Algoma
PUBLIC HEALTH
Santé publique Algoma

BOARD OF HEALTH MEETING

SEPTEMBER 27, 2017

5:00 PM

Sault Ste. Marie Community Rooms A

www.algomapublichealth.com

September 27, 2017 - Board of Health Meeting Book

Algoma Public Health Board of Health Meeting Table of Contents

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
SEPTEMBER 27, 2017 @ 5:00 PM
SAULT STE MARIE ROOM A&B, SSM
A*G*E*N*D*A

1.0 Meeting Called to Order — Mr. Ian Frazier, 2nd Vice-Chair

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda Items — Mr. Ian Frazier, 2nd Vice-Chair

Resolution
THAT the agenda items dated be adopted as circulated.

3.0 Adoption of Minutes of Previous Meeting — Mr. Ian Frazier, 2nd Vice-Chair

Resolution
THAT the Board of Health minutes for the meeting dated, 2017 be adopted as circulated.

4.0 Delegations/Presentations.

a. Immunization: School Immunization for Grade 7 Students — Mrs. Roylene Bowden, Program Manager

5.0 Business Arising from Minutes — Mr. Ian Frazier, 2nd Vice-Chair

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Report — Dr. Marlene Spruyt MOH/CEO

Resolution
THAT the report of the Medical Officer of Health and CEO for the month of 2017 be adopted as presented.

b. Finance and Audit Committee Report — Mr. Ian Frazier, Committee Chair

i. Committee Chair Report for September 2017

ii. Draft Financial Statements for the Period Ending — Mr. Ian Frazier, Committee Chair

Resolution
THAT the Finance and Audit Committee report for the of September 2017 be adopted as presented; and

THAT the Financial Statements for the Period Ending July 31, 2017 be approved as presented.

iii. Approved minutes: June 14, 2017 ***– for information only***

c. Governance Standing Committee Report — Ms. Deborah Graystone Committee Chair

i. Committee Chair Report for September 2017

Resolution
THAT the Governance Standing Committee report for the month of 2017 be adopted as presented.

ii. 02-05-075 – Election of Chair, Vice-Chair or Committee Members

Resolution
THAT the Board of Health approves the new policy 02-05-075 – Election of Chair, Vice-Chair or Committee Members as presented.

iii. Approved Minutes June 15, 2017 – ***for information only***

7.0 New Business/General Business – N/A Mr. Ian Frazier, 2nd Vice-Chair

a. Plain and Standard Tobacco Packaging and Products

Resolution

WHEREAS *Tobacco use is still the number one cause of preventable death in Canada; and*

WHEREAS *Tobacco advertising bans restrict much of the promotion of tobacco products but tobacco packages and products are currently not included in these bans; and*

WHEREAS *The tobacco industry recognizes that the product and its package are valuable marketing spaces used to communicate many messages; and*

WHEREAS *The primary impacts of plain and standardized packaging include, diminished appeal of tobacco products; increased effectiveness of the health warnings; and reduced ability of the product and its packaging to mislead consumers about the harmful effects of tobacco use.; and*

WHEREAS *Plain and standardized packaging has already reduced tobacco use in Australia, and should have the same effect in Canada; and*

WHEREAS *Plain and standardized tobacco packaging and products was part of the Federal Liberal Party's 2015 election platform and included in Prime Minister Trudeau's mandate letter to the Minister of Health.*

NOW THEREFORE BE IT RESOLVED THAT *the Board of Health of Algoma endorses the Canadian Coalition for Tobacco recommendation for plain and standardized packaging of all tobacco products in Canada;*

AND FURTHER *that Algoma Public Health supports ongoing public education and awareness of this issue in Algoma;*

AND FURTHER*; that Algoma Public Health in keeping with its endorsement continues to monitor the progress of this issue and the need for any further action to support the Canadian Coalition for Tobacco recommendations of plain and standardized packaging of all tobacco products in Canada.*

b. Governance Training Workshop Mr. Ian Frazier & Ms. Karen Raybould

8.0 Correspondence Mr. Ian Frazier, 2nd Vice-Chair

a. Bill 148: Fair Workplaces, Better Jobs Act
   i. Letter to Premier Wynne from Sudbury & District Health Unit dated June 30, 2017
   ii. Letter from Northwestern Health Unit dated September 1, 2017
b. Blastomycosis
   Letter to Minister Hoskins from an Algoma Resident dated September 5, 2017
c. Contraband Tobacco
   i. Letter to Minister Hoskins from North Bay Parry Sound District Health Unit dated July 6, 2017
d. Fluoride Varnish Programs for Children at Risk of Dental Caries
   i. Letter to Minister Hoskins from Association of Local Public Health Agencies (alPHa) dated July 21, 2017
e. Health Promotion Resource Centres
   i. Letter to Minister Hoskins from Leeds Grenville & Lanark District Health Unit dated July 5, 2017
f. Healthy Babies Healthy Children Program Targets and Funding
   i. Memorandum to Premier Wynne from Durham Region dated June 15, 2017
g. Human Papillomavirus (HPV) Immunization Program
   i. Letter from MOHLTC dated August 17, 2017
h. Human Papillomavirus (HPV) Immunization Catch-up for Boys
   i. Letter to Minister Hoskins from Grey Bruce Health Unit dated June 29, 2017
   ii. Memorandum to Premier Wynne from Durham Region dated June 15, 2017
i. Inspection and Enforcement Activities of Personal Service Settings
   i. Letter to Minster Hoskins from Niagara Region dated June 14, 2017
j. Legalization of Cannabis
   i. Letter to Minister Naqvi from Peterborough Public Health dated September 14, 2017
k. Low Income Adult Dental Program
   i. Letter to Minister Hoskins from Middlesex-London Health Unit dated August 8, 2017
l. Provincial Alcohol Strategy
   i. Letter to Minister Hoskins from Grey Bruce Health Unit dated June 29, 2017
   ii. Memorandum to Premier Wynne from Durham Region dated June 15, 2017
   iii. Letter to Minister Hoskins from Middlesex-London Health Unit dated August 8, 2017
   iv. Letter to OPHA from Middlesex-London Health Unit dated August 8, 2017

9.0 Items for Information Mr. Ian Frazier, 2nd Vice-Chair

a. 2017 alPHa Conference Proceedings
b. alPHa Information Break – July 18, 2017 and August 17, 2017
c. alPHa Summary: Expert Panel on Public Health

10.0 Addendum Mr. Ian Frazier, 2nd Vice-Chair

11.0 That The Board Go Into Committee Mr. Ian Frazier, 2nd Vice-Chair

Resolution
THAT the Board of Health goes into committee.

Agenda Items:

a. Adoption of previous in-committee minutes dated June 28, 2017
b. Litigation or Potential Litigation
c. Labour Relations and Employee Negotiations
d. Security of the Property of the Board

12.0 That The Board Go Into Open Meeting Mr. Ian Frazier, 2nd Vice-Chair

Resolution
THAT the Board of Health goes into open meeting

13.0 Resolution(s) Resulting from In-Committee Session Mr. Ian Frazier, 2nd Vice-Chair

14.0 Announcements: Mr. Ian Frazier, 2nd Vice-Chair

Next Board Meeting:
October 28, 2017 at 5:00pm
Sault Ste. Marie, Room A

15.0 That The Meeting Adjourn Mr. Ian Frazier, 2nd Vice-Chair

Resolution
THAT the Board of Health meeting adjourns

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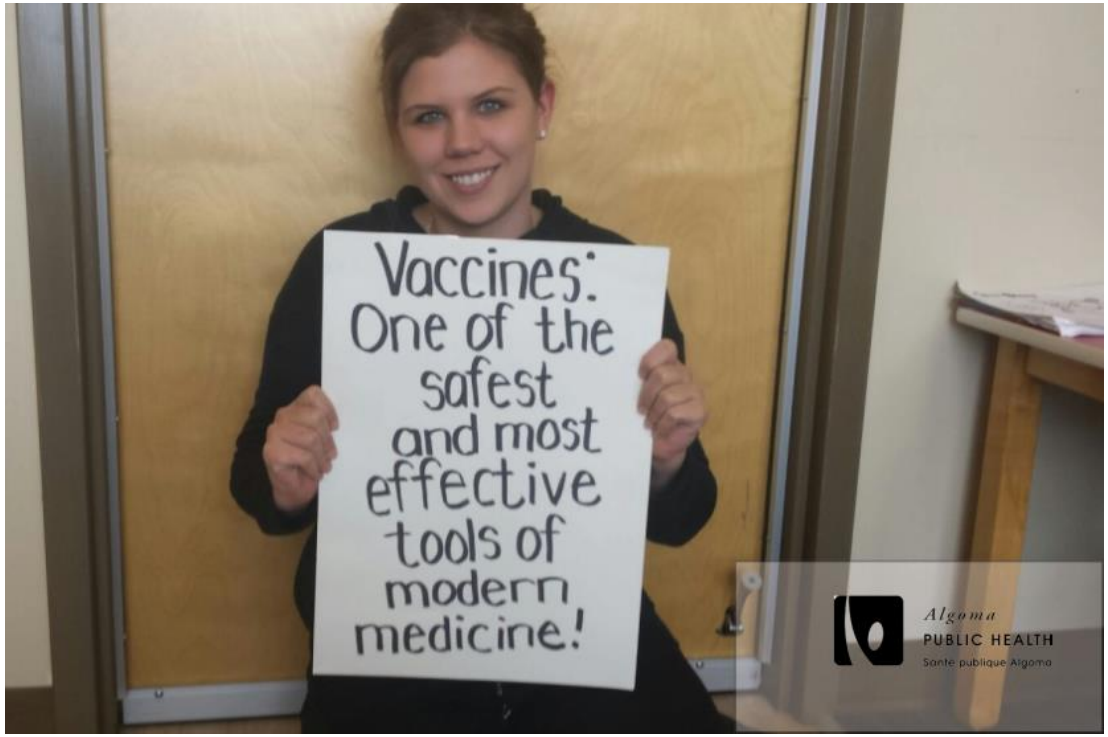
Immunization
School Immunization for Grade 7 Students

Roylene Bowden RN, BScN, IBCLC



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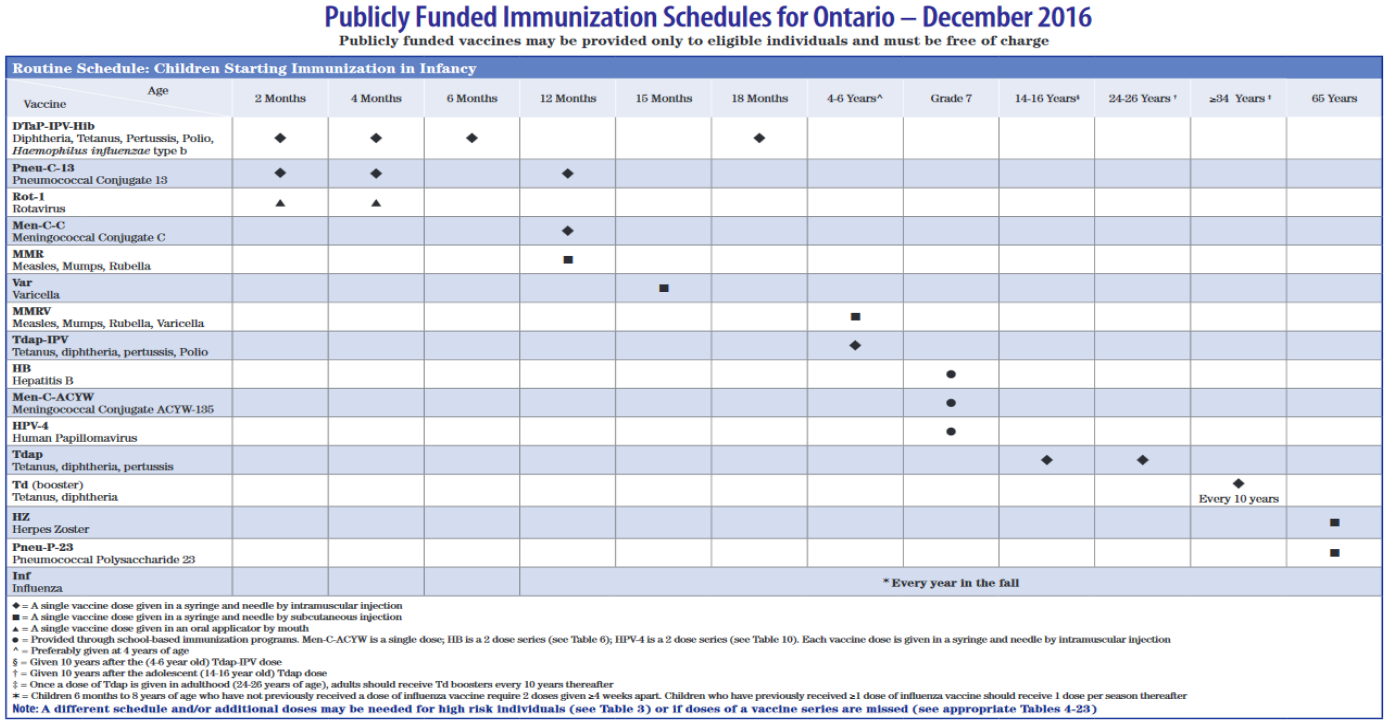
Immunization Goals

- Reduce or eliminate the burden of vaccine preventable diseases through immunization

- Children have up to date immunizations in accordance with the Immunization of School Pupils Act (ISPA) and the current Publicly Funded Immunization Schedule.

Publicly Funded Immunization Schedules for Ontario



Publicly Funded Immunization Schedules for Ontario – December 2016

Publicly funded vaccines may be provided only to eligible individuals and must be free of charge

Routine Schedule: Children Starting Immunization in Infancy

Vaccine \ Age	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	4-6 Years^	Grade 7	14-16 Years‡	24-26 Years †	≥34 Years †	65 Years
DTaP-IPV-Hib Diphtheria, Tetanus, Pertussis, Polio, *Haemophilus influenzae* type b	◆	◆	◆			◆						
Pneu-C-13 Pneumococcal Conjugate 13	◆	◆		◆								
Rot-1 Rotavirus	▲	▲										
Men-C-C Meningococcal Conjugate C				◆								
MMR Measles, Mumps, Rubella				■								
Var Varicella					■							
MMRV Measles, Mumps, Rubella, Varicella							■					
Tdap-IPV Tetanus, diphtheria, pertussis, Polio							◆					
HB Hepatitis B								●				
Men-C-ACYW Meningococcal Conjugate ACYW-135								●				
HPV-4 Human Papillomavirus								●				
Tdap Tetanus, diphtheria, pertussis									◆	◆		
Td (booster) Tetanus, diphtheria											◆ Every 10 years	
HZ Herpes Zoster												■
Pneu-P-23 Pneumococcal Polysaccharide 23												■
Inf Influenza				*** Every year in the fall**								

◆ = A single vaccine dose given in a syringe and needle by intramuscular injection
■ = A single vaccine dose given in a syringe and needle by subcutaneous injection
▲ = A single vaccine dose given in an oral applicator by mouth
● = Provided through school-based immunization programs. Men-C-ACYW is a single dose; HB is a 2 dose series (see Table 6); HPV-4 is a 2 dose series (see Table 10). Each vaccine dose is given in a syringe and needle by intramuscular injection
^ = Preferably given at 4 years of age
§ = Given 10 years after the (4-6 year old) Tdap-IPV dose
† = Given 10 years after the adolescent (14-16 year old) Tdap dose
‡ = Once a dose of Tdap is given in adulthood (24-26 years of age), adults should receive Td boosters every 10 years thereafter
* = Children 6 months to 8 years of age who have not previously received a dose of influenza vaccine require 2 doses given ≥4 weeks apart. Children who have previously received ≥1 dose of influenza vaccine should receive 1 dose per season thereafter

Note: A different schedule and/or additional doses may be needed for high risk individuals (see Table 3) or if doses of a vaccine series are missed (see appropriate Tables 4-23)

Ontario

www.ontario.ca/vaccines

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Immunization of School Pupils Act (ISPA)

- Diphtheria
- Tetanus
- Polio
- Measles
- Mumps
- Rubella
- Meningococcal Disease
- Pertussis (Whooping Cough)
- Varicella (Chicken Pox)

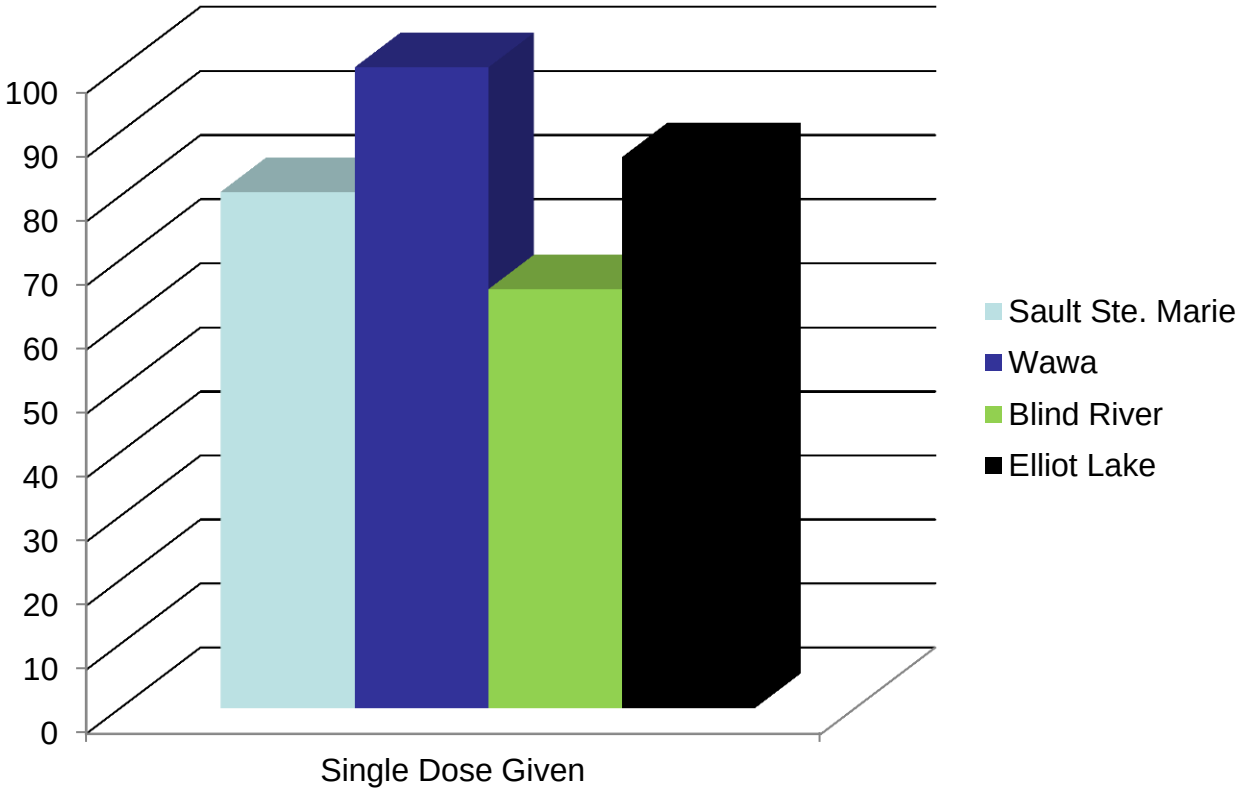
School Immunization for Grade 7 Students - Meningococcal

SSM

- 667 Students Immunized

District

- 103 Students Immunized



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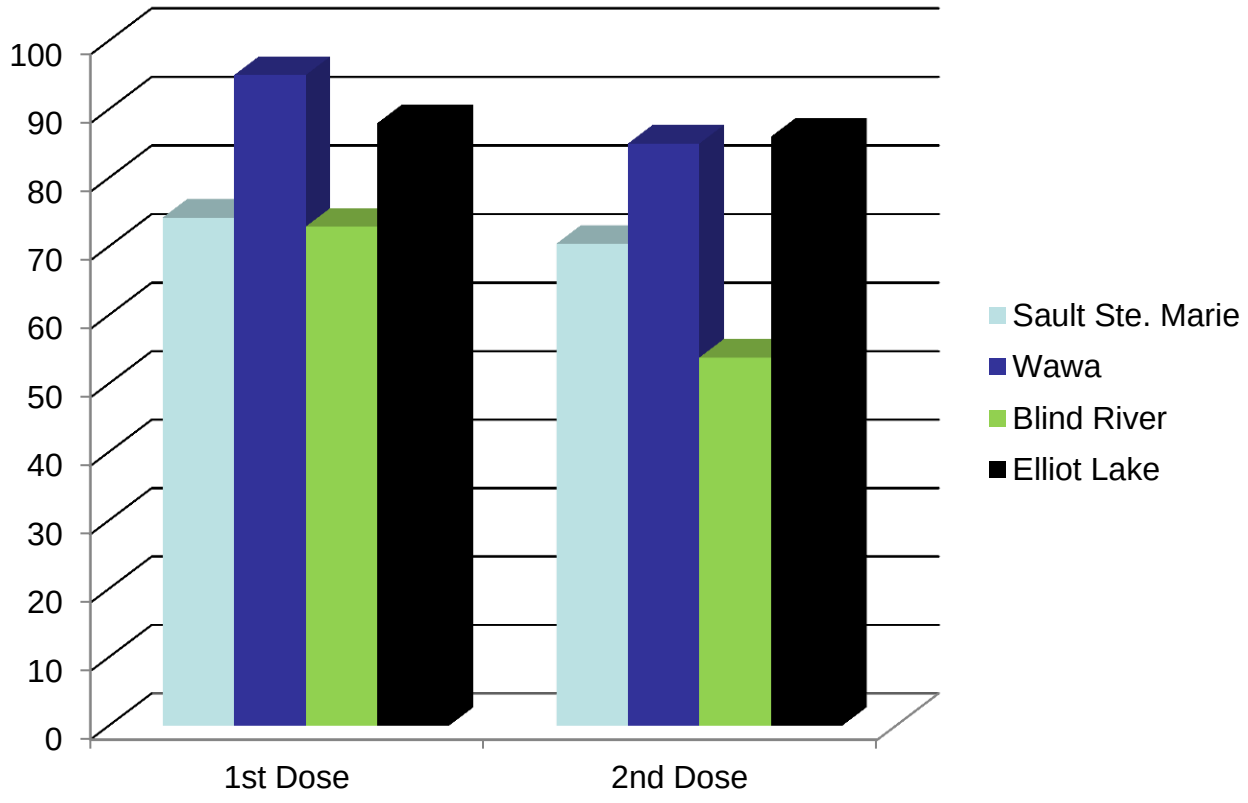
School Immunization for Grade 7 Students – Hepatitis B

SSM

- Dose 1 – 589
- Dose 2 – 518

District

- Dose 1 – 131
- Dose 2 – 122



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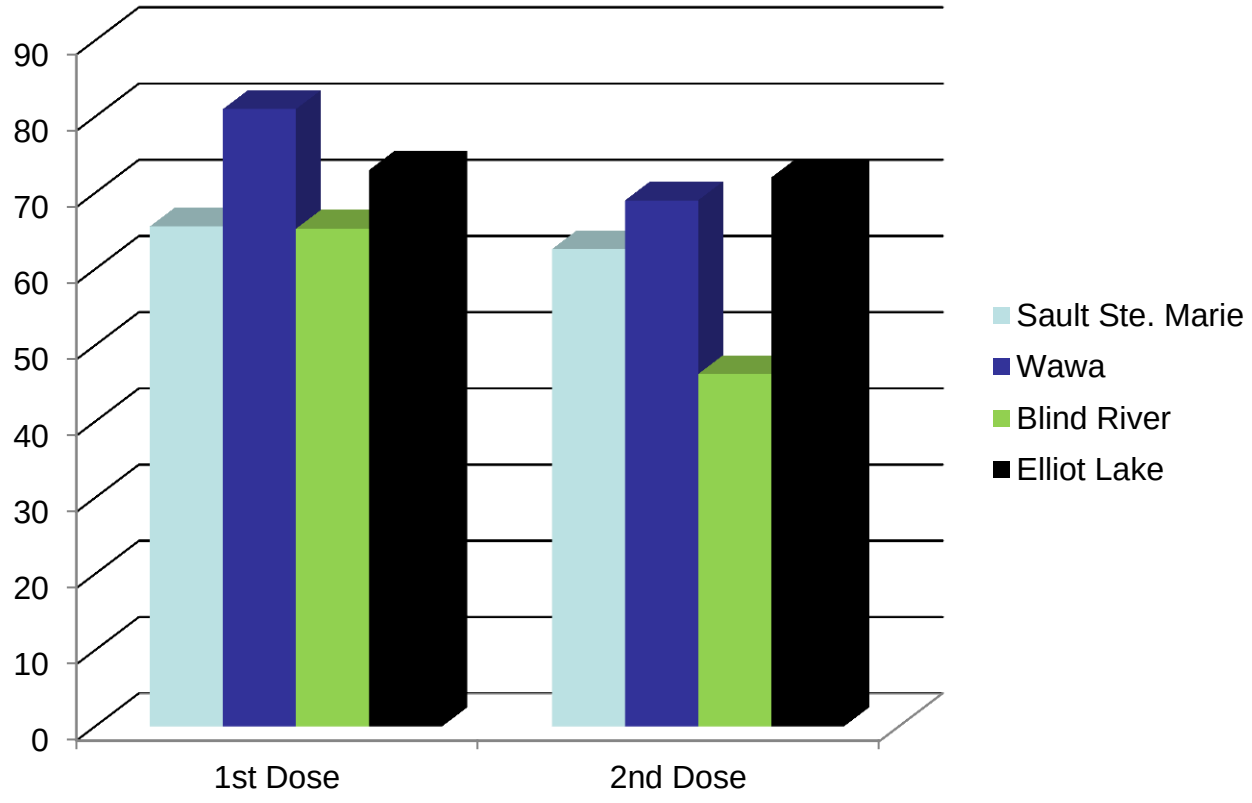
School Immunization for Grade 7 Students - Gardasil

SSM

- Dose 1 – 533
- Dose 2 – 472

District

- Dose 1 – 114
- Dose 2 – 104



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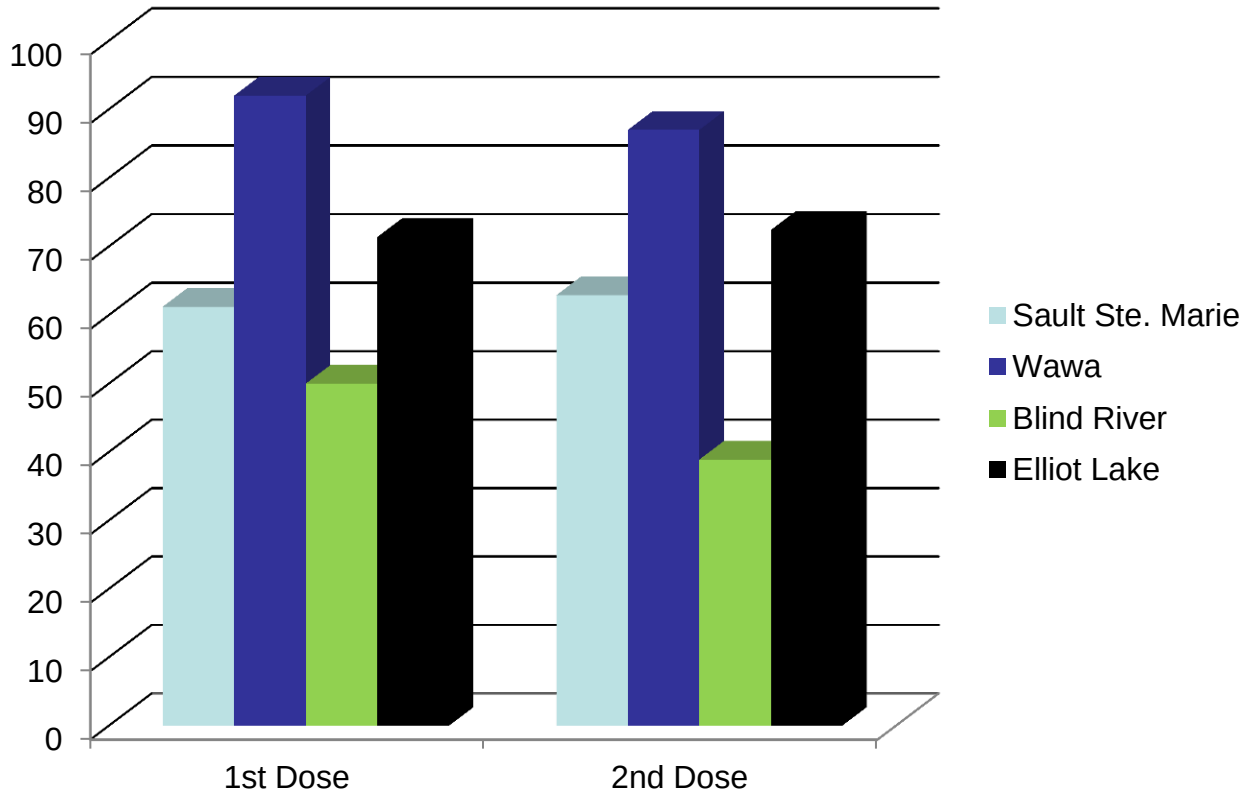
School Immunization for Grade 8 Students – Gardasil

