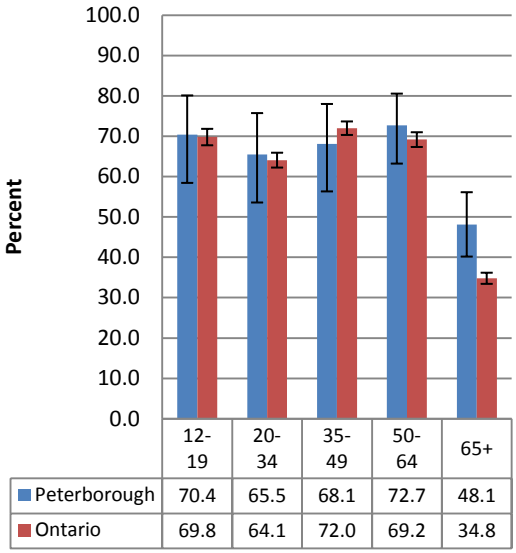



**Figure 4.** Proportion of Peterborough and Ontario residents who have dental insurance by age group; 2009/10

The majority of people who had insurance for dental care reported having an employee sponsored plan – 84.7% in Peterborough and 84.0% in Ontario – indicating employment as an important factor to having insurance for dental services (Table 5).

**Table 4.** Type of dental insurance plan, Peterborough and Ontario; 2009/10

| Type of Dental Insurance Plan | Peterborough % (95%CI) | Ontario % (95%CI) |
|---|---|---|
| Employee sponsored | 84.7 (79.8-88.7) | 84.0 (83.2-84.7) |
| Government sponsored | 8.7† (6.3-14.8) | 8.5 (8.0-9.1) |
| Private plan | 4.8† (3.1-7.5) | 6.5 (6.0-7.1) |

† estimates should be interpreted with caution due to large sampling variability

A number of sociodemographic indicators (SDI) such as income, education and geography can influence whether or not an individual has insurance for dental services. This is partly because they can affect, or are affected by, employment. In Peterborough, 70.6% of people with high income reported having dental insurance compared to 41.1% of those with lower incomes, a statistically significant difference (Figure 5). Similarly, a smaller proportion of people with lower education reported having insurance for dental services compared to those with higher education, though the difference was not significant (51.6% and 65.7%, respectively). There was little difference observed between urban and rural populations. Like Peterborough, significant differences were found between those in high and low income groups (72.8% and 38.3%, respectively) as well as a significant difference between high and low education groups (67.4% and 48.8%) in Ontario.

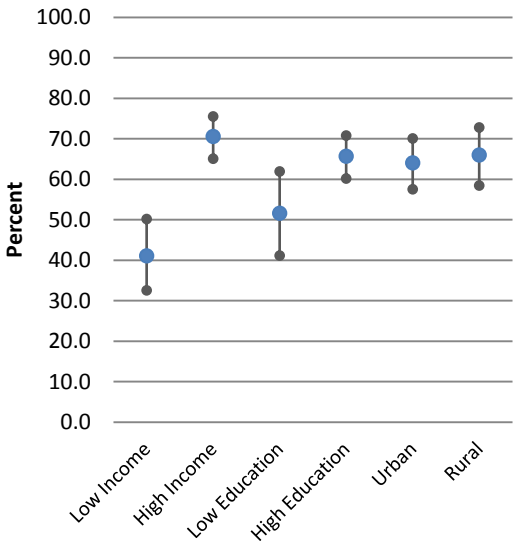



**Figure 5.** Proportion of Peterborough residents who have dental insurance by SDI; 2009/10

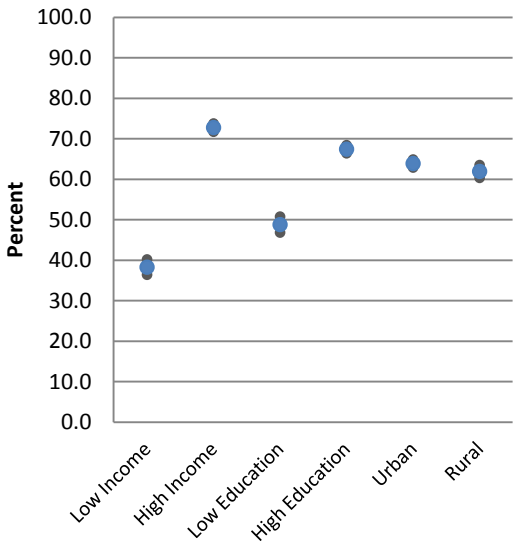



**Figure 6.** Proportion of Ontario residents who have dental insurance by SDI; 2009/10

Dental insurance and SDI can also play a role in accessing and affording dental care services. A smaller proportion of Peterborough residents in low income or with lower education report visiting a dentist in the past 12 months compared to those in high income and higher education, though the differences were not significant (Figure 7). The proportion of people who did not have insurance and report visiting a dentist in the past 12 months was significantly smaller than those who have insurance (63.5% and 82.2%, respectively). Differences among income, education and insured groups in Ontario are more apparent (Figure 8). Compared to Ontario, significantly larger proportions of Peterborough residents with low income, lower education, and those who were uninsured reported visiting a dentist in the past 12 months.

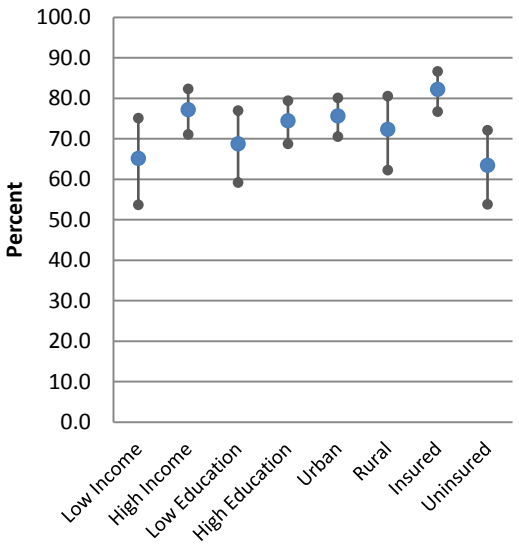



**Figure 7.** Proportion of Peterborough residents who have visited the dentist in the past 12 months by SDI and insurance coverage; 2009/10

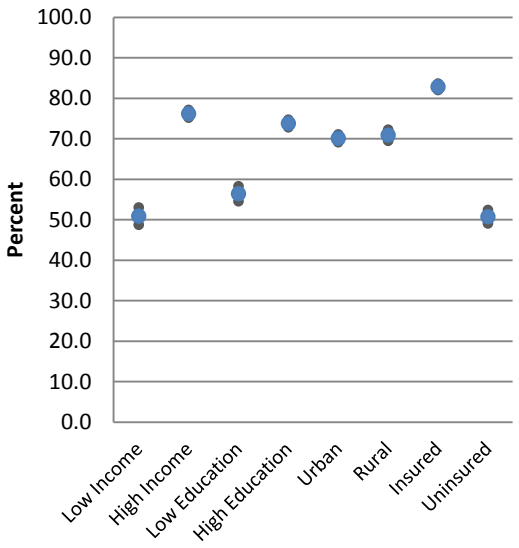
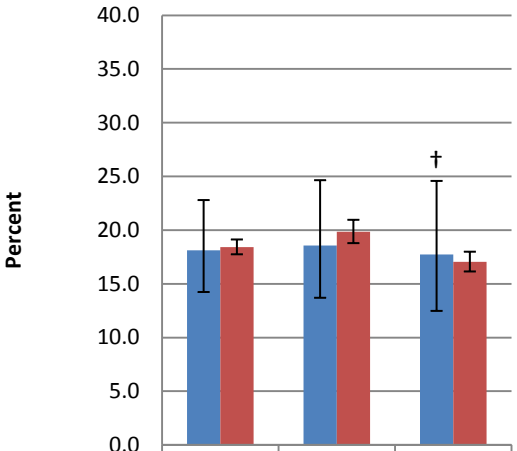


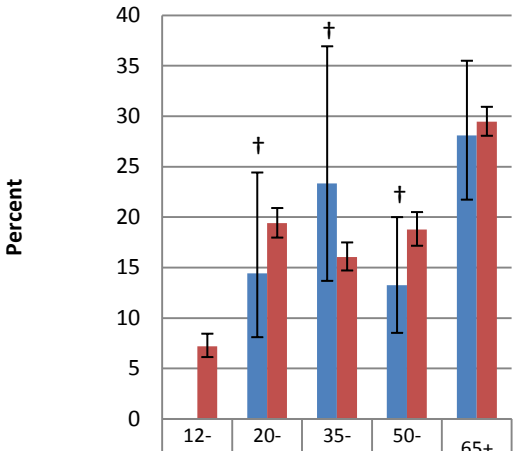

**Figure 8.** Proportion of Ontario residents who have visited the dentist in the past 12 months by SDI and insurance coverage; 2009/10

In 2009/10, nearly one in five Peterborough residents (18.1%) reported usually visiting a dentist only for emergency care, similar to the 18.4% in Ontario (Figure 9). There were no differences by gender in Peterborough; however, in Ontario a smaller proportion of women only visited the dentist only for emergency care compared to men (17.1% and 19.9%, respectively). The proportion of people visiting the dentist only for emergency care also varies by age group: over one quarter of older adults usually visit the dentist only for emergency care in Peterborough and Ontario (28.1% and 29.5%, respectively); in Ontario, this is significantly more than other age groups (Figure 10). By comparison, a significantly smaller proportion of youth in Ontario only visit the dentist for emergency care compare to other age groups. Among other age groups in Peterborough, the proportion of people who only visit the dentist for emergency care ranged from 13.2% for 50 to 64 year olds and 23.4% for those aged 35 to 49.




| | Total | Male | Female |
|---|---|---|---|
| Peterborough | 18.1 | 18.6 | 17.7 |
| Ontario | 18.4 | 19.9 | 17.1 |

**Figure 9.** Proportion of Peterborough and Ontario residents who usually only visit the dentist for emergencies by gender; 2009/10




| | 12-19 | 20-34 | 35-49 | 50-64 | 65+ |
|---|---|---|---|---|---|
| Peterborough | ‡ | 14.4 | 23.4 | 13.2 | 28.1 |
| Ontario | 7.2 | 19.4 | 16.1 | 18.8 | 29.5 |

**Figure 10.** Proportion of Peterborough and Ontario residents who usually only visit the dentist for emergencies by age group; 2009/10

† estimates should be interpreted with caution due to large sampling variability
‡ these data do not meet Statistics Canada's quality standards; conclusions based on these data will be unreliable and most likely invalid and are therefore not included

In Peterborough, smaller proportions of people with higher education and incomes reported only visiting a dentist for emergencies compared to those with low education and incomes (Figure 11). A significantly greater proportion of uninsured individuals report only visiting the dentist for emergency care compared to those who had insurance for dental coverage (34.4% and 10.9%, respectively). In Ontario, the differences between most SDI groups were statistically significantly different: 13.6% of people with higher incomes, 15.3% of those with high education and 9.6% of insured persons visit the dentist only for emergency care compared to 34.8% of those with low income, 32.7% of those with lower education and 36.8% of uninsured people (Figure 12).

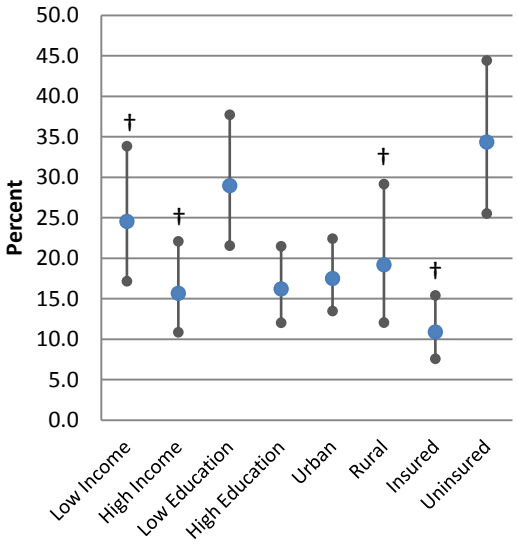



**Figure 11.** Proportion of Peterborough residents who usually only visit the dentist for emergencies by SDI and insurance coverage; 2009/10

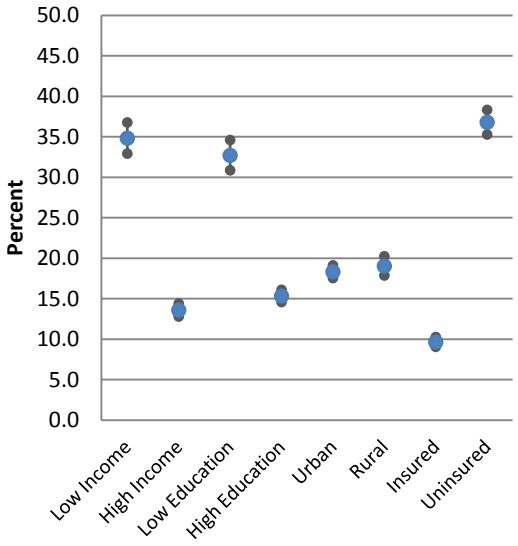



**Figure 12.** Proportion of Ontario residents who usually only visit the dentist for emergencies by SDI and insurance coverage; 2009/10

† estimates should be interpreted with caution due to large sampling variability

**Key Points:**

- In 2009/2010, three quarters of Peterborough residents visited the dentist in the past 12 months
  - A significantly greater proportion of Peterborough youth 12 to 19 visited a dentist in the past year compared to older adults aged 65 and older
- The most common reason for not visiting a dentist in the past three years was cost
- Two thirds of Peterborough residents have dental insurance
  - Less than half of older adults 65 years of age and older have dental insurance
  - Nearly nine in ten people report having their dental insurance through an employee sponsored plan
  - Seven out of ten people living in high income have dental insurance compared to four out of ten in low income
  - A greater proportion of people with dental insurance visited the dentist in the past 12 months compared to people without insurance
- Almost one in five Peterborough residents visit a dentist only for emergency care
  - A significantly great proportion of people who are uninsured visit a dentist only for emergency care compared to those who are insured

## 2.2 Oral Health Status

Some conditions of the mouth can provide an indication of poor oral health. For example toothaches may indicate dental caries while bleeding gums may suggest gum disease. When asked about the health of their teeth and mouth in the past month, just over half of Peterborough residents experienced oral/facial pain or discomfort, significantly more than 45.4% of Ontarians (Table 5). Some oral health issues were more prevalent, such as temperature sensitivity (31.0%) while others were not as common (i.e. pain in jaw joint [9.4%]).

In addition, in Peterborough, 14.0% of people had a tooth removed by a dentist in the past 12 months, with more than half (56.0%) reporting the tooth had been removed due to decay or gum disease. Similarly, 10.3% of Ontarians had a tooth removed by a dentist in the past 12 months with 44.8% reporting the teeth were removed due to decay or gum disease.

**Table 5.** Proportion of people reported oral or facial pain or other conditions in the past 12 months, Peterborough and Ontario; 2009/10

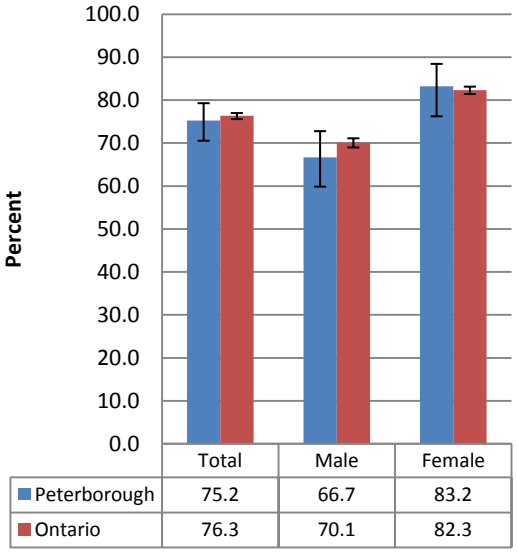
| | Peterborough % (95%CI) | Ontario % (95%CI) |
|---|---|---|
| **Oral/facial pain** | 51.9 (46.9-56.8) | 45.4 (44.6-46.2) |
| **Sensitivity to hot/cold** | 31.0 (27.1-35.2) | 27.3 (26.5-28.0) |
| **Bleeding gums** | 13.2 (10.0-17.3) | 11.3 (10.7-11.8) |
| **Bad breath** | 15.3 (11.7-19.7) | 11.4 (10.9-11.9) |
| **Dry mouth** | 11.4 (8.4-15.3) | 11.0 (10.5-11.5) |
| **Toothache** | 10.6 (7.7-14.3) | 10.1 (9.6-10.7) |
| **Pain in jaw joint** | 9.4 (6.4-13.5)† | 8.6 (8.1-9.1) |
| **Other pain of face/mouth** | 5.5 (3.6-8.3)† | 5.5 (5.1-5.9) |

† estimates should be interpreted with caution due to large sampling variability

In addition to the physical burden placed on an individual due to oral health issues, one's oral health status can also impact social functioning by avoiding conversation or contact with others, or by avoiding laughing or smiling. One in twenty (4.9%†) Peterborough residents experienced social limitation due to oral conditions compared to 3.4% in Ontario. Similarly, 4.9%† of Peterborough residents reported having a mouth condition which made speaking clearly difficult compared to 2.8% of Ontarians.
(† estimates should be interpreted with caution due to large sampling variability)

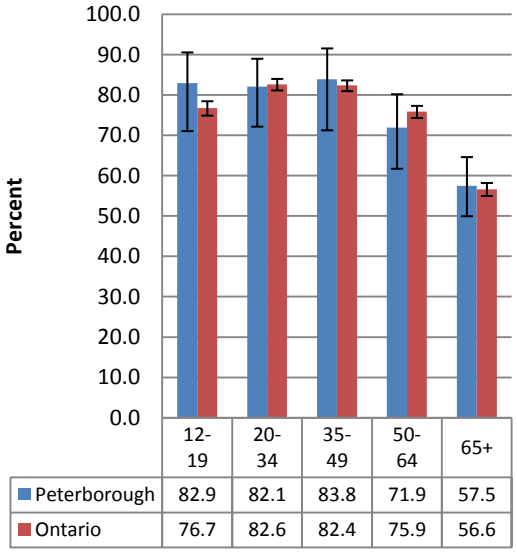
Brushing the teeth twice a day has been shown to protect against dental caries and gum disease. Three-quarters (75.2%) of Peterborough residents brushed their teeth twice or more per day in 2009/10 and a significantly greater proportion of females reporting brushing their teeth twice or more per day than males (83.2% and 66.7%, respectively; Figure 13). Similar patterns for tooth brushing were found in Ontario. Frequent tooth brushing is more common among youth and younger adults in Peterborough: over 80% of people under the age of 50 report brushing their teeth twice or more per day compared to

only 57.5% of older adults. One of the reasons older adults in Peterborough brush their teeth less frequently may be due to the fact that a smaller proportion report having one or more of their own teeth (76.1%) compared to the general population (92.7%) and over half report wearing dentures (51.2%).




| | Total | Male | Female |
|---|---|---|---|
| Peterborough | 75.2 | 66.7 | 83.2 |
| Ontario | 76.3 | 70.1 | 82.3 |

**Figure 13.** Proportion of Peterborough and Ontario residents who brush their teeth twice or more per day by gender; 2009/10



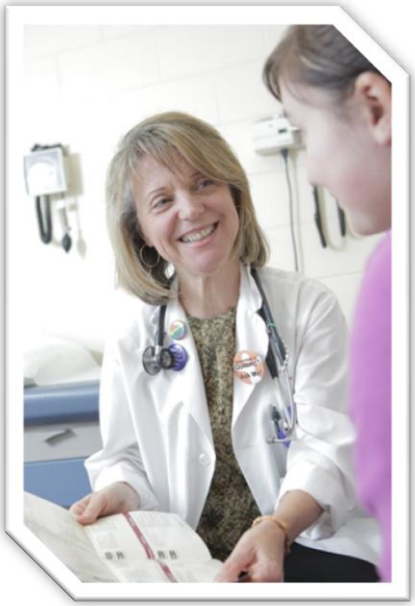

| | 12-19 | 20-34 | 35-49 | 50-64 | 65+ |
|---|---|---|---|---|---|
| Peterborough | 82.9 | 82.1 | 83.8 | 71.9 | 57.5 |
| Ontario | 76.7 | 82.6 | 82.4 | 75.9 | 56.6 |

**Figure 14.** Proportion of Peterborough and Ontario residents who brush their teeth twice or more per day by age group; 2009/10

**Key Points:**

- A greater proportion of people in Peterborough had oral or facial pain in the past 12 months compared to Ontarians
- One in six Peterborough residents have had a tooth removed by a dentist in the past 12 months and more than half of those due to decay or gum disease
- One in twenty residents experience social limitations due to oral health issues
- One quarter of people in Peterborough do not brush their teeth twice or more daily

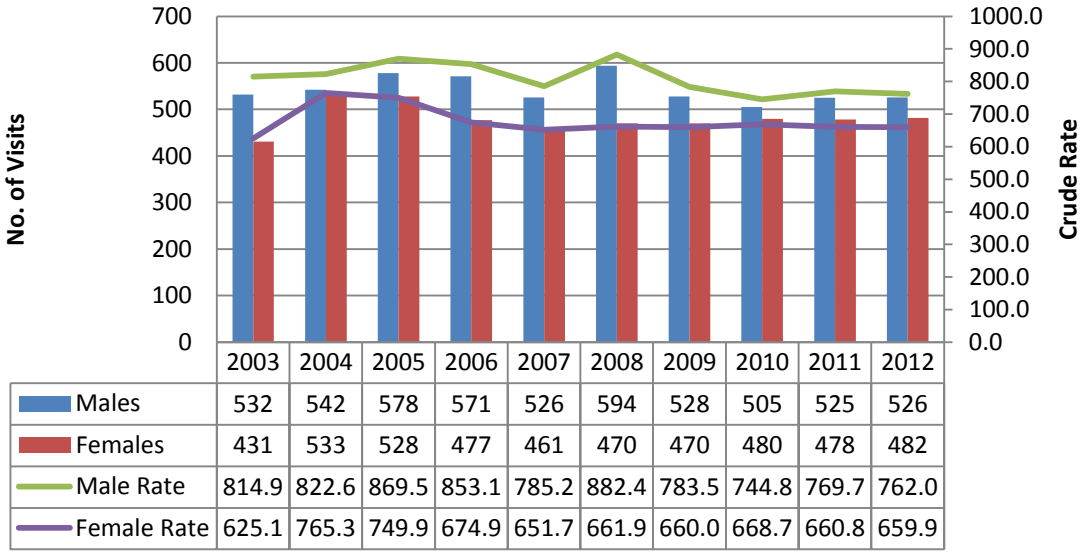
## Section 3. Impact of Oral Health on the Medical System



In the event of an oral health emergency, if access or costs are barriers to regular dental services, it is likely that people will visit the emergency department (ED). This section provides a summary of data available on ED visits due to diseases of the oral cavity, salivary glands and jaws (DOC) including caries, impacted teeth and periodontal disease.

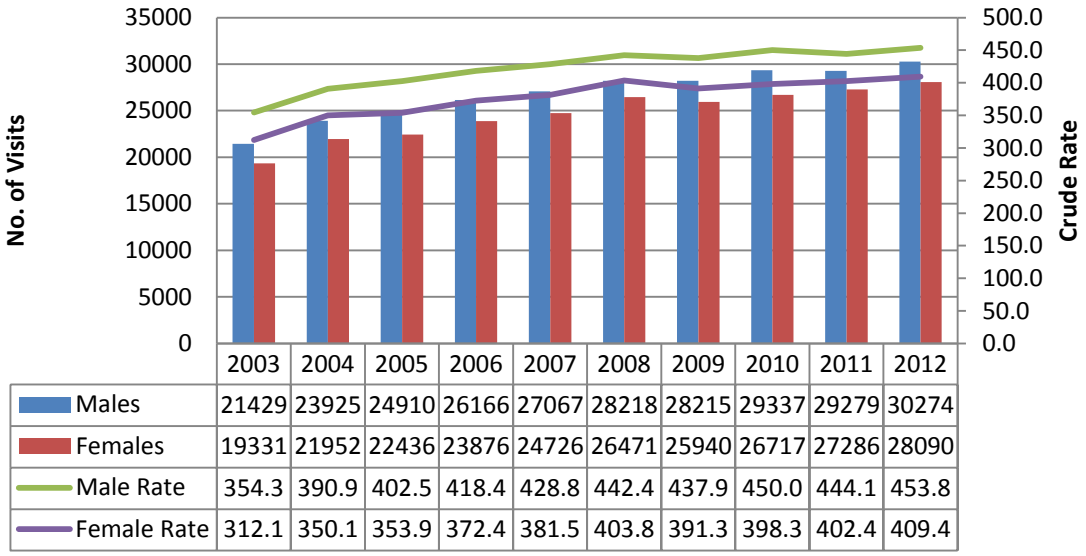
### 3.1 Emergency Department Visits

Between 2003 and 2012, there were 10,237 ED visits due to DOC among Peterborough residents with an average of 1,024 visits per year (543 among men and 481 among women). Males accounted for a slightly greater proportion of the visits during this time frame (5,427, or 53.0%) compared to women (4,810 or 47.0%). The number of ED visits due to DOC was generally stable between 2003 and 2012, ranging from a low of 963 visits in 2003 to a high of 1,064 visits in 2008 (Figure 15). Overall the crude rates among Peterborough males decreased between 2003 and 2012 while rates for women have remained relatively stable since 2006. By comparison, the numbers of ED visits due to DOC have increased steadily in Ontario as have the crude rates among men and women (Figure 16). Despite this, crude rates among Peterborough men are approximately 70% greater than the province, and among Peterborough women, crude rates are approximately 60% greater than Ontario.




| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|
| Males | 532 | 542 | 578 | 571 | 526 | 594 | 528 | 505 | 525 | 526 |
| Females | 431 | 533 | 528 | 477 | 461 | 470 | 470 | 480 | 478 | 482 |
| Male Rate | 814.9 | 822.6 | 869.5 | 853.1 | 785.2 | 882.4 | 783.5 | 744.8 | 769.7 | 762.0 |
| Female Rate | 625.1 | 765.3 | 749.9 | 674.9 | 651.7 | 661.9 | 660.0 | 668.7 | 660.8 | 659.9 |

**Figure 15.** Number and crude rate of DOC ED visits by sex, Peterborough; 2003-2012




| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|
| Males | 21429 | 23925 | 24910 | 26166 | 27067 | 28218 | 28215 | 29337 | 29279 | 30274 |
| Females | 19331 | 21952 | 22436 | 23876 | 24726 | 26471 | 25940 | 26717 | 27286 | 28090 |
| Male Rate | 354.3 | 390.9 | 402.5 | 418.4 | 428.8 | 442.4 | 437.9 | 450.0 | 444.1 | 453.8 |
| Female Rate | 312.1 | 350.1 | 353.9 | 372.4 | 381.5 | 403.8 | 391.3 | 398.3 | 402.4 | 409.4 |

**Figure 16.** Number and crude rate of DOC ED visits by sex, Ontario; 2003-2012

Young adults in Peterborough aged 20 to 29 accounted for the largest proportion (30.3%) of ED visits due to DOC during the 2003 to 2012 period followed by persons between the ages of 30 and 39 at 20.4% (Table 6). By comparison, in Ontario, those aged 20 to 29 and 30 to 39 accounted for 25.9% and 18.9% of visits, respectively. In Peterborough, children under the age of ten only accounted for 4.8% of visits compared to 8.2% in Ontario.