SSM

- Dose 1 – 263
- Dose 2 – 266

District

- Dose 1 – 50
- Dose 2 – 48



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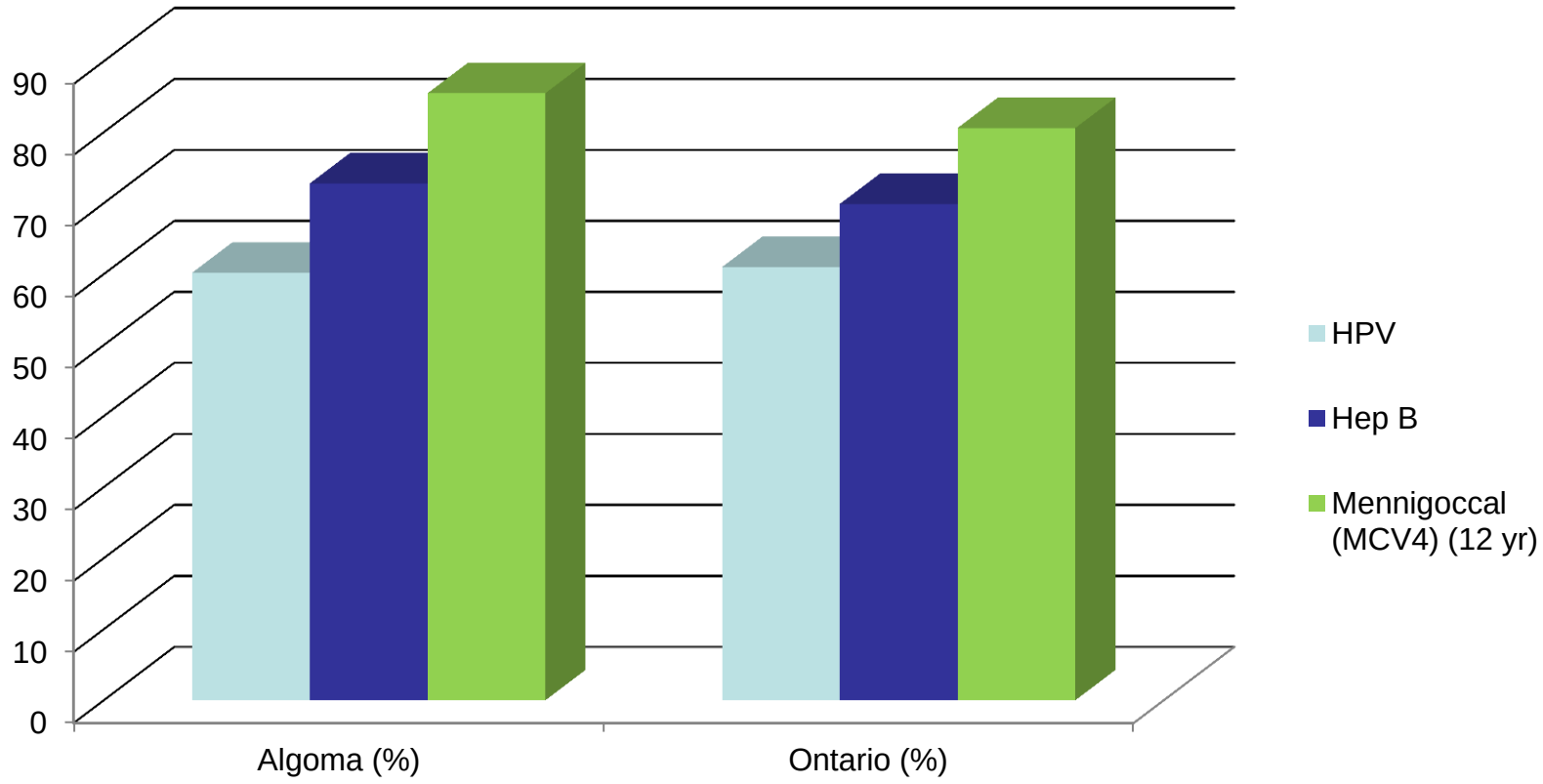
2015-2016 Grade 7 Immunization Program



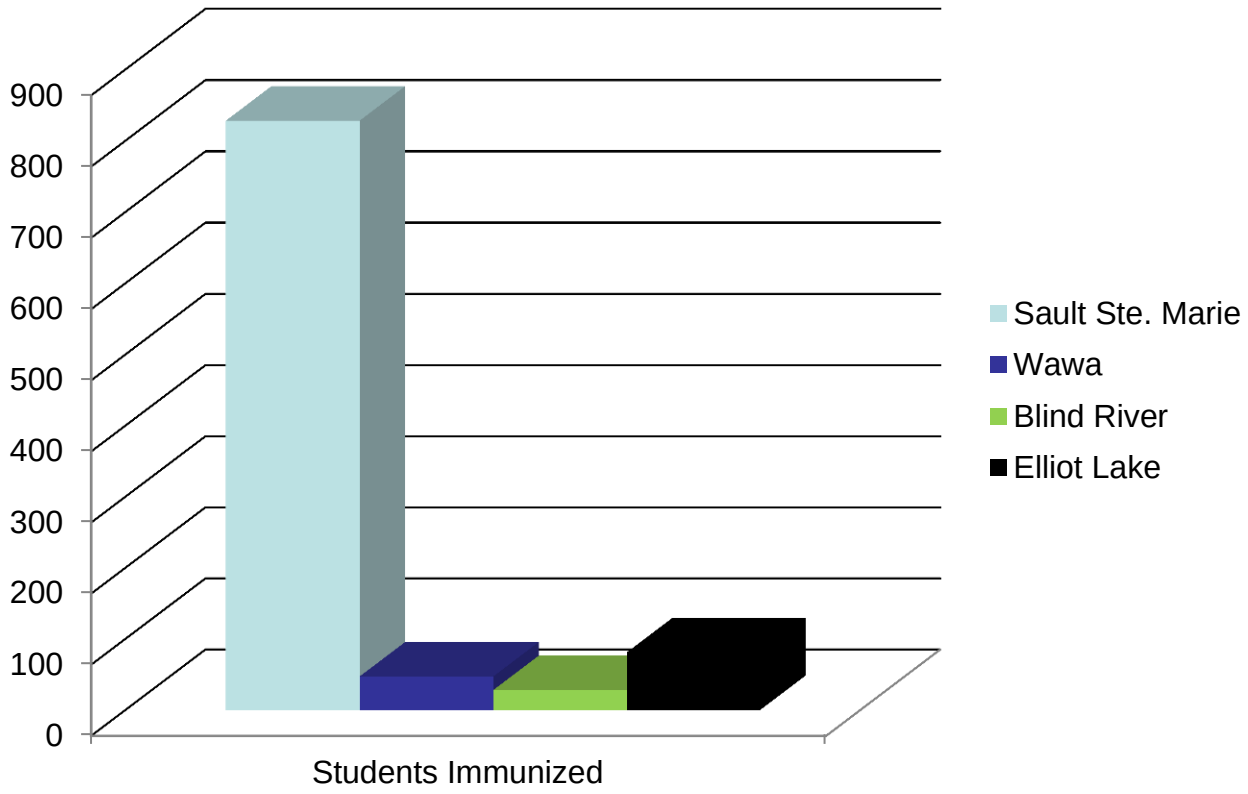
2017-2018 Grade 7 Immunization Program

Sault Ste. Marie
828

Wawa
47

Blind River
28

Elliot Lake
81



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Ministry Legislation Amendments

- MOHLTC announced 2 amendments to ISPA as part of immunization 2020, a five year strategy to improve overall effectiveness and efficiency of Ontario's publicly funded immunization system.

Ministry Legislation Amendments

1. Strengthen requirements for school vaccine exemptions

2. Improve how ISPA designated immunization are reported

Implementation of Amendment

Role	Responsibility
Parent	• Completes education session with local PHU in-person • Receives a certificate of completion (Vaccine Education Certificate) from PHU • Completes Statement of Conscience or Religious Belief Form by swearing or affirming in front of a Commissioner for Taking Affidavits • Submits signed Statement of Conscience or Religious Belief Form and Vaccine Education Certificate to local PHU
Local PHU	• Delivers education session to parent in-person • Provides Vaccine Education Certificate to parent upon completion • Uploads Statement of Conscience or Religious Belief Form and the Vaccine Education Certificate to Panorama for each child who is under the parent's guardianship

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#VaccinesWork
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MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER BOARD REPORT

SEPTEMBER 2017

Prepared by: Dr. Marlene Spruyt, Medical Officer of Health/CEO

and the Leadership Team

APH Employees participated in Bell Canada's Backpack for Kids campaign again this year. Bell Canada provided all the backpacks and staff donated the supplies needed to fill 103 backpacks this year. APH was able to keep all 103 assembled backpacks and distribute to local families.

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APH AT-A-GLANCE

We welcomed Dr. Jennifer Loo who started in the position of Associate Medical Officer of Health (pending Ministry approval) on August 28, 2017. She is currently focused on work to meet the requirements of the Ministry's Harm Reduction Program Enhancement. This additional funding is to be directed towards

ii. Local Opioid Response
iii. Naloxone Distribution and Training
iiii. Opioid Overdose Early Warning and Surveillance.

Municipal presentations continued through the summer, travelling to North Shore on July 12, 2017 and Dubreuilville on August 22, 2017. In addition, I was able to travel to to Elliot Lake, Blind River and Wawa for site visits.

The Ministry continues its work on the Modernized Standards. The final version was initially intended to be released in June and this has now been delayed until October. Concurrently there are many committees working on revising the associated Protocols and Guidance documents. I have been invited to sit on the Implementation Task Force which has been tasked with reviewing the protocols and guidance documents, identifying implementation difficulties and suggesting amendments to minimize operational difficulties.

The Council of Medical Officers of Health (COMOH) met in Toronto on September 13, 2017 to discuss the recommendations of the Expert Panel on Public health within an Integrated Health System.

PROGRAM HIGHLIGHTS

ENVIRONMENTAL HEALTH
Director: Sherri Cleaves
Manager: Jonathon Bouma

Topic: Vectorborne Disease

This report addresses OPHS Health Hazard Prevention and Management Requirement #8: The board of health shall develop a local vector-borne management strategy based on surveillance data and emerging trends in accordance with the Infectious Diseases Protocol, 2008 (or as current).

This report addresses the following Strategic Directions: Be Accountable

Background:
The goal of the Health Hazard Prevention and Management standard is to prevent or reduce the burden of illness from health hazards in the physical environment. Vectorborne diseases are spread by living organisms (mosquitos, ticks) that can transmit infectious diseases between animals and humans.

Algoma Public Health (APH) conducts annual vector surveillance and vector testing in the summer season across the district. APH provides education and public health promotion messaging to the public on prevention strategies to reduce potential exposure to Lyme disease and West Nile virus (WNv) vectors.

Lyme Disease:
APH investigates all reported human cases of Lyme disease and provides information on testing and treatment upon request.
Lyme disease is transmitted through the bite of infected blacklegged tick and if left untreated, can result in neurological effects, recurring arthritis and in very rare cases, death.

Lyme disease is becoming more common in Ontario. In 2011 90 cases of Lyme disease were reported in compared to 316 cases in 2016, a 251% increase.

APH conducts tick surveillance every spring and summer season to determine if blacklegged ticks are present in our areas. Ticks found and submitted by residents are forwarded to the national lab for identification and testing as part of the provincial strategy. In addition APH is fortunate to be located near the Great Lakes Forestry Centre which has supported the submission of ticks found on pets.

During 2010-2015,there was an average of 12 ticks per year submitted to APH. In 2016 24 ticks were submitted and in 2017, 100 ticks have been submitted as of Sept 1.This suggests increasing awareness of Lyme disease and the tick surveillance program.

An average of one tick per year has tested positive for Lyme disease but in 2017, two positives were found, indicating that ticks carrying Lyme disease are present in Algoma.

Further surveillance is needed to establish whether the blacklegged tick is becoming endemic in Algoma or is being identified in greater numbers due to increased submissions and bird migration.

West Nile Virus:

APH investigates all reported human cases of WNv and provides information on testing and treatment upon request.

West Nile virus infection is spread to humans through the bite of an infected mosquito which acquired its infection from a bird. It can cause fever, headache and muscle aches usually lasting a week or less. Rash and swollen glands are common. Occasionally (less than 1% of cases) it causes encephalitis (swelling of the brain) or meningitis

In 2017 there were no identified human cases of WNv but we did have a report of a horse that tested positive.

Ground vaults (catch basins used in electrical systems that service Sault Ste. Marie (SSM)) are surveyed for mosquitoes by summer students with the help of the PUC. In June, following determination of the presence of live mosquito larvae, APH requested PUC to treat the 536 ground vaults. Roughly 4-6 weeks after the completion of larviciding, we surveyed the ground vaults to check for effectiveness of treatment. No larvae were found.

Adult mosquitoes are also trapped to identify type of species present and if positive for the virus. Every two weeks, 8 traps in Sault Ste. Marie, two in Elliot Lake, and two in Blind River are submitted and once a summer, they test three traps around Wawa and White River. As of Sept 1/17, no mosquitoes in these traps have tested positive for West Nile virus. The last known human case of West Nile virus found in Algoma was in 2013.

The consistently low population of prominent vectors suggests that Algoma is an area of low risk of transmission of WNv to humans, but Culex species of mosquito (type of mosquito that can spread WNv) are increasing in proportion in Algoma and across the province. Climate change influences temperature and rainfall could change this picture in the future.

FAMILY HEALTH

Director: Laurie Zeppa
Manager: Hannele Dionisi

Topic: Nutri-eSTEP

This report addresses the following requirements of the Ontario Public Health Standards (2014):

- Child Health – Requirement 7 and 11
- Chronic Disease Prevention – Requirement 12
- Ministry of Health and Long Term Care (MOHLTC) Public Health Unit Accountability Indicator NutriSTEP® Preschool Screen Implementation Status Report

This report addresses the following Strategic Directions:

- Health Equity
- Collaborate Effectively

The toddler and preschooler years are an important time in a child's growth and development. Poor nutrition in young children can lead to growth problems such as failure to thrive and obesity, anemia, lifelong poor eating habits, lack of school readiness and inability to learn at school.

Nutri-eSTEP (www.nutritionscreen.ca) is a free online validated and reliable nutrition screening questionnaire that parents and caregivers of toddlers and preschoolers can complete to identify nutrition, weight, activity and feeding concerns. Nutri-eSTEP helps parents and care-providers find out what is going well with their child, get tips for improvement and get immediate feedback about their child. It also directs users to useful tools and community services for support.

Dietitians of Canada (DC) accumulate local and provincial data from users of Nutri-eSTEP based on postal codes entered. The data is being shared with Ontario Public Health Units to help monitor uptake of screening implementation of Nutri-eSTEP and to assist with program planning to address identified needs. According to the number of Nutri-eSTEP screens completed in Algoma in 2015 and 2016, some of the issues identified were that more children in Algoma scored at "moderate" and "high" nutrition risk as compared to Ontario. The DC data also indicates that a significant number of children in Algoma are not meeting their requirements for vegetables and fruit and parents in Algoma are 2-3 times more likely to report having difficulty buying food to feed their child compared to the rest of Ontario.

Algoma Public Health (APH) in partnership with the Sault Ste. Marie and Algoma District Best Start Networks is promoting Nutri-eSTEP as a community strategy with the goal of increasing awareness and utilization of this screening tool. This strategy was developed with a focus on parents and caregivers of children 18 months to 5 years of age. The Sault Ste. Marie and North Channel Healthy Kids Community Challenge projects provided funding to support the promotion of Nutri-eSTEP. Nutri-eSTEP was introduced in Sault Ste. Marie during August as part of a Back to School event hosted

by Child Care Algoma. A formal district wide communication of Nutri-eSTEP will include the development of promotional resources that can be used by agencies and at community events that reach families of young children. An online advertising campaign is being developed in an effort to promote the Nutri-eSTEP website to families throughout Algoma.

VACCINE PREVENTABLE DISEASE

Director: Sherri Cleaves
Manager: Roylene Bowden

Topic: Universal Influenza Immunization Program (UIIP)

This report addresses requirement #7 of OPHS

The board of health shall promote and provide provincially funded immunization programs to any eligible person in the health unit, including:

- Board of health-based clinics;
- School-based clinics (including, but not limited to, hepatitis B and meningococcal immunization);
- Community-based clinics; and
- Outreach clinics to priority populations

This report addresses the following Strategic Directions:

- Improve Health Equity
- Collaborate Effectively
- Be Accountable

Influenza, commonly referred to as “the flu” is a serious respiratory illness that is caused by a highly contagious virus. The flu most commonly occurs in the winter months. Children under 5 years of age and the elderly are at high risk for developing serious side effects such as pneumonia.

Algoma Public Health in collaboration with Ministry of Health and Long Term Care, local health care providers, long term care homes and pharmacies are participating in the 2017-2018 Universal Influenza Immunization Program (UIIP). UIIP is an annual program offered by the Ministry of Health and Long-Term Care (MOHLTC). Influenza vaccine is provided FREE of charge to all individuals over the age of 6 months who live work or go to school in Ontario.

The Immunization (Vaccine Preventable Disease) team at Algoma Public Health completed 38 refrigerator inspections ensuring that external agencies participating in UIIP are prepared to accept the publicly funded influenza and other vaccines. The purpose of fridge inspections is to ensure that the vaccine is stored and handled appropriately according to cold chain recommendations. **http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guide_vaccine_storage.pdf**

Influenza vaccine will continue to be offered at all Algoma Public Health offices by appointment, as well as at many "outreach" locations within our communities; meeting clients where they are, decreasing barriers to assist our communities in staying healthy this flu season. .

The Universal Influenza Immunization Program is yet another opportunity for our programs at APH to work in collaboration with community partners.

The following chart illustrates the number of influenza vaccines administered during October 1, 2016-May 26, 2017 by Algoma Public Health.

Vaccine: IFLULAVAL, IFLUMIST, IFLUVIRAL, IFLUZONE, IINFLUVAC

Provider	Total Shots
C01 - SSM Immunization Clinic	506
C27 - Wawa Immunization Clinic	86
C28 - Elliot Lake Immunization Clinic	609
C29 - Blind River Immunization Clinic	841
C51 - Wawa Community Clinic	375
C52 - White River Community Clinic	97
C53 - Missanabie Community Clinic	12
C55 - Iron Bridge Community Clinic	105
C56 - Desbarats Community Clinic	8
C57 - Thessalon Community Clinic	23
CFC - Community Flu Clinics-SSM*	5085
Total Shots	**7749**
*Includes SSM office clinics and SSM Outreach clinics. Outreach clinics included Echo Bay and Soup Kitchen clinics.	

PARTNERSHIPS

FIRST NATIONS ENGAGEMENT IN THE NORTH EAST
(A LOCALLY DRIVEN COLLABORATIVE PROJECT FUNDED BY PHO)

APH continues its work as a supporting partner in this project. All HU in the province have been surveyed with respect to their affiliations and working relationships with First Nations communities. Further focus groups are planned with individual FN communities to identify engagement strategies that have worked well and to identify area where they have been difficulties.

THE HEALTHY KIDS COMMUNITY CHALLENGE

Ontario's Healthy Kids Community Challenge (HKCC) is a community-led program where partners from different sectors (e.g. municipal, education, recreation, local business, and public health) work together on initiatives that promote healthy living behaviours in children. Under the leadership of municipalities, selected communities are receiving funding and support from the Ministry of Health and Long Term Care (MOHLTC) to implement local activities related to healthy eating and physical activity. In Algoma, both The City of Sault Ste. Marie (SSM) and The North Channel (NC) are involved. Each of these projects has a network of community partnerships that support activities.

Currently, The HKCC is in its third year and the theme is "Choose to Boost Veggies and Fruit". Some examples of the current activities in this theme include (not limited to):

HKCC Sault Ste. Marie

- Community Take Out Days is a multi-sectoral initiative that was developed with the goal to provide children and their families with access to fresh vegetables and fruits. HKCC Sault Ste. Marie partnered with the Sault Ste. Marie Police Service, John Howard Society, The Soup Kitchen Community Centre, Social Services, Active Sault, Algoma Public Health, and community volunteers to bring the Community Take Out Days initiative to life. Each week, families that have signed up for the program pick up pre-packaged and prepared fruits and vegetables. The food items change week to week. The program is currently available in the following neighborhoods: Gore Street, Albion Street, Second Line Hub and Boston Avenue. Residents from these four community hub neighbourhoods volunteer to prepare and package the take out bags for distribution to their neighbours. To date, Community Take out Days has been able to feed approximately 400 individuals each week. The HKCC is supporting this initiative until the end of October, and is exploring sustainability options.
- Working with the City of Sault Ste. Marie to develop Healthier Food and Beverage Guidelines. The goal is to create an environment that provides families and children with healthier food and beverage options at municipal recreation facilities.

North Channel HKCC

- Good Food Boxes are up and running in all communities involved in the North Channel HKCC. The food boxes are subsidized through HKCC. Families purchase a box for 10$ and receive 25$ of fruits and vegetables. Each community has these boxes located in different areas.
- Coupons for fruits and vegetables are available throughout the North Shore. Children are provided coupons which can be used in many grocery outlets within the area. The grocery vendors (grocery stores, farmer's markets, etc.) will accept the coupon as cash and can be reimbursed through the NCHKCC.

Both HKCC

- HKCC Sault Ste. Marie and North Channel have partnered with school boards to explore opportunities for increasing food skills in children and youth

- Continue to raise awareness about the HKCC and healthy living behaviours (e.g. participation at community events, social media, websites, billboards, print and radio ads)

Algoma Public Health's Role

The City of Sault Ste. Marie and Algoma Public Health have a unique partnership in this project; a transfer payment agreement between the city and APH exists, which includes the employment and office space for the project manager as well as implementing the HKCC. Algoma Public Health is working with the City of Sault Ste. Marie as well as many other community partners many of the activities.

Algoma Public Health's involvement in The North Channel project is that of a community partner along with the many other community partners. We provide resources and support as the initiatives and programs roll out. Algoma Public Health is also an active participant on the steering committee.

PREFORMANCE INDICATOR

2017 Prevention and Promotion Performance Indicator Report

HBHC POSTPARTUM	January – March 2017					April – June 2017					YTD - TOTAL
	Wawa	SSM	BR	EL	Total	Wawa	SSM	BR	EL	Total	
Phone calls	4	120	14	4	**142**	10	124	14	7	**155**	**297**
Home visits	4	46	0	0	**50**	1	56	7	5	**69**	**119**

INFANT FEEDING SURVELIANCE	January – March 2017					April – June 2017				
	Wawa	SSM	BR	EL	District of Algoma	Wawa	SSM	BR	EL	District of Algoma
% of mothers breastfeeding at hospital discharge	80%	79%	95%	61%	79%	83%	83%	82%	80%	82%
% of mothers breastfeeding at 48 hour contact	80%	78%	95%	69%	80%	83%	78%	82%	90%	83%
% of mothers breastfeeding at 2 week contact	42%	71%	65%	39%	65%	63%	72%	76%	77%	72%
% of mothers infant feeding at 6 week contact	50%	61%	62%	46%	56%	63%	63%	76%	77%	69%

TOBACCO CESSATION	January – March 2017			April – June 2017			YTD - TOTAL
	SSM	District	Total	SSM		Total	
Number of APH clients assessed or reassessed for tobacco use using Brief Contact Interventions(BCI)	788	158	**946**	678	99 -	**777**	**1723**
Number of clients referred by staff to further intensive smoking cessation supports at APH during BCI	155 (includes district)	-	**155**	148 (includes district)	-	**148**	**303**
Number of clients receiving clinic or in-home intensive tobacco cessation services from APH staff	-	-	**-**	-	-	**-**	**140**

COMMUNITY MENTAL HEALTH	Jan – Mar 2017	Apr – Jun 2017	Jul – Present 2017	YTD TOTAL	NOTES
CMH New Clients: Individuals receiving 1st service	50	49	39	138	Individuals receiving 1st service are the number of new clients to CMH who have been referred, received an intake, are eligible for psychiatric case management services and have been assigned a case manager.
CMH non registered: Client Interactions	296	289	233	818	Unidentified client interactions are the number of interactions with individuals who are not registered with the program. This includes program inquiries and brief service provision. These interactions require program staff intervention either by phone or in person.

COMMUNITY ALCOHOL DRUG ASSESSMENT PROGRAM		January to March 2017					April to June 2017					YTD - TOTAL
		Wawa	SSM	BR	EL	Total	Wawa	SSM	BR	EL	Total	
Addictions-Overdose Prevention	Naloxone trainings completed- with at risk individuals	-	-	-	-	**-**	-	-	-	-	**-**	**-**
Addictions-Harm Reduction	inhalation 2-packs distributed	-	331	-	-	**331**	-	329	-	-	**329**	**660**
	Injection kits- 10packs distributed	-	259	-	-	**259**	-	280	-	2	**282**	**541**
	Needles out - distributed	-	76307	-	-	**76307**	-	70143	-	-	**70143**	**146450**
	Needles in thru APH/JHS sites	-	21233	-	-	**21233**	-	27436	-	-	**27436**	**48669**
	Needles returned thru Drop bins in SSM- estimate*	-	36000	-	-	**36000**	-	36000	-	-	**36000**	**72000**
Back on track Remedial Measures- individuals trained	Partnership with CAMH and MTO	-	44	-	-	**44**	-	18	-	-	**18**	**62**

COMMUNITY ALCOHOL DRUG ASSESSMENT PROGRAM		*July – August only 2017*					October – December 2017					YTD - TOTAL
		Wawa	SSM	BR	EL	Total	Wawa	SSM	BR	EL	Total	
Addictions-Overdose Prevention	Naloxone trainings completed- with at risk individuals	-	38	-	-	**38**	-	-	-	-	**-**	**38**
Addictions-Harm Reduction	inhalation 2-packs distributed	-	251	-	7	**258**	-	-	-	-	**-**	**918**
	Injection kits- 10packs distributed	-	373	-	6	**379**	-	-	-	-	**-**	**920**
	Needles out - distributed	-	1180	-	-	**51180**	-	-	-	-	**-**	**197630**
	Needles in thru APH/JHS sites	-	6179	-	-	**6179**	-	-	-	-	**-**	**54848**
	Needles returned thru Drop bins in SSM- estimate*	-	24000	-	-	**24000**	-	-	-	-	**-**	**96000**
Back on track Remedial Measures- individuals trained	Partnership with CAMH and MTO	-	-	-	-	**-**	-	-	-	-	**-**	**62**

***bins emptied 1- 2x per week x 8 wks = 2000 sharps per full bin x 2 bins

CARIES FREE IN ALGOMA	September 1 – December 31, 2016					January 1 – March 31, 2017				
	Central Algoma	North Algoma	SSM	East Algoma	Elliot Lake & area	Central Algoma	North Algoma	SSM	East Algoma	Elliot Lake & Area
Percentage of caries free students in JK/SK for the 2016-17 School Year	79%	67%	62%	29%	64%	65%	-	64%	-	71%

CARIES FREE IN ALGOMA	April 1 – June 30, 2017					YTD TOTAL
	Central Algoma	North Algoma	SSM	East Algoma	Elliot Lake & area	55.6%
Percentage of caries free students in JK/SK for the 2016-17 School Year	64%	76%	67%	59%	67%	

- North Algoma – Goulais River, Wawa, White River, Dubreuilville
- East Algoma – Blind River and Serpent River
- Central Algoma – Echo Bay, CASS, St. Joseph Island, Bruce Mines, Thessalon
- Elliot Lake & Area – Elliot Lake and Spanish
- Sault Ste. Marie

0% - no schools screened during this period.
Caries free is defined as no history or current decayed, missing, or filled teeth.