**Table 6.** Number and relative frequency of DOC ED visits by gender and age group, Peterborough and Ontario; 2003-2012

| Age Group | Peterborough n (%) | | | Ontario n (%) | | |
|---|---|---|---|---|---|---|
| | M | F | Total | M | F | Total |
| **0-9** | 279 (5.1) | 216 (4.5) | 495 (4.8) | 23,222 (8.6) | 18,921 (7.7) | 42,143 (8.2) |
| **10-19** | 357 (6.6) | 453 (9.4) | 810 (7.9) | 18,156 (6.8) | 22,022 (8.9) | 40,178 (7.8) |
| **20-29** | 1,718 (31.7) | 1,385 (28.8) | 3,103 (30.3) | 66,747 (24.8) | 61,753 (25.0) | 128,500 (24.9) |
| **30-39** | 1,160 (21.4) | 929 (19.3) | 2,089 (20.4) | 53,341 (19.8) | 44,324 (18.0) | 97,665 (18.9) |
| **40-49** | 936 (17.2) | 816 (17.0) | 1,752 (17.1) | 49,743 (18.5) | 49,945 (17.0) | 91,688 (17.8) |
| **50-59** | 522 (9.6) | 535 (11.1) | 1,057 (10.3) | 30,833 (11.5) | 28,671 (11.6) | 59,504 (11.5) |
| **60-69** | 272 (5.0) | 230 (4.8) | 502 (4.9) | 14,779 (5.5) | 14,736 (6.0) | 29,515 (5.7) |
| **70-79** | 123 (2.3) | 137 (2.9) | 260 (2.5) | 8,315 (3.1) | 8,905 (3.6) | 17,220 (3.3) |
| **80+** | 60 (1.1) | 109 (2.3) | 169 (1.7) | 3,684 (1.4) | 5,548 (2.2) | 9,232 (1.8) |
| **Total** | **5,427** | **4,810** | **10,237** | **268,820** | **246,825** | **515,645** |

Between 2003 and 2012, youth and young adults between the ages of 20 to 34 in Peterborough had the highest age-specific rates of ED visits due to DOC. Specifically, young adults aged 25 to 29 had the highest rate at 1,853.0 visits per 100,000 people during this time frame followed by those aged 30 to 34 at 1,759.8 visits per 100,000. Older adults 90 years of age and older had the lowest rate at 136.7 per 100,000 (Figure 17). A similar pattern of the distribution of ED visits also exists in Ontario with higher rates among young adults and smaller rates among older adults. However, age-specific rates in Peterborough were an average of 1.6 times greater than the province. The rate ratio (RR) was three times greater among 30 to 34 years old; rates among Peterborough youth and young adults aged 15 to 44 were on average 2.4 times greater than the province.

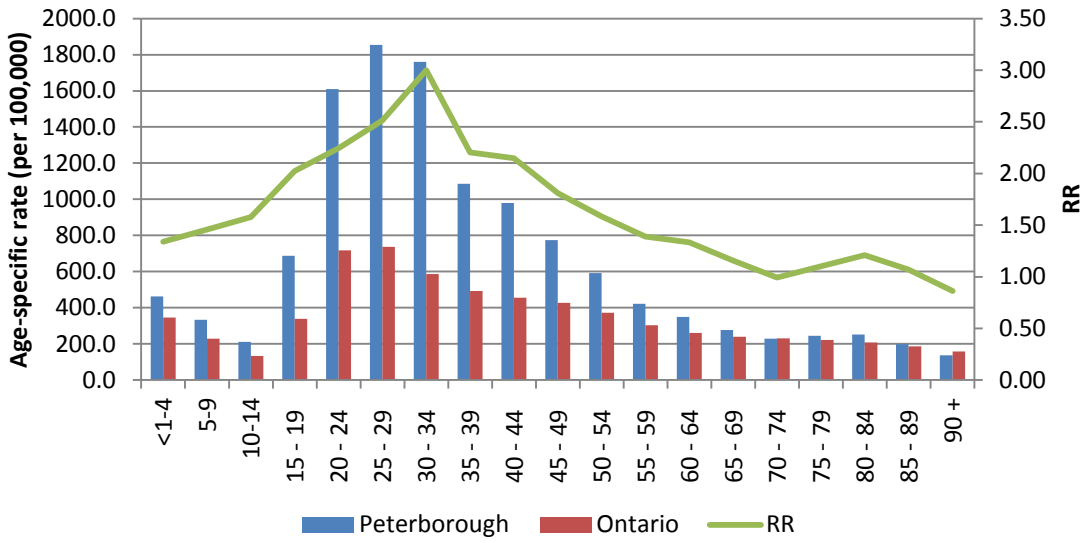



**Figure 17.** Age-specific rates of DOC ED visits by age group, Peterborough and Ontario; 2003-2012

Standardized rates of ED visits due to DOC have in general decreased since 2003 among Peterborough men, though were stable between 2009 and 2012 (Figure 18). Among Peterborough women, rates decreased between 2004 and 2007 and have since been stable. In Ontario, rates of ED visits due to DOC among men and women have increased steadily between 2003 and 2012 by approximately 35.8% and 30.6%, respectively. However, despite the increases provincially, rates of visits in Peterborough were nearly double that of the province in 2012: the rate among men in Peterborough was 1.9 times greater than Ontario; among women, rates were 1.8 times larger.

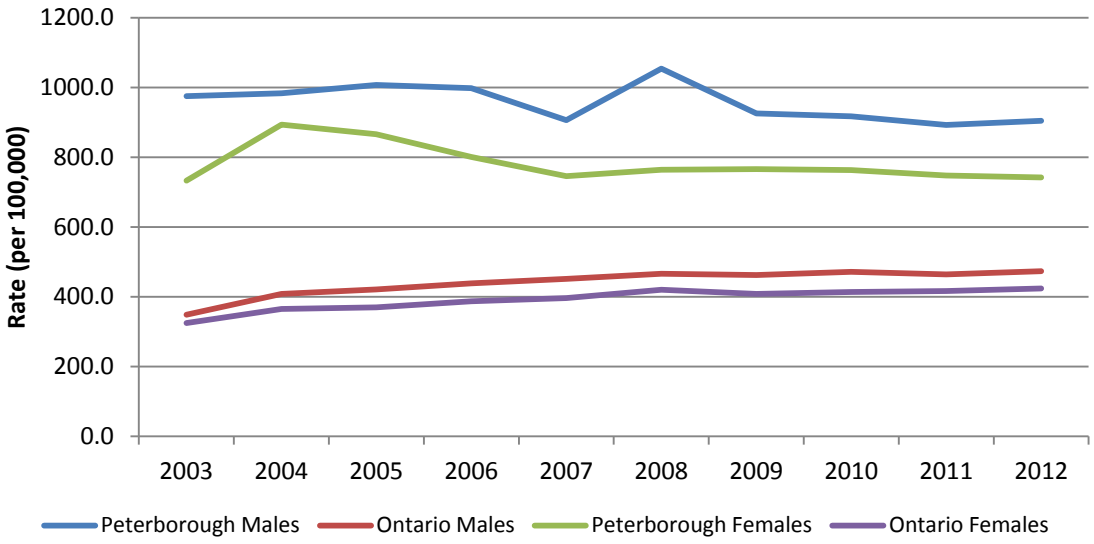



**Figure 18.** Standardized rates of ED visits due to Doc, Peterborough and Ontario; 2003-2012

Visits to the ED can be further sub-classified in order to better understand of the types of DOC diagnoses that are occurring. Diseases of the pulp and periapical tissues (K04) accounted for a third (34.4%) of ED visits in Peterborough between 2003 and 2012, similar to 33.9% in Ontario (Table 7). Visits of this type include localized infections at the tip of the root of a tooth. The next most common visit was "other disorders of teeth and supporting structures" (K08). The K08 code ("other disorders") includes toothaches and accounts for just over one quarter of the ED visits in Peterborough and Ontario (29.7% and 27.4%, respectively). Dental caries (K02) accounted for 6.3% of the visits; stomatitis, or inflammation of the mouth (K12) at 6.2%; and diseases of the salivary glands (K11) at 5.7%. The frequency at which different visit types occur in Peterborough is similar to Ontario.

**Table 7.** Five most frequent DOC ED visit types by ICD-10 code, Peterborough and Ontario; 2003-2012

| ICD-10 Code | Peterborough n (%) | | | Ontario n (%) | | |
|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total |
| K04 | 2,034 (37.5) | 1,485 (30.9) | 3,519 (34.4) | 96,294 (35.8) | 78,405 (31.8) | 174,699 (33.9) |
| K08 | 1,701 (31.3) | 1,338 (27.8) | 3,039 (29.7) | 76,412 (28.4) | 64,801 (26.3) | 141,213 (27.4) |
| K02 | 396 (7.3) | 245 (5.3) | 650 (6.3) | 16,487 (6.1) | 11,230 (4.5) | 27,717 (5.4) |
| K12 | 318 (5.9) | 317 (6.6) | 635 (6.2) | 17,803 (6.6) | 18,064 (7.3) | 35,867 (7.0) |
| K11 | 232 (4.3) | 351 (7.3) | 583 (5.7) | 11.449 (4.3) | 13,888 (5.6) | 25,337 (4.9) |

**Key Points:**

- On average, there are over 1,000 visits per year to the ED due to DOC among Peterborough residents
- Crude ED rates in Peterborough were over 65% greater than those in Ontario
- Young adults between the ages of 20 and 39 make up over half the ED visits due to DOC
- Age-specific rates varied dramatically by age group
    - Young adults aged 20 to 34 had the highest rates of ED visits
    - The ED rate among 30 to 34 year olds in Peterborough were three times larger than Ontario
- Standardized rates of ED visits in Peterborough were nearly twice as high as those in Ontario
- Diseases of pulp and periapical tissues (e.g.: abscesses) and other disorders of teeth and supporting structures (e.g.: toothache) were the most common ED visit types in Peterborough accounting for over half of visits

## 3.2 Oral Cancers

Oral cancer is any abnormal growth and spread of cells occurring in the mouth cavity including the lips, tongue, roof of the mouth, under the tongue, gums, and inside the lips and cheeks. Tobacco and alcohol are the two most important risk factors for oral cancer and the risk is even higher when these two factors are combined. Other risk factors for developing oral cancer include human papillomavirus (HPV), sun exposure to the lips, and a diet low in fresh fruits and vegetables. The incidence of oral cancer is highest after the age of 40.

Between 1986 and 2007 there were 395 new cases of oral cancer diagnosed among Peterborough residents, the majority of which (265, or 67.1%) occurred in males (Table 8). The incidence rate of oral cancers between 1986 and 2007 was significantly higher among Peterborough males (15.9 cases per 100,000) compared to females (6.4 per 100,000). A slight majority of males (51.1%) and females (56.5%) diagnosed with oral cancer in Peterborough between 1896 and 2007 were 65 years of age or older. Peterborough women between the ages of 45 to 64, 65 to 74, and those aged 75 and older had significantly lower rates of oral cancer than men in those age groups. Peterborough women aged 45 to 64 had significantly higher incidence rates than their provincial counterparts.

Compared to some other common cancers, deaths due to oral cancer are not frequent in Peterborough: there were 140 deaths due to oral cancer between 1986 and 2007 and only 12 deaths in 2007. Males also account for the majority (98, or 70.0%) of oral cancer deaths. Mortality rates of oral cancers between 1986 and 2007 were significantly higher among Peterborough males (5.8 deaths per 100,000) compared to females (2.0 per 100,000). Approximately two-thirds of oral cancer deaths in Peterborough males (64.2%) and females (61.0%) between 1986 and 2007 occurred among those aged 65 and older. Peterborough women ages 45 to 64, 65 to 74, and those 75 and older had significantly lower oral cancer mortality rates than men. Peterborough women aged 45 to 64 had significantly higher rates than their provincial counterparts.

**Table 8.** New cases, deaths, and incidence and mortality rates per 100,000 of oral cancer by gender, Peterborough; 1986-2007

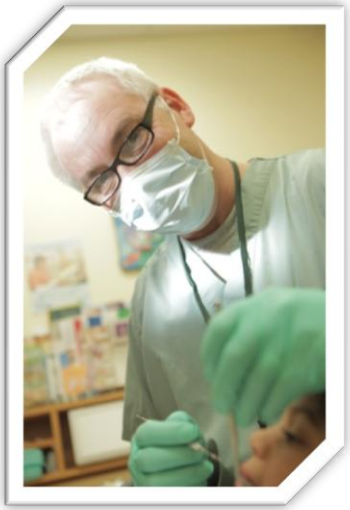
| Time Period | Males events (rate) | | Females events (rate) | |
|---|---|---|---|---|
| | New Cases | Deaths | New Cases | Deaths |
| **1986-2007** | 265 (15.9) | 98 (5.8) | 130 (6.4*) | 42 (2.0*) |

* significantly different

**Key Points:**

- Peterborough men have significantly higher incidence and mortality rates of oral cancer than women
- Peterborough women aged 45 to 64 had significantly higher rates of oral cancer incidence and mortality compared to Ontario women of the same age
- Deaths from oral cancer are rare in Peterborough

# Section 4: Discussion & Recommendations



## 4.1 Discussion

In general, Peterborough residents have excellent oral health behaviours; most have visited the dentist in the past 12 months and brush their teeth twice or more per day. However, half of residents report oral or facial pain in the past month, which may be indicative of oral health issues. The data also suggests areas of concern in terms of affording oral care: over half of the people who had not visited a dentist in the past three years cited cost as the main reason. Also, only two thirds of Peterborough residents over the age of 12 are insured for dental care which was shown to be a significant factor in visiting a dentist. Most dental care insurance was employee sponsored implicating employment as a contributing factor to receiving oral care. In addition, a smaller proportion of people with lower income had dental insurance: seven out of ten people living in high income have dental insurance compared to four out of ten in low income. Higher incomes are likely related to gainful employment, which is in turn related to dental care insurance resulting in improved access and affordability of dental care; however, no analyses of the available data were conducted to verify this statement.

In addition to the affordability of dental care and the disparity of accessing care between the insured and the uninsured, other priority groups are made evident in this report. A smaller proportion of older adults over the age of 65 had visited the dentist in the past year compared to other age groups. In addition, smaller proportions of older adults had dental insurance or brushed their teeth regularly compared to other age groups. Finally, over one quarter of older adults only visited a dentist for emergency care. The inability to pay for dental care is a major barrier for adults, especially adults with low incomes.

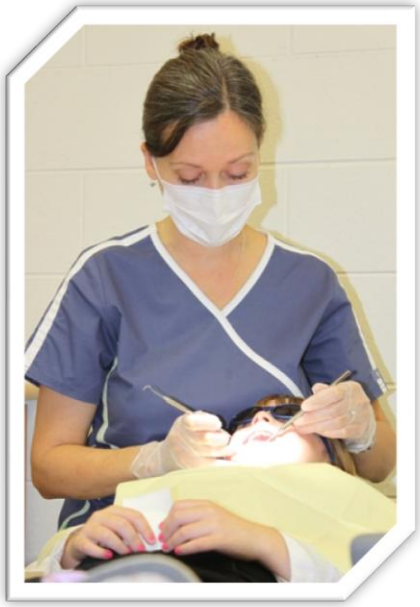
When people experience an oral health crisis or are unable to access or afford dental care they are likely to visit an ED for care. Based on the volume of visits to the ED due to diseases of the oral cavity, salivary glands, and jaws (an average of 1,000 per year) and the standardized rates of visits being nearly double those of the province , there is apparent need for improved access to timely, affordable dental care in this community. This is all the more evident among young adults between the ages of 20 and 39 who account for half of the ED visits and who age-specific rates of ED visits were as much as three times greater than Ontario. Approximately two-thirds of the ED visits between 2003 and 2012 were due to oral health issues that were likely preventable such as infections at the root of a tooth and toothaches. Improved access to affordable timely dental care and improved oral health behaviours may reduce the need for ED visits for diseases of the oral cavity.

## 4.2 Recommendations

Based on the data presented in this report, PCCHU has the following recommendations for action:

- Continue to promote and support policies and provision for residents of Peterborough City to have access to optimally fluoridated community drinking water, and advocate for provincial coordination and incentives to provide CWF.

- Maintain, and expand where possible, the current level of data collection concerning oral health including expanding use of the Ministry of Health and Long-term Care's Oral Health Information Support System (OHISS) to enable: analysis of trends and changes; business and program planning; dental health centre sustainability; engaging and working with new partners; and supporting provincial expansion of publically funded dental services.



- Continue to improve access to dental services for underserved populations by ensuring the sustainability and long-term viability of community dental health centre at its full capacity.

- Continue to remove barriers to accessing dental services by optimizing the utilization of the mobile dental health centre.

- Explore the feasibility of expanding the overall scope of services offered in the mobile and community dental health centre, including denture plans, by exploring opportunities available through other community partners.

- Work in partnership with community champions and advocates to maintain emergency dental funding for residents not able to afford dental care and expand eligibility criteria to current oral health programs and services.

- Develop health promotion activity to expand capacity building within community to improve oral health behaviours and knowledge.

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# Oral Health In Peterborough

## A Summary of the Oral Health of Peterborough Residents

Presentation to: PCCHU Board of Health
Presentation by:
Andrew Kurc, Epidemiologist
Date: December 11, 2013

# Importance of Oral Health

- Poor oral health is associated with some major systematic disease such as diabetes and heart disease

- Affects quality of life – pain; difficulty eating which can affect nutrition; difficulty sleeping; speech difficulties; poor self-esteem interfering social interactions; employment and school tasks

# What we know from Canadian Studies…

- 19,000 day surgery operations each year among Canadian children <6 to treat cavities
- 8.6x higher in neighbourhoods with high Aboriginal populations
- 3.9x higher for children from the least vs. most affluent neighbourhoods
- 3.1x higher in rural vs. urban neighbourhoods

# What we know about local access to Oral Health Services:

- In 2009/2010, three quarters of Peterborough residents visited the dentist in the past 12 months
- The most common reason for not visiting a dentist in the past three years was cost (43.0%)
- Two thirds of Peterborough residents have dental insurance
  - 9/10 of those are employee sponsored
  - 7/10 among those in high income vs. 4/10 those in low income
  - Larger proportion of people with insurance visited a dentist in past 12 months
- Roughly 1/5 visit a dentist *only* for emergency care

# PCCHU's role in local Oral Health:

PCCHU partners with local providers and stakeholders to advocate for better oral health.

PCCHU screens school children.

PCCHU administers and/or provides a range of services for eligible children, youth, and adults

- ~260 CINOT applicants
- ~280 HSO applicants
- ~900 children covered by OW
- ~1,900 adults OW discretionary benefits

# PCCHU Role: School Screenings

| | 2011-2012 | 2012-2013 |
|---|---|---|
| Children screened | 4,824 | 4,116 |
| % caries-free | 59 | 60 |
| % in need of urgent treatment | 8.1 | 7.3 |
| Avg. DMFT/deft | 1.5 | 1.4 |
| High-risk schools | 9.3 | 13.6 |

# PCCHU Role: Dental Health Centres

- 2,769 registered clients at the CDHC and MDHC, just over half of which (1,478 or 53.4%) were female and 898 (32.4%) were under the age of 18.
- Between April 2012 and March 2013, there were 2,518 completed appointments which consisted of 1,271 patient visits; ~41% diagnostic, 28% restorative, 17% surgical

# Oral Health Status

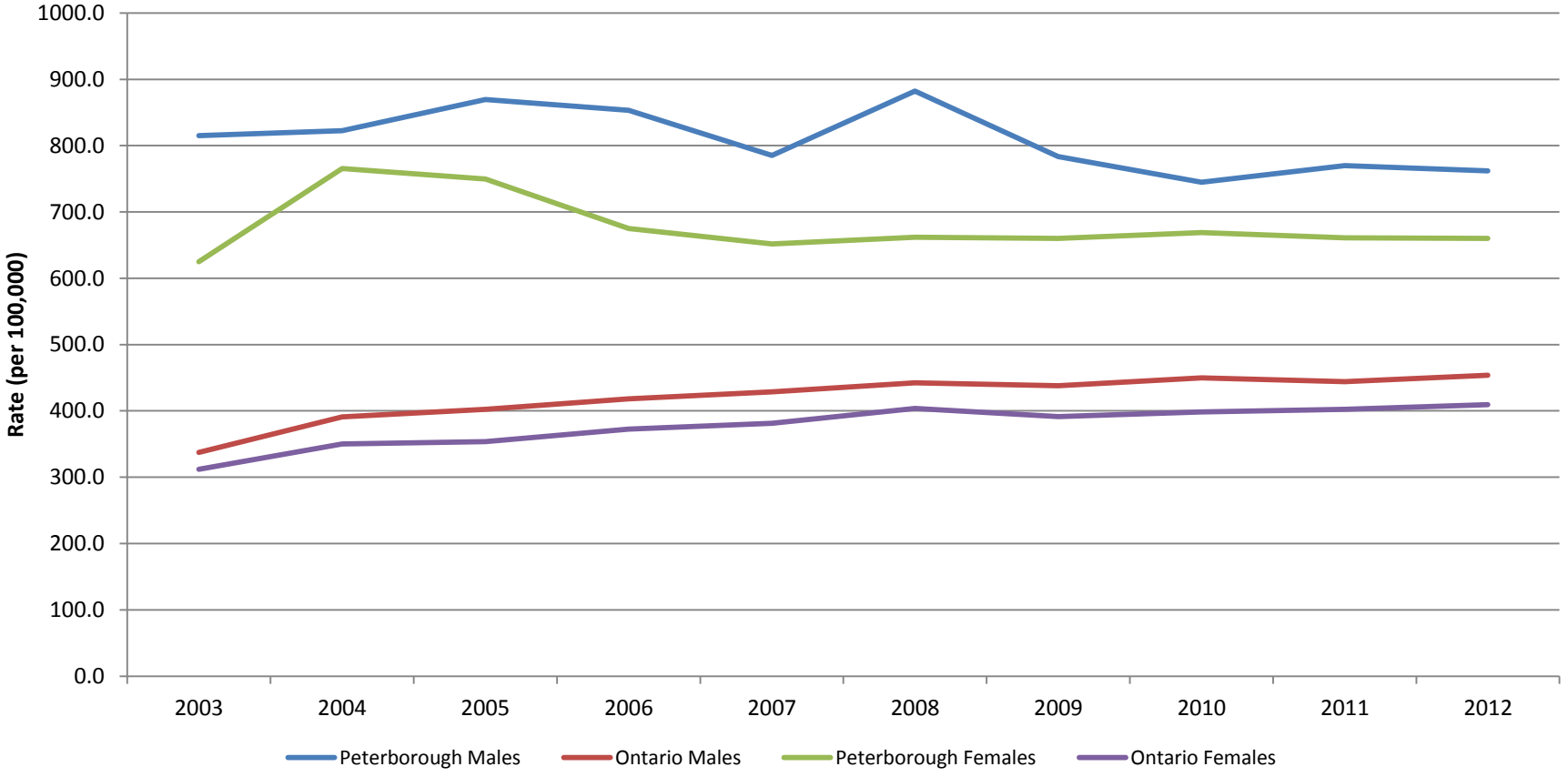
- A greater proportion of people in Peterborough had oral or facial pain in the past 12 months compared to Ontarians (~52% vs 45%)
- Approximately 1/6 have had tooth removed by dentist in past 12 months (>50% due to decay/gum disease)
- Approximately 5%* of people experience social limitations due to oral health issues
- Three quarters of Peterborough residents brush twice a day or more

# Oral Health Status

- Between 2003-2012 in Peterborough ~10,250 ED visits for diseases of the oral cavity, salivary glands and jaws
  - ~1,000 per year
  - Slightly more males
  - Young adults 20 – 39 account for over half of visits
  - Most common visit types: abscesses/localized infections (35%); toothache (30%)
  - Crude rates 60-70% greater than Ontario
  - Standardized rates 80-90% greater
  - Age-specific rates up to 3x greater