CONTRACEPTIVE PURCHASES	January – March, 2017					April – June, 2017					YTD - TOTAL
	Wawa	SSM	BR	EL	Total	Wawa	SSM	BR	EL	Total	
14-19 years	1	85	1	6	**93**	1	100	-	10	**111**	**204**
20-24 years	-	172	1	8	**181**	-	156	1	5	**162**	**343**
25 -2 9 years	1	186	-	9	**196**	-	198	-	4	**202**	**398**
30+ years	-	187	1	4	**192**	1	181	1	3	**186**	**378**
Total	**2**	**630**	**3**	**27**	**662**	**2**	**635**	**2**	**22**	**661**	**1323**

CONTRACEPTIVE PURCHASES	*July – September 1, 2017**					October – December 2017					YTD - TOTAL
	Wawa	SSM	BR	EL	Total	Wawa	SSM	BR	EL	Total	
14-19 years	-	59	-	-	**59**	-	-	-	-	**-**	**263**
20-24 years	-	103	-	-	**103**	-	-	-	-	**-**	**446**
25 -2 9 years	-	136	-	-	**136**	-	-	-	-	**-**	**534**
30+ years	-	108	-	-	**108**	-	-	-	-	**-**	**486**
Total	**-**	**406**	**-**	**-**	**406**	**-**	**-**	**-**	**-**	**-**	**1729**

CALLS TO THE SEXUAL HEALTH PHONE LINE	January 1 – March 31, 2017	March 31 – June 30, 2017	July 1 – September 1, 2017	Total for 2017 as of September 1, 2017
	889	908	717	2514

2017 Health Protection Indicators

		First Quarter (January – March)					Second Quarter (April–June)					YTD - TOTAL
		Wawa	SSM	BR	EL	Total	Wawa	SSM	BR	EL	Total	
Safe Water	Private Wells – Adverse DW	0	3	0	0	**3**	0	9	5	3	**17**	**20**
	Regulated Premise – ADW (O.reg.319)	0	1	0	0	**1**	0	0	1	0	**1**	**2**
	BWA issued	0	0	1	1	**2**	0	0	0	2	**2**	**4**
	DWA issued	0	0	0	0	**0**	0	0	0	0	**0**	**0**
	Beach closures	0	0	0	0	**0**	0	1	1	0	**2**	**2**
Rabies	#Rabies risk Investigations Initiated	0	31	8	5	**44**	0	41	5	8	**54**	**98**
Food Safety	Special Event Permits issued	0	26	5	7	**38**	0	35	25	11	**71**	**109**
	Food Handler Training (#persons)	0	98	21	0	**119**	0	94	1	30	**125**	**244**
	Farmer's Market Approvals	0	30	0	0	**30**	0	25	35	0	**60**	**90**
Health Hazard	Complaint/Investigations all types	0	60	7	0	**67**	0	51	6	0	**57**	**124**
Land Control – OBC	Applications/Permits – Class IV	0	3	0	0	**3**	2	37	12	1	**52**	**55**
Communicable Disease Control	#Institutional outbreaks	1	8	4	2	**15**	0	0	1	1	**2**	**17**
	Total outbreak days in quarter	50	137	38	21	**246**	0	0	11	0	**11**	**257**
	Gonorrhea	0	17	0	0	**17**	0	7	0	0	**7**	**24**
	Chlamydia (6 cases-location not identified)	5	61	1	7	**79**	0	48	1	8	**58**	**137**
	BBI (Hep B, C, HIV)	N/A	N/A	N/A	N/A	**31**	N/A	N/A	N/A	N/A	**18**	**49**
	Other Reportable Diseases	3	3	3	2	**29**	0	2	1	1	**24**	**59**
	Confirmed influenza cases	2	29	22	4	**57**	3	10	4	11	**28**	**85**

		Third Quarter (July - August)*					4th Quarter (October - December)					YTD - TOTAL
		Wawa	SSM	BR	EL	Total	Wawa	SSM	BR	EL	Total	
Safe Water	Private Wells – Adverse DW	1	27	8	3	**39**	0	0	0	0	**0**	**59**
	Regulated Premise – ADW (O.reg.319)	3	2	1	3	**9**	0	0	0	0	**0**	**11**
	BWA issued	3	0	1	0	**4**	0	0	0	0	**0**	**8**
	DWA issued	0	1	0	0	**1**	0	0	0	0	**0**	**1**
	Beach closures	0	3	3	0	**6**	0	0	0	0	**0**	**8**
Rabies	#Rabies risk Investigations Initiated	0	39	9	3	**51**	0	0	0	0	**0**	**149**
Food Safety	Special Event Permits issued	1	55	20	16	**92**	0	0	0	0	**0**	**201**
	Food Handler Training (#persons)	0	27	0	0	**27**	0	0	0	0	**0**	**271**
	Farmer's Market Approvals	0	8	5	0	**13**	0	0	0	0	**0**	**103**
Health Hazard	Complaint/Investigations all types	0	48	4	0	**52**	0	0	0	0	**0**	**176**
Land Control – OBC	Applications/Permits – Class IV	1	31	8	0	**40**	0	0	0	0	**0**	**95**
Communicable Disease Control	#Institutional outbreaks	0	4	1	0	**5**	0	0	0	0	**0**	**22**
	Total outbreak days in quarter	0	67	42	0	**109**	0	0	0	0	**0**	**366**
	Gonorrhea	0	1	0	2	**3**	0	0	0	0	**0**	**27**
	Chlamydia (6 cases-location not identified)	0	33	1	2	**36**	0	0	0	0	**0**	**173**
	BBI (Hep B, C, HIV)	N/A	N/A	N/A	N/A	**17**	N/A	N/A	N/A	N/A	**0**	**66**
	Other Reportable Diseases	0	5	0	1	**10**	0	0	0	0	**0**	**69**
	Confirmed influenza cases	0	0	0	0	**0**	0	0	0	0	**0**	**85**

Respectfully submitted,
Dr. Marlene Spruyt

ALGOMA PUBLIC HEALTH

FINANCE AND AUDIT COMMITTEE REPORT

FOR THE SEPTEMBER 27, 2017 BOARD MEETING

Meeting held on: September 13, 2017 – Started at 4:32 pm

In attendance:

Justin Pino, Joel Merrylees, Dr. Jennifer Loo, Ian Frazier, Lee Mason, Dr. Patricia Avery, Dennis Thompson

Secretary – Christina Luukkonen

Dr. Loo was welcomed to the meeting.

The Committee received a presentation regarding insurance brokerage services from Carlo DiCandia and Aldo Greco who represented Algoma Financial Group. The Committee will continue to review this topic and develop a recommendation to the Board prior to the Health Unit's insurance renewal period.

Justin provided a review of the financial statements for the period ended July 31, 2017. A few questions regarding variances were asked with acceptable answers provided. It is going to be the recommendation of the Committee that the Board approve the financial statements presented for the period ended July 31, 2017.

Justin provided an update that the Ministry' follow-up audit on the Health Unit has been deferred until sometime in the spring of 2018. The Ministry Audit Committee has directed that another public health unit be audited prior to APH. The Finance Committee took this to be a positive in that APH has moved down the priority list.

Next meeting is scheduled for November 8, 2017 at 4:00pm.

Meeting was adjourned at 5:39 pm.

Dan M Brown

Chair, Finance and Audit Committee
Algoma Public Health

9/15/17

Date

Algoma Public Health
(Unaudited) Financial Statements July 31, 2017

Algoma Public Health
Statement of Operations
July 2017
(Unaudited)

	Actual YTD 2017	Budget YTD 2017	Variance Act. to Bgt. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017
Public Health Programs						
Revenue						
Municipal Levy - Public Health	$ 2,615,526	$ 2,613,590	$ 1,936	$ 3,484,786	0%	100%
Provincial Grants - Public Health 75% Prov. Funded	4,263,699	4,263,700	(1)	7,309,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	1,569,889	1,569,866	23	2,691,200	0%	100%
Fees, other grants and recovery of expenditures	340,947	361,419	(20,473)	670,476	-6%	94%
Provincial Grants - Funding for Prior Yr Expenses	0	0	-	-		
Total Public Health Revenue	$ 8,790,060	$ 8,808,575	$ (18,515)	$ 14,155,662	0%	100%
Expenditures						
Public Health 75% Prov. Funded Programs	$ 6,035,024	$ 6,680,087	$ 645,063	$ 11,464,463	-10%	90%
Public Health 100% Prov. Funded Programs	1,410,468	1,557,175	146,707	2,691,200	-9%	91%
Total Public Health Programs Expenditures	$ 7,445,492	$ 8,237,263	$ 791,770	$ 14,155,662	-10%	90%
Excess of Rev. over Exp. 75% Prov. Funded	$ 1,185,147	$ 558,621	$ 626,525	$ (1)		
Excess of Rev. over Exp. 100% Prov. Funded	159,421	12,691	146,730	1		
Provincial Grants for Prior Yr Expenses	-	-	-	-		
Total Rev. over Exp. Public Health	$ 1,344,568	$ 571,313	$ 773,255	$ (0)		
Public Health Programs - Fiscal 17/18						
Provincial Grants and Recoveries	$ -	-	-	-		
Expenditures	-	-	-	-		
Excess of Rev. over Fiscal Funded	-	-	-	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ 623,011	$ 623,006	$ 5	$ 1,068,011	0%	100%
Municipal, Federal, and Other Funding	208,092	200,421	7,671	338,455	4%	104%
Total Community Health Revenue	$ 831,103	$ 823,427	$ 7,676	$ 1,406,466	1%	101%
Expenditures						
Healthy Babies and Children	$ 615,692	$ 623,006	$ 7,314	$ 1,068,011	-1%	99%
Child Benefits Ontario Works	13,732	14,077	345	24,135	-2%	98%
Algoma CADAP programs	171,489	176,353	4,864	302,319	-3%	97%
One-Time Funding programs	11,901	12,000	99	12,000	-1%	99%
Total Calendar Community Health Programs	$ 812,814	$ 825,436	$ 12,622	$ 1,406,465	-2%	98%
Total Rev. over Exp. Calendar Community Health	$ 18,289	$ (2,009)	$ 20,298	$ 1		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 1,890,017	$ 1,886,505	$ 3,512	$ 5,572,199	0%	100%
Municipal, Federal, and Other Funding	218,387	243,576	(25,188)	728,603	-10%	90%
Other Bill for Service Programs	15,618		15,618			
Total Community Health Revenue	$ 2,124,022	$ 2,130,080	$ (6,058)	$ 6,300,802	0%	100%
Expenditures						
Brighter Futures for Children	39,031	36,482	(2,548)	109,447	7%	107%
Infant Development	210,636	213,478	2,842	640,434	-1%	99%
Preschool Speech and Languages	211,619	204,752	(6,867)	614,256	3%	103%
Nurse Practitioner	42,760	42,584	(176)	127,753	0%	100%
Genetics Counseling	144,804	122,802	(22,001)	367,806	18%	118%
Community Mental Health	1,086,959	1,148,766	61,807	3,449,498	-5%	95%
Community Alcohol and Drug Assessment	219,360	241,386	22,025	724,157	-9%	91%
Healthy Kids Community Challenge	69,644	70,250	605	161,350	-1%	99%
Stay on Your Feet	32,569	33,333	764	100,000	-2%	98%
Bill for Service Programs	17,505	-	(17,505)	-		
Misc Fiscal	-	-	-	-		
Total Fiscal Community Health Programs	$ 2,074,888	$ 2,113,834	$ 38,945	$ 6,294,701	-2%	98%
Total Rev. over Exp. Fiscal Community Health	$ 49,134	$ 16,247	$ 32,887	$ 6,101		

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months

and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health
Revenue Statement
For the Seven Months Ending July 31, 2016
(Unaudited)

	Actual YTD 2017	Budget YTD 2017	Variance Bgt. to Act. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017	Comparison Prior Year: YTD Actual 2016	YTD BGT 2016	Variance 2016
Levies Sault Ste Marie	1,817,229	1,817,229	0	2,422,972	0%	75%	1,772,134	1,772,134	0
Levies Vector Bourne Disease and Safe Water	44,575	44,575	(0)	59,433	0%	75%	44,575	44,575	0
Levies District	753,722	751,786	1,936	1,002,381	0%	75%	739,560	733,134	6,426
Total Levies	**2,615,526**	**2,613,590**	**1,936**	**3,484,786**	**0%**	**75%**	**2,556,269**	**2,549,843**	**6,426**
MOH Public Health Funding	4,159,692	4,159,692	0	7,130,900	0%	58%	4,328,295	4,373,717	(45,422)
MOH Funding Vector Bourne Disease	63,407	63,408	(1)	108,700	0%	58%	63,407	63,408	(1)
MOH One Time Funding Dental Health	0	0	0	0		0%	27,967	19,833	8,134
MOH Funding Safe Water	40,600	40,600	0	69,600	0%	58%	40,600	40,600	0
Total Public Health 75% Prov. Funded	**4,263,699**	**4,263,700**	**(1)**	**7,309,200**	**0%**	**58%**	**4,460,269**	**4,497,558**	**(37,289)**
MOH One Needle Exchange	29,579	29,575	4	50,700	0%	58%	29,579	29,575	4
MOH Funding Haines Food Safety	14,350	14,350	0	24,600	0%	58%	14,350	14,350	0
MOH Funding CINOT/Healthy Smiles	449,108	449,108	(0)	769,900	0%	58%	276,802	239,517	37,285
MOH Funding - Social Determinants of Health	105,293	105,292	1	180,500	0%	58%	105,293	105,292	1
MOH Funding Chief Nursing Officer	70,879	70,875	4	121,500	0%	58%	70,879	70,875	4
MOH Enhanced Funding Safe Water	9,043	9,043	0	15,500	0%	58%	9,042	9,042	0
MOH Funding Unorganized	300,479	300,475	4	515,100	0%	58%	291,843	291,842	1
MOH Funding Infection Control	182,236	182,233	3	312,400	0%	58%	182,237	182,233	4
MOH Funding Diabetes	87,500	87,500	0	150,000	0%	58%			
MOH Funding Northern Ontario Fruits & Veg.	68,484	68,484	0	117,400	0%	58%			
Funding Ontario Tobacco Strategy	252,937	252,931	7	433,600	0%	58%	252,933	252,933	(0)
One Time Funding	0	0	0	0					
Total Public Health 100% Prov. Funded	**1,569,888**	**1,569,866**	**22**	**2,691,200**	**0%**	**58%**	**1,232,958**	**1,195,658**	**37,300**
Funding for Prior Yr Expenses	**0**	**0**	**0**	**0**		**0%**	**139,000**	**0**	**139,000**
Recoveries from Programs	5,868	5,869	(1)	10,061	0%	58%	5,873	5,869	4
Program Fees	138,953	145,684	(6,731)	249,743	-5%	56%	125,283	144,167	(18,884)
Land Control Fees	72,610	93,333	(20,723)	160,000	-22%	45%	63,940	93,333	(29,393)
Program Fees Immunization	96,113	104,708	(8,595)	179,500	-8%	54%	104,963	93,333	11,630
HPV Vaccine Program	8,458	3,300	5,158	12,500	0%	68%	3,018	5,833	(2,816)
Influenza Program	5,490	1,100	4,390	40,000	398%	14%	1,405	35,000	(33,595)
Meningococcal C Program	1,386	1,200	186	8,000	0%	17%	2,849	5,833	(2,984)
Interest Revenue	7,293	6,225	1,068	10,672	17%	68%	5,810	1,167	4,643
Other Revenues	4,777	0	4,777	0	0%	100%	0	96,250	(96,250)
Total Fees, Other Grants and Recoveries	**340,947**	**361,419**	**(20,473)**	**670,476**	**-6%**	**51%**	**313,141**	**480,786**	**(167,645)**
Total Public Health Revenue Annual	**$ 8,790,060**	**$ 8,808,575**	**$ (18,515)**	**$ 14,155,662**	**0%**	**62%**	**$ 8,701,637**	**$ 8,723,845**	**$ (22,209)**
Public Health Fiscal									
Panorama			0			0%			
Rabies Software			0			0%			
Smoke Free Ontario NRT			0			0%			
Practicum			0			0%			
Total Provincial Grants Fiscal	**$ -**	**$ -**	**$ -**	**$ -**		**0%**	**$ -**	**$ -**	**$ -**

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health

Expense Statement- Public Health

For the Seven Months Ending July 31, 2016

(Unaudited)

	Actual YTD 2017	Budget YTD 2017	Variance Act. to Bgt. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017	*Comparison Prior Year:* *YTD Actual 2016*	*YTD BGT 2016*	*Variance 2016*
Salaries & Wages	4,394,577	4,926,447	$ 531,871	$ 8,454,202	-11%	52%	$ 4,512,332	$ 4,848,357	$ 336,025
Benefits	1,164,678	1,161,208	(3,471)	1,993,632	0%	58%	1,131,698	1,212,089	80,392
Travel - Mileage	47,613	74,586	26,972	127,861	-36%	37%	64,281	85,390	21,108
Travel - Other	49,322	45,466	(3,856)	77,942	8%	63%	33,181	55,280	22,099
Program	334,026	422,591	88,564	735,528	-21%	45%	407,619	327,178	(80,441)
Office	71,098	78,687	7,590	135,250	-10%	53%	73,506	53,667	(19,839)
Computer Services	318,540	408,052	89,512	699,518	-22%	46%	391,511	522,613	131,101
Telecommunications	134,594	143,963	9,370	325,994	-7%	41%	146,195	127,115	(19,079)
Program Promotion	45,387	99,632	54,244	170,797	-54%	27%	50,846	124,883	74,037
Facilities Expenses	458,578	466,871	8,292	800,350	-2%	57%	477,865	474,789	(3,076)
Fees & Insurance	234,635	180,806	(53,829)	242,096	30%	97%	275,942	140,703	(135,239)
Debt Management	268,858	268,858	1	460,900	0%	58%	271,531	266,000	(5,531)
Recoveries	(76,414)	(39,905)	36,510	(68,408)	91%	112%	(54,688)	(82,182)	(27,494)
	$ 7,445,493	$ 8,237,263	$ 791,770	$ 14,155,662	-10%	53%	$ 7,781,819	$ 8,155,882	$ 374,063

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months
and variances of 10% and $10,000 occurring in the final 6 months

Notes to Financial Statements – July 2017

Reporting Period

The July 2017 financial reports include seven months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, Child Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting four month result from operations year ended March 31st, 2018.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of July 31st, 2017, Public Health programs are reporting a $773k positive variance.

Total Public Health Revenues are indicating a negative $19k variance. This is a result a result of Fees, Other Grants & Recoveries being less than budgeted. Land Control Fees are driving this negative variance. APH typically captures the bulk of its fees between the spring and fall months. The magnitude of the negative variance has been decreasing month over month.

There is a positive variance of $792k related to Total Public Health Expenses being less than budgeted. The $532k positive variance associated with Salary & Wages expense is driving this positive variance. The inherent time lag in filling positions within the agency is the primary contributor to the positive variance associated with Salary & Wages expense. In addition, the 2017 Public Health Operating Budget included the new positions of Associate Medical Officer of Health (AMOH) and Human Resource (HR) Manager. As of July 31st, the HR Manager position has been filled while the AMOH position is scheduled to start at the end of August 2017. Travel – Mileage, Program expenses, Computer Services expenses and Program Promotion expenses are also contributing to the positive variance. These positive variances are related timing of expenditures not yet incurred.

Community Health Calendar programs are operating within budget.

APH's Community Health Fiscal Programs are four months into the fiscal year.

On the revenue side, $6k negative variance is associated with timing of receipt of funding.

Genetics Counseling is showing a negative $22k variance. APH management is utilizing deferred revenue associated with the program by increasing the program FTE compliment by 0.2, by Public Health increasing the charges associated with the Genetics program for General Administration support to more accurately reflect actual usage, and by conducting an additional clinic with the goal of reducing wait times.

Notes Continued...

Public Health Revenue (see page 2 for details)

Public Health funding revenues are showing a negative $19k variance.

The municipal levies are within budget.

Provincial Grants are within budget.

There is a negative variance of $20k associated with Fees, Other Grants & Recoveries. This is a result of Land Control Fees being less than budgeted. APH typically captures the bulk of its fees between the spring and fall months. The magnitude of the negative variance has been decreasing month over month.

Public Health Expenses (see page 3)

Salary & Wages
Salary & Wages expense is indicating a positive variance of $532k. The inherent time lag in filling positions within the agency is the primary contributor to the positive variance associated with the Salary & Wages expense. In addition, the 2017 Public Health Operating Budget included the new positions of the AMOH and the HR Manager. As of July 31st, the HR Manager position has been filled while the AMOH position is scheduled to start at the end of August 2017.

Travel - Mileage
Travel – Mileage expense is indicating a positive variance of $27k. Staff travel typically occurs between the spring and fall months.

Program
Program expense is indicating a positive variance of $89k variance. This is a result of Program Materials and Supplies expense being less than budget, specifically vaccine purchases. Management will continue to monitor this line item as the year progresses.

Computer Services
Computer Services expense is showing a positive variance of $90k. The noted variance is a result of timing as general IT equipment purchases that have yet to be made. Furthermore, the annual Microsoft License renewal has yet to be purchased but is forthcoming which will reduce the noted positive variance.

Program Promotion
Program Promotion expense is indicating a positive $54k variance which is due to timing of expenditures not yet incurred. Specifically, staff professional development typically occurs between the spring and fall months.

Notes Continued…

Fees & Insurance

Fees & Insurance expense is showing a negative $54 variance. This is a result of higher than anticipated legal fees associated with various matters.

Recoveries
Recoveries are indicating a positive $37k variance. This is a result of Public Health increasing the charges associated with the Genetics program for General Administration support to more accurately reflect actual usage.

Financial Position - Balance Sheet (see page 7)

APH's cash flow position continues to be stable and the bank has been reconciled as of July 31st, 2017. Cash includes $325k in short-term investments.

Long-term debt of $5.34 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $331k of the loan relates to the financing of the Elliot Lake office renovations with the balance related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie.

There are no material collection concerns for accounts receivable.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of July 2017	**July 2017**	December 2016
Assets		
Current		
Cash & Investments	**$ 3,075,756**	$ 2,146,361
Accounts Receivable	**191,072**	509,998
Receivable from Municipalities	**99,235**	9,159
Receivable from Province of Ontario		
Subtotal Current Assets	**3,366,063**	2,665,518
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,102,170**	1,587,880
Payable to Gov't of Ont/Municipalities	**61,854**	321,402
Deferred Revenue	**514,742**	494,864
Employee Future Benefit Obligations	**2,550,458**	2,550,458
Term Loan	**5,903,861**	5,903,861
Subtotal Current Liabilities	**10,133,086**	10,858,466
Net Debt	**(6,767,022)**	(8,192,947)
Non-Financial Assets:		
Building	**22,732,421**	22,732,421
Furniture & Fixtures	**1,914,772**	1,914,772
Leasehold Improvements	**1,572,807**	1,572,807
IT	**3,244,030**	3,244,030
Automobile	**40,113**	40,113
Accumulated Depreciation	**(7,690,685)**	(7,690,685)
Subtotal Non-Financial Assets	**21,813,456**	21,813,456
Accumulated Surplus	**15,046,434**	13,620,509

ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE MEETING
JUNE 14, 2017
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Patricia Avery Ian Frazier Lee Mason Dennis Thompson	
APH STAFF PRESENT:	Dr. Marlene Spruyt	Medical Officer of Health
	Justin Pino	Chief Financial Officer
	Joel Merrylees	Manager of Accounting and Budgeting
	Christina Luukkonen	Recording Secretary
Regrets:	Dennis Thompson	

1) CALL TO ORDER:
Mr. Frazier called the meeting to order at 4:33pm. Mr. Frazier welcomed Ms. Avery to the Committee.

2) DECLARATION OF CONFLICT OF INTEREST
Mr. Frazier called for any conflict of interests; none were reported.

3) ADOPTION OF AGENDA ITEMS

FC2017-17 Moved: L. Mason
Seconded: P. Avery

THAT the agenda items for the Finance and Audit Committee dated June 14, 2017 be adopted as amended.
CARRIED.

4) ADOPTION OF MINUTES

FC2017-18 Moved: I. Frazier
Seconded:

THAT the minutes for the Finance and Audit Committee dated April 19, 2017 be adopted as circulated.
CARRIED.

5) FINANCIAL STATEMENTS

a. Draft Financial Statements for the Period ending April 30, 2017
J. Pino spoke to the draft financial statement that was included in the agenda package.

P. Avery asked questions regarding the fraud incident and the steps the Finance & Audit Committee have taken to ensure no future incidents occur at APH. L. Mason and I. Frazier spoke to the work the committee has done to ensure policies and procedures are up-to-date and better checks are in place.

FC2017-19 Moved: P. Avery
Seconded: L. Mason

THAT the Finance and Audit Committee recommends the draft Financial Statements for the Period ending April 30, 2017 and puts forth to the Board for approval.

CARRIED.

6) BUSINESS ARISING FROM MINUTES

a. Summary of Budget Expenses
As previously requested by the Finance and Audit Committee, management provided the committee with a listing of larger expenses incorporated into the budget in the month that the expense is projected to occur.

b. Building Condition Assessment Update
A brief history was provided on the process for the building condition assessment for the new committee member. The Ministry of Child and Youth Services is conducting building condition assessments. APH's assessment has been delayed again until 2018-2020 time frame. More information will be provided in 2018. The committee agrees to wait for the ministry's assessment at this time as our building is only 6 years old.

7) NEW BUSINESS/GENERAL BUSINESS

a) Insurance Broker Services
J. Pino spoke to the briefing note provided in the agenda package. The committee discussed providing a forum for other insurance brokers to present their services.

FC2017-20 Moved: L. Mason
Seconded: P. Avery

THAT the Finance and Audit Committee recommends providing a forum for interested brokers to present their service offerings with a five-year commitment offered to the successful broker and puts forth to the Board of Health for approval.

b) 02-04-030 Procurement Policy
Procurement policy was attached for reference for the Insurance Broker Services discussion.

c) Land Control Fees – Briefing Note
The committee discussed the proposed fee increases.

FC2017-21 Moved: P. Avery
Seconded: L. Mason

THAT the Finance and Audit Committee recommends puts forth to the Board of Health the noted fee increases for the 2018-2020 budget years inclusive for approval.

PROPOSED FEE CHANGES	2017 Rate	2018 Rate (Proposed)	2019 Rate (Proposed)	2020 Rate (Proposed)
Class 2 - Greywater system (leaching pit)	$250	$250	$275	$300
Class 3 - Cesspool System	$250	$250	$275	$300
Class 4 - Leaching bed system (septic tank and leaching bed)	$750	$850	$900	$950
Class 4 - Tank replacement	$300	$325	$350	$375
Class 4 - Leaching bed replacement/alteration	$500	$550	$600	$650
Class 5 - Holding tank system	$500	$800	$850	$900
Sewage system demolition/decommissioning	$100	$125	$150	$150
Transfer of Permit	$50	$75	$100	$100

Revision of Permit (no inspection required)	$100	$100	$125	$150
Revision of Permit (inspection required)	$250	$300	$325	$350
File Request (copy of permit on file)				
▪ **Greater than 5 days' notice**	$75	$100	$125	$125
▪ **Less than 5 days' notice**	$150	$175	$200	$200

d) 02-05-065 – Algoma Board of Health Reserve Fund Policy Review
Minor changes made to the policy.

FC2017-22 Moved: L. Mason
Seconded: P. Avery

THAT the Finance and Audit Committee recommends puts forth to the Board of Health changes to policy 02-05-068 Algoma Board of Health Reserve Fund for approval.