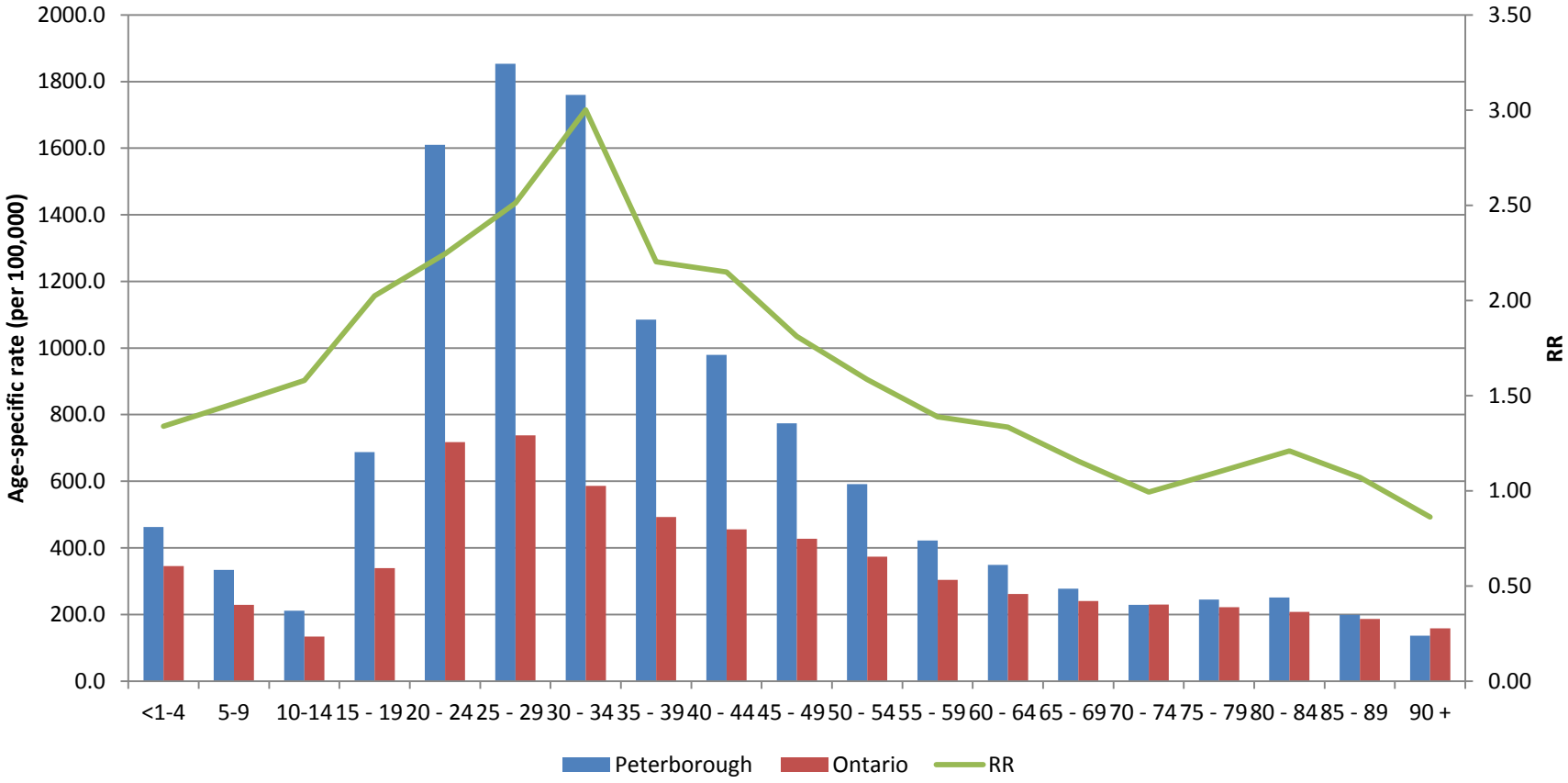
# Oral Health Status

## Standardized ED rates, Peterborough; 2003-2013



# Oral Health Status

## Age specific ED rates, Peterborough; 2003-2013



# Summary & Recommendations

- In general, Peterborough residents have good oral health & oral health behaviours, however:
  - priority populations identified: low income; those without dental insurance; older adults; young children; young adults
- Maintain / expand current level of data collection & reporting to enable: analysis of trends and changes; business and program planning; dental health centre sustainability;
- Engage and work with new partners; and
- Support provincial expansion of publically funded dental services
- Continue to advocate for provincial support of CWF

# Questions?

# Social Media Update

Presentation to: Board of Health

Presentation by: Brittany Cadence,
Supervisor, Communications Services

Date: December 11, 2013

# Our Goals Today

- How are Ontario's health units using social media and where does PCCHU fit in?
- Overview of PCCHU social media policies and procedures
- Next steps

# Social Media in Public Health

"Social media emphasizes relationships, co-creation of knowledge, and rapid response"


– Dr. Cameron Norman,
*Developing A Social Media Strategy*

# Why should PHUs use social media?

1. Improve loyalty, trust and confidence in your organization
2. Strengthening brand awareness, allowing Public Health to be a trusted voice
3. Capture public sentiment on health topics and correct misinformation
4. Increase interactions and build relationships with others, including the public and partners
5. Improve reach and accessibility; increase access to health information

# Why should PHUs use social media?

6. Support healthy behaviours  provide peer/social/emotional support
7. Tailor messages to specific audiences
8. Influence policy
9. Respond in an emergency
10. Surveillance
11. Raising awareness of the breadth of topics and activities public health is involved in
12. Amplify messages
13. Educate within each interaction

# Study Findings

- The increasing shift to communication, education and connection online within our communities has catalyzed a need identified by all PHUs in Ontario to be both a listener and a voice in this forum.
- Though challenges such as issues of control, access, capacity and technology exist, so too do the perceptions that social media enriches relationships with the community; increases the profile, trust and voice of the PHUs and its message

# Study Findings

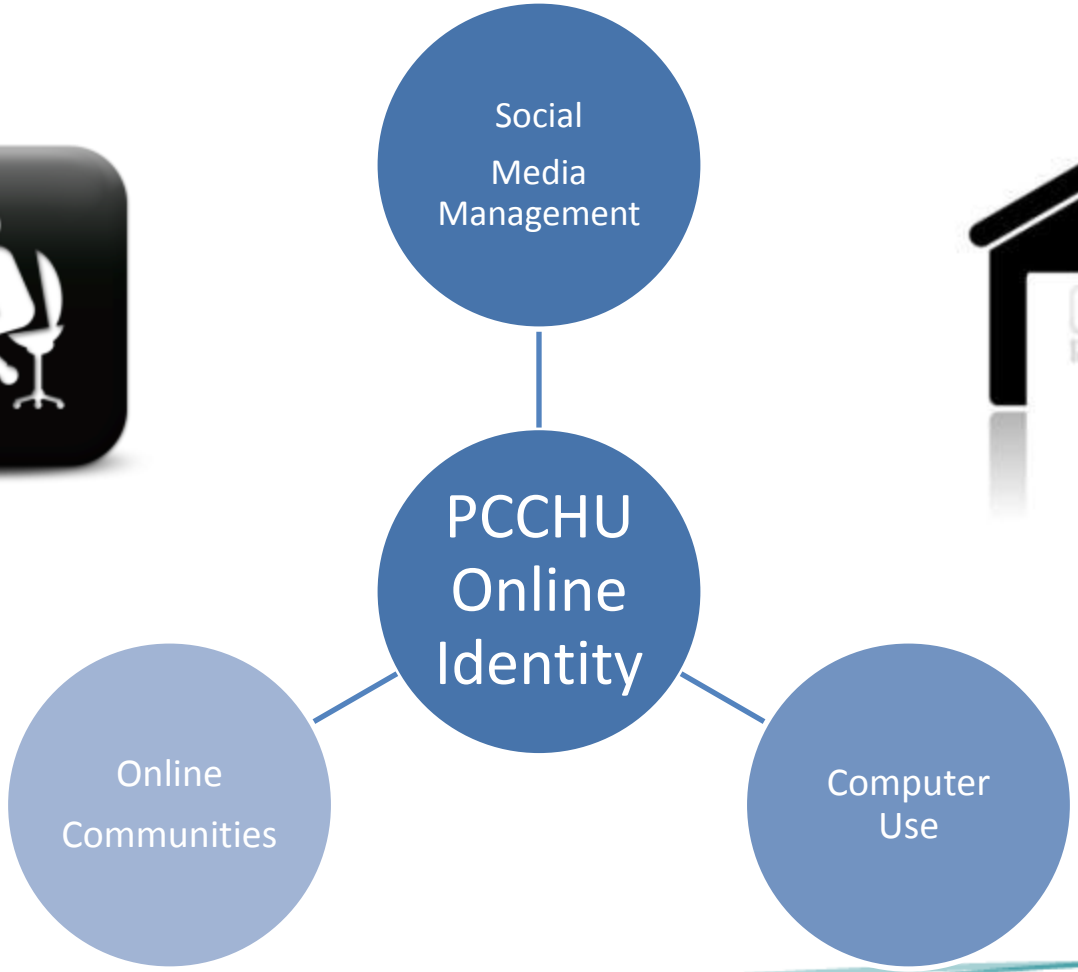
- What is primarily recommended by PHUs for successful integration of social media into public health are guidelines specific to the need and context of public health; training for staff and management; two-way communication on social media platforms; an evaluation framework; and sustaining enthusiasm.
- Social media toolkit under development for Ontario PHUs

# What are other PHUs doing?

- 34 of 36 PHUs using social media
- Half of PHUs have developed, are in the process of developing, or intend to develop policies and procedures
- Most PHUs have not formally approved their social media policy and are developing their strategies and guidelines.
- Early adopters used a “soft approach” to familiarize themselves first with social media and then develop P&Ps once

| Step | Indicators |
|---|---|
| **Step 1: Piloting** | Policies and standards are not fully developed. Social media being used to "listen" and push out content rather than creating conversation. Little or no evaluation is occurring. Social media is at the pilot stage.<br>• If you're at Step 1, consider using this entire toolkit from Planning to Evaluation. Go at your own pace. |
| **Step 2: Emerging** | Social media is being incorporated across the agency, complementing traditional communication strategies. Interaction is minimal, but content is created specifically for social media (not just repurposed from other channels). Evaluation is limited to basic metrics (likes, follows, retweets, etc.).<br>• If you're at Step 2, you might want to start in the Managing Social Media section. |
| **Step 3: Integrating** | Social media is routinely used to engage in multi-way conversations with stakeholders. Response times are short. Social media has increased trust with stakeholders and helps strengthen the overall agency brand. Evaluation incorporates qualitative and quantitative measures, and is ongoing.<br>• If you're at Step 3, you might want to jump ahead to Evaluation. |

# Policies & Procedures



# Policies & Procedures

1. **Social media management policy and procedure** governs the use of these tools for corporate communications
2. **Online communities policy and procedure** ensures staff maintain a positive image as a representative of our organization when participating in social media or other online communities.
3. **Computer use policy and procedure** defines appropriate and inappropriate use of PCCHU computers and personal cell phones during work hours

# Current Social Media Stats

As of November 26, 2013 (since inception July 2012):

- Twitter:
  - 723 followers
  - We are following 43 others
  - We've issued 518 tweets
- Facebook:
  - 68 likes

# Next Steps

- Staff training
- Developing social media guidelines
- Implementing the Social Media Toolkit
  - Engagement
  - Evaluation

# Questions?

***Thank you!***

# Staff Report

## 2014 Cost-Shared Budget Approval

| | |
|---|---|
| **Date:** | December 11, 2013 |
| **To:** | Board of Health |
| **From:** | Dr. Rosana Pellizzari, Medical Officer of Health |

| ***Original approved by*** | ***Original approved by*** |
|---|---|
| Rosana Pellizzari, M.D. | Brent Woodford, Director, Corporate Services |

**Recommendations**

That the Board of Health for the Peterborough County-City Health Unit approve the proposed 2014 cost-shared budget for public health programs and services in the total amount of $7,454,137.

**Financial Implications and Impact**

This budget includes all cost-shared budgets funded by the Ministry of Health and Long-Term Care (MOHLTC) as well as City, County and First Nations, but does not include other programs and services of the Health Unit funded 100% MOHLTC or by other Ministries of the Province. These will be provided to the Board as budget information becomes available.

The cost-shared budget in the amount of $7,454,137 represents an increase of $228,595 over the final provincial approved 2013 budget of $7,225,542. This is an overall 3.16% budget cost increase to the funding partners.

To maintain 2013 operations into 2014, the following increases and savings are projected:

| | |
|---|---|
| Known and anticipated contracted wages increases | $130,376 |
| Benefit increase due to additional salary and Health and dental | $52,839 |
| Allowance for inflation | $9,935 |
| Anticipated losses of clinic fees/OHIP fees and offset revenues | $80,930 |

Less: Savings from operations in travel and purchased services ($45,485)

In anticipation of purchasing a new premises, an occupancy and capital budget were also developed:

| | **2014 Budget** | **2013 Budget** | **Change** |
|---|---|---|---|
| Building Occupancy | $278,396 | $ - | $278,396 |
| Anticipated one-time costs | $564,609 | $ - | $564,609 |
| **Expenditures** | **$843,005** | | **$843,005** |

A separate recommendation for approval will be submitted to the Board for these costs upon successful completion of the Jackson Square building purchase.

**Decision History**

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

The 2014 budget is prepared on the basis of 75% funding grant from the MOHLTC, and 25% from the County of Peterborough, City of Peterborough, Curve Lake First Nation and Hiawatha First Nation. The County of Peterborough, City of Peterborough fund the Health Unit based on census population data. The Curve Lake First Nation and Hiawatha First Nation contribute based on funding agreements with the Board of Health.

The MOHLTC has not yet provided the Health Unit with budget guidelines for 2014.

We understand that the City has approved their share of the Board's 2014 budget.

The Board approved the 2013 cost-shared budget at its November 14, 2012 Board meeting.

**Background**

The Ministry has not provided guidance on what, if any budget increase will be provided.

Historical Ministry approvals have been:

| | Increase |
|---|---|
| Increase in 2010 over 2009 | 3.0% |
| Increase in 2011 over 2010 | 2.85% |
| Increase in 2012 over 2011 | 1.62% |
| Increase in 2013 over 2012 | 2.00% |

For the proposed budget the following assumptions have been made:

1) No additional wage freeze will be imposed (ONA and CUPE agreement increased October 1, 2013);
2) All union employees not at top rate will move up the pay grid;
3) No increase has been budgeted for OPSEU or management;
4) Pension rates will remain at levels provided;
5) There will be no Pay Equity adjustments;
6) Increased occupancy costs for King Street are calculated separately;
7) General inflation will be 1%;
8) There will be no significant change in HPV or Meningitis C funding rates;
9) There will be no increase in swine, bird flu activities;
10) There will be no significant changes to operating plans which will increase or decrease costs;
11) There is no allowance for but there is risk the CINOT expansion will go over budget and will need to be covered off from this budget;
12) Allocation of local contributions between the City and County are based on published 2011 population census data and First Nation contributions are an estimate of per capita cost based on population data provided by the First Nations
13) Local reserves will be used to offset the difference in First Nation provided population versus census data.

**Rationale**

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

**Strategic Direction**

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

**Contact:**

Brent Woodford
Director Corporate Services
(705) 743-1000, ext. 231
bwoodford@pcchu.ca

**Attachments:**

Attachment A – Draft 2014 Public Health Budget - Operations
Attachment B – Draft 2014 Public Health Budget - New Building and Move

PETERBOROUGH COUNTY CITY HEALTH UNIT — Draft December 11, 2013

DRAFT 2014 PUBLIC HEALTH BUDGET – Operations Only

| | | 2014 Budget | 2013 Budget | Change | % Increase |
|---|---|---|---|---|---|
| | EXPENDITURES | | | | |
| 1 | Salaries and wages | 5,186,171 | 5,055,795 | 130,376 | 2.58% |
| 2 | Employee benefits | 1,398,290 | 1,345,450 | 52,839 | 3.93% |
| 3 | % benefits of salary and wages | 26.962% | 26.612% | | |
| 4 | Staff Education | 5,000 | | 5,000 | |
| 4 | Staff Training | 30,890 | 35,535 | -4,645 | -13.07% |
| 5 | Board Training and Employee Recognition | 41,753 | 41,340 | 413 | 1.00% |
| 6 | Travel | 83,636 | 90,272 | -6,636 | -7.35% |
| 7 | Building Occupancy | 237,977 | 235,621 | 2,356 | 1.00% |
| 8 | Office Expenses, Printing, Postage | 33,148 | 32,820 | 328 | 1.00% |
| 9 | Materials, Supplies | 332,462 | 332,462 | 0 | 0.00% |
| 10 | Office Equipment | 7,388 | 7,315 | 73 | 1.00% |
| 11 | Professional and Purchased Services | 333,290 | 367,494 | -34,204 | -9.31% |
| 12 | Communication costs | 121,359 | 120,157 | 1,202 | 1.00% |
| 13 | Information and Information Technology Equipmer | 56,862 | 56,299 | 563 | 1.00% |
| | EXPENDITURES | 7,868,226 | 7,720,560 | 147,666 | 1.91% |
| | FEES & OTHER REVENUES | | | | |
| 14 | Expenditure Recoveries Flu, HPV, MenC | 37,300 | 37,300 | | |
| 15 | Expenditure Recoveries & Offset Revenues | 376,788 | 457,718 | -80,930 | -17.68% |
| | FEES & OTHER REVENUES | 414,088 | 495,018 | -80,930 | -16.35% |
| | NET EXPENDITURES - Cost Shared Budget | 7,454,137 | 7,225,542 | 228,595 | 3.16% |
| | PARTNER CONTRIBUTIONS – 2014 | | | | |
| 16 | Ministry of Health (Cost Shared Programs) | 5,590,603 | 5,419,157 | 171,446 | 3.16% |
| 17 | County of Peterborough | 757,659 | 734,657 | 23,002 | 3.13% |
| 18 | City of Peterborough | 1,086,469 | 1,053,484 | 32,985 | 3.13% |
| 19 | Curve Lake First Nation | 8,977 | 8,702 | 275 | 3.16% |
| 20 | Hiawatha First Nation | 2,900 | 2,811 | 89 | 3.15% |
| 21 | Local Reserves needed to match Provincial fundir | 7,529 | 6,731 | 798 | 11.86% |
| | FUNDING PARTNER CONTRIBUTIONS | 7,454,137 | 7,225,542 | 228,595 | 3.16% |
| | Balanced Budget | | 0 | | |

## Salary & Benefit Assumptions

1 No additional provincial freeze therefore have applied ONA & CUPE agreement increases October 1, 2013
2 OPSEU assumed no rate increase effective May 1, 2013
3 OMERS rate is known, YMPE is known
4 Non Union, ONA and CUPE assumed no rate increase in 2014
5 No allowance for salary adjustments such as Pay Equity

## Other Assumptions

Budget includes Cost-shared: Manadatory prgs, CINOT, cost shared SDW and Flu, HPV and Men C activities.
No additional increase in occupancy except for 185 King Street interest expense.
Allows for 1% inflation in 2014
Assumes province will continue funding 100% of enhanced MOH salary - currently there is no agreement.
Assumes no significant change to HPV or MenC immunization levels.
Budget does not allow for increased swine, bird or seal flu activities.
Budget does not consider any significant changes to operational plans which could increase or decrease costs.
Budget includes all Come Cook Program (Food Security).
Allocation of local contributions between City and County based on published 2011 population census data.
First Nation allocations are estimate of per-capita cost based on band provided population number.
Local Reserves needed per line 22 represents the cost of the difference in Band population versus census data.

PETERBOROUGH COUNTY CITY HEALTH UNIT Draft December 11, 2013

DRAFT 2014 PUBLIC HEALTH BUDGET – Related to Building and Move

| | | 2014 Budget | 2013 Budget | Change |
|---|---|---|---|---|
| | EXPENDITURES | | | |
| 1 | Building Occupancy | 278,396 | | 278,396 |
| 2 | Anticipated one-time Move\Capital costs | 564,609 | | 564,609 |
| | EXPENDITURES | 843,005 | | 843,005 |
| | PARTNER CONTRIBUTIONS – 2014 | | | |
| 3 | Ministry of Health (Cost Shared Programs) | 632,254 | | 632,254 |
| 4 | County of Peterborough | 85,712 | | 85,712 |
| 5 | City of Peterborough | 122,911 | | 122,911 |
| 6 | Curve Lake First Nation | 1,015 | | 1,015 |
| 7 | Hiawatha First Nation | 328 | | 328 |
| 8 | Local Reserves needed to match Provincial fundir | 785 | | 785 |
| | FUNDING PARTNER CONTRIBUTIONS | 843,005 | | 843,005 |

Balanced Budget

# Staff Report

## One-Time Funding Requests

| | |
|---|---|
| **Date:** | December 11, 2013 |
| **To:** | Board of Health |
| **From:** | Dr. Rosana Pellizzari, Medical Officer of Health |

| ***Original approved by*** | ***Original approved by*** |
|---|---|
| Rosana Pellizzari, M.D. | Brent Woodford, Director, Corporate Services |

**Recommendations**

That the Board of Health approve the following supplemental budgets for one-time funding as 2014 budget items:

| **COST SHARED** | | | |
|---|---|---|---|
| | **Provincial (75%)** | **Local (25%)** | **Total** |
| Facilities Renewal | $575,000 | $191,667 | $766,667 |
| Data Security Project | $41,250 | $13,750 | $55,000 |
| Server Virtualization Project | $98,625 | $ 32,875 | $131,500 |
| Office Equipment Replacement | 127,792 | $42,598 | $170,390 |
| **Total Cost Shared** | **$842,667** | **$280,890** | **$1,123,557** |
| **100% FUNDED** | | | |
| Vaccine Refrigerator | $5,500 | | |

That the Board of Health approve the following supplemental budgets for one-time funding as 2013 budget items:

| **COST SHARED** | | | |
|---|---|---|---|
| | **Provincial (75%)** | **Local (25%)** | **Total** |
| Server Room Emergency Repair | $68,250 | $22,750 | $91,000 |
| **100% FUNDED** | | | |
| Panorama | $59,042 | | |

**Financial Implications and Impact**

The province has approved all of the above items for expenditure in 2013. With the exception of the Vaccine Refrigerator proposal and Panorama, all proposals are funded 25% local, 75% provincial. The Board of Health is in the process of securing funds from our local partners for 2014 with regard to the purchase of the Jackson Square property. Part of the Jackson Square funding includes capital items. For all of the above items that we are asking the Board to approve in 2014, the expenditures are required to maintain the Board's infrastructure and are not contingent on the purchase of the property. It would, however, be advantageous to utilize the funds after there is a determination if the acquisition of the property will go through. By the time the status of the building sale is determined, it will be too late to procure the items before the 2013 year end and comply with the purchasing policy and procedure requirements of the Board.

The Server Room Emergency Repairs and Panorama expenditure have occurred in 2013. There should be enough local funds within approved cost shared operations in 2013 to cover off the $22,750 of local funding.

**Decision History**

On April 10, 2013, the Board of Health approved in principle one-time budget items for the Server Room Emergency Repair, Data Security Project, Server Virtualization Project and Office Equipment Replacement. The Board approved in principle these one-time budget items based on the following: "If the Province approves one or more proposals, the Board will need to consider the following options: accepting the funding and pulling the municipal share from reserves; accepting the funding and requesting additional financing from the municipalities; or rejecting the funding."

On March 12, 2013, the Board of Health was approved $575,000 one-time facility renewal funding from the province. This funding was to facilitate the construction of a parking garage for the Mobile Dental Clinic vehicle and to allow the Health Unit to pursue the purchase of office space. The funding is contingent on the Health Unit receiving local funding ($191,667 or 25%). This information has previously been brought to the Board "for information" as part of the quarterly financial reports. The City has approved $29,000 for their share of the garage. The County will be providing property to build the garage on, and the property is valued at at least $20,800.

**Background**

Due to timing differences caused by different fiscal year ends, it is difficult to align provincial, local and board approval for an uncertain transaction that spans more than one budget cycle.

We have asked the province to roll or re-approve these one-time items in 2014 and are in the process of asking for local approvals and the approval of the Board of Health for 2014.

**Rationale**

Approval of these budgets by the Province will enable the Board of Health to improve effective operation of computer servers, enhance data security, build a garage for the Mobile Dental Clinic vehicle, replace old furniture and either help facilitate the move to Jackson Square or allow the health unit to do necessary maintenance on Hospital Drive.

**Strategic Direction**

The funding requests in this report support the Board's strategic direction of *Capacity and Infrastructure*, and will allow the Board to:

- maintain the infrastructure and systems needed to improve access and enhance the level of service for the community; and
- pursue the resources necessary to acquire the most suitable facility based on established infrastructure needs.

**Contact:**

Brent Woodford
Director, Corporate Services
(705) 743-1000, ext. 231
bwoodford@pcchu.ca

# Staff Report

## Estimate of Reserves and Restrictions

| | |
|---|---|
| **Date:** | December 11, 2013 |
| **To:** | Board of Health |
| **From:** | Dr. Rosana Pellizzari, Medical Officer of Health |

| ***Original approved by*** | ***Original approved by*** |
|---|---|
| Rosana Pellizzari, M.D. | Brent Woodford, Director, Corporate Services |

**Recommendations**

That the Board of Health for the Peterborough County-City Health Unit receive this report for information.

**Financial Implications and Impact**

There are no financial implications to this report.

**Decision History**

This issue has not come before the Board to date.

**Background**

From time to time the Health Unit runs a surplus which can be retained. When there is a surplus, the Board is requested to approve retaining the surplus in reserves (if the Board agrees we will request municipalities for their approval to retain. Depending on where the surplus occurs, the reserves may be restricted (that is: only used in the program that generated the surplus) or unrestricted (can be used in any area approved by the Board).

Restricted reserves are used to offset future program deficits and unrestricted reserves can be used in lieu of a one-time contribution from the obligated municipalities. Thus, used strategically, the reserves can be used to access additional provincial funding without having to request additional funds or make unbudgeted in-year requests from the municipalities.

As of December 2, 2013 the estimate of reserves and restrictions are:

| | Estimate of Reserve | Unrestricted Reserve*** |
|---|---|---|
| Occupancy | $229,381 | $229,381 |
| Vaccine | $ 580 | |
| Vector Borne Diseases | $ 4,927 | |
| Infant Toddler Program | $ 15,504 | |
| Local Contingency | $ 99,092 | $ 59,092 |
| **Totals** | **$349,483** | **$288,473** |

*** Available for general operations and occupancy costs.

**Rationale**

With the Board considering a purchase of a new premises, the Board has a small unrestricted reserve that can be used for unanticipated costs.

**Strategic Direction**

This will allow the Board to address its strategic direction of *Capacity and Infrastructure*.

**Contact:**

Brent Woodford
Director Corporate Services
(705) 743-1000, ext. 231
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# Staff Report

## CINOT Deficits

| | |
|---|---|
| **Date:** | December 11, 2013 |
| **To:** | Board of Health |
| **From:** | Dr. Rosana Pellizzari, Medical Officer of Health |

| ***Original approved by*** | ***Original approved by*** |
|---|---|
| Rosana Pellizzari, M.D. | Brent Woodford, Director, Corporate Services |

**Recommendations**

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

- receive the staff report, CINOT Deficits, for information;
- request the assistance of the Association of Local Public Health Agencies (alPHa) in addressing the CINOT funding shortfall; and
- direct the Medical Officer of Health raise the issue with the Assistant Deputy Minister of the Health Promotion Division, Ministry of Health and Long-Term Care.

**Financial Implications and Impact**

The Health Unit incurred a $4,755 deficit last year due to underfunding of the CINOT Expansion Program and is projecting a deficit of $14,800 for the current year.

**Decision History**

This issue has not come to the Board before.

**Background**

Children in Need of Treatment Expansion Program (CINOT) was launched as a 100% provincially funded program in 2009 and changed to cost shared in 2010. Under the legislation we are not able to deny treatment to any eligible child.

The first year the Ministry did not know how much funding would be required, so it provided an arbitrary amount, in the PCCHU case this was $117,638.

The Ministry's assumption was that there would be a large initial in-rush of patients then demand would level off so in 2010 the program became cost shared and the approved budget was $21,852 but we spent $45,308, with the provincial share being $33,981. The province covered their share. In subsequent years the budget has been set as the previous year's actual cost plus 2% for inflation.