8) IN-COMMITTEE - Deferred

9) OPEN MEETING – N/A

10) Addendum - None

11) NEXT MEETING: September 13, 2017

12) THAT THE MEETING ADJOURN:

FC2017-23 Moved: L. Mason
Seconded:

THAT the meeting of the Finance and Audit Committee adjourns at 5:53pm.
CARRIED.

Algoma Public Health

Governance Standing Committee Meeting Report

September 13, 2017

The committee was presented with a draft dashboard template for Prevention and Promotion Performance Indicator Report.

Some clarifications were made regarding the indicators within the report. The data was program specific and will be presented to the board for their review and input. It was agreed that this was a good start and will develop as the performance indicators are clarified with the ministry and the APHU team is able to develop data collection mechanisms that provide the most relevant data.

A policy and procedure is being finalized regarding the Elections and Selection Process for Board Chair, Vice-Chairs and Committee members.

Review of the following policies has been started

- Conflict of Interest Policy
- Code of Conduct
- Performance Evaluation for MOH CEO

The Governance Committee will review these policies and provide feedback for next meeting in November.

The orientation process for incoming Board Members will be reviewed at our next meeting.

Deborah Graystone
Chair, Governance Standing Committee

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-075
DATE:	O: September 2017 R:	**SECTION:**	Board
PAGE:	**1** of **3**	**SUBJECT:**	Election of Chair, Vice-Chairs or Committee Members

POLICY:

The purpose of this policy is:

a) To ensure that the Board of Health for the District of Algoma Health Unit (the Board) utilizes fair, reasonable and efficient methods to elect its Chair, Vice-Chair and appoint committee members.
b) To promote the involvement of all Board members by encouraging participation on standing committees.
c) To ensure for representation from across entire district on each committee to allow for an authentic voice in discussions.
d) To detail the process to elect the Chair of the Board, the First Vice-Chair of the Board (Chair of the Finance and Audit Committee), the Second Vice-Chair of the Board (Chair of the Governance Committee) and to appoint the two Standing Committee members -Governance Committee and Finance and Audit Committee at the first meeting of the Board each year.
e) To hold the election/selection process at the first meeting of every year.
f) It is the policy of Algoma Public Health to follow all applicable regulations as set out in the Municipal Act and the Heath Promotion and Prevention Act when conducting elections in at APH.

Nominations

The Secretary to the Board will send a callout for expressions of interest for nominations the week before the first Board meeting of the New Year.

A candidate may nominate themselves or another Board member for any position. Seconders are not required. If the number nominated is equal to the number of positions available at hand, then the member(s) will be considered acclaimed. If the number nominated is more than the number of positions available at hand, then a formal election process will be held. A call for nominations will occur three times.

PROCEDURES:

Call for Nominations

Board Chair/MOH/CEO or Delegate:

1) Call for nomination to the seat at hand.
   "*Nominations* are now open for the position of_____. This is the first call." Any names are written down. "This is the second call for nominations for the position of _____." New names are noted. "This is the third and final call for nominations for the position of _____." Final names are recorded. "Nominations are closed for the position of _____."

2) Once nomination call is completed, nominees will be asked if they accept the nomination.

"_____, you have been nominated for the position of _____. Do you accept the nomination to stand?" Any nominee that does not accept will have their name removed from the nomination call list.

3) If only one is received that person is acclaimed for the position. If more than one nomination is received a formal election process will take place. See Election of Board Chair or Board Vice-Chair

Election of Board Chair

MOH/CEO or Delegate:

1) Read out the names of the candidates in the order they were nominated.

2) Each member will have up to two minutes to explain their candidacy platform

3) Vote will be conducted by secret ballot. Each board member will write the candidate they are voting for on a piece of paper.

   The candidate with the most votes will be ordered and the seat will be filled.

4) In the event of a tie, the other nominees will be dropped from the vote and a re-ballot will occur with remaining nominees

5) In the event of tie for the seat still exists after a second ballot, the tied members names will be put into a container and a name drawn out.

6) Successful candidate of the election process will be considered appointed to the seat at hand.

7) Should no one be nominated for the position of Board Chair, the process will continue for the remaining positions of the Vice Chairs.

   The First Vice-Chair would then become the acting Chair until that position is filled formally.

Election of Board Vice-Chairs

Elected Board Chair

1) Takes charge of the meeting and proceeds with the election of the Vice Chairs.

2) Follow same procedure for electing chair.

Selection Procedure for Committee Members

Board Chair

1) Call for names to be submitted of Board members interested in sitting on a specific committee.

Board Members

2) Submit a form with their name and any information they believe is pertinent to being selected for a committee.

Board Chair and Vice-Chairs	3) Collect completed forms of interested board members and discuss who will be place on which committee. Members will be placed on one committee to allow for the most possible people to take part. 4) Should there remain any vacancies on the committees, they will be filled by appointment through application to the Chair and Vice-Chairs and serve the remainder of the term of the committee.

Knowledge

Bylaw 95-1 – To Regulate the Proceeding of the board of Health

ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE MEETING
JUNE 15, 2017 @ 5:00PM
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Ian Frazier	Deborah Graystone Lee Mason
COMMITTEE MEMBER REGRETS:	Heather O'Brien	
APH STAFF PRESENT:	Marlene Spruyt	Medical Officer of Health/CEO
	Christina Luukkonen	Recording Secretary

1) CALL TO ORDER:
Ms. Graystone called the meeting to order at 5:04pm

2) DECLARATION OF CONFLICT OF INTEREST
Ms. Graystone called for any conflict of interests; none were reported.

3) ADOPTION OF AGENDA ITEMS
Adopted with the addition of 6a) New Board Member Orientation

GC2017-10 Moved: L. Mason
Seconded: I. Frazier

THAT the agenda items for the Governance Standing Committee dated June 15, 2017 be adopted as amended.
CARRIED.

4) ADOPTION OF MINUTES

GC2017-11 Moved: L. Mason
Seconded: I. Frazier

THAT the minutes for the Governance Standing Committee dated April 12, 2017 be adopted as presented.
CARRIED.

5) BUSINESS ARISING FROM MINUTES

a. By-law Review
   i. By-Law 95-1 – To Regulate the Proceeding of the Board
   ii. By-Law 95-2 – To Provide for Banking and Finance
   iii. By-Law 95-3 – To Provide for the Duties of the Auditor of the Board
   iv. By-Law 2015-01 – To Provide for the Management of Property
   v. By-Law 06-01 – Construction, Demolition and Change of Use Permits and Inspections
   vi. By-Law 06-02 – To Appoint a CBO and Inspectors and to Establish a Code of Conduct for the CBO and Inspectors

The Committee discussed changes to reviewed bylaws. Dr. Spruyt to make final changes to Bylaw 06-02 and circulate electronically among the committee members before bringing forth to the board. All revised and reviewed bylaw will go forth to board for approval on June 28, 2017

GC2017-12 Moved: I. Frazier

Seconded: L. Mason

THAT the Governance Standing Committee recommends and puts the following reviewed/revised Bylaws to the Board of Health for approval:

- Bylaw 95-1 – To Regulate the Proceedings of the Board (Revised)
- Bylaw 95-2 – To Provide for Banking and Finance (Reviewed)
- Bylaw 95-3 – To Provide for the Duties of the Auditor of the Board (Revised)
- Bylaw 2015-01 – To provide for the Management of Property (Reviewed)
- Bylaw 06-01 – Sewage Systems Part 8 of the Ontario Building Code Act (Revised)
- Bylaw 06-02 – To Appoint a Chief Building Officer and Inspectors and to Establish a Code of Conduct (Revised)

CARRIED.

b. MOH Performance Indicator Report Template

Dr. Spruyt provided a copy of the health protection indicator report that she will be adding to her MOH/CEO monthly report to the Board. The Ministry's Accountability Indicators are to not included on this report as they are already reported to the Board in a separate report. Currently there is no way to measure health promotion. Dr. Spruyt will speak with our Epidemiologist about other measurements that are available to incorporate in the report.

The committee members made formatting suggestions that will be incorporated. Committee members inquired about Sharps pickup in the district offices. Dr. Spruyt will follow-up.

c. Elections and Selection Process for Board Chair and Committees

Mrs. Luukkonen will make the approved changes and bring forth to the September committee meeting.

d. Board of Health Evaluations

i. 02-05-055 Board of Health Evaluation Policy
ii. Annual Self-Evaluation Template
iii. Monthly Board Meeting Evaluation Template

Mrs. Luukkonen to make the approved changes and bring forth to the Board for approval on June 28, 2017

GC2016-13 Moved: I. Frazier
Seconded: L. Mason

THAT the Governance Standing Committee recommends and puts forth to the Board of Health policy 02-05-055 Board of Health Evaluation and the revised annual self-evaluation and monthly board meeting evaluation for approval.

CARRIED.

6) NEW BUSINESS/GENERAL BUSINESS

a. Orientation for new Board members

Mrs. Luukkonen to forward current orientation checklist used for new board members to committee members for input.

7) ADDENDUM – N/A

8) IN COMMITTEE – N/A

9) OPEN MEETING – N/A

10) NEXT MEETING:

11) THAT THE MEETING ADJOURN:

GC2016-14 Moved: L. Mason
Seconded: I. Frazier

THAT the Governance Standing Committee meeting adjourns.
CARRIED.

Algoma PUBLIC HEALTH
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www.algomapublichealth.com

Briefing Note

To: The Board of Health

From: Chronic Disease Prevention Program - Tobacco

Date: September 27, 2017

Re: Plain and Standard Tobacco Packaging and Products

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Advertising bans restrict much of the promotion of tobacco products but tobacco packages are currently not included in these bans

RECOMMENDED ACTION:

The Board of Health for Algoma endorse the Canadian Coalition for Tobacco recommendation for plain and standardized packaging of all tobacco products in Canada.

BACKGROUND:

Tobacco use is still the number one cause of preventable death in Canada. [2]

The tobacco industry recognizes that the product and its package are valuable marketing spaces used to communicate many messages. [1, 2]

The standardization of tobacco product packages include those for cigarettes, cigars, cigarillos/little cigars, pipe tobacco, smokeless tobacco or chew, waterpipe tobacco/shisha, loose/roll-your-own tobacco, cigarette papers, filters, tubes, and blunt wraps/bluntarillos. [2]

Plain packaging would prohibit brand colours, logos and graphics on tobacco packages, and ensure all brand packages look the same and equally convey messages warning the user on the harms of tobacco. [2, 3]

Package dimensions would be standardized, thus eliminating slims packs targeting women. [2]

The visual appearance of the cigarette itself also needs to be standardized including the shape, size, colour and filters. [2]

Marketing and advertising features on the cigarette such as logos, text, embossment, characterizing features and any other enhancements would be banned. [2]

Primary impacts of plain and standardized packaging include, diminished appeal of tobacco products; increased effectiveness of the health warnings; and reduced ability of the product and its packaging to mislead consumers about the harmful effects of tobacco use(e.g.use of mild or light terminology) [2, 3]

Plain and standardized packaging has already reduced tobacco use in Australia, and would be expected to have the same effect in Canada. [1, 3]

Plain and standardized tobacco packaging and products was part of the Federal Liberal Party's 2015 election platform and included in Prime Minister Trudeau's mandate letter to the Minister of Health. [2]

ASSESSMENT OF RISKS AND MITIGATION:

None identified

FINANCIAL IMPLICATIONS:

None identified

OPHS STANDARD:

Chronic Disease and Injury Prevention Standard

STRATEGIC DIRECTION:

Improve Health Equity, Collaborate Effectively

CONTACT:

Laurie Zeppa, Director

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[1] Non-Smokers' Rights Association/Smoking and Health Action Foundation, July (2016). Plain and Standardized Tobacco Packaging: Correcting the Myths
http://nsra-adnf.ca/key-issue/plain-and-standardized-tobacco-packaging-correcting-the-myths/

[2] Heart and Stroke Foundation, Plain and standardized tobacco packaging and products: Protecting our children's health from tobacco marketing
http://www.cacpr.ca/documents/PSPHSFstatement.pdf

[3] Canadian Cancer Society, June (2016). Plain Packaging – International Overview
https://www.cancer.ca/~/media/cancer.ca/CW/for%20media/Media%20releases/2016/plain-packaging-overview---2016-01-11.pdf?la=en

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June 30, 2017

VIA EMAIL

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

Dear Premier Wynne:

Re: The Fair Workplaces, Better Jobs Act (Bill 148)

At its meeting on June 15, 2017, the Sudbury & District Board of Health carried the following resolution #37-17:

> WHEREAS the Sudbury & District Board of Health has a mandate to decrease health inequities such that everyone has equal opportunities for health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances; and
>
> WHEREAS the Board of Health discharges this mandate through a long history of strategies including advocacy, strategic direction, policy development and program interventions; and
>
> WHEREAS the Sudbury & District Board of Health participated in the 2015 Changing Workplaces Review public consultations and recommended that the provincial government strengthen minimum employment standards and reduce barriers to collective bargaining for all workers, especially those in precarious employment, to ultimately improve health outcomes;
>
> THEREFORE BE IT RESOLVED that the Sudbury & District Board of Health commend the provincial government's actions to address the root causes of precarious work through the Changing Workplaces Review of 2015-16 and subsequent introduction of Bill 148; and
>
> FURTHER THAT the Board of Health support the proposed changes to the Employment Standards Act that expand the pay equity provisions and increase the minimum wage for workers and the proposed changes to the Labour Relations Act that better support precarious workers' rights; and
>
> FURTHER THAT the Board of Health urge the provincial government to adopt the World Health Organization (WHO) definition of a healthy workplace; and

> THAT the Sudbury & District Board of Health share this motion and supporting materials with SDHU community agencies, municipalities and elected representatives, and the Association of Local Public Health Agencies (alPHa), Ontario Boards of Health and others as appropriate.

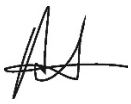
Workplaces are a critical determinant of health, and the health promoting or heath damaging nature of workplaces impacts all workers, their families, neighbourhoods, communities and society[i].

Support from public health for an increase in minimum wage comes from the overwhelming evidence confirming the link between income and health. People living with lower incomes have far greater risks of premature morbidity and mortality than those people living with higher incomes[ii,iii,iv,v,vi].

Precarious work is also a significant contributor to poor health and health inequalities[vii,viii,ix]. Precarious workers are more likely to experience more difficult working conditions and lower autonomy and control over working conditions and arrangements than non-precarious workers[x].

Members of the Sudbury & District Board of Health commend the provincial government on the proposed mechanisms in the Fair Workplaces, Better Jobs Act (Bill 148) to strengthen employment standards in support of workplace health. Further, the members of the Sudbury & District Board of Health strongly urge the provincial government to ratify the (Bill 148) in order to protect and promote the health of Ontarians including those individuals working in precarious employment.

Sincerely,



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

cc: Hon. Eric Hoskins, Minister of Health and Long-Term Care, Ontario Government
Hon. Kevin Flynn, Minister of Labour, Ontario Government
Ms. Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Ms. Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ms. Pegeen Walsh, Executive Director, Ontario Public Health Association
Ms. Alison Stanley, Executive Director, Federation of Northern Ontario Municipalities
Mr. Glenn Thibeault, MPP, Sudbury
Ms. France Gélinas, MPP, Nickel Belt
Mr. Michael Mantha, MPP, Algoma-Manitoulin
Ontario Boards of Health

[i] Jackson, A., & Rao, G. (2016). The unhealthy Canadian workplace. In: Raphael D, editor. Social determinants of health: Canadian perspectives. 3rd ed. Toronto, ON: Canadian Scholars' Press Inc; 2016. p. 99-113.

[ii] Commission on Social Determinants of Health. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization, 2008.

[iii] Health Canada. Chief Public Health Officer's Report on the State of Public Health in Canada 2008 (Catalogue HP2-10/2008E) Ottawa: Minister of Health, 2008.

[iv] McIntosh CN, Finès P, Wilkins R, Wolfson MC. Income disparities in health-adjusted life expectancy for Canadian adults, 1991 to 2001. Health Reports 2009; 20(4): 55-64. Erratum in: Health Reports 2010; 21(4): 101.

[v] Braveman PA, Cubbin C, Egerter S, et al. Socioeconomic disparities in health in the United States: what the patterns tell us. American Journal of Public Health 2010; 100(S1): S186-96.

[vi] Tjepkema, M., Wilkins, R., Long, A. (2013). Cause-specific mortality by income adequacy in Canada: A 16-year follow-up study. Health Reports, Vol. 24, no. 7, pp. 14-22, July 2013 • Statistics Canada, Catalogue no. 82-003-X

[vii] European Foundation for the Improvement of Living Working Conditions. (2002). Quality of work and employment in Europe: Issues and challenges. Foundation paper No. 1. Retrieved from http://www.eurofound.europa.eu/publications/foundation-paper/2002/working-conditions/quality-of-work-and-employment-in-europe-issues-and-challenges-foundation-paper-no-1-february-2002

[viii] Quinlan, M., Mayhew, C., & Bohle, P. (2001). The global expansion of precarious employment, work disorganization, and consequences for occupational health: a review of recent research. International Journal of Health Services 31(2):335-414.

[ix] Ontario Society of Nutrition Professionals in Public Health Food Security Workgroup. (2015). Income-related policy recommendations to address food insecurity. Retrieved from www.osnpph.on.ca/membership/documents.

[x] Lewchuk, W., Lafleche, M., Dyson, D., Goldring, L., Meisner, A., Procyk, S., et al. (2013). It's more than poverty: Employment precarity and household well-being. Poverty and Employment Precarity in Southern Ontario Research Group. United Way Toronto: McMaster University.

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September 1, 2017

The Fair Workplaces, Better Jobs Act, 2017 (Bill 148)

The Northwestern Health Unit expects Provincial Bill 148: Fair Workplaces, Better Jobs Act, 2017 will lead to significantly improved health outcomes for many residents in the region. As such, the Board of Health has shown its support of the Bill by passing a resolution (attached) at its August 28th meeting commending the provincial government for taking steps to improve income levels and working conditions.

Decades of research show that people with lower incomes have poorer physical and mental health and higher rates of mortality. The poorer you are, the more likely you are to have health risks in your daily life, and difficulties accessing adequate healthy food or affordable safe housing. It is estimated that the changes to the minimum wage outlined in Bill 148 will increase the wages and improve the working conditions of more than one quarter of Ontario workers.

The Bill, now under consideration by the Standing Committee on Finance and Economic Affairs, will move into Second Reading in September 2017, and must go through Third Reading and Royal Assent prior to the proposed implementation date of January 1st, 2018. As the Bill proceeds, it is important to be aware of the potential health, social and economic benefits this significant piece of legislation may provide for local families, employers and the community as a whole. The attached Public Health Communique provides further details regarding these benefits and outlines the rationale for the Board of Health support for this Bill.

If you have any questions please feel free to contact me at 807-468-3147 or email kyounghoon@nwhu.on.ca.

Sincerely,

K. Young Hoon.

Dr. Kit Young Hoon, MBBS, MPH, MSc, FRCPC
Medical Officer of Health
Northwestern Health Unit

Northwestern Health Unit
www.nwhu.on.ca

NORTHWESTERN HEALTH UNIT
BOARD OF HEALTH
MOTION/RESOLUTION

No. 64 -2017

Moved by .....

Seconded by .....

WHEREAS, the Northwestern Health Unit Board of Health has a mandate to decrease health inequities such that everyone has equal opportunities for health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances; and

WHEREAS, a day's work deserves a fair day's pay and no one working full-time to support a family should have to live in poverty; and

WHEREAS, the current minimum wage is not adequate to cover basic needs, and low-income individuals and families are more likely to be challenged with social factors such as low education, precarious employment, inadequate housing, and social exclusion; and

WHEREAS, the costs of food, housing, child care and transportation make it increasingly difficult for low-wage workers to make ends meet; and

WHEREAS, over 1 in 10 people in the NWHU catchment area (11.1%) are in low-income households and nearly 1 in 5 children (19.4%) live in low-income houses compared with 18.1% provincially; and

WHEREAS, the NWHU region has a higher proportion of the population considered to have lower socioeconomic status when compared with the rest of the province, and this population is at risk of experiencing health inequities, both in terms of health outcomes and access to care; and

WHEREAS, evidence confirms that people with lower incomes have higher rates of mortality, and poorer physical and mental health; and
WHEREAS, through the proposed amendments to the Employment Standards Act and the Labour Relations Act, it is estimated that more than one quarter of Ontario workers will receive an increase in their wages, along with more stable and fair employment conditions; and
WHEREAS, Bill 148 will help to assure health, social and economic benefits for the communities as a whole;

THEREFORE BE IT RESOLVED that the Northwestern Board of Health commend the provincial government's actions to address the root causes of precarious work through the Changing Workplaces Review of 2015-16 and subsequent introduction of Bill 148; and

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NORTHWESTERN HEALTH UNIT
BOARD OF HEALTH
MOTION/RESOLUTION

FURTHER BE IT RESOLVED THAT the Board of Health support the proposed changes to the Employment Standards Act that expand the pay equity provisions and increase the minimum wage for workers and the proposed changes to the Labour Relations Act that better support precarious workers' rights; and that the Northwestern Board of Health share this motion and supporting materials with community agencies, municipalities and elected representatives, and the Association of Local Public Health Agencies (alPHa), Ontario Boards of Health and others as appropriate.

carried ✓ Aug. 25/17.

Paul Pape
Chair

Public Health
COMMUNIQUÉ

September 1, 2017

Health Benefits of the Fair Workplaces, Better Jobs Act, 2017 (Bill 148)

Issue

On May 30, 2017, Bill 148, the *Fair Workplaces, Better Jobs Act*[i] was introduced, which includes a number of amendments to the Employment Standards Act (ESA) and the Labour Relations Act (LRA) to address issues related to the growth of precarious employment in Ontario. From a public health perspective, this significant piece of legislation will provide important mechanisms that will contribute to substantial health benefits for individuals and communities in Northwestern Ontario and throughout the province.

Background

Bill 148 outlines proposed amendments to the ESA and LRA identified through the Changing Workplaces Review of 2015-16. Key elements of Bill 148 that will contribute to improvements in individual and workplace health include:

- Increasing Ontario's minimum wage to $14 per hour on January 1, 2018, and $15 per hour on January 1, 2019, followed by annual increases at the rate of inflation;
- Pay equity for part-time, temporary, casual and seasonal employees doing the same work as full-time employees;
- Mandating increased employee benefits for all employees (e.g., two days of personal emergency leave per year, three weeks' vacation after five years of employment, making scheduling fairer for employees through compensation for shift cancellations with less than 48 hours' notice)[ii].

The Bill will move into Second Reading in September 2017, and must go through Third Reading and Royal Assent prior to the proposed implementation date of January 1st, 2018.

Income and Health

The World Health Organization has declared poverty as the single largest determinant of health. An accumulation of evidence over many decades confirms that people with lower incomes have higher rates of mortality, and poorer physical and mental health. The poorer you are, the more likely you are to have health risks in your daily life, such as not having access to adequate healthy food or affordable, safe housing. You are also less likely to access important health services, more likely to have multiple chronic conditions that can lead to further health problems (such as diabetes and heart disease), and more likely to die younger. A 2013 report by Statistics Canada demonstrates that income inequality is associated with the premature death of 40,000 Canadians a year. That's equal to 110 Canadians dying prematurely each day.[iii] Children who live in poverty are more likely to have low birth weights, asthma, type 2 diabetes, poorer oral health and suffer from malnutrition. They also have higher rates of death due to unintentional injuries, and are more likely to live in poverty as adults. As incomes increase, health risks decrease, access to high quality health care gets better, and health outcomes, such as life expectancy, improve.[iv]

In Northwestern Ontario

For too many Ontario workers, full time work does not guarantee a life above the poverty line. Low income, job insecurity and costs of living make it increasingly more difficult to make ends meet. In Northwestern Ontario, people tend to be more disadvantaged than the rest of the province when considering the factors that determine health. Over 1 in 10 people in the region (11.1%) are in low-income households. Nearly 1 in 5 children (19.4%) live in low-income houses compared with 18.1% provincially. Formal education rates are also lower in the area when compared to the province: 76% of people aged 25-29 have completed high school compared with 91% provincially, and 54% of people aged 25-54 have post-secondary education compared with 67% provincially. In 2016 there were about 1600 people in our municipalities who reported being food insecure.[v]

These statistics indicate that in general, the region has a higher proportion of the population considered to have lower socioeconomic status when compared with the rest of the province; and this population is at risk of experiencing health inequities, both in terms of health outcomes and access to care. These statistics also highlight the significant impact that Bill 148 would have on the lives of individuals, families and communities in our region.

Impact of Bill 148

Low income is a major contributor to many of the problems that put strain on public resources and affect the overall quality of life in our communities. Providing a living wage and benefits not only leads to better lives for employees and their families, but also reduces the strain on health services, policing, food banks, housing programs, and other public services. The potential benefits of supporting, paying and earning an increased minimum wage are far reaching for families, employers and the community as a whole.[vi]

EMPLOYEES and FAMILIES

- Paid fair compensation for their work
- Increased sense of worth/dignity
- Raised out of poverty
- Better quality of life
- Improved health
- Increased social inclusion, access to leisure activities, material resources and education/skills training

EMPLOYERS

- Reduced absenteeism
- Decreased turnover rates
- Lower recruitment and training costs
- Increased morale, productivity and loyalty
- Recognized as a responsible employer

COMMUNITY

- Greater consumer spending power
- Increased spending in local economy
- Increased civic engagement
- Improved health
- Perception of increased standard of fairness

It is estimated that over 30 percent of Ontario workers were engaged in precarious employment in 2014, and part time work has grown to make up nearly 20 percent of total employment. The provincial government estimates that half of workers in Ontario who earn less than $15 per hour are between the ages of 25 and 64, and that the majority of these workers are women. Through the proposed changes to minimum wage, the ESA and LRA, it is estimated that more than one quarter of Ontario workers will receive an increase in their wages, along with more stable and fair employment conditions [vii]

In a recent Maclean's article, economist Armine Yalnizyan highlights that although there may be some job loss in the short term, increasing the minimum wage will boost the local economy in the long run. She states, "When lower income households see a sustained rise in incomes, they spend virtually all of it. Most goes to food, better health care and more education. Sometimes it goes to rent (improved housing). Almost all of this spending stays in the local economy."[viii] The Canadian Centre for Policy Alternatives also reported that there is "no consistent evidence that minimum wage levels affect employment in either direction. The net effect of reduced terminations combined with reduced hiring is that the proportion of adults who are employed at any given time is the same when minimum wage is higher or lower. But the nature of the work conditions and relationship are changed."[ix] [x]

Conclusions

Currently, poor people in Ontario pay for their low income with their health.[xi] Increasing the provincial minimum wage will help families to cover basic needs and lead to improvements with respect to health, poverty, unaffordable housing, food insecurity, and social exclusion. The proposed changes to pay equity and employee benefits supports the health of those who are in unstable forms of employment such as part time, temporary and casual work. Bill 148 can have significant health benefits and is one of the most important initiatives the government could undertake to promote health, well-being and equity amongst all people.