This has worked well for the larger health units and they are not having financial issues.

However for Peterborough, (and several other small health units) our allocation is so small that one child coming in requiring a general anesthetic or one unanticipated large family coming in for treatment is enough to push the Health Unit over budget.

In 2011 the budget was $36,750. We spent $30,711 (provincial share $23,033) so the province recovered their share of the surplus, in the amount of $13,717.

In 2012 the approved budget was $26,473 but the actual costs were $28,813. The province should have paid $21,610 but they only paid $19,855, leaving a $4,755 deficit. The municipalities paid their full share.

In 2013 the approved budget is $35,509. As of September 30 we have spent $37,772 and we are estimating we will spend $50,363. This means the Ministry share should be $37,772 but the Ministry has only approved $26,632 so we anticipate incurring a $11,140 deficit.

Staff have requested in-year one-time funding to avoid going into deficit but the Ministry will not approve the request.

Staff requested suggestions from the Ministry to avoid going into deficit. The Ministry suggested we review all files to ensure costs could not be allocated to Healthy Smiles Ontario (HSO), ensure all treatment is really necessary and, depending on the condition, we defer treatment to the next fiscal year.

The Health Unit's Dental Consultant, Dr. Laleh Sadeghi, has confirmed that costs have been allocated correctly and that all treatment was appropriate and necessary. She also advised that the Haliburton, Kawartha, Pine Ridge District Health Unit is facing a shortfall for similar reasons.

Deferring treatment as suggested does not make sense for several reasons:

- we would have had to start deferring treatment in early June; and

- deferring treatment to the start of the next fiscal year will result in a large waiting list so we would have to start deferring treatment even earlier the next year.

**Rationale**

The Health Unit cannot run a deficit, it is inappropriate to use cost-shared funding to subsidize a 100% provincial program and staff have had no success at the Ministry staff level.

**Strategic Direction**

This addresses the Board's strategic direction of *Determinants of Health and Health Equity.*

**Contact:**

Brent Woodford
Director Corporate Services
(705) 743-1000, ext. 231
bwoodford@pcchu.ca

**To:** All Members
Board of Health

**From:** Mr. David Watton on behalf of
Chief Phyllis Williams, Chair, Governance Committee

**Subject:** **Committee Report: Governance**

**Date:** December 11, 2013

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**Recommendation:**

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

- receive for information, meeting minutes of the Governance Committee for August 29, 2013 (approved by the Committee on December 3, 2013);

- approve the following document referred by the Committee at the December 3rd meeting:

  - 2-120 –By-Law Number 3, Calling of and Proceedings at Meetings (revised)

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Please refer to the attached.

**Board of Health for the**
**Peterborough County-City Health Unit**
**MINUTES**
**Governance Committee Meeting**
**Thursday, August 29, 2013 – 1:00 – 3:00 p.m.**
**(City and County Rooms, 150 O'Carroll Avenue, Peterborough)**

**Present:** Mr. Jim Embrey
Brittany Cadence, Communications Supervisor
Dr. Rosana Pellizzari, Medical Officer of Health
Mayor Mary Smith
Mrs. Alida Tanna, Administrative Assistant (Recorder)
Mr. David Watton
Chief Phyllis Williams, Chair
Mr. Brent Woodford, Director, Corporate Services

## 1. Call To Order

Chief Williams called the meeting to order at 1:05 p.m.

## 2. Confirmation of the Agenda

MOTION:
*That the agenda be approved as circulated.*
Moved by: Mr. Embrey
Seconded by: Mr. Watton
Motion carried. (M-13-22-GV)

## 3. Declaration of Pecuniary Interest

None.

## 4. Delegations and Presentations

None.

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

5.1 May 30, 2013

MOTION:
*That the minutes of May 30, 2013 be approved as written, and brought forward to the next Board of Health meeting.*
Moved by: Mr. Watton
Seconded by: Mr. Embrey
Motion carried. (M-13-23-GV)

## 6. Business Arising from the Minutes

Dr. Pellizzari advised that M.P.P. Leal visited the Health Unit earlier in the week on another matter. At that meeting, she provided him with a copy of the letter sent to his office in March regarding the recommended applicants for the Provincial Appointee position. Alida Tanna has also sent an e-mail inquiry to the Public Appointments Unit at the Ministry of Health and Long-Term Care to follow up on the status of the appointment process.

## 7. Correspondence

None.

## 8. New Business

### 8.1 2013-17 Strategic Plan – Implementation Plan

*Reference Document: 2013-17 Strategic Plan*

Dr. Pellizzari reviewed the implementation plan for the Board of Health's new Strategic Plan which will run over the course of the next five years.

The following items were discussed in relation to that report:

- *Fundraising* – Potential options/ideas for fundraising could be to fund the new building, additional services and programs, or create a bursary for professional development for staff. Members discussed options on how to proceed with this work, which would likely start in 2014. Mayor Smith noted that Andrea Dicks, Executive Director for the Greater Peterborough Community Foundation, would be a useful resource in determining how to proceed with this. **ACTION: Mayor Smith will schedule an initial information gathering meeting with Ms. Dicks and Mr. Watton.**
- *Dissemination of the Strategic Plan* – Dr. Pellizzari advised that a presentation would be created for staff, and that Managers have been directed to have discussions with their teams, preferably with a member of the Strategic Planning Working Group in attendance. Future staff reports to the Board will also link to the relevant strategic direction, and in addition, operational planning for 2014

will also begin to incorporate the new plan. Committee Members determined that semi-annual reporting to the Board would be sufficient. **ACTION: Dr. Pellizzari will discuss this with the Executive Committee for 2014. An update will be provided to the Board at the next Board of Health meeting.**

- ***Sponsorship –*** Committee members discussed the ongoing issue of the Health Unit's exclusion from applying for Trillium funding. **ACTION: Mr. Woodford will confirm the reason for this exclusion and update the Committee at a future meeting.** It was also noted that the Health Unit should approach the Community Futures Development Corporation.

MOTION:
*That the 2013-17 Strategic Plan – Implementation Plan be received for information.*
Moved by: Mayor Smith
Seconded by: Mr. Watton
Motion carried. (M-13-24-GV)

8.2 BOH Policies and Procedures for Review

a. 2-240, Honourariums and Allowances (Policy)

**ACTION: Staff were directed to combine this Policy with By-Law 6, Remuneration of Members, and bring this forward to the next Committee meeting for consideration.**

b. 2-261, Appointments, Provincial Representatives (Procedure)

**DECISION: Changes approved. ACTION: This item will be brought forward to the next Board meeting**

c. 2-190, Sponsorship (Policy)

No changes.

d. 2-191, Sponsorship, EthicScan (Procedure)

**ACTION: Mrs. Tanna will confirm the fee schedule for the EthicScan report order. If this has changed, this will be updated as a housekeeping revision.**

MOTION:
*That Procedure 2-261, Appointments, Provincial Representatives, be brought forward to the next Board of Health meeting for approval.*
Moved by: Mr. Embrey
Seconded by: Mayor Smith
Motion carried. (M-13-25-GV)

8.3 Health Unit Branding

*Brittany Cadence joined the meeting for this item.*

Dr. Pellizzari and Mrs. Cadence presented information on the rebranding of the Health Unit. Should the Health Unit change its name (e.g., Peterborough Public Health), this would not require a legal change of name, so any legal documents, contracts, etc., would still remain status quo. Financial implications would be staff time to implement this, or costs associated with a consultant should the Board wish to utilize the services of a consultant for this process. A number of Health Units have recently rebranded, and rebranding is currently being considered at the provincial level as well.

Mayor Smith suggested that staff should speak with Tania Goncalves, Deputy Clerk Township of Selwyn, since she recently led the Township through its renaming and rebranding process. **ACTION: Staff were directed to prepare a report for the Board once additional information become available, including a potential schedule and costing.**

## 9. In Camera to Discuss Confidential Personal Matters

MOTION:
*That the Committee go In Camera to discuss confidential personal matters.*
Moved by: Mr. Watton
Seconded by: Mr. Embrey
Motion carried. (M-13-26-GV)

MOTION:
*That the Committee rise from In Camera.*
Moved by: Mr. Embrey
Seconded by: Mayor Smith
Motion carried. (M-13-27-GV)

## 10. Date, Time and Place of Next Meeting

The next meeting will be scheduled in November 2013, or at the call of the Chair.

## 11. Adjournment

MOTION:
*That the meeting be adjourned.*
Moved by: Mayor Smith
Seconded by: Mr. Embrey
Motion carried. (M-13-28-GV)

The meeting adjourned at 3:00 p.m.

Chair

Recorder

Board of Health
**POLICY**

| | | |
|---|---|---|
| **Section: Board of Health** | **Number: 2-120** | **Title: By-Law Number 3, Calling of and Proceedings at Meetings** |
| **Approved by:** Board of Health<br><br>**Signature:**<br><br>**Date** (YYYY-MM-DD)**:** 2013-04-10<br><br>**Housekeeping Revision**<br>**Approved by:**<br>**On** (YYYY-MM-DD)**:** | | **Original Approved by Board of Health**<br>**On** (YYYY-MM-DD)**: 1989-10-11**<br><br>**Revision**<br>**Approved by:** Board of Health<br>**On** (YYYY-MM-DD)**:** 2013-04-10<br>**Reviewed by:** Governance Committee<br>**On** (YYYY-MM-DD)**:** 2013-03-13 |
| Reference: | | |

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

# By-Law Number 3
# Calling of and Proceedings at Meetings

## Section 1 - Interpretation

In this By-law:

1.1. "Act" means the Health Protection and Promotion Act;

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

1.3. "Director, Corporate Services" means the business administrator of the Board as defined in the Regulations under the Act;

1.4. "Chairperson" means the presiding officer at a meeting;

1.5. "Chairperson of the Board" means the Chairperson elected under the Act;

1.6. "Committee" means an assembly of two or more members that must meet together to transact business;

1.7. "Councils" means the municipal ~~c~~Councils of the Corporations of the County of Peterborough and the City of Peterborough, and the ~~Band~~ Councils of Curve Lake and Hiawatha First Nations;

1.8. "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the Act and Regulations;

1.9. “Meeting" means an official gathering of members of the Board or a committee in one place to transact business;

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

1.11. "Motion" means a formal proposal by a member in a meeting that the Board or a committee take certain action;

1.12. "Resolution" means a motion that is carried at a meeting by a majority vote in the affirmative of the members present; and

1.13. "Vice-Chairperson of the Board" means the Vice-Chairperson elected under the Act.

## Section 2 – General

2.1. The rules in this By-law shall be observed in the calling of and the proceedings at all meetings of the Board and committees.

2.2. Except as herein provided, the most recent edition of Robert's Rules of Order shall be followed for governing the calling of and proceedings of meetings of the Board and committees.

2.3. No persons shall consume alcohol or tobacco products at a meeting.

2.4. In exceptional circumstances, and with the approval of the Chairperson of the Board or committee, members of the Board of Health can attend meetings by teleconference.

## Section 3 - Convening of Meetings

3.1 The Medical Officer of Health shall call the first meeting of each calendar year.

3.2 The first meeting shall be held after the municipal members, appointed to the Board by their respective councils, are confirmed, and shall be held no later than the 1st day of February.

3.3 At the first meeting of each calendar year, the Board shall:

3.3.1 elect the Chairperson and the Vice-Chairperson of the Board for the year;

3.3.2 appoint members to its committees;

3.3.3 fix, by resolution, the date and time of regular meetings; and,

3.3.4 establish the honourarium paid to each member eligible for compensation in accordance with the Health Protection and Promotion Act.

3.4 ~~The Board may alter, by resolution, the day, time or place of any regular meeting.~~

A meeting may be rescheduled or cancelled due to the following circumstances:

3.4.1 in the event that an emergency has been declared by the Medical Officer of Health;

3.4.2 if there is indication from members in advance of the meeting that quorum will not be achievable; or

3.4.3 if upon consultation with the Medical Officer of Health, the Chairperson determines there is insufficient business to be considered.

In all instances, the Chairperson will poll members to obtain consensus to proceed with a cancellation. If approval is obtained through a majority vote, members will be notified and a public notice will be issued.

3.5 The Chairperson of the Board can call a special meeting and shall call a special meeting at the written request of a majority of the members.

3.6 The Medical Officer of Health shall:

3.6.1 give notice of the first and each regular and special meeting;

3.6.2 ensure that the notice accompany the agenda and any other matter, so far as known, to be brought before such meeting;

3.6.3 cause the notice to be delivered to the residence or place of business of each member or by e-mail or telephone so as to be received not later than two clear days in advance of the meeting.

3.7 The lack of receipt of the notice shall not affect the validity of the holding of the meeting or any action taken thereat.

3.8 No business other than that stated in the notice of a special meeting shall be considered at such meeting except with the unanimous consent of the members present.

3.9 Special meetings can be held by teleconference.

## Section 4 - Agenda and Order of Business

4.1 The Medical Officer of Health shall have prepared for the use of each member at the first and regular meetings an agenda of the following items.

4.1.1 Call To Order

4.1.2 Confirmation of the Agenda

4.1.3 Declaration of Pecuniary Interest

4.1.4 Delegations and Presentations

4.1.5 Confirmation of the Minutes of the Previous Meeting

4.1.6 Business Arising from the Minutes

4.1.7 Correspondence

4.1.8 New Business

4.1.9 In Camera to Discuss Confidential Matters

4.1.10 Date, Time and Place of the Next Meeting

4.1.11 Adjournment

4.2 Any items not included on the prepared agenda may be added by resolution.

4.3 Agenda packages will be posted on the Health Unit's website on the same day that agendas are distributed to Board of Health members.