Resources (links)

For more information, please visit:
Fair Workplaces, Better Jobs Act, 2017
Living Wage Canada
Northwestern Health Unit – Health Equity
Canadian Centre for Policy Alternatives – Ontario Needs a Raise

Contact

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[i] Legislative Assembly of Ontario. (2017). *Bill 148, Fair Workplaces, Better Jobs Act, 2017.* Standing Committee on Finance and Economic Affairs. Retrieved from http://www.ontla.on.ca/web/committee-proceedings/committee_business.do?locale=en&BillID=4963&CommID=144&BusinessType=Bill
[ii] Ontario Ministry of Labour. (2017). *Backgrounder - Proposed Changes to Ontario's Employment and Labour Laws* [News release]. Retrieved from https://news.ontario.ca/mol/en/2017/05/proposed-changes-to-ontarios-employment-and-labour-laws.html
[iii] Upstream. The Health Effects of Income Inequality. (2014). Retrieved from http://www.thinkupstream.net/health_effects_of_income_inequality
[iv] Health Quality Ontario. Income and Health: Opportunities to achieve health equity in Ontario. Toronto: Queen's Printer for Ontario; 2016.
[v] Northwestern Health Unit. (2016). Health equity and the social determinants of health: Information for program planning and evaluation
[vi] Living Wage Canada http://www.livingwagecanada.ca/index.php/about-living-wage/living-wage-makes-sense/
[vii] Office of the Premier. (2017). *Fair Workplaces, Better Jobs* [News release]. Retrieved from https://news.ontario.ca/opo/en/2017/05/fair-workplaces-better-jobs.html
[viii] Maclean's. Why a $15 minimum wage is good for business. (2017). Retrieved from http://www.macleans.ca/economy/economicanalysis/why-a-15-minimum-wage-is-good-for-business/
[ix] CCPA. The Case for Increasing the Minimum Wage (2015). Retrieved from https://www.policyalternatives.ca/sites/default/files/uploads/publications/BC%20Office/2015/04/CCPA-BC-Case-for-Incr-Minimum-Wage_0.pdf
[x] CCPA. Dispelling Minimum Wage Mythology. (2014). Retrieved from https://www.policyalternatives.ca/publications/reports/dispelling-minimum-wage-mythology
[xi] Health Quality Ontario. Income and Health: Opportunities to achieve health equity in Ontario. Toronto: Queen's Printer for Ontario; 2016

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Tuesday, September 5, 2017

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Ontario Minister of Health and Long-Term Care
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Tel 416-327-4300 / ehoskins.mpp@liberal.ola.org

Re. Returning *Blastomycosis* (Blasto) to Ontario's Reportable Disease List

Dear Dr. Hoskins,

Over a period of a year and a half I lost two dogs to this horrible disease. I have since tested positive myself for the presence of blasto exposure in my blood.

My husband and I live in a beautiful waterfront home approximately 40 minutes east of Sault Ste. Marie, Ontario and I work in the Sault on the administrative staff of the Sea Lamprey Control Centre, Fisheries and Oceans Canada.

When my first dog became sick I was fortunate that his veterinarian had dealt with past cases and diagnosed the blasto immediately, and the appropriate treatment was followed for several months. Unfortunately, the disease returned a short time after that and my poor dog succumbed. My second dog's vet was not familiar with blasto and at first the illness was misdiagnosed as lameness then cancer. After I suggested she be tested for blasto, as it turned out to be, it was too late to save her. I asked my vets if they informed the Algoma Health Unit of such cases and I was told no; blastomycosis is not a reportable disease and therefore they are not obliged to report it.

Naturally I was devastated and I shared my sadness at the office. Many of my colleagues had never heard of blasto but I was amazed at the stories that **did** come forth from some; of dogs, horses, and even relatives that had been damaged or killed by what turned out to be caused by the *Blastomyces dermatiditis* fungus. A young girl died from its disease and three people were hospitalized with it last year alone, here in Sault Ste. Marie.

I began my research into it in greater depth and after reading up on testimonials from across Ontario I became extremely concerned for our many field technicians who work in the very ecosystems where *Blastomyces dermatiditis* thrives and are dangerously exposed each year from spring to winter; yet if they were to become sick would probably not be properly diagnosed in a timely manner. Medical professionals are simply not familiar enough with it.

Since the horrible death of my second dear dog, and the discovery of its presence in my own body, I have had no choice but to become a noisy advocate for blasto awareness.

Blastomycosis was removed from Ontario's Reportable Disease List in 1989 and I firmly believe, as do many, many others, that it should be reinstated immediately so that a database can be compiled, cases tracked and studied, which may eventually lead to some type of prevention, better form of treatment, or at the least, education.

Please read my attachments.

Please return **Blastomycosis** to the **List of Reportable Diseases in Ontario**.

Thank you,

Christine Reid.

Christine Reid

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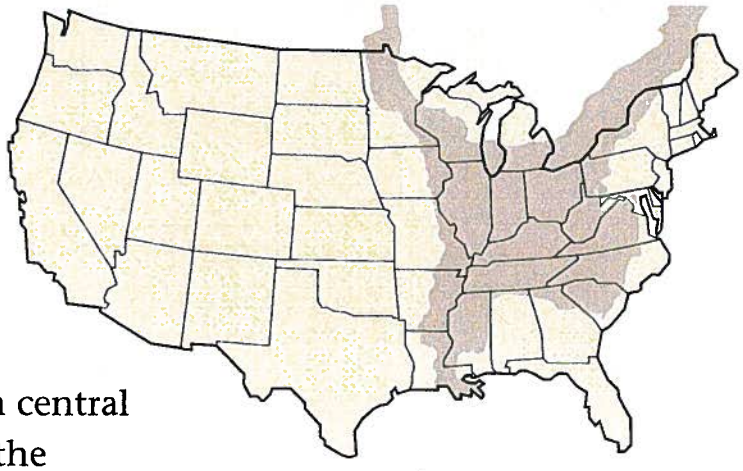
:cr
Attach

cc John Fraser, Parliamentary Assistant to the Minister of Health and Long-term Care
Dr. David Williams, Ontario's Chief Medical Officer of Health
Board of Health, Algoma Public Health
Environmental Health Officer, Algoma Public Health
Ross Romano, MPP (Sault Ste. Marie)
Michael Mantha, MPP (Algoma-Manitoulin)

AMERICAN THORACIC SOCIETY
Patient Information Series

Blastomycosis

Fungal Disease Series #1



Map source: www.familyvet.com/Dogs/Fungi.html

Blastomycosis is a disease caused by breathing in a fungus named *Blastomyces dermatidis*. This fungus is found in moist soil of rotting plants or wood. *Blastomyces dermatidis* is found in central and southeastern United States (the darkened area on the map, right) and parts of Canada. There has been an increase in the rate of blastomycosis in North America in the last 10 years.

PHYSICIANS: CLIP AND COPY

Blastomyces enters the body through the lungs and causes a lung infection, usually pneumonia. From the lungs, the fungus can spread to other areas of the body including your skin, bones, joints and central nervous system. This disease is rare and more commonly affects people involved with outdoor activities. The symptoms are usually more severe in people with a weakened immune system (e.g. organ transplants, HIV/AIDS or on medications that suppress/ overpower the immune system). Blastomycosis is not known to spread from person to person.

What are the signs and symptoms of Blastomycosis?

The signs and symptoms of Blastomycosis vary and may occur from 3 to 15 weeks after inhaling the fungus. You may develop mild symptoms, but recover without ever knowing you had been infected. Symptoms such as a cough, fever, sputum/phlegm production, chest pain, weight loss, shortness of breath, joint pain and body aches are common. The most common problem with Blastomycosis, however, is pneumonia. Since the symptoms of Blastomycosis are the same as many other problems (like the common cold), your health care provider may not test you for Blastomycosis unless your symptoms do not go away or worsen despite taking antibiotics.

Blastomycosis can also be slow growing and grow to look like a lung tumor, which can be mistaken for lung cancer. In some cases, Blastomycosis may spread beyond your lungs and infect other organs such as your skin, bones, joints and central nervous system. Skin problems can include a rash, sores or nodules (small elevated areas on the skin). Bone and joint problems can include joint swelling or infected bone (osteomyelitis) which cause joint or bone pain. Blastomycosis of the central nervous system can cause meningitis, but this is rare in healthy people. If you have HIV/AIDS or have had an organ transplant, you are more likely to develop meningitis.

How is Blastomycosis diagnosed?

The diagnosis of Blastomycosis is made by growing the fungus in a sample of your

Am J Respir Crit Care Med Vol. 184, P3–4, 2011 • **Online Version Updated October 2013** www.thoracic.org

Blastomycosis

Manitoba

Communicable Disease Control Unit

This disease has also been referred to as Gilchrist's Disease, North American Blastomycosis, Chicago Disease and Namekagon River Fever.

Case Definition

A person from whom *Blastomyces dermatitidis* is detected either by culture or direct visualization by microscopy of the characteristic broad-based budding yeast from a clinical specimen (1).

Reporting Requirements

The true incidence of blastomycosis is not known as it is not reportable nationally in Canada or the United States (2).

In Manitoba: Blastomycosis has been reportable to the Communicable Disease Control Unit, Manitoba Health by laboratories as of Sept. 1, 2006 for surveillance purposes only and will generally not require Public Health follow-up.

In Ontario: Blastomycosis was removed from the list of reportable diseases in 1989 (3); however, a passive reporting system for laboratory confirmed cases was initiated in 2000 by the Northwestern Health Unit jurisdiction (4). As well, a database was created in 2002 to track local cases.

Clinical Presentation and Natural History

Blastomycosis is caused by a thermally dimorphic fungus (*Blastomyces dermatitidis*), found in soil (1, 2, 5, 6). Symptomatic disease has been found to occur in less than 50 per cent of infected individuals (5, 7, 8). The high frequency of asymptomatic infection suggests that healthy people are fairly resistant to infection by *B. dermatitidis* (7). Isolated pulmonary involvement occurs in approximately 70 per cent of patients (7, 9).

Pulmonary Blastomycosis:

Blastomycosis is usually acquired by inhaling aerosolized spores (conidia) from a source in nature, presumably soil (5, 10). Upon entering the lungs, the conidia transform into yeasts and may cause disease. Clinical disease with *B. dermatitidis* is variable however, and symptomatic infection usually presents as a flu-like illness with fever, chills, night sweats, productive cough, myalgia, arthralgia, weight loss and pleuritic chest pain (10-12). The pulmonary disease may be acute or chronic and mimics other fungal and bacterial infections, including tuberculosis (7, 13). Misdiagnosis with community-acquired pneumonia is not uncommon (10, 12, 14). Chronic pulmonary disease appears similar to lung cancer and tuberculosis (15). The similar presentation of blastomycosis to other illnesses may result in delayed diagnosis and treatment (12).

The radiologic appearance of pulmonary blastomycosis varies depending on the stage of infection and the clinical presentation and is not specific to blastomycosis (16). The predominant finding is air-space infiltrates, followed by mass-like and interstitial infiltrates (17). Air-space infiltrates are more often associated with acute disease, and mass-like infiltrates with chronic disease (17). Blastomycosis has been diagnosed in patients with significant underlying illnesses (6, 18), including diabetes mellitus (10) and infection with the Human Immunodeficiency Virus (HIV) (19). However, as *B. dermatitidis* has caused disease in otherwise healthy individuals, it is considered to be a primary rather than an opportunistic pathogen (15, 20, 21). Only a few reports have indicated that *B. dermatitidis* can act as an opportunistic pathogen (7). Hematogenous dissemination occurs in approximately 30 per cent of patients with pulmonary blastomycosis (9). The most common extrapulmonary sites are the skin, bone and genitourinary and central nervous systems (CNS) (9, 17, 20, 22).

Skin: Cutaneous blastomycosis is the most common extrapulmonary manifestation (16). Skin lesions may be the first indication of blastomycosis in patients where pulmonary infection is asymptomatic (7, 16, 23). Cutaneous lesions can be

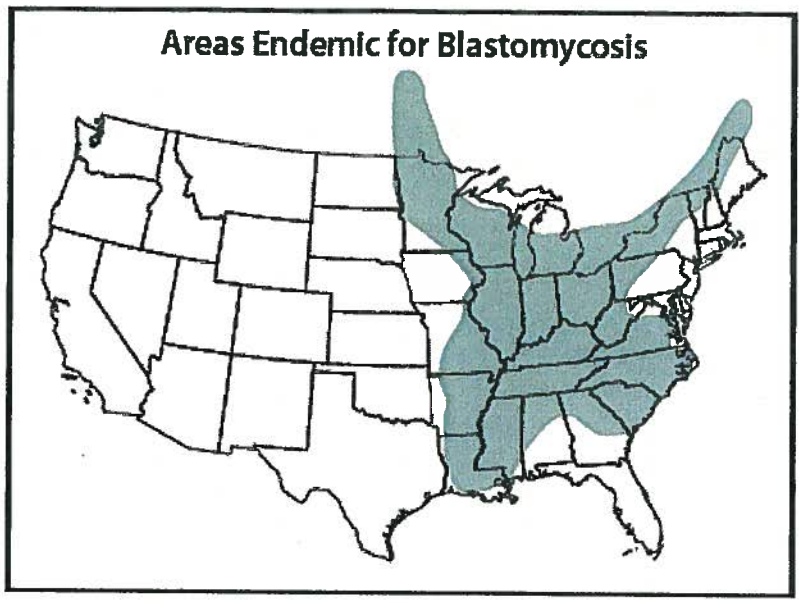


Image by the CDC

Nationally, Blastomyces dermatitidis has a wide distribution in North America.

- Endemic Areas, US – Mississippi, Missouri, Ohio River valleys, Eastern Seaboard, areas adjacent to the Great Lakes. States with highest endemnicity are Wisconsin, Minnesota, Missouri, Illinois, Michigan, Kentucky, West Virginia, Arkansas, Tennessee, North Carolina, South Carolina, Louisiana, and Mississippi. Other endemic states include Indiana, Iowa, Ohio, Virginia, Georgia, and Alabama. However, cases do occur outside the endemic areas.

- Endemic Areas, Canada – Blasto is prevalent in Kenora, Ontario. Also found in Manitoba, Ontario (Kenora, Sault Ste. Marie, Chapleau), Quebec, New Brunswick, in particular areas around the Great Lakes and in a small area a small area in New York and Canada along the St. Lawrence River. Has also been increasingly reported along the Georgian Bay coastline (including Midland and Penetang), Dryden, and in Southern Ontario at the Rockwood Conservation area.

Dogs at the greatest risk for developing blastomycosis are 2- to 4-year-old intact male dogs living in endemic regions. Sporting dogs and hound breeds are most likely predisposed due to running and sniffing in high-risk areas during hunting. However, all breeds and ages are susceptible and the fungi can occur in any *rural* and *urban* environment. Residence near a river or lake and access to recently excavated sites has demonstrated an increased risk of infection. Blasto is not communicable

Blastomycosis in Ontario, 1994–2003

Shaun K. Morris,* Jason Brophy,* Susan E. Richardson,* Richard Summerbell,† Patricia C. Parkin,* Frances Jamieson,‡ Bill Limerick,§ Lyle Wiebe,§ and E. Lee Ford-Jones*

We describe a case of blastomycosis in an 8-year-old boy with *Blastomyces*-associated osteomyelitis and possible pulmonary involvement. We also identify 309 cases of blastomycosis in Ontario that were seen during a 10-year period, 57% of which occurred from 2001 to 2003. The overall incidence during the study period was 0.30 cases per 100,000 population. Most patients were from north Ontario (n = 188), where the incidence was 2.44 cases per 100,000. The incidence in the Toronto region was 0.29 per 100,000. Thirteen percent of cases occurred in children <19 years of age. These findings substantially increase the number of known cases in Ontario and Canada. Clinicians may encounter persons infected with *Blastomyces dermatitidis* and must be familiar with its signs and symptoms and be aware of locations, such as northwestern Ontario, where disease is endemic or hyperendemic. We advocate resuming blastomycosis as a reportable disease in Ontario to facilitate tracking cases.

First described by Gilchrist in 1894 (*1*), blastomycosis has been documented in Canada since at least 1910 (*2*). The incidence and epidemiologic features of the disease are poorly understood because of underrecognition, difficulty in isolating *Blastomyces dermatitidis* from natural sites, lack of an effective skin test, and because blastomycosis is not nationally reportable in either Canada or the United States (*3*). Blastomycotic infections in Canada have recently been reported in international (*4*) and Canadian (*5–7*) literature. We report a case of pediatric blastomycotic osteomyelitis and the results of an almost 10-year review of *Blastomyces* infection in Ontario through reports of laboratory isolates submitted to the Central Public Health Laboratory (CPHL), Ontario Ministry of Health and Long-term Care, Toronto. The objectives of the review were to define in the province of Ontario 1) the geographic epidemiologic features of laboratory-confirmed blastomycosis, 2) changes in the number of cases over time, and 3) demographic characteristics of infected persons. The case report and study were approved by the research ethics board of the Hospital for Sick Children, Toronto, Ontario.

*Hospital for Sick Children, Toronto, Ontario, Canada; †CBS Fungal Biodiversity Center, Utrecht, the Netherlands; ‡Ontario Ministry of Health and Long-term Care, Toronto, Ontario, Canada; and §Northwestern Ontario Health Unit, Kenora, Ontario, Canada

Case Report

An 8-year-old, previously healthy Caucasian boy, was brought to his family physician with a 2-month history of neck pain and stiffness. The pain was not sufficient to wake the child at night, but it prevented participation in athletics. No history of trauma, fever, weakness, paresthesias, weight loss, or change in bowel or bladder function was noted. The initial diagnosis was muscular strain, and rest and antiinflammatory medication was recommended. When his symptoms did not improve, a cervical spine radiograph showed a lytic lesion of the fifth cervical vertebra.

On hospital admission, physical examination was unremarkable, with the exception of pain on palpation over the posterior cervical spine. Laboratory results at admission showed normal leukocyte count (8.0×10^9/L), differential (polymorphs 4.48×10^9/L, eosinophils 0.08×10^9/L, lymphocytes 2.80×10^9/L, monocytes 0.56×10^9/L), electrolytes, and renal function. Erythrocyte sedimentation rate was mildly elevated at 38 mm/h. Computed tomographic scan of the region showed a well-defined lytic lesion with a "bubbly" appearance involving the posterior elements of the C5 vertebral body. An incidental note was made of a small, nonspecific lesion within the posterior upper lobe of the right lung. Bone scintillography showed positive uptake at C5. Magnetic resonance imaging (MRI) of the cervical spine demonstrated an enhancing mass that involved the posterior aspects of C5 plus an abnormal signal within the adjacent spinous processes.

The patient underwent a C5 laminectomy and a C4 partial hemilaminectomy. During dissection, a small amount

true incidence of disease in the province. The number of cases diagnosed in northwestern Ontario increased after an education campaign. To our knowledge, no similar campaign has been carried out elsewhere in the province, and therefore the diagnosis is likely often missed. Some samples may have been only identified at a regional laboratory and not counted among our data. Because of the geographic proximity, patients in northwestern Ontario are often transferred to Winnipeg, Manitoba, rather than to an Ontario tertiary centre for investigation and treatment. Additionally, persons from outside the province who are infected may be diagnosed in their home provinces. As a result, some cases of blastomycosis acquired in Ontario may be diagnosed in Manitoba or elsewhere and therefore are not included in our data.

Conclusion

The understanding of the natural distribution of blastomycosis and other mycoses endemic in Ontario (such as histoplasmosis) is minimal. This study is the first to describe the Ontario-wide incidence of blastomycosis and to provide incidence rates in each of the 7 provincial health regions. Clinicians practicing throughout the province and country may encounter persons infected with this organism and need to be familiar with its varied clinical signs and symptoms and be aware of regions where disease is endemic or hyperendemic. Our data suggest that the number of diagnoses of blastomycosis has increased over several years. However, the disease likely remains underrecognized. As delay to diagnosis can contribute to illness and death, clinicians should consider blastomycosis in their differential diagnoses of lung, skin, and bone diseases, particularly if the patient does not respond to conventional antimicrobial drug therapy. The lack of rapid and effective diagnostic tools contributes to the underrecognition of blastomycosis. Advances in molecular diagnosis of *B. dermatitidis* (*39*), particularly in regions identified as higher risk, hold the potential for improving case detection and decreasing delay to diagnosis.

Infection by *B. dermatitidis* is more common than was thought before its removal from the list of reportable diseases in Ontario in 1989. Our group advocates strongly for returning blastomycosis to the reportable diseases list in this province. Travel history must be included in the reporting of blastomycosis. While identifying the point of infection in well-traveled individuals may be impossible, a specific or negative travel history would make a valuable contribution to understanding where blastomycosis is contracted in Ontario. Such reporting would facilitate tracking cases and clinical education regarding this potentially fatal invasive fungal infection.

Acknowledgments

The assistance of Ursula Bunn and Edna Kristjanson of the Central Toronto Public Health Laboratory and the staff of the Northwestern Ontario Health Unit is greatly appreciated. Special thanks to Peter Sarsfield and the staff of the Northwestern Ontario Health Unit for their roles in the collection of data and to Dr Sarsfield for his review of the manuscript.

Dr Morris is a resident in the Department of Pediatrics at The Hospital for Sick Children and the University of Toronto, Toronto, Ontario. His research interests include infectious diseases, global health, and the effects of socioeconomic disparities on children's health.

References

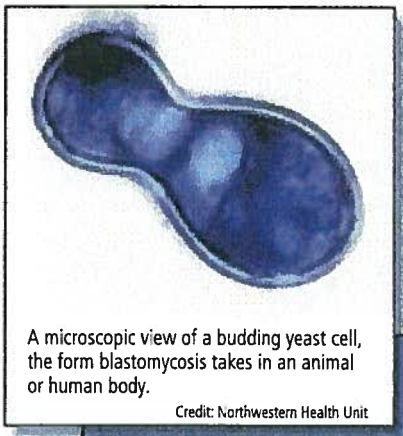
1. Gilchrist TC. Protozoan dermatitis. J Cutaneous Gen Dis. 1894;12:496–9.
2. St. Germain G, Murray G, Duperval R. Blastomycosis in Quebec (1981–90): Report of 23 cases and review of published cases from Quebec. Can J Infect Dis. 1993;4:89–94.
3. Centers for Disease Control. Blastomycosis—Wisconsin, 1986–1995. MMWR Morb Mortal Wkly Rep. 1996;45:601–3.
4. Catherinot E, Rivaud E, Epardeau B, Cahen P, Condette-Auliac S, Couderc LJ. A holiday in Canada. Lancet. 2002;360:1564.
5. Lester RS, DeKoven JG, Kane J, Simor AE, Krajden S, Summerbell RC. Novel cases of blastomycosis acquired in Toronto, Ontario. CMAJ. 2000;163:1309–12.
6. Bernstein S, Brunner HI, Summerbell RC, Allen U, Babyn P, Richardson SE. Blastomycosis acquired by three children in Toronto. Can J Infect Dis. 2002;13:259–63.
7. Leone N, Feldman VB. Common diagnostic challenges posed by North American blastomycosis as seen in a patient in Toronto, Canada. J Can Chiropr Assoc. 2002;46:101–6.
8. Klein BS, Vergeront JM, Weeks RJ, Kumar UN, Mathai G, Varkey B, et al. Isolation of *Blastomyces dermatitidis* in soil associated with a large outbreak of blastomycosis in Wisconsin. N Engl J Med. 1986;314:529–34.
9. Ajello L, Weeks RJ. Soil decontamination and other control measures. In: DiSalvo AF, editor. Occupational mycoses. Philadelphia: Lea & Febiger; 1983. p. 22938.
10. Bakerspigel A, Kane J, Schaus D. Isolation of *Blastomyces dermatitidis* from an earthen floor in southwestern Ontario, Canada. J Clin Microbiol. 1986;24:890–1.
11. Kane J, Righter J, Krajden S, Lester RS. Blastomycosis: a new endemic focus in Canada. Can Med Assoc J. 1983;129:728–31.
12. Chaturvedi S, Chaturvedi HS, Khan Z. Efficacy of brain heart infusion–egg albumen agar, yeast extract phosphate agar and peptone glucose agar media for isolation of *Blastomyces dermatitidis* from sputum. Mycopathologia. 1990;112:105–12.
13. Klein BS, Vergeront JM, DiSalvo AF, Kaufman L, Davis JP. Two outbreaks of blastomycosis along rivers in Wisconsin: isolation of *Blastomyces dermatitidis* from riverbank soil and evidence of its transmission along waterways. Am Rev Respir Dis. 1987;136:1333–8.
14. Wallace J. Pulmonary blastomycosis: a great masquerader. Chest. 2002;121:677–9.
15. Steele RW, Abernathy RS. Systemic blastomycosis in children. Pediatr Infect Dis. 1983;2:304–7.
16. Schutze GE, Hickson SL, Fortin EM, Schellhase DE, Darville T, Gubbins PO, et al. Blastomycosis in children. Clin Infect Dis. 1996;22:496–502.

Blastomycosis: Awareness can Save Lives

By Jane-Anne Campbell

A fifteen year-old is recovering well from blastomycosis, a fungal disease endemic to Georgian Bay, Northwestern Ontario, and Manitoba. In September of last year, the young man began to experience difficulty breathing and was taken to a hospital emergency department. Two months and many tests later, a lung biopsy revealed blastomycosis. After a week in hospital, the young man is on the road to recovery.

The young man's dog is also doing well. He too fell ill with blastomycosis, along with a number of other dogs from the Pointe au Baril area. This dog was one of the lucky ones. Three of eleven dogs have died in this, the largest cluster of confirmed cases that we know of in Georgian Bay.



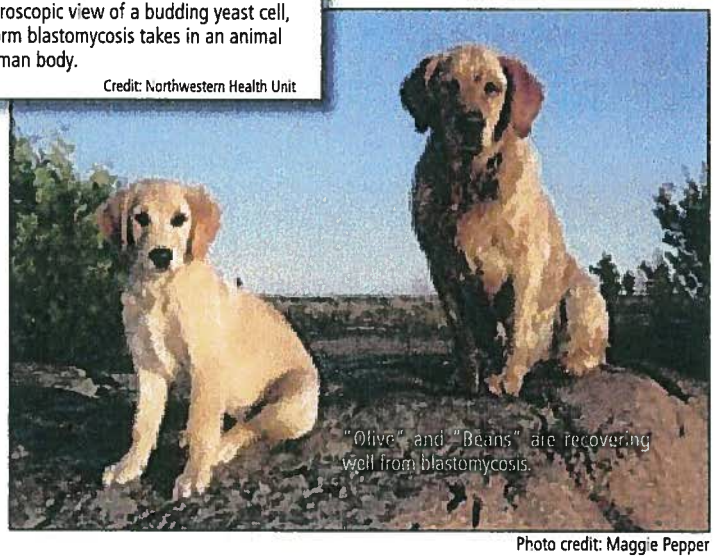
A microscopic view of a budding yeast cell, the form blastomycosis takes in an animal or human body.
Credit: Northwestern Health Unit

Is blastomycosis new to Georgian Bay? Certainly not. The Bay has been long considered an endemic area for the disease. Isolated cases and small clusters involving dogs and people have occurred in various parts of the Bay including Sans Souci, Bayfield/Nares and Key River.

Is blastomycosis on the increase? On average, thirty cases every year are reported to the Northwestern Health Unit from across Ontario, though most are from the Kenora area. In 2004, that number rose to 53 cases, but Lyle Wiebe, Environmental Health Specialist at the Northwestern Health Unit, cautions against assuming any upward trend. Greater awareness of blastomycosis might be causing more people to be correctly diagnosed. Blastomycosis is not a disease that must be reported to public health authorities; so there is inadequate information from which to draw conclusions.

Bill Limerick, Director of Environmental Health, has been working with others at the Northwestern Health Unit to put blastomycosis back on the list of diseases that must be reported to public health officials. (Blastomycosis was removed from the list in 1989, because it can rarely be transmitted between people and/or animals, and because very few cases were being reported.)

What *we do* know is that blastomycosis is an uncommon disease in dogs, and a rare disease among humans and other animals. While many dogs and people are probably exposed to the fungus, most do not get sick because their immune systems overcome it. In very rare cases, and most often when an individual is elderly, has a compromised immune system or other health problems, blastomycosis can cause, organ damage, long-term health complications and even death. We must, however, keep the risk in perspective. According to Dr. John Embil, Director of the Infection Control Unit at the Health Sciences Centre in Winnipeg, getting blastomycosis is about as common as being struck by lightening.



"Olive" and "Beans" are recovering well from blastomycosis.

Photo credit: Maggie Pepper

Prompt diagnosis and treatment are critical for people and their pets. It is very important for Georgian Bay cottagers, their physicians and veterinarians to be aware of the illness.

With blastomycosis, delays in diagnosis and treatment are common for four main reasons.

First, blastomycosis is very uncommon. Many physicians and veterinarians, especially those practicing outside Georgian Bay and other endemic areas, have never seen a case of it and do not know much about it.

Second, blastomycosis is often hard to recognize. It can cause different symptoms in different individuals and can resemble many other diseases, including tuberculosis and cancer.

Third, blastomycosis can be difficult and time-consuming to diagnose.

Fourth, symptoms do not appear for several weeks and sometimes months after the fungus is contracted. A person with vague symptoms in January is thus unlikely to suspect that he/she has blastomycosis.

What is the Georgian Bay Association doing to help?

Blastomycosis is difficult if not impossible to prevent; so our top priority is to increase awareness of the disease so that people and pets with blastomycosis are diagnosed and treated as quickly as possible.

We have organized for Sunday, April 17 a seminar to help us learn about the disease.

GBA has written to the Chief Medical Officer for Ontario to encourage her to put blastomycosis back on the list of reportable illnesses, and we are encouraging others, including our townships, associations and individual cottagers, to do the same.

We are working with partners in the human and animal medicine communities to increase awareness among physicians and veterinarians. We plan to prepare information sheets that cottagers can share with their own physicians and veterinarians.

Finally, we are looking for researchers who

Watch out for blastomycosis, Thunder Bay vet warns dog owners

Fungal disease from soil can affect animals, people and can be fatal

CBC News Posted: Jun 09, 2017 10:14 AM ET Last Updated: Jun 09, 2017 10:14 AM ET

People who spend a lot of time outdoors, particularly those that own dogs, are being reminded about the presence of an illness caused by a fungus in the soil.

Blastomycosis is a fungal infection that can affect both humans and animals, and can be fatal. The fungus that causes it lives in the ground and the resulting infection can transmitted to people or pets if it's dug up and inhaled.

- **Kenora cottagers warned about rare disease**

"I would say that just generally over the last seven to 10 years, we are seeing and diagnosing more cases of it," Calli Thompson, a veterinarian with the Northwestern Veterinary Hospital in Thunder Bay, Ont., told CBC News, but added that could be due to an increased awareness of the illness.

In addition to being transmitted through inhalation, blastomycosis can also find its way into the body through skin wounds.

Tracking where the illness was actually contracted is next to impossible, Thompson said as it can take anywhere between four and 12 weeks for symptoms to occur.

"An animal can move in a lot of areas and that's the other thing that makes it really, really difficult for us to put our finger on exactly where they've picked it up," she said.

Tough to track

The fungus that causes blastomycosis is typically found in acidic soil where there's rotting organic material, such as dead trees, according to Donna Stanley, the manager of infectious diseases at the Northwestern Heath Unit's office in Dryden, Ont.

She also noted that there's no evidence of any dramatic increase of the illness in the region, although reported instances can spike from time-to-time. Blastomycosis is not transmitted between animals or people.

It's also not a reportable disease as far as public health is concerned, Stanley added, meaning that doctors or hospitals that record positive tests don't have to share the findings with the health unit. That results in incomplete data, she said. Additionally, doctors may not think to specifically test for blastomycosis when a patient comes in sick, Stanley said.

Pet owners can take some basic precautions to minimize the risk of exposure, Thompson said, including keeping watch over how much your dog digs or rolls around in the dirt, or takes shelter in cavernous areas, like under a deck or camp.

Some symptoms in dogs can include wounds that don't heal properly or a persistent cough or apparent shortness of breath, Thompson added. In people, they can resemble the appearance of any number of

your family and pets' health records, or in another prominent spot. If they are not knowledgeable about blastomycosis, give them a copy of this article.

3. **Recognize early symptoms of blastomycosis and go to your physician/veterinarian promptly.** If a family member or pet becomes ill with unusual symptoms, ask your physician or veterinarian about the possibility of blastomycosis.
4. **Inform visitors to Georgian Bay about blastomycosis.**
5. **Consider obtaining veterinary insurance.** Blastomycosis is very expensive to diagnose and treat.
6. **If someone in your family is diagnosed with blastomycosis, report it to the Northwestern Health Unit at 1-800-830-5978 or 1-807-468-3147.**
7. **Write a letter to Dr. Sheila Basrur, Chief Medical Officer for Ontario.** (See address at end of article.) Ask her to make blastomycosis a reportable illness!

Can we prevent blastomycosis?

Blastomycosis is difficult if not impossible to prevent for four main reasons:

a) It can be almost anywhere in the soil. Blastomycosis is considered to be ubiquitous in the environment, appearing and disappearing in specific areas without notice.

b) Its presence/absence is extremely difficult to confirm with soil testing. While many attempts have been made, blastomycosis has been successfully isolated from the natural environment only a couple of times. If an animal or human becomes ill with blastomycosis, it is usually IMPOSSIBLE to determine the source of the fungus. Don't let anyone tell you otherwise! Experts agree that it is generally useless and a waste of money to test for blastomycosis on your property, or to try to eradicate it.

c) Little is known about the conditions that cause spores to be released.

d) Little is known about the reasons some animals and people become ill while most do not. The good news is that many dogs and people frequenting Georgian Bay have probably been in contact with blastomycosis already, and have successfully fought it off.

Public health units frequently offer the following suggestions, although there is no scientific evidence that they will reduce your chances of contracting blastomycosis.

1. Wearing a disposable NIOSH H100 approved HEPA filter dust mask (available from your home improvement store), gloves, proper footwear, long pants and a long-sleeved shirt when working in moist areas where the fungus may grow (e.g under cottages, porches and sheds), may help to prevent blastomycosis, although there is no guarantee.
2. If you have an organ transplant, cancer, HIV/AIDS or are otherwise immune-suppressed, discuss with your physician the advisability of avoiding activities that involve close contact with soil in Georgian Bay and other endemic areas.
3. Avoid allowing piles of rotten wood to accumulate under or right around your cottage.

While there is no scientific evidence that following these suggestions will reduce a dog's chances of contracting blastomycosis, many veterinarians suggest that owners discourage their dogs from digging and from chewing/eating rotten wood or other decomposing matter, especially in areas where blastomycosis is more likely to be contracted, such as under cottages and around rotting wood piles, old docks, beaver houses, or construction areas. All advise against allowing pets to wander extensively unsupervised. Aside from any risk of contracting blastomycosis, many pets are injured and killed every year in accidents such as falls off rocks and encounters with wildlife.

Jane-Anne Campbell is a volunteer resource for GBA on wildlife and a cottager at Sans Souci.

http://www.apg-wi.com/sawyer_county_record/news/local/early-spring-brings-threat-of-blastomycosis-to-dogs-people/article_4c8475d8-d2ff-11e4-bdf8-43d4b326cddd.html

TOP STORY

Early spring brings threat of Blastomycosis to dogs, people

by Frank Zufall, staff reporter Mar 28, 2015

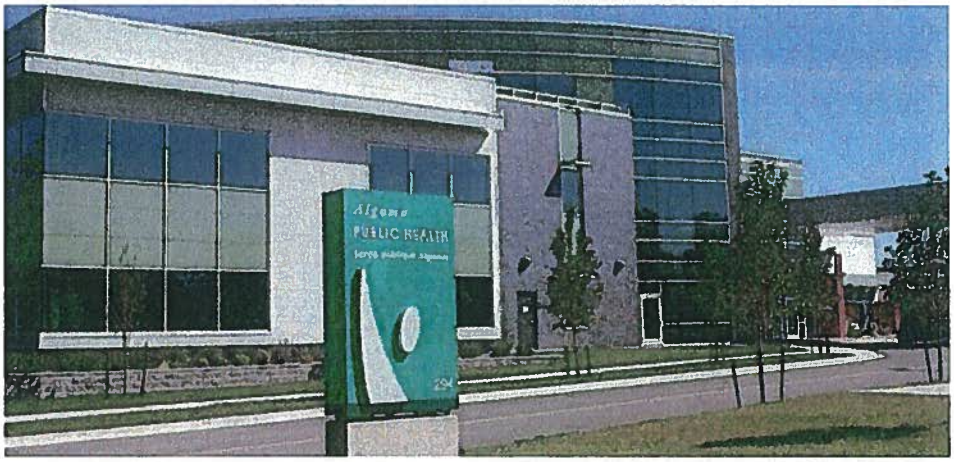
Here's one reason this spring to wait a few weeks before raking the leaves, turning the soil, letting the dog dig in the yard or getting anywhere near wet, rotting, decaying muck of any kind (be that soil, leaves, or wood)—Blastomycosis.

Blastomycosis is disease caused by the fungus Blastomyces dermatitidis. It's a fungus/mold that lives in moist soil around decomposing mater. Under the right conditions, the fungus produces a spore which, if inhaled, can cause sickness and even death.

Symptoms of blastomycosis typically occur several weeks to months after inhaling. They include fever, dry cough, weight loss and chest pains.

The disease is often detected with an X-ray of the lungs or a tissue or urine sample confirming its presence.

Antibiotics don't work with this fungal infection. Three anti-fungal drugs are on the market and they are expensive, over $2,000 for humans and close to $500 for dogs. And the side effects can be painful.



Algoma Public Health Confirms Three Cases of Rare Infectious Disease

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BY STEFFANIE PETRONI ON OCTOBER 25, 2016 ENVIRONMENT

Editor's Note: *The presence of blastomycosis in the Sault Ste. Marie area was brought forward by a concerned reader who has knowledge of a recent tragic loss of life brought on by complications associated with the disease. Our condolences are extended to this family during this sorrowful time.*

*****

Three cases of blastomycosis have recently been reported to the Algoma Public Health (APH) this month. John Buoma, Program Manager for Environmental Health and Communicable Disease Control at APH, confirmed that four weeks ago, APH alerted local physicians to watch for signs and symptoms and to consider blastomycosis in diagnosis.

Blastomycosis is a rare fungal infection caused by a mould called Blastomyces. The fungus loves decomposing wood and leaves, and moist, acidic soil that is found throughout the province and especially along the Great Lakes. Though blastomycosis can be acquired through superficial scrapes or cuts, it is more commonly acquired through the inhalation of fungal spores. Where the fungus is viable, exposure to blastomycosis can occur when gardening, chopping wood and participating in the many activities that attract people outdoors in the summer and fall.

Worth mentioning is that pets, and in particular. dogs, are susceptible to blastomycosis. "Veterinarians are the ones that most often see this," remarked Buoma. "Vets are more blasto experts than health care practitioners because it's more commonly seen in dogs. Dogs have their noses in everything."

Those with blastomycosis present flu-like symptoms and while the condition often resolves without treatment and often without the sufferer even knowing they had contracted the infection in the first place, there are instances when people do become seriously ill from the infection. If left undiagnosed and untreated, blastomycosis can lead to death.

According to Buoma, administering an anti-fungal drug prescribed by a physician is a quick and effective cure of blastomycosis. The challenge, therefore, is not in treatment but in diagnosis.

ABOUT THE AUTHOR

Steffanie Petroni has dedicated much of her professional career to researching and writing about the issues and people in Northern Ontario. Her work is often controversial as she delves into the heart of the matter while still ensuring that the background details are captured. In 2013 Steffanie received a National Journalism award from Beyond Borders ECPAT Canada for her investigative piece 'Story of A Child Prostitute.'

SOOTODAY.com

LECLAIR, Mary-Jane

Posted Oct 19, 2016 9:10 AM

Blasto

Mary-Jane was given her angel wings on Friday, October 14, 2016, at just 10 years old. She is definitely not alone in heaven; she is joined by her Nona, Papa Tom, Christina, "Merle Haggard" and many others. Loving daughter of Danny and Tina. Little sister of Mandy, Dallas, Kayla and Danny-Mae. She will be missed by Grandma Val, Nanny Shelah and Papa Cameron. Mary will also be missed by many aunts, uncles, cousins and friends. With Mary-Jane's passing, we remind others that her life is one to be celebrated. She loved to be at camp, surrounded by family and friends where they would hunt, four-wheel and enjoy endless campfires laughing together. She was never afraid to get dirty and always the first to jump into the river. Mary-Jane's life would seem too short to many, but those who were touched by her, understood that the quality of her existence far exceeds the quantity of time in which one lives. Her gentle smile could melt the hearts of those around her, her quick wit made anyone around her laugh and her determination showed us all that anything is possible. Mary's favourite colour was blue and we ask that you wear your favourite blue article of clothing in honour of Mary-Jane. Friends are

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
681 Commercial Street, North Bay, ON P1B 4E7 TEL: 705 474 1400
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL: 705 746 5801
myhealthunit.ca
TOLL FREE: 1 800 563 2808

July 6, 2017

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

Dear Minister Hoskins:

Subject: The Revealing of Imperial Tobacco Canada Ltd.'s Anti-Contraband Campaign – BOH Resolution #BOH/2017/06/11

On June 28, 2017, at a meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board approved the following motion #BOH/2017/06/11:

***Whereas**, a 2012 slide deck from Imperial Tobacco Canada Ltd. (ITCL) demonstrates that the National Coalition Against Contraband Tobacco (NCACT) and the Ontario Convenience Stores Association (OCSA) have worked on behalf of ITCL to convince Ontario municipalities of the importance of the contraband tobacco problem; and*

***Whereas,** the 2012 ITCL slide deck makes clear that the anti-contraband campaign pursued by the NCACT and the OCSA in Ontario is designed in part to block tobacco excise tax increases and regulation of tobacco products generally; and*

***Whereas**, these other campaign objectives were either not communicated to municipalities by either the NCACT or the OCSA during meetings with municipal staff or councillors; and*

***Whereas**, the North Bay Parry Sound District Health Unit supports tobacco excise tax increases as a proven effective means of encouraging tobacco cessation; and*

***Whereas**, contrary to tobacco industry messaging, impartial research by the Ontario Tobacco Research Unit at the University of Toronto has shown that tobacco excise tax increases do not lead to large increases in contraband; and*

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

***Whereas**, the North Bay Parry Sound District Health Unit previously passed a smoke-free bylaw and supports protection of the public from second-hand tobacco smoke, protection of our youth from tobacco industry products, and tobacco tax increases to encourage smokers to quit and to raise revenue to offset the healthcare costs of tobacco use, which are more than double the current revenue raised from provincial tobacco taxes;*

***Therefore Be It Resolved**, that elected representatives and staff of the North Bay Parry Sound District Health Unit will have no further meetings or discussions about any tobacco-related issue with representatives of the NCACT, the OCSA, or individuals otherwise representing the tobacco industry, but forward any communication to the medical officer of health or designate;*

***Furthermore Be It Resolved,** that the North Bay Parry Sound District Health Unit commends the Ontario Ministry of Finance for raising tobacco excise taxes in the recent budget, and encourages this Ministry to enhance enforcement activities designed to reduce the presence of contraband tobacco in Ontario communities;*

***Furthermore Be It Resolved,** that a copy of this resolution be forwarded to the Minister of Health and Long-Term Care, the Association of Local Public Health Agencies, the Ontario Campaign for Action on Tobacco, MPP Victor Fedeli, and Premier of Ontario, Kathleen Wynne.*

Sincerely,

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

/sb

C: Hon. Kathleen Wynne, Premier of Ontario
Victor Fedeli, MPP, Nipissing
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Campaign for Action on Tobacco

alPHa
Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
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Hon. Eric Hoskins
Minister of Health and Long-Term Care
10th Flr, 80 Grosvenor St,
Toronto, ON M7A 2C4

July 21 2017

Dear Minister Hoskins,

Re: alPHa RESOLUTION A17-6, Fluoride Varnish Programs for Children at Risk for Dental Caries

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHa), I am writing to inform you of the attached resolution, which was adopted by our members at our annual general meeting on June 12 2017.

This resolution calls on the Government of Ontario to to provide funding through the Healthy Smiles Ontario program for the implementation of school and community-based programs to use fluoride varnish to reduce the risk of tooth decay among children at risk for dental caries.

The topical application of fluoride to teeth is a well-known and effective means of preventing dental decay. The application of fluoride varnish is safe, easy and well accepted by young children and can be provided by a variety of public health and primary care workers (e.g. oral health/dental staff, physicians, nurses, medical assistants) in a variety of settings without the use of specialized equipment.

We see this as an important opportunity to further reduce the risk and incidence of dental caries in Ontario, thereby reducing the costs of expensive and preventable dental treatments.

We hope you will give this serious consideration as an important addition to Ontario's Healthy Smiles Program.

Yours sincerely,

Carmen McGregor
alPHa President

COPY: Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Division
Chairs, Ontario Boards of Health

alPHa Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A17-6

TITLE: **Fluoride Varnish Programs for Children at Risk for Dental Caries**
SPONSOR: **Board of Health for Wellington-Dufferin-Guelph Public Health**

WHEREAS In Ontario, 23% of Junior Kindergarten, 31% of Senior Kindergarten and 44% of Grade 2 children have at least one tooth that has experienced tooth decay (i.e. filled or decayed tooth);

WHEREAS Dental caries is a preventable disease and untreated tooth decay may lead to pain, infection, abscesses, tooth loss, chewing problems, poor nutritional status, poor self-esteem, and may negatively affect school performance, ability to learn, and growth and development; and

WHEREAS Dental surgery to treat severe tooth decay is the leading cause of day surgery among children five years and under. Approximately 19,000 of these operations are performed each year in Canada at a cost of $21.2 million. This cost is only a fraction of the true cost because it does not include the cost of dental treatment or travel; and

WHEREAS A Cochrane evidence-based review reported that the application of fluoride varnish is an effective intervention to reduce the risk of dental caries and reverse early carious lesions. This review found a 43% reduction in decayed, missing and filled tooth surfaces among permanent teeth and a 37% reduction among primary teeth; and

WHEREAS Biannual topical fluoride applications are recommended by the Centres of Disease Control and Prevention for the prevention of dental caries in children at risk. Primary care clinicians are also recommended to apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption; and

WHEREAS The application of fluoride varnish is not a regulated act and does not require a lengthy course of training to learn application techniques and contraindications for use. Fluoride varnish is safe, easy to apply, well accepted by young children and can be provided by a variety of public health and primary care workers (e.g. oral health/dental staff, physicians, nurses, medical assistants); and

WHEREAS Fluoride varnish can be readily applied in different community outreach locations and does not require the use of dental equipment and special applicators; and

WHEREAS By reducing the risk and incidence of dental caries, Fluoride Varnish Programs (FVPs) reduce the costs of restorative dental treatment (i.e. dental fillings) and other costly dental treatments, such as root canal therapy, crown and bridge, and dentures; and

WHEREAS Ontario public health units conduct annual screening of elementary schools in order to classify schools as low, moderate or high screening intensity based on the percentage of Grade 2 children with two or more decayed teeth;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario Government to provide funding through the Healthy Smiles Ontario program for the implementation of school and community-based programs which use fluoride varnish to reduce the risk of tooth decay among children at risk for dental caries;

AND FURTHER that alPHa write to all boards of health in Ontario encouraging them to start a Fluoride Varnish Program for children at risk, if they have not already done so.

ACTION FROM CONFERENCE: **Resolution CARRIED**

July 5, 2017

VIA EMAIL

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

Dear Minister Hoskins:

On March 31, 2017, many agencies funded as Health Promotion Resource Centres were informed that their funding for the Resource Centre would end as of March 2018. These Resource Centres provide crucial support to our local level work in tobacco, alcohol and nutrition, including access to data, research, and evaluation support.

- The Training Enhancement in Applied Cessation Counselling program (TEACH) provides the high level, in-depth cessation training needed by the frontline staff at health units.
- The Program Training and Consultation Centre (PTCC) provides training, education, and knowledge sharing to ensure our activities are evidence based, new staff are knowledgeable, and current staff stay informed.
- The Ontario Tobacco Research Unit (OTRU) provides the expertise in monitoring and evaluation that is needed to ensure that objectives are realistic and activities are effective.
- The effect that the Youth Advocacy Training Institute (YATI) has had on youth tobacco prevention in Ontario is extremely significant. Their collective experience and knowledge of youth engagement and training is why there are so many passionate youth advocates in tobacco control today!
- The Smoking and Health Action Foundation (SHAF) provides supports for smoke-free housing Ontario and support for tenants and landlords looking to make a positive change in their environment when living in a multi-unit dwelling whether it be an apartment, a condo, rental unit, or supportive housing.
- The Health Promotion Capacity Building-Alcohol Policy Centre (HPCB-AP) addresses alcohol-related harm in communities across Ontario. HPCB-AP supports the development, implementation, assessment, and coordination of alcohol policies across different settings and levels (e.g., schools, colleges, workplaces, municipalities, provinces, etc.).
- The Nutrition Resource Centre (NRC) provides training, education, and knowledge sharing to ensure program and policy development are evidence-based and can be tailored to meet local needs.

Our local health promotion work is more effective and efficient because of the dedicated and proficient staff at these centres. These Resource Centres support cross-pillar work and have been very useful in collaborative campaigns at the provincial, regional, local, and even federal level.

The substitute of having a Health and Wellness grant available to fill the void left by these Resource Centres is not a viable alternative. Annual competitive grants do not offer the stability needed for any kind of sustainable resources or support. The projects that are supported by the Resource Centres can span several years from planning to evaluation.

I would appreciate it if you could reconsider the decision to eliminate the funding for the Health Promotion Resource Centres, and I look forward to your response.

Sincerely,

Anne Warren, Chair
Board of Directors
Leeds, Grenville and Lanark District Health Unit

AW/hb

cc: Gord Brown, MP Leeds-Grenville
Steve Clark, MPP Leeds-Grenville
Randy Hillier, MPP Lanark-Frontenac-Lennox and Addington
Jack MacLaren, MPP Carleton-Mississippi Mills
Ontario Boards 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

June 15, 2017

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

COPY

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Healthy Babies Healthy Children Program (HBHC) Targets and Funding
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on June 14, 2017, Council adopted the following recommendations of the Committee:

A) That the correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health urging the Government of Ontario to align program service delivery expectations with annual funding; and to fully fund all program costs related to the HBHC, including all staffing, operating and administrative costs, as well as the annual increases in cost to deliver services, be endorsed; and

B) That the Premier of Ontario, Ministers of Children and Youth 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.

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health, dated June 7, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

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

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The Regional Municipality of Durham

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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: June 7, 2017

Re: Healthy Babies Healthy Children Program (HBHC) Targets and Funding

---

On May 3, 2017, the Chair of the Wellington-Dufferin-Guelph Board of Health sent the attached correspondence to all Ontario boards of health for support.

In essence, the correspondence urges the Government of Ontario to align program service delivery expectations with annual funding; and to fully fund all program costs related to the HBHC, including all staffing, operating and administrative costs, as well as the annual increases in cost to deliver services.

Support for this correspondence is consistent with Council's role as Durham's board of health to provide all components of HBHC.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health as regards Healthy Babies Healthy Children program targets and funding is endorsed; and

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

Respectfully submitted,

Original signed by

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

PublicHealth

May 3, 2017

DELIVERED VIA EMAIL & REGULAR MAIL

The Honourable Michael Coteau
Minister of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto ON M5S 2S3

Dear Minister Coteau:

Re: Healthy Babies Healthy Children Program Targets and Funding

On May 3, 2015 at a regular meeting of the Board of Health for Wellington-Dufferin-Guelph Public Health, the Board reviewed the ongoing and increasing challenge to meet Ministry expectations for HBHC service provision within the 100% funding envelope. MCYS program enhancements have increased the range and evidence base for interventions that can be offered by HBHC, however, chronic underfunding continues to challenge program integrity and fidelity as limited resources preclude full compliance and achievement of MCYS implementation targets.

The following motion was passed:

> "That the Board of Health for Wellington-Dufferin-Guelph Public Health advocates for the Ministry of Children and Youth Services to commit to aligning program service delivery expectations with the annual budget; and the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs, and the annual increases in cost to deliver services."

Thank you for giving this request your every consideration.

Sincerely,

Nancy Sullivan
Chair, WDGPH Board of Health

cc via email: MPP Liz Sandals, Guelph
MPP Sylvia Jones, Dufferin-Caledon
MPP Ted Arnott, Wellington-Halton Hills
Dianne Alexander, Director, Healthy Living Policy and Programs Branch, MOHLTC
Ontario Boards of Health

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Ministry of Health and Long-Term Care

Office of the Minister

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Ministère de la Santé et des Soins de longue durée

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Ontario

August 17, 2017

HLTC6605IT-2017-169

Dear colleague:

I am pleased to inform you that, as part of our government's ongoing commitment to help protect youth from Human Papillomavirus (HPV) infection and related cancers, starting mid-September 2017 Ontario will offer the nine-valent HPV vaccine (HPV9 or Gardasil®9) as part of the provincial publicly funded immunization program.

The HPV9 vaccine protects against the same HPV types as the HPV4 vaccine, plus five additional HPV types, which can lead to cervical and anogenital cancers, as well as certain cancers of the head and neck. Offering the HPV9 vaccine is in line with current scientific and expert recommendations, including Canada's National Advisory Committee on Immunization (NACI).

School-Based HPV Immunization Program

Beginning September 2017, the HPV9 vaccine will be offered to all students in Grade 7 in the 2017/18 school year. Students eligible prior to the 2017/18 school year (including males in Grade 8 and females in Grades 8 to 12) who have not started or completed their HPV vaccine series will continue to receive HPV4 vaccine.

High-Risk HPV Immunization Program

HPV9 vaccine will also be offered to eligible MSM individuals who have not received HPV vaccine previously. Those individuals who have not completed their HPV4 series will continue to be eligible to receive HPV4.

In addition, for a time limited period until August 31, 2018, HPV4 vaccine may be offered through public health-run sexual health clinics to individuals 26 years of age and younger who have multiple sex partners and have not been vaccinated.

Public health units will continue to be the primary delivery mechanism for the publicly funded HPV immunization program. However, the HPV vaccine may also be administered by a student's health care provider (physician, nurse practitioner) through special release of the vaccine from the public health unit on a case by case basis.

We look forward to collaborating with you to implement this important initiative. Thank you for your continued support and commitment to Ontario's publicly funded immunization program.

Yours sincerely,

Dr. Eric Hoskins
Minister

(Français au verso)

Ministry of Health and Long-Term Care

Office of the Minister

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Ontario

17 août 2017

HLTC6605IT-2017-169

Madame, Monsieur,

Notre gouvernement demeure déterminé à continuer de protéger les jeunes contre l'infection par le virus du papillome humain (VPH) et les cancers qui y sont associés. À cet effet, j'ai le plaisir de vous informer qu'à partir de la mi-septembre 2017, l'Ontario offrira le vaccin contre le VPH nonavalant (VPH-9 ou Gardasil®9) dans le cadre de son programme public de vaccination.

Le vaccin VPH-9 protège contre les mêmes types de VPH que le vaccin quadrivalent (VPH-4), en plus de cinq types supplémentaires de VPH susceptibles de causer des cancers cervicaux et anogénitaux, ainsi que certains cancers de la tête et du cou. La distribution du vaccin VPH-9 est conforme aux dernières recommandations formulées par des scientifiques et des experts, dont le Comité consultatif national de l'immunisation (CCNI) du Canada.

Programme scolaire de vaccination contre le VPH

À partir de septembre 2017, le vaccin VPH-9 sera administré à tous les élèves qui sont en 7e année durant l'année scolaire 2017-2018. Quant aux élèves admissibles avant l'année scolaire 2017-2018 (y compris les garçons en 8e et les filles de la 8e à la 12e année), ils continueront à recevoir le vaccin VPH-4 s'ils n'ont pas commencé ou terminé leur série de vaccins contre le VPH.

Programme de vaccination contre le VPH pour les personnes à risque élevé

Un vaccin VPH-9 sera également offert aux personnes HSH admissibles qui n'ont pas déjà reçu de vaccin contre le VPH. Les personnes qui n'ont pas terminé leur série de vaccins VPH-4 continueront d'être admissibles à recevoir ce même vaccin.

En outre, pour quelque temps encore, à savoir jusqu'au 31 août 2018, les personnes de 26 ans et moins qui ont eu de multiples partenaires sexuels et n'ont pas encore été vaccinées peuvent recevoir le vaccin VPH-4 dans des cliniques de santé sexuelle relevant des bureaux de santé publique.

Les bureaux de santé publique continueront d'être les principaux sites de prestation du programme public de vaccination contre le VPH. Cependant, le vaccin contre le VPH peut également être donné à l'élève par son fournisseur de soins (médecin, infirmière praticienne) par autorisation spéciale du bureau de santé publique, attribuée au cas par cas.

Nous sommes impatients de collaborer avec vous pour mettre en œuvre cette initiative importante. Nous vous remercions de votre soutien continu et de votre engagement envers le programme public de vaccination de l'Ontario.

Veuillez agréer l'expression de mes sentiments les meilleurs.