4.4 On the day following Board of Health meetings, Board members will be contacted and advised of the date, time, and location of the next meeting, and asked about their availability for the next meeting.

4.5 The business of each regular meeting shall be taken up in the order described in section 4.1 of this By-law unless otherwise decided by the members.

4.6 The Chairperson of the Board shall direct the preparation of an agenda for a special meeting.

4.7 The business of each special meeting shall be taken up in the order as listed on the agenda of such meeting unless otherwise decided by the members.

## Section 5 - Commencement of Meetings

5.1 As soon as there is a quorum after the time fixed for the meeting, the Chairperson or Vice-Chairperson of the Board or the person appointed to act in their place and stead, shall take the chair and call the members to order.

5.2 A quorum for any meeting of the Board or a committee shall be a majority of the appointed members.

5.3 If the Chairperson or Vice-Chairperson of the Board or the Chairperson of a committee does not attend a meeting by the time a quorum is present, the Medical Officer of Health shall call the members to order and a presiding officer shall be appointed to preside during the meeting or until the arrival of the person who ought to preside.

5.4 Upon any members directing the attention of the Chairperson to the fact that a quorum is not present, the Medical Officer of Health, at the request of the Chairperson, shall record the names

of those members present and advise the chairperson if a quorum is or is not present. If there is no quorum within thirty minutes after the time fixed for the meeting, the Chairperson shall then adjourn until the day and time fixed for the next meeting.

## Section 6 - Delegations and Debate

6.1 The Chairperson shall preside over the conduct of the meeting, including preserving good order and decorum, ruling on points of order and deciding all questions relating to the orderly proceedings of the meeting.

6.2 Any individual or group who wishes to make a presentation to the Board shall make a written request to the Chairperson of the Board up to a minimum of twenty-four hours before the start of the meeting.

6.3 The Chairperson of the Board (in consultation with the Medical Officer of Health) shall decide whether the delegation may make a presentation at a meeting and accordingly, shall inform the individual or group whether their request has been approved or denied.

6.4 The Chairperson shall give due consideration to the length of the agenda and the number of delegation requests received, and may limit the number of delegations to a maximum of five (5) per meeting.

6.5 All delegations appearing before the Board shall be permitted to speak only once on an item, unless new information is being brought forward, and/or unless permission is given by the Chairperson of the Board, in consultation with the Medical Officer of Health.

6.6 Delegations and presentations of general interest shall not exceed ten minutes except when answering questions posed by the Chairperson for clarification.

6.7 Unless otherwise directed by resolution, no action respecting a delegation will be taken until the Board has had an opportunity to discuss the delegation and to receive advice from the Medical Officer of Health.

6.8 The Board will be informed of all requests from delegations and the disposition of such requests and, upon review, the Board may reverse the decision of the Chairperson of the Board by resolution.

6.9 Every member shall address the Chairperson respectfully previous to speaking to any motion.

6.10 When two or more members ask to speak, the Chairperson shall name the member who, in their opinion, first asked to speak.

6.11 If the Chairperson desires to leave the Chair to participate in a debate or otherwise, they shall call on the Vice-Chairperson to fill their place until they resume the Chair.

6.12 A member may speak more than once to a motion, but after speaking, shall be placed at the foot of the list of members wishing to speak.

6.13 No member shall speak to the same motion at any one time for longer than ten minutes except that extensions for speaking for up to five minutes for each time extended may be granted by resolution.

6.14 6.14.1 A member may ask a question of the previous speaker and then only to clarify any part of their remarks.

6.14.2 When it is a member's turn to speak, before speaking, they may ask questions of the Medical Officer of Health or staff present, to obtain information relating to the matter in question and with the consent of the speaker, or other members may ask a question of the same persons.

6.14.3 All questions shall be stated concisely and shall not be used as a means of making statements or assertions.

6.14.4 Any question shall not be ironical, offensive, rhetorical, trivial, vague or meaningless or shall not contain epithet, innuendo, ridicule, or satire.

6.15 Any member who has the floor may require the motion under discussion to be read.

## Section 7 - Decorum and Discipline

7.1 A member shall not:

7.1.1 speak disrespectfully of Her Majesty the Queen or any member of the Royal Family, the Governor-General, a Lieutenant Governor, the Board or any member thereof;

7.1.2 use offensive words or unparliamentary language;

7.1.3 disobey the rules of the Board or a decision of the Chairperson or the Board on questions of order, practice or an interpretation of the rules;

7.1.4 speak other than to the matter in debate;

7.1.5 leave their seat or make any disturbance when the Chairperson is putting a question and while a vote is being taken and until the result is declared; and

7.1.6 interrupt a member while speaking except to raise a point of order.

7.2 If a member commits an offense, the Chairperson shall interrupt and correct the member.

7.3 If an offense is serious or repeated, the Board may decide, by resolution, not to permit the member to resume speaking.

7.4 If a member ignores or disregards a decision of the Chairperson or the Board, the Chairperson shall not recognize the member except to receive an apology by the member and until it has been accepted by the Board.

7.5 If a member persists in committing an offense, the Board may order, by resolution, the member to leave the meeting and not resume their seat until they have tendered an apology and it has been accepted by the Board.

## Section 8 - Questions of Privilege and Points of Order

8.1 The Chairperson shall permit any member to raise a question relating to the rights and benefits of the Board or one or more of the members thereof and questions of privilege shall take precedence over all other motions except to adjourn and to recess.

8.2 When a member desires to assert that a rule has been violated, they shall ask leave of the Chairperson to raise a point of order with a concise explanation and then shall not speak until the Chairperson has decided on the point of order.

8.3 The decision of the Chairperson shall be final unless a member appeals immediately to the Board.

8.4 If the decision is appealed, the Board shall decide the question "Shall the decision of the chair be sustained?" by majority vote without debate and its decision shall be final.

8.5 When the Chairperson calls a member to order, the member shall cease speaking immediately until the point of order is dealt with and they shall not speak again without the permission of the Chairperson unless to appeal the ruling of the Chairperson.

## Section 9 - By-laws

9.1 No motion to pass a By-law shall be considered unless written notice has been received by the members in the manner set out in section 3.6 of this By-law.

9.2 A motion to pass a By-law shall be carried by a two-thirds vote in the affirmative of the members present at that meeting.

9.3 A By-law shall come in to force on the date of passing thereof unless otherwise specified by the Board.

9.4 No motion for the amendment or repeal of the By-laws, or any part thereof, shall be considered unless written notice has been received by the members in the manner set out in section 3.6 of this By-law.

9.5 A motion to amend or repeal the By-laws, or any part thereof, shall be carried by a two-thirds vote in the affirmative of the members present at the meeting at which the amendment or repeal is to be considered.

## Section 10 - Motions

10.1 Every motion shall be verbal unless the Chairperson requests that the motion be submitted in writing.

10.2 Debate on a debatable motion shall not proceed unless it has been seconded.

10.3 Every motion shall be deemed to be in possession of the Board for debate after it has been presented by the Chairperson, but may, with permission of the members who moved and seconded a motion, be withdrawn at any time before amendment or decision.

10.4 A main motion before the Board shall receive disposition before another main motion can be received except a motion:

10.4.1 to adjourn;

10.4.2 to recess;

10.4.3 to raise a question of privilege;

10.4.4 to lay on the table;

10.4.5 to order the previous question (close debate);

10.4.6 to limit or extend limits of debate;

10.4.7 to postpone definitely (defer);

10.4.8 to commit or refer;

10.4.9 to postpone indefinitely (withdraw); or

10.4.10 to amend;

which have been listed in order of precedence.

10.5 When a motion that the vote be taken is presented, it shall be put to a vote without debate, and if carried by resolution, the motion and any amendments under debate shall be put forthwith without further debate.

10.6 A motion relating to a matter not within the jurisdiction of the Board shall not be in order.

10.7 A motion to adjourn a meeting or debate shall be in order, except:

10.7.1 when a member has the floor;

10.7.2 when it has been decided that the vote be now taken; or

10.7.3 during the taking of a vote;

and when rejected, shall not be moved again on the same item.

## Section 11 - Voting

11.1 Only one primary amendment at a time can be presented to a main motion and only one secondary amendment can be presented to a primary amendment, but when the secondary amendment has been disposed of, another may be introduced, and when a primary amendment has been decided, another may be introduced.

11.2 A secondary amendment, if any, shall be voted on first, and, if no other secondary amendment is presented, the primary amendment shall be voted on next, and if no other primary amendment is presented, or if any amendment has been carried, the main motion as amended shall be put to a vote.

11.3 A main motion may be divided by resolution and each division thereof shall be voted on separately.

11.4 After the Chairperson commences to take a vote, no member shall speak or present another motion until the vote has been taken on such motion.

11.5 Every member present at a meeting shall vote when a vote is taken unless prohibited by statute and if any member present refuses or fails to vote, he shall be deemed as voting in the negative.

11.6 Any member may require that a vote be recorded.

11.7 If a member disagrees with the declaration by the Chairperson of the result of any vote, the member may object immediately and require that the vote be retaken and recorded.

11.8 After any matter has been decided, any member may move for reconsideration of the matter at a subsequent meeting in the same year but no discussion of the question that has been decided shall be allowed until the motion for reconsideration has carried by two-thirds of the members, and no matter shall be reconsidered more than once in the same calendar year.

## Section 12 - Committees

12.1 The Board may strike committees and appoint members to such committees to consider such matters as directed by the Board.

12.2 The Medical Officer of Health shall preside over the first meeting of each calendar year until a Chairperson and Vice-Chairperson of the committee are elected by its members.

12.3 The Chairperson of a committee shall:

12.3.1 preside over all meetings of the committee;

12.3.2 report on the deliberations and recommendations of the committee to the Board; and

12.3.3 perform such other duties as may be determined from time to time by the Board or the committee.

12.4 The Chairperson of a committee may appoint non-Board members to the committee.

12.5 The number of non-Board members of a committee shall not exceed the number of Board members of the same committee at any time.

12.6 The number of Board members on a committee shall not be a majority of the members of the Board of Health.

12.7 It shall be the duty of a committee:

12.7.1 to report to the Board on all matters referred to it and to recommend such action as it deems necessary;

12.7.2 to forward to an incoming committee for the following year any matters not disposed of; and

12.7.3 to provide to the Board any information relating to the committee that is requested by the Board.

12.8 All committees shall be dissolved no later than immediately preceding the first meeting as set out in section 3 of this By-law.

12.9 The Board may dissolve, by resolution, any committee at any time.

## Section 13 - Minutes

The Medical Officer of Health shall ensure that full and accurate minutes are kept of the proceedings of all meetings including a text of the By-laws and the resolutions passed by the Board.

*Historical Record*
*Revisions:*

*Board of Health, October 13, 2010*
*Board of Health, October 11, 2007*
*Board of Health, January 12, 2005*
*Board of Health, July 3, 2003*
*Board of Health, October 28, 1998*
*Board of Health, October 14, 1992*

*Review:*
*Governance Committee, January 27, 2012*
*By-Laws, Policies and Procedures Committee, October 13, 2010*
*Governance Committee, September 27, 2010*

**To:** All Members
Board of Health

**From:** Deputy Mayor Sharpe, Chair, Property Committee

**Subject:** **Committee Report: Property**

**Date:** December 11, 2013

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**Recommendation:**

That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Property Committee for June 5, 2013 (approved by the Committee on November 7, 2013).

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Please refer to the attached.

**Board of Health for the**
**Peterborough County-City Health Unit**
**Property Committee Meeting**
**MINUTES**
**June 5, 2013 – 5:00 p.m. to 6:00 p.m.**
**Board Room, 10 Hospital Drive, Peterborough**

Present: Councillor Henry Clarke
Councillor Lesley Parnell
Dr. Rosana Pellizzari
Deputy Mayor Andy Sharpe, Chair
Mrs. Alida Tanna, Recorder
Mr. Brent Woodford

Regrets: Mr. David Watton

## 1. Call To Order

Deputy Mayor Sharpe called the meeting to order at 5:30 p.m.

## 2. Confirmation of the Agenda

Moved by Councillor Clarke — Seconded by Councillor Parnell
That the agenda be approved as circulated.
Carried (M–13–13–PR)

## 3. Declaration of Pecuniary Interest

Nil.

## 4. Delegations and Presentations

Nil.

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

### 5.1 March 6, 2013

Moved by Councillor Parnell — Seconded by Councillor Clarke
That the minutes of the Property Committee meeting held on March 6, 2013 be approved as circulated, and brought forward to the next Board of Health meeting.
Carried (M–13–14–PR)

**6. Business Arising from the Minutes**

Nil.

**7. Correspondence**

Nil.

**8. New Business**

Nil

**9. In Camera to Discuss Confidential Property Matters**

| Moved by | Seconded by |
|---|---|
| Councillor Clarke | Councillor Parnell |

That the Committee go In Camera to discuss confidential property matters.

Carried (M–13–15–PR)

| Moved by | Seconded by |
|---|---|
| Councillor Parnell | Councillor Clarke |

That the Committee rise from In Camera.

Carried (M–13–16–PR)

**10. Date, Time and Place of Next Meeting**

To be determined.

**11. Adjournment**

| Moved by | Seconded by |
|---|---|
| Councillor Parnell | Councillor Clarke |

That the meeting be adjourned.

Carried (M–13–17–PR)

Chair

Recorder