Dr Eric Hoskins
Ministre

June 29, 2017

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

Dear Honourable Hoskins:

Re: Human Papillomavirus (HPV) Immunization Catch-up for Boys

On May 26, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Wellington Dufferin Guelph Public Health regarding implementation of a publically-funded human papillomavirus (HPV) immunization catch-up program for boys. The following motion was passed:

Motion No: 2017-56

Moved by: Al Barfoot Seconded by: Laurie Laporte

"In support of equity of access to publically funded human papillomavirus immunization, the Board of Health for the Grey Bruce Health Unit supports the call by Wellington Dufferin Guelph Public Health that the Ontario government implement a publically funded HPV immunization catch-up program for boys similar to catch up program undertaken for girls in 2012."

Carried

Sincerely,

Christine Kennedy, MSc, MS, DPhil, MD, CCFP, FRCPC
Medical Officer of Health and CEO
Grey Bruce Health Unit

Encl.

Cc: Ontario Public Health Units

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

May 3, 2017

DELIVERED VIA E-MAIL & REGULAR MAIL

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

Attention: The Honourable Eric Hoskins
Office of the Minister

Dear Hon. Hoskins:

Re: Human Papillomavirus (HPV) Immunization Catch-up for Boys

The Board of Health (BOH) for Wellington-Dufferin-Guelph Public Health (WDGPH) would like to request that the Ontario Government implement a publicly-funded human papillomavirus (HPV) immunization catch-up program for boys similar to the catch-up program implemented for girls in 2012. It is important to close this gap in publicly-funded vaccine eligibility for boys.

In 2012, NACI recommended HPV vaccination for all males between the ages of 9 and 26 and for all men who have sex with men (MSM) aged 9 and older. PIDAC-I also recommends publicly-funded Gardasil for MSM or males who identify as homosexual up to the age of 26 years. As the most common preventable sexually-transmitted infection (STI), HPV has been directly linked to serious health conditions such as cervical, oral, penile and anal cancers, as well as abnormal cell growth in these areas of the body that are causally associated with various cancers and anal warts.

Some families with health benefit coverage may have the opportunity to purchase the vaccine. However, lower income families and families without extended health benefits are not afforded equal opportunity to be protected from HPV-related cancers. Universal funding would also protect the highly vulnerable group of boys who will go on to identify as MSM but are currently not identifying their eligibility for the publicly-funded vaccine.

.../2

160 Chancellors Way, Guelph, ON N1G 0E1
T: 1-800-265-7293 | **F:** 519-836-7215 | **wdgpublichealth.ca**

The WDGPH BOH would like to request that the Ministry of Health and Long-Term Care address this public health concern by expanding the publicly-funded HPV immunization programs to include a catch-up program for boys. We believe this is the approach that aligns with the Ontario Government's stance on health equity and would reduce the burden of HPV-related cancers in Ontario.

Sincerely,

Nancy Sullivan
Chair, WDGHU Board of Health

c.c. alPHa – via e-mail
c.c. Liz Sandals, MPP (Guelph) – via e-mail
c.c. Ted Arnott, MPP (Wellington-Halton Hills) – via e-mail
c.c. Sylvia Jones, MPP (Dufferin-Caledon) – via e-mail
c.c. Randy Pettapiece, MPP (Perth-Wellington) – via e-mail
c.c. Ontario Public Health Units – via e-mail

DURHAM REGION

June 15, 2017

The Honourable Kathleen Wynne
Premier
Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
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Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Human Papillomavirus (HPV) Immunization Catch-up for Boys
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on June 14, 2017, Council adopted the following recommendations of the Committee:

A) That the correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health urging the Government of Ontario to expand the publicly-funded HPV immunization program to include a catch-up program for boys, currently in grades 8 to 12, similar to the catch-up program implemented for girls in 2012, be endorsed; and

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

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health dated June 7, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

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

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The Regional Municipality of Durham

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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: June 7, 2017

Re: Human Papillomavirus (HPV) Immunization Catch-up for Boys

---

On May 3, 2017, the Chair of the Wellington-Dufferin-Guelph Board of Health sent the attached correspondence to all Ontario boards of health for support.

In essence, the correspondence urges the Government of Ontario to expand the publicly-funded HPV immunization program to include a catch-up program for boys, currently in grades 8 to 12, similar to the catch-up program implemented for girls in 2012. Currently the publicly-funded HPV immunization program applies to boys born on or after 2004/Jan/01 and males ages 9 to 26 that meet high risk eligibility criteria.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health as regards HPV Immunization Catch-up for boys is endorsed; and

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

Respectfully submitted,

Original signed by

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

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

May 3, 2017

DELIVERED VIA E-MAIL & REGULAR MAIL

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

Attention: The Honourable Eric Hoskins
Office of the Minister

Dear Hon. Hoskins:

Re: Human Papillomavirus (HPV) Immunization Catch-up for Boys

The Board of Health (BOH) for Wellington-Dufferin-Guelph Public Health (WDGPH) would like to request that the Ontario Government implement a publicly-funded human papillomavirus (HPV) immunization catch-up program for boys similar to the catch-up program implemented for girls in 2012. It is important to close this gap in publicly-funded vaccine eligibility for boys.

In 2012, NACI recommended HPV vaccination for all males between the ages of 9 and 26 and for all men who have sex with men (MSM) aged 9 and older. PIDAC-I also recommends publicly-funded Gardasil for MSM or males who identify as homosexual up to the age of 26 years. As the most common preventable sexually-transmitted infection (STI), HPV has been directly linked to serious health conditions such as cervical, oral, penile and anal cancers, as well as abnormal cell growth in these areas of the body that are causally associated with various cancers and anal warts.

Some families with health benefit coverage may have the opportunity to purchase the vaccine. However, lower income families and families without extended health benefits are not afforded equal opportunity to be protected from HPV-related cancers. Universal funding would also protect the highly vulnerable group of boys who will go on to identify as MSM but are currently not identifying their eligibility for the publicly-funded vaccine.

.../2

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The WDGPH BOH would like to request that the Ministry of Health and Long-Term Care address this public health concern by expanding the publicly-funded HPV immunization programs to include a catch-up program for boys. We believe this is the approach that aligns with the Ontario Government's stance on health equity and would reduce the burden of HPV-related cancers in Ontario.

Sincerely,

Nancy Sullivan
Chair, WDGHU Board of Health

c.c. aIPHa – via e-mail
c.c. Liz Sandals, MPP (Guelph) – via e-mail
c.c. Ted Arnott, MPP (Wellington-Halton Hills) – via e-mail
c.c. Sylvia Jones, MPP (Dufferin-Caledon) – via e-mail
c.c. Randy Pettapiece, MPP (Perth-Wellington) – via e-mail
c.c. Ontario Public Health Units – via e-mail

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www.niagararegion.ca

June 14, 2017

Hon. Eric Hoskins
Minister of Health & Long Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Hoskins:

Re: Requesting Support for the Enactment of Legislation under the Health Protection & Promotion Act (HPPA) to Allow for Inspection and Enforcement Activities of Personal Service Settings

I am writing to you on behalf of the Board of Health for Niagara Region.

We thank you for your emphasis on transparency and patient safety during your tenure as Minister. Under your leadership, local public health agencies now investigate complaints concerning infection prevention and control (IPAC) in a wider array of facilities, and we disclose our investigation findings in short order to the public. While this work has resulted in considerable additional work for local public health during a time of constrained funding, we think the residents and many visitors to Niagara are safer because of it.

I am writing today to request your government's help in streamlining this work to ensure Ontarians can expect the highest standards of IPAC practices. Specifically, we have endorsed the enclosed requests by Wellington-Dufferin-Guelph Public Health and the Board of Health for the District of Algoma Health Unit to enact a regulation specific to personal service settings (PSS) coupled with the authority to ticket under the Provincial Offenses Act.

Local public health agencies inspect all PSS to ensure adherence to IPAC standards of practice. Whether through these proactive inspections or through complaint investigations, when deficiencies in IPAC practices are identified, we seek to rectify the practices using education in the first instance. While effective in the vast majority of cases, on occasion, repeated attempts to educate prove unsuccessful at bringing about needed changes. In these cases, graduated enforcement processes are needed.

Currently, the only enforcement measures afforded under the HPPA are the closure of the premise and the use of legal orders. These are blunt and coercive tools that are not always proportionate. As well, when a PSS owner/operator does not adhere to a legal order to correct practices, the

process of laying a charge for breach of the order is lengthy, costly, and, most critically, delays correction of the health risk. Where education is ineffective, but the health risk is not sufficiently severe to justify a closure or legal order, there are currently no tailored enforcement tools that would permit a graduated escalation of actions.

Conversely in food premises, where deficiencies in food safety are identified, there is the option of issuing a ticket under Part I of the Provincial Offences Act. This is possible since food safety practices have been embedded in a regulation specific for food safety (Regulation 562: Food Premises) coupled with a schedule of offences listed in a regulation under the Provincial Offences Act (Regulation 950: Proceedings Commenced by Certificate of Offence). The time needed to prepare and serve the ticket is also considerably less than the time required for a closure or legal order under the HPPA. Few tickets are actually issued for food safety; the threat of receiving tickets alone deters owners/operators from operating in contravention of established standards of practice.

A provincial regulation specific to IPAC practices in PSS, coupled with a schedule of offences under the Provincial Offences Act would facilitate adherence to best practice standards, and not impose any new or additional requirements on PSS businesses. More importantly, it would better protect the public by enabling swifter correction of IPAC breeches, reduce the need for heavy-handed enforcement, and reduce expenditure of provincial and local tax dollars on enforcement. Such a PSS enforcement regimen would also align with other public health enforcement regimens.

Thank you for considering this request, and for your ongoing leadership of Ontario's integrated health system.

Yours Truly,

Alan Caslin
Regional Chair

Cc:
David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Population & Public Health Division
Association of Local Public Health Agencies
Ontario Boards of Health
Niagara MPPs

Encl.
Wellington-Dufferin-Guelph Public Health Letter to Premier (January 4, 2017)
Algoma Public Health Letter to Premier (March 29, 2017)

PUBLIC HEALTH
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March 29, 2017

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

Dear Premier Wynne,

Re: Requesting Support for Enactment of Legislation under the HPPA to Allow for the Inspection and Enforcement Activities of Personal Service Settings.

At its meeting on March 22, 2017, the Board of Health for the District of Algoma Health Unit considered the correspondence forwarded by Wellington-Dufferin-Guelph Public Health in regards to support for enactment of legislation under the to allow for the inspection and enforcement activities of personal service settings.

The Board of Health for the District of Algoma Health Unit passed the following resolution in support of Wellington-Dufferin-Guelph Public Health's request for support:

Resolution 2017-

WHEREAS the Hepatitis C rate in Algoma between 2012-2016 has increased by 7.2% compared with a decrease in the province of 4%; and

WHEREAS some services provided by Personal Service Settings (PSS) potentially expose individuals to bloodborne infections; and

WHEREAS due to the lack of legislation for PSS, APH instituted an optional program where operators are provided with a "Registered for Inspection " certificate that they post at their premise to showcase to the patrons that they have voluntarily been inspected; and

WHEREAS education and training are the first steps to ensure Infection Prevention and Control Practices (IPAC) best practices are adhered to, there are occasions when enforcement maybe needed; and

WHEREAS due to the lack of legislation, associated regulations, and set fee schedules to allow for issuing of certificates of offence (tickets) for enforcement purposes, API-I has had to utilize more cumbersome and inefficient Section 13 orders to ensure compliance; and

WHEREAS some PSS providers are conducting the procedures in uninspected environments such as private homes in the Algoma district, and

WHEREAS creation of provincial legislation governing PSSs would support a consistent, progressive enforcement model amongst Ontario's public health units.

THEREFORE BE IT RESOL VED THAT the Algoma Public Health Board support the Wellington Dufferin-Guelph Public Health in recommending that the Government of Ontario

enact legislation under the HPPA to support inspection and enforcement activities within PSSs; and

FURTHER THAT this resolution is shared with the Minister of Health and Long Term Care, Members of Provincial Parliament, Chief Medical Officer of Health, Association of Local Public Health Agencies and all Ontario Boards of Health.

Sincerely,

Dr. Marlene Spruyt Bsc, MD, CCFP, FCFP, MSc-PH
Medical Officer of Health/CEO
On behalf of Algoma Public Health Board of Health

Encl. Wellington-Dufferin-Guelph Public Health correspondence

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Michael Mantha, MPP Algoma-Manitoulin
Association of Local Public Health Agencies
Ontario Public Health Units

January 4, 2017

DELIVERED VIA E-MAIL & REGULAR MAIL

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

Dear Premier,

Re: Requesting Support for Enactment of Legislation under the HPPA to Allow fot the Inspection and Enforcement Activities of Personal Service Settings

On behalf of the Board of Health of Wellington-Dufferin-Guelph Public Health (WDGPH), I am writing to request your support of the enactment of legislation under the Health Promotion and Protection Act (HPPA) to allow for the inspection and enforcement activities of personal service settings.

Six provinces and territories currently have specific legislation for the regulation of personal service settings which increases the enforcement abilities of public health staff and provides an incentive for operators to comply with infection protection and control best practices. Ontario has no provincial legislation that requires operators to comply with these best practices.

In those provinces and territories where regulations exist, non-compliance with the regulations by personal service setting staff or operators can result in a conviction and/or monetary fines, without requiring public health staff to prove the existence of a health hazard in order to proceed with enforcement actions.

The creation of legislation under the HPPA, specific to personal service settings, would contribute to the standardization of minimum infection best practices in personal service settings. Based on an assessment of complaints received by WDGPH, most complaints in personal service settings are associated with potentially invasive services such as manicure, pedicure and aesthetics services. The enactment of legislation for all premises offering personal services could help mitigate infection control risks to staff working in these premises and members of the public receiving these services.

The most recent complaint to WDGPH was in December 2016 and pertained to the cleanliness of reusable tools and equipment and the reuse of single-use items such as nail files and buffer blocks. If legislation was in place that allowed for inspection and enforcement procedures similar to those in food premises, a ticket could have been issued on the spot with a set fine for non-compliance with infection prevention and control best practices. This would have helped lower infection risks for current staff and clients as well as been an

incentive for ongoing infection control for this specific owner and a general incentive for the wider community of personal service setting operators.

Recently, WDGPH has observed an expansion in the range of services offered within personal service settings to include more invasive services such as micro-needling, botox injections and microdermabrasion. The invasive nature of these services is accompanied by an increased risk of subsequent infection if infection prevention and control practices are not followed during the provision of these services. In many cases, these services are being offered by non-Regulated Health Professionals, meaning that inspection of these services and enforcement of minimum infection control best practices falls to public health.

It is therefore our hope that you will consider enacting legislation for infection protection and control requirements for all personal service settings under the HPPA, supported by short-form wording under the Provincial Offences Act.

Thank you for giving this correspondence your every consideration.

Sincerely,

Nancy Sullivan
Chair, Wellington-Dufferin-Guelph Board of Health

Encl. to enforce infection prevention and control practices within personal service settings, Board of Health Report, December, 2016)

cc (via e-mail):
Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
MPP Liz Sandals, Guelph
MPP Sylvia Jones, Dufferin-Caledon
MPP Ted Arnott, Wellington-Halton Hills
Dr. David Wiliams, Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Boards of Health

Enactment of legislation to enforce infection prevention and control practices within personal service settings under the HPPA

TO:	Chair and members of the Board of Health
MEETING DATE:	December 7, 2016
REPORT NO:	BH.01.DEC0716.R21 Pages: 6
PREPARED BY:	Katherine Paphitis, Public Health Inspector, Control of Infectious Diseases
APPROVED BY:	Christopher Beveridge, Director, Health Protection Division
SUBMITTED BY:	Original signed document on file _____ Dr. Nicola J. Mercer, MD, MBA, MPH, FRCPC Medical Officer of Health & CEO

Recommendations

It is recommended that:

1. The Board of Health receive this report for information.
2. The Chair, on behalf of the Board of Health, write a letter to the Honourable Kathleen Wynne, Premier of Ontario, in support of the creation of regulations for Personal Service Settings (PSS).

Key Points

- This report provides a rationale for the enactment of legislation under the HPPA to support inspection and enforcement activities within PSS.
- No provincial legislation currently exists that requires operators to comply with infection prevention and control (IPAC) best practices.
- Several provinces and territories within Canada have legislation specific to PSS premises, increasing the enforcement abilities of public health staff and providing an incentive for operators to comply with IPAC best practices.
- While education is considered the first step in gaining operator compliance, sometimes enforcement actions are the only means of gaining compliance with minimum requirements in order to ensure public safety

- Several boards of health have submitted letters to The Honourable Kathleen Wynne, Premier of Ontario, in support of enacting legislation specific to PSS, and specifically in support of the creation of wording under the Provincial Offences Act (POA) that would allow public health staff additional enforcement options when dealing with infractions in these premises.

Discussion

Public health staff across the province of Ontario enforce infection prevention and control (PAC best practice recommendations under the Infection Prevention and Control Best Practices for Personal Service Settings document (2009) by performing annual inspection of all PSS, with additional inspections in response to operator requests, complaints and to follow-up on any outstanding issues identified during routine compliance inspections. 1-3 In accordance with the Infection Prevention and Control in Personal Service Settings Protocol (2015), if WDGPH receives a complaint regarding a PSS, public health staff are required to initiate a response to the complaint within 24 hours in order to 'determine the risk of communicable disease transmission, and the appropriate board of health response' and must then 'take action based on the findings of its assessment, up to and including issuing orders under the HPPA' 2-4. Currently public health inspectors (PHIs) conduct routine, follow-up and complaint inspections of PSS premises, using the Infection Prevention and Control Best Practices for Personal Service Settings document (2009) as a guideline, and classify identified infractions as either 'critical' or 'non-critical', with critical infractions defined as those that potentially pose an infection control risk if found to be non-compliant with best practices. PHIS revisit premises to ensure that infractions are corrected and will work with operators in order to achieve compliance with minimum infection control best practices.

This year, WDGPH has received 26 PSS complaints from the public regarding infection control (the majority associated with manicure/pedicure/aesthetic services) as well as several public requests for infection control information. The majority of complaints associated with PSS were due to the re-use of single-use disposable items or due to infection following a cut or other injury accidentally received during a manicure/pedicure or other potentially invasive service. While onsite operator education can be helpful in gaining voluntary compliance in correcting infection control infractions, public health staff have limited enforcement actions available to them to ensure compliance in premises with repeat infractions or where operators are unwilling to comply with IPAC best practices.

If additional enforcement is required to gain compliance from operators, a PHI may issue a Section 13 Order under the HPPA 4 This is a lengthy process and requires the PHI to believe that a "health hazard" (as defined under Section 1 of the HPPA) exists

that may pose a risk to the health of any member of the public.4 This is in contrast to inspections of food premises (such as restaurants, grocery stores and institutional food service departments) — in these premises PHIs have several enforcement options, including the issuance of a Section 13 Order, a ticket under Part t of the POA or a direct summons to court under Part Ill of the POA 4-7. The additional enforcement options for food premises are due to the existence of a regulation under the HPPA that legislates specific requirements for food premises, and which is supported by a document that sets out set monetary fines for any non-compliance with the regulation 57. This document allows PHIS across the province to issue tickets to operators on the spot, which has proven to be helpful both in gaining immediate compliance from operators as well as from other premise operators via general deterrence. Regulations exist under the HPPA for public swimming pools, recreational camps, spas and rabies, however none currently exist for personal service settings.

In early 2016, a provincial working group was created with the purpose of updating the Ontario Best Practices document; an equivalent federal working group is currently updating a similar document for use by provinces that don't have specific guidelines for PSS premises. Six provinces and territories in Canada currently have legislation for the regulation of PSS premises; Alberta, Newfoundland/Labrador, NWT, Yukon, Nunavut and Nova Scotia, with the remaining provinces relying on provincial or federal guidance documents, as applicable. In those provinces and territories where regulations exist for PSS premises, non-compliance with the regulations can result in a conviction and/or strict monetary fines, without requiring public health staff to prove the existence of a health hazard in order to proceed with enforcement actions.

In addition to infection control complaints, WDGPH receives requests for information from members of the public, looking for guidance on where to go to receive personal services, particularly regarding services such as manicures, pedicures, tattooing or body piercing. Subsequent to BOH report BH.OI .APR0214.RIO (Online disclosure of personal service settings inspection results), WDGPH made inspection results for PSS premises available online in October of 2014. This was to increase transparency of inspection results and to assist members of the public in making informed decisions when deciding where to go to receive a personal service. 9 Public disclosure of inspection results has also been shown to have a positive impact on operator compliance with relevant legislation and best practices. 10

Annual inspection of all PSS premises is an accountability indicator for the Ministry of Health and Long-Term Care. 11 The creation of legislation under the HPPA, specific to personal service settings would contribute to the standardization of minimum 'PAC best practices in PSS premises, and assist public health staff in enforcing minimum standards. The overall goal is to prevent infectious disease transmission risks to PSS staff and members of the public who use these services. Several public health units in

Ontario have written letters to The Honourable Kathleen Wynne, Premier of Ontario, in support of the creation of regulations specific to PSS and particularly those that offer invasive services, such as tattooing and body modification.12.13

Conclusion

Legislation regulating PSS activities along with annual public health inspections are necessary to reduce infection control risks to the public. Having PSS Regulations would give public health inspectors enforceable infection control requirements while assessing PSS practices.

Ontario Public Health Standard

The management of infectious diseases, inspection of PSS and increased public awareness of infection prevention and control practices are required under the Infectious Diseases Program Standards (2008), with the goal of reducing the burden of infectious diseases of public health importance.

Specific requirements of the Infectious Diseases Program Standard are outlined in:

Requirement #14: The board of health shall inspect settings associated with risk of infectious diseases of public health importance in accordance with the Infection Prevention and Control in Licensed Day Nurseries Protocol, 2008 (or as current); the Infection Prevention and Control in Personal Services Settings Protocol, 2008 (or as current); and the Risk Assessment and Inspection of Facilities Protocol, 2008 (or as current).

Requirement #10: The board of health shall ensure that the medical officer of health or designate receives reports of and responds to complaints regarding infection prevention and control practices in settings for which no regulatory bodies, including regulatory colleges exist, particularly personal service settings. This shall be done in accordance with the Infection Prevention and Control in Personal Services Settings Protocol, 2008 (or current) and the Infection Prevention and Control Practices Complaint Protocol, 2008 (or as current).

W GPH Strategic Direction(s)

Check all that apply:

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

Service Centred Approach
We are committed to providing excellent service to anyone interacting with Public Health.

Health Equity
[Check] We will provide programs and services that integrate health equity principles to reduce or eliminate health differences between population groups.

Organizational Capacity
We will improve our capacity to effectively deliver public health programs and services.

Health Equity

The proposed legislation applies a compliance centered approach to equitably increase positive outcomes to all users of these services equally and would ensure that workers in PSS establishments understand their obligations and are protected from risk by a comprehensive communication plan promoting the proposed legislated requirements.

Appendices

None.

References

Ontario. Ministry of Health and Long-Term Care (2009). Infection Prevention and Control Best Practices for Personal Service Settings. Accessed online at:

http://www.health.qov.on.ca/en/pro/proqrams/publichealth/oph standards/docs/pssp 2008.

Ontario. Ministry of Health and Long Term Care (2008). Ontario Public Health Standards: Infectious Diseases Program Standards. Accessed online at:

http://www.health.qov.on.ca/en/pro/proqrams/publichealth/oph standards/docs/ophs 2008.

Ontario. Ministry of Health and Long-Term Care (2008). Infection Prevention and Control in Personal Service Settings Protocol. Accessed online at:

http://www.health.qov.on.ca/en/pro/programs/publichealth/oph standards/docsfinfection pr evention personal services.pdf

Health Protection and Promotion Act, R.S.O. 1990. Accessed online at: http://www.elaws.qov.on.ca/html/statutes/enqlish/elaws statutes 90h07 e.htm

Health Protection and Promotion Act. R.R.O. 1990, Ontario Regulation 562 — Food Premises. Accessed online at: https://www.ontario.ca/laws/requlation/900562

Provincial Offences Act. R.S.O. 1990. Accessed online at: https://www.ontario.ca/laws/statute/90p33

Ontario Court of Justice (2001). Set Fines I of the Provincial Offences Act: Schedule 40. Accessed online at: http://www.ontariocourts.ca/ocj/how-do-i/set-fines/changes-to-the-

consolidated-set-fine-schedules/schedule-40-2001-11-27/

Alberta. (2014). Alberta Regulation 20/2003 Public Health Act: Personal Services Regulation. Accessed online at: http://www.canlii.orq/en/ab/laws/requ/alta-req-202003[latest/alta-req-20-2003.html

Wellington-Dufferin-Guelph Public Health (2014). BOH Report - BH.OI .APR0214.RIO Online Disclosure of Personal Service Settings Inspection Results. Accessed online at: http://www.wdqpublichealth.ca/?q=bohreports

Lee, B. (2012). Food Safety Interventions of Food Service Establishments: Current Evidence. CIPHI National PowerPoint presentation. Accessed online at:

http://www.ncceh.ca/sites/default/files/ClPHl 2012 Food Service Establishments-Lee.pdf

Ontario. Ministry of Health and Long-Term Care (2016). Technical Document: Health Protection Indicators. Accessed online via the Public Health Performance Management Data Sharing Network (DON) secure website.

Personal communication. (2016). Letter from the Peterborough County-City Health Unit Board of Health to The Honourable Kathleen Wynne.

Personal communication. (2016). Letter from the Sudbury & District Health Unit Board of Health to The Honourable Kathleen Wynne.

Peterborough Public Health

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

September 14, 2017

The Honourable Yasir Naqvi
Attorney General of Ontario
720 Bay Street, 11th Floor
Toronto, ON M7A 2S9
ynaqvi.mpp@liberal.ola.org

Dear Minister Naqvi:

Re: Ontario's safe and sensible framework to manage federal legalization of cannabis

On behalf of our Board of Health, I would like to congratulate the Province of Ontario and the Cannabis Secretariat on releasing their plans for regulating federally legalized cannabis. Consultation was invited by the Province through to July 31st, 2017, to which Peterborough Public Health contributed to a submission as part of the Ontario Public Health Unit Collaboration on Cannabis (OPHUCC). We are pleased to see that the Province's newly released plan is aligned with various components of this submission such as:

- Establishing a safe and responsible supply chain of cannabis using a government monopoly, where cannabis will not be sold alongside alcohol in Ontario;
- Setting the minimum age of purchase to 19 (suggested as a minimum);
- Prohibiting smoking of cannabis in public places;
- Developing a public information campaign, to complement the federal government's public awareness campaign;
- Developing a comprehensive prevention and harm reduction approach to promote awareness of cannabis-related harms;
- Working with and supporting enforcement partners to keep our roads safe; and
- Working with municipalities to choose most appropriate store locations.

It is our hope that the Province continues to use a public health approach in the legalization of cannabis. While the federal government has responsibility for setting packaging and advertising restrictions, we request that the provincial regulations include the following:

- Adopt plain packaging;
- Prohibit the production and sale of products that are attractive to youth;
- Require that all cannabis products be sold in a child-resistant container and be marked with a universal symbol indication the container holds cannabis; and
- Avoid all forms of cannabis product promotion, including sponsorship, endorsement, branding and point-of-sale advertising.

We are very encouraged by Ontario's promise that "revenues associated with cannabis legalization will be reinvested to ensure [the Province] meets [their] priorities of protecting young people, focusing on public

health and community safety, promoting prevention and harm reduction and eliminating the illegal market". We look forward to learning more about the reinvestment strategy and how our public health work may be supported by this.

Our board of health is committed to protecting and promoting the health and well-being of our residents. We look forward to further details in order to support our community in this transition period.

Yours in health,

Original signed by

Mayor Mary Smith
Chair, Board of Health

/ag

cc: Hon. Kathleen Wynne, Premier
Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Local MPPs
Dr. David Williams, Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Boards of Health
Allan Seabrooke, CAO, City of Peterborough
Gary King, CAO, County of Peterborough

August 8, 2017

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

Dear Minister Hoskins,

Re: Support of Low Income Adult Dental Program in Ontario

At its July 20, 2017 meeting, under Correspondence item b), the Middlesex-London Board of Health considered the attached correspondence from the Leeds, Grenville and Lanark Board of Health regarding the support of low income adult dental programs in Ontario and voted to endorse the following:

b) Date: June 7, 2017
Topic: Letter in Support of Low Income Adult Dental Program in Ontario
From: Leeds, Grenville & Lanark District
To: The Honourable Eric Hoskins

Background:
The Leeds, Grenville & Lanark District Health Unit sent correspondence encouraging the Ministry of Health and Long-Term Care to consider the funding of low income adult dental programs in Ontario. The Middlesex-London Board of Health passed a motion at the January 2014 meeting to send a letter to the Minister of Health and Long-Term Care and local Members of Provincial Parliament, copied to the Association of Local Public Health Agencies and all Ontario Boards of Health to advocate for a program that provides both publicly-funded dental treatment and prevention to low-income adults, including seniors. At this juncture, it is important to reaffirm this position.

Recommendation:
Endorse.

It was moved by Mr. Ian Peer, seconded by Ms. Maureen Cassidy, *that the Board of Health endorse item b).*
Carried

The Middlesex-London Board of Health supports extending dental programs to low-income adults and redirecting the funds currently spent in emergency rooms and physician's offices to preventive care and dental treatment.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Anne Warren, Chair, Board of Directors, Leeds, Grenville and Lanark District Health Unit
Ontario Boards of Health

June 7, 2017

VIA EMAIL

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

Dear Minister Hoskins:

RE: LGL Board of Health Letter in Support of Low Income Adult Dental Program in Ontario

In Ontario, there is no provincial dental program for low-income working adults and seniors. Despite the well documented importance of good oral healthcare, it is not covered by our provincial healthcare system. In 2014, the Ontario government promised to extend dental programs to low-income adults by 2025. This gap in our healthcare system cannot wait.

Untreated oral disease not only affects an individual's health, well-being, and self-esteem, but has significant cost implications on our health care system as well. Poor oral health is linked to diabetes, cardiovascular disease, respiratory diseases, adverse pregnancy outcomes, and poor nutrition. When tooth decay and periodontal disease are left untreated, chronic pain and/or infection may result.

In Ontario, an estimated 2-3 million people cannot afford to see a dentist (Ontario Oral Health Alliance, 2017). Limited dental coverage is available for adults in receipt of OW or ODSP benefits, but low-income working adults and seniors must pay for dental care. If they cannot afford to see a dentist, they may visit a hospital emergency department or family doctor for relief of pain.

- In 2015, there were almost 61,000 visits to hospital emergency rooms across Ontario for oral health problems. The most common complaints were abscesses and pain. At a minimum cost of $513 per visit, the estimated cost was at least $31 million (Ontario Oral Health Alliance, 2017).

- In 2014, there were approximately 222,000 visits to physicians for similar oral health problems. At a minimum cost of $33.70 per visit, the estimated cost was at least $7.5 million (Ontario Oral Health Alliance, 2017).

Many of these locations are not staffed or equipped to deal with oral health concerns. Patients are provided with a "band-aid" solution of antibiotics and/or pain killers, referred to a dentist for treatment, and sent home. Still without the means to pay for dental treatment, the cycle begins again – the patient's only option is to live in pain or return to the emergency room or doctor's office for a short-term solution. Approximately $38 million provincial health dollars, at minimum, are spent annually to address oral health problems, but not to treat them.

A commitment to a sustainable dental program that appropriately addresses the dental problems of those in need would deliver better value for the people and for the province. We recommend redirecting the funds currently spent in emergency rooms and physician's offices to preventive care and dental treatment.

The Leeds, Grenville and Lanark District Board of Health looks forward to hearing from you regarding this important issue.

Sincerely,

Anne Warren

Anne Warren, Chair
Board of Directors
Leeds, Grenville and Lanark District Health Unit

AW/hb

cc: Steve Clark, MPP Leeds-Grenville
Randy Hillier, MPP Lanark-Frontenac-Lennox and Addington
Jack MacLaren, MPP Carleton-Mississippi Mills
Ontario Boards of Health
Linda Stewart, Executive Director, alPHa

June 29, 2017

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

Dear Honourable Hoskins:

Re: Provincial Alcohol Strategy

On May 26, 2017 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Wellington Dufferin Guelph Public Health regarding development of a comprehensive, province-wide strategy to support the safe consumption of alcohol. The following motion was passed:

Motion No: 2017-55

Moved by: David Shearman Seconded by: Mike Smith

"Recognizing that increased availability of alcohol since new regulations in 2014 has not been accompanied by a strategy to address harms. The Board of Health for the Grey Bruce Health Unit supports the call by Wellington Dufferin Guelph Public Health that the Ontario government develop a comprehensive province-wide strategy to support safe consumption of alcohol. And that the strategy encompass 1) Socially responsible pricing of alcohol; 2) Limit of retail outlets and hours of sale; and, 3) Alcohol marketing controls."

Carried

Sincerely,

Christine Kennedy, MSc, MS, DPhil, MD, CCFP, FRCPC
Medical Officer of Health and CEO
Grey Bruce Health Unit

Encl.

Cc: Ontario Public Health Units

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

May 3, 2017

DELIVERED VIA E-MAIL & REGULAR MAIL

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

Attention: The Honourable Eric Hoskins
Office of the Minister

Dear Hon. Hoskins:

Re: Provincial Alcohol Strategy

The Board of Health (BOH) for Wellington-Dufferin-Guelph Public Health (WDGPH) would like to urge the Ontario Government to develop a comprehensive, province-wide strategy to support the safe consumption of alcohol. The health harms associated with alcohol consumption impact tens of thousands of individuals in Ontario every year. With the increasing availability of alcohol in the province, it is important that the government move forward with the commitment it made to social responsibility in the 2015 Ontario Budget to correspond with the increasing availability of alcohol.

Since 2014, Ontarians have been able to purchase alcohol at grocery stores, farmers' markets, online sales through the LCBO and the expansion of bars and restaurants permitted at alcohol manufacturing sites. This increased availability has not been accompanied by a strategy to address the harms associated with alcohol use and misuse.

It is well established that an increase in the availability of alcohol leads to an increase in alcohol-related harms. Alcohol misuse is responsible for addiction, disease, social disruption and is one of the leading risk factors for disability and death in Canada. The health and financial costs to the individual and society are significant and include health care, law enforcement, lost productivity and premature mortality.

.../2

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PublicHealth
WELLINGTON·DUFFERIN·GUELPH
Stay Well.

For the health of our communities, there is a need for a provincially led alcohol policy that mitigates the health harms associated with alcohol. A comprehensive, evidence-based approach will limit the harmful effects of alcohol to individuals and our communities.

Effective interventions to reduce alcohol-related problems include: (1) socially responsible pricing of alcohol; (2) limits on the number of retail outlets and hours of sale; and (3) alcohol marketing controls. There is strong evidence that these three policy levers are among the most effective interventions available, especially when they are paired with targeted interventions such as drinking and driving counter measures and enforcement of the minimum drinking age.

In order to support healthy outcomes for Ontarians and to reduce health care costs associated with alcohol consumption, a comprehensive, evidenced-based alcohol strategy is required as soon as possible. With the expansion of alcohol sales in the province, the current lack of a province-wide strategy to promote the safe consumption of alcohol is cause for concern. The WDGPH BOH urges the Ontario Government to move forward with this important priority for the health and well-being of our communities.

Sincerely,

Nancy Sullivan
Chair, WDGHU Board of Health

c.c. alPHa – via e-mail
c.c. Liz Sandals, MPP (Guelph) – via e-mail
c.c. Ted Arnott, MPP (Wellington-Halton Hills) – via e-mail
c.c. Sylvia Jones, MPP (Dufferin-Caledon) – via e-mail
c.c. Randy Pettapiece, MPP (Perth-Wellington) – via e-mail
c.c. Ontario Public Health Units – via e-mail

DURHAM REGION

June 15, 2017

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

COPY

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

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Matthew L. Gaskell
Commissioner of
Corporate Services

RE: Memorandum from Dr. R. Kyle, Commissioner and Medical Officer of Health, re: Provincial Alcohol Strategy
Our File: P00

Please be advised that Committee of the Whole of Regional Council considered the above matter and at a meeting held on June 14, 2017, Council adopted the following recommendations of the Committee:

A) That the correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health urging the Government of Ontario to develop a provincial alcohol strategy to mitigate the health harms associated with alcohol use and misuse to accompany the increased access to alcohol in the province since 2014, be endorsed; and

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

Attached for your reference is a copy of the Memorandum from Dr. Kyle, Commissioner and Medical Officer of Health, dated June 7, 2017.

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

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

DURHAM REGION

The Regional Municipality of Durham

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An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: June 7, 2017

Re: Provincial Alcohol Strategy

On May 3, 2017, the Chair of the Wellington-Dufferin-Guelph Board of Health sent the attached correspondence to all Ontario boards of health for support.

In essence, the correspondence urges the Government of Ontario to develop a provincial alcohol strategy to mitigate the health harms associated with alcohol use and misuse to accompany the increased access to alcohol in the province since 2014.

Support for this correspondence is consistent with Council's role as Durham's board of health to influence the development of healthy policies that address alcohol use and misuse.

Accordingly, I recommend that the Committee of the Whole recommends to Regional Council that:

a) The correspondence from the Chair of the Wellington-Dufferin-Guelph Board of Health as regards Provincial Alcohol Strategy is endorsed; and

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

Respectfully submitted,

Original signed by

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

PublicHealth

May 3, 2017

DELIVERED VIA E-MAIL & REGULAR MAIL

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

Attention: The Honourable Eric Hoskins
Office of the Minister

Dear Hon. Hoskins:

Re: Provincial Alcohol Strategy

The Board of Health (BOH) for Wellington-Dufferin-Guelph Public Health (WDGPH) would like to urge the Ontario Government to develop a comprehensive, province-wide strategy to support the safe consumption of alcohol. The health harms associated with alcohol consumption impact tens of thousands of individuals in Ontario every year. With the increasing availability of alcohol in the province, it is important that the government move forward with the commitment it made to social responsibility in the 2015 Ontario Budget to correspond with the increasing availability of alcohol.

Since 2014, Ontarians have been able to purchase alcohol at grocery stores, farmers' markets, online sales through the LCBO and the expansion of bars and restaurants permitted at alcohol manufacturing sites. This increased availability has not been accompanied by a strategy to address the harms associated with alcohol use and misuse.

It is well established that an increase in the availability of alcohol leads to an increase in alcohol-related harms. Alcohol misuse is responsible for addiction, disease, social disruption and is one of the leading risk factors for disability and death in Canada. The health and financial costs to the individual and society are significant and include health care, law enforcement, lost productivity and premature mortality.

.../2

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T: 1-800-265-7293 | F: 519-836-7215 | wdgpublichealth.ca

For the health of our communities, there is a need for a provincially led alcohol policy that mitigates the health harms associated with alcohol. A comprehensive, evidence-based approach will limit the harmful effects of alcohol to individuals and our communities.

Effective interventions to reduce alcohol-related problems include: (1) socially responsible pricing of alcohol; (2) limits on the number of retail outlets and hours of sale; and (3) alcohol marketing controls. There is strong evidence that these three policy levers are among the most effective interventions available, especially when they are paired with targeted interventions such as drinking and driving counter measures and enforcement of the minimum drinking age.

In order to support healthy outcomes for Ontarians and to reduce health care costs associated with alcohol consumption, a comprehensive, evidenced-based alcohol strategy is required as soon as possible. With the expansion of alcohol sales in the province, the current lack of a province-wide strategy to promote the safe consumption of alcohol is cause for concern. The WDGPH BOH urges the Ontario Government to move forward with this important priority for the health and well-being of our communities.

Sincerely,

Nancy Sullivan
Chair, WDGHU Board of Health

c.c. alPHa – via e-mail
c.c. Liz Sandals, MPP (Guelph) – via e-mail
c.c. Ted Arnott, MPP (Wellington-Halton Hills) – via e-mail
c.c. Sylvia Jones, MPP (Dufferin-Caledon) – via e-mail
c.c. Randy Pettapiece, MPP (Perth-Wellington) – via e-mail
c.c. Ontario Public Health Units – via e-mail

August 8, 2017

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

Dear Minister Hoskins:

Re: Modernization of alcohol sales in Ontario

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

The Ontario Government has committed to social responsibility as it increases the availability of alcohol; however, actions by government since 2014 indicate that economic interests are superseding the health and well-being of Ontarians.

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

In order to address the health and social harms of alcohol, and the impact of increased access, a comprehensive strategy is needed. The Middlesex-London Board of Health calls on the government to prioritize the health and wellbeing of Ontarians by enacting a comprehensive, evidence-based alcohol strategy to minimize harms.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Premier Kathleen Wynne
The Ontario Public Health Association

August 8, 2017

The Ontario Public Health Association
44 Victoria Street, Suite 502
Toronto, ON M5C 1Y2

Re: Modernization of alcohol sales in Ontario

At its July 20, 2017 meeting, under Correspondence item e), the Middlesex-London Board of Health considered correspondence from the Ontario Public Health Association and voted to endorse the following:

e) Date: June 8, 2017
Topic: Modernization of Alcohol Sales in Ontario
From: Ontario Public Health Association
To: All Health Units

Background:
The Ontario Public Health Association (OPHA) Alcohol Workgroup recently created and advocacy package highlighting the ongoing modernization of retail alcohol sales in Ontario. The workgroup prepared a briefing note, template cover letter and infographic to help engage
senior leadership and Boards of Health to help facilitate advocacy efforts on this issue.

Recommendation:
Endorse.

It was moved by Mr. Ian Peer, seconded by Ms. Maureen Cassidy, *that the Board of Health endorse item e)*
Carried

The Middlesex-London Board of Health supports the Ontario Public Health Association's advocacy package highlighting the ongoing modernization of retail alcohol sales in Ontario and calls on the government to enact a comprehensive alcohol strategy to minimize harms.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Ontario Boards of Health

DRIVING THE FUTURE OF PUBLIC HEALTH

A conference exploring change management in a transformed health system
2017 Annual Conference, June 11-13, Chatham-Kent John D Bradley Convention Centre
565 Richmond St, Chatham, ON N7M 1R2

2017 alPHa Conference Proceedings

PRESENTATIONS ARE AVAILABLE FOR DOWNLOAD IN OUR PRESENTATIONS LIBRARY

SUNDAY, JUNE 11, 2017

Final Meeting of 2016-17 alPHa Board of Directors

The final meeting of the 2016-2017 alPHa board was held from 4 – 7 PM on Sunday evening. Minutes of the meeting will be distributed separately to Board members, but highlights included ongoing discussion of health system transformation, weighing in on the legalization of cannabis, and wrapping up the business of the year to ensure a smooth transition for the incoming Board members for 2017 – 18.

Opening Reception

Delegates were invited to warm up for the business of the coming days at an evening reception in the airy atrium of the John D Bradley Convention Centre that featured an array of healthy and tasty snacks, an opportunity to catch up with colleagues from across the province and musical accompaniment by versatile solo guitarist Tom Lockwood.

MONDAY, JUNE 12, 2017

Annual Business Meeting
Chair, Dr. Valerie Jaeger, alPHa President

The Annual Business Meeting included regular business as well as recognition of the 2016-17 alPHa Board of Directors and 2017 alPHa Fitness Challenge health unit winners Sudbury, Huron County and Northwestern as well as runner-up Porcupine, which achieved 98% participation.

ABM AGENDA
ANNUAL REPORT

Resolutions Session
Chair, Dr. Robert Kyle, alPHa Treasurer

The alPHa membership considered six resolutions for action in 2017, which included consideration of alPHa positions on low income dental programs for adults, Truth and Reconciliation, accessible contraception, healthy workplaces (mental health), tobacco endgame, and fluoride varnish programs. All six were quickly passed and alPHa will be advocating on these issues over the coming year.

DISPOSITION OF RESOLUTIONS

Opening Remarks

George Sims, the Town Crier for Chatham-Kent, called on conference delegates to reassemble in the ballroom to hear introductory remarks from Chatham-Kent Mayor, Randy Hope, and alPHa President, Valerie Jaeger.

"*Change is a word that can cause all manner of feelings from fear and trepidation to great joy. It has been said that some people would rather die than change, while others embrace change as an invigorating part of life. I suspect that most of us live somewhere in between those two extremes*." - Valerie Jaeger, alPHa President

Keynote – Change Management to the Rescue?
Presenter: Glen Paskiw, Change Management Consultant

Objective: After active participation in this session, participants will be able to understand, describe and apply the concepts of and approaches to change management.

Some say Public Health in Ontario is facing (and will continue to face) unprecedented change. Can change management assist in this effort and, if so, how? This keynote address by Glen Paskiw, Change Management Consultant, was designed to provide insights to successful change management through a strategic and systematic approach that focuses on both organizational and individual success.

Glen greeted delegates to the meeting and gave an outline of what he was to be covered, with the understanding that this session is an edited version of a much longer and in-depth seminar that he uses to introduce the concept of change management and the notion of change itself. The definition of change and the evidence about the challenges that change presents (to individuals and organizations alike) were presented, followed by a discussion of the specific changes that are facing public health and some table-top discussions aimed at devising solutions to maximize the chances of successfully adapting to them.

Fully understanding the complexity and nature of the change is the key to success, but this is more difficult than it sounds. Humans are much better at seeing a destination than knowing how to get there, and process failures are the most common reasons for losing the path. These are often enabled by our natural tendencies towards judgement, invention, and defensiveness. We need to be mindful of these tendencies and recognize that they are obstacles to successful change.

Glen identified three personalities within individuals that stand in the way of change in the interests of self preservation:

- *The Judge*: We react to things we don't like far more readily than to things we do. The Judge tends towards negativity.
- *The Magician*: We fabricate things to fill in gaps in information and then completely believe the half-told story to be true.
- *The Lawyer*: This is our own psychological immune system, which rationalizes outcomes by ignoring our own agency in a given situation.

He went on to estimate that 70% of organizational change doesn't go well. Most organizational change projects fall behind on schedule and budget, and an even greater percentage of them are not being followed in the way that was intended within 6 months. Vision and strategy are essential, but they can only be realized through proper execution and being open to innovation.

Successful change management thus depends on many factors, and the one that must be considered at the outset of the process is to understand the types of change in order to assess what's at stake:

1) *Developmental*: This is about assessing what an organization is doing to make improvements. It is the simplest (though not without challenges) and is ongoing. Improvements to service delivery, enhancing skills or enhancing business practices are the usual aims.
2) *Transitional*: This involves taking a new approach to something. Healthy Smiles and Ontario Public Health Standards (OPHS) were examples. Business is the same but business processes are different. This is a license to innovate.
3) *Transformational*: This is reshaping how you do your business and in some cases changing elements of the business itself. This one is much more difficult because the future state is much more difficult to predict. This is a license to re-invent.

At this point, he invited delegates to interact with one another to answer the following questions:

1. What is the biggest organizational change or challenge over the next year, why and what type?
2. What is your biggest individual change or challenge over the next year, why and what type?

Popular topics were predictably focused around OPHS and Patients First (relationships with LHINS) at the organizational level, with the associated individual changes related to competencies and duties related to each. Upcoming municipal elections and relationships with Aboriginal populations were also raised, as were some infrastructure updates. A common side effect of most of these is the requirement for re-orientation of leadership teams, re-assignment of staff and changes in processes.

Communication of anticipated changes was raised as well, with the observation that communicating change is a challenge in and of itself, and the climate is such that we are spending more time justifying what we're doing at the possible expense of doing it.

Glen then urged us as individuals to go beyond our working personas when thinking about these questions by being mindful of how personal change during the year ahead might be related.

He then outlined the elements of successful change management:

1. *Vision* – expressed in a series of value propositions that will interest and motivate the individuals within the organization.
2. *Model* – a plan for how the organization is going to get to the desired future state and get buy in from the individuals involved. It identifies stations along the way.
3. *Framework* – related to the Model, but accounts for the things that the organization needs to pay attention to regardless of the present stage. Communication and training are good examples.
4. *Principles* – an expression of the features of the organization and how they will be measured during the change process. People are more likely to accept change if they are involved in effectuating it. Champions are an example – people who are excited about something without having a major stake.
5. *Plans* – this is about devising a project plan (budget, scope, time etc.) that outlines what you plan to do with all the key players who are impacted and when you're going to do it. This requires a clear statement of what the change is, what the scope is going to be, and the probable impacts.

In addition to the foregoing, Glen advised that one needs to be equipped to go well beyond the basics above. He recommended an article entitled "Transformation with a capital T" as further reading. He also emphasized the importance of systems leadership, which embodies the notion of thinking and acting as one. Setting the vision, creating a collective focus and demonstrating that we are all acting as a unit are important aspects of this.

CHANGE MANAGEMENT TO THE RESCUE? - SUMMARY OF KEY MESSAGES
TABLE-TOP Q&A SUMMARY

Concurrent Breakout Sessions

Concurrent Breakout Session A - *The Road Ahead – CQI, Organizational Change and Change Management.*

Objective: After active participation in this session, participants will be able to summarize and apply considerations for local public health units in the areas of CQI, organizational change and change management.

Presenters: **Madelyn Law**, Associate Professor, Department of Health Sciences, Brock University; **Glen Paskiw**, Change Management Consultant; **Alex Berry**, Manager, Communications & Foundations Services, Northwestern Health Unit

Reporter: Dr. Robert Kyle, Commissioner & Medical Officer of Health for the Regional Municipality of Durham

The focus of this session was quality improvement, and the key message delivered to participants on the theme of managing change was "think big but work small, scaled and savvy", as marginal improvements in many individual areas can lead to significant gains in the organizational whole. The approach to CQI was largely based on the Institute for Health Care Improvement's Triple Aim, and it is meant to examine goals and objectives while measuring change and implementing lessons learned along the way. This can begin at granular levels before scaling tests up to the organizational level.

Implementing change depends on creating the appetite for it. A strategy needs to be developed that is reflective of the organization's size and characteristics, and individuals within the organization need to feel that they are included. This can be done from the top down, where the focus is on changing culture and focusing on appropriate problems and solutions, or from the bottom up, where the focus in on behaviour, people and messages. Enablers to overcome organizational resistance were also outlined.

SLIDE DECK

Concurrent Breakout Session B - *Flourishing Under the 2018 Budget - Understanding Program Based Marginal Analysis*

Objective: After active participation in this session, participants will be able to identify and explain strategies to address budget constraints at the health unit level.

Presenters: Francois Dionne, Centre for Clinical Epidemiology and Evaluation within Vancouver Coastal Health Research Institute; **Dr. Charles Gardner**, Medical Officer of Health, Simcoe Muskoka District Health Unit

Reporter: Dr. Penny Sutcliffe, Medical Officer of Health and CEO of Sudbury & District Health Unit

Program Based Marginal Analysis (PBMA) was introduced as a tool for allocating scarce resources for the greatest positive impact. It addresses financial implications, fairness and equity, and opportunity costs through an eight-step Priority Setting Framework. It is a process that is formal and transparent and presents options for change against multiple criteria across the entire organization. It is action-oriented and considers ethical conditions alongside economic principles to prioritize activities and reallocate resources for greater overall gains. Dr. Charles Gardner provided the local perspective through a presentation of the Simcoe-Muskoka District Health Unit's experience with using PBMA. His conclusion was that despite some challenges and resistance, using the tool was well worth the time, as it strengthened organizational thinking and increased rigour in determining how scarce resources are allocated.

SLIDE DECK (DIONNE)
SLIDE DECK (GARDNER)

Concurrent Breakout Session B - *Age Friendly Framework – Fostering the Health and Well-being of People as They Age*

Objective: After active participation in this session, participants will be able to describe the World Health Organization's Age Friendly Framework and apply the experiences of others in creating a supportive environment that facilitates healthy aging.

Presenters: **Greg Shaw**, Director, International & Corporate Relations, International Federation on Ageing (official agency of World Health Organization); **Dr. David Colby**, Medical Officer of Health, Chatham Kent Public Health Unit; **April Rietdyk**, CEO, Chatham Kent Public Health Unit

Reporter: **Trudy Sachowski**, Provincial Appointee to the Northwestern Board of Health

This session provided an overview of the WHO Age-Friendly Framework and its role in facilitating age-friendly communities. With the observation that age-friendly should not be strictly interpreted as "elderly-friendly", this approach uses universality, integration, and transformation in eight domains (outdoor spaces and public buildings, transportation, housing, social participation, respect and social inclusion, civic participation and employment, communication and information, community support and health services) to create structures and services that are inclusive of different needs and capacities.

The Age-Friendly network's aim is to keep people integrated in and useful to their communities for as long as possible by transforming the communities themselves. Some of the returns on investment include positive consumer experience, inclusiveness, and increased intergenerational cohesion.

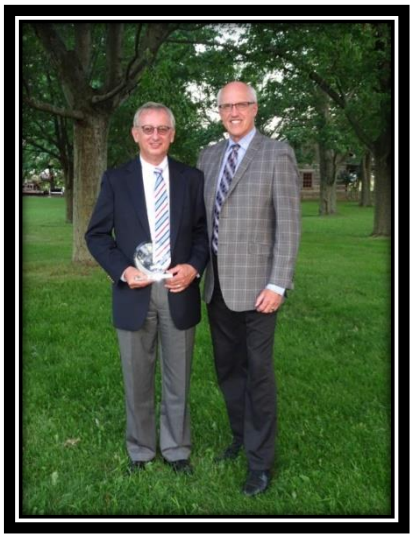
April Rietdyk and Dr. David Colby spoke of the local experience in using a tri-sector approach to build a diverse, inclusive, accessible, and respectful community, that enables independence and healthy lifestyles at all stages of life.

SLIDE DECK (SHAW)
SLIDE DECK (COLBY / RIETDYK)

Stacy Rybansky & Maureen Cava

Cynthia St. John & Pat Hewitt

Linda Stewart & Valerie Jaeger



Bjorn Christensen & Ken Gorman

Click above for full program and on pictures for full-sized files.

Dr. Dick Ito & Mary Johnson (Unable to attend in person)

2017 DSA Recipients: Valerie Jaeger, Linda Stewart, Bjorn Christensen, Maureen Cava, Cynthia St. John

- Concurrent Business Meetings for alPHa's Council of Ontario Medical Officers of Health and Boards of Health Sections
- Inaugural Meeting of 2017-18 alPHa Board of Directors

Agendas, Minutes and other materials related to these meetings will be circulated to meeting participants as appropriate via the usual channels.

This event was supported in part by an educational grant from the following:

PLATINUM SPONSORS

Ontario Neurotrauma Foundation
Fondation ontarienne de neurotraumatologie

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Ontario Neurotrauma Foundation
Sanofi Pasteur
UPnGO with ParticipACTION

SPEAKER BIOGRAPHIES

GLEN PASKIW is a change management expert who has supported, managed and led a wide variety of change over the past fifteen years. He is obsessed with ensuring that organizations and their people are successful with change. Within change management, Glen has extensive experience addressing and enhancing change leadership, change planning, coaching, training, and change communication. He is also a certified Lean Leader. Glen's experience has included key change-related assignments with eHealth Saskatchewan, Yukon Health and Social Services, Canada Health Infoway and the British Columbia Ministry of Health.

MADELYN LAW is an Associate Professor in the Department of Health Sciences at Brock University. She has an undergraduate degree in sport management, masters in sport psychology and a PhD in health administration. Madelyn's research is examining and helping to create high performance systems. Madelyn is the founder and director of I-EQUIP which is the Inter-professional Education for Quality Improvement Program where she engages community partners and students in the health sector to improve the quality of health services. Madelyn is currently part of the Public Health Ontario funded Locally Driven Collaborative Project focused on Continuous Quality Improvement in Public Health.

ALEX BERRY is the Manager of Communications & Foundations Services at the Northwestern Health Unit (NWHU) where he provides leadership in the development and implementation of agency performance management systems, including planning and evaluation, monitoring and reporting, and quality improvement initiatives and systems. He is one of the co-leads of the Locally Driven Collaborative Project Strengthening Continuous Quality Improvement in Ontario's Public Health Units. Based in Fort Frances, Alex has been with NWHU since 2009. As the leader of the Communications and Foundations teams, he also provides agency-wide guidance and support in the areas of research and knowledge exchange, communications, emergency management, privacy, risk management, board development, and policy and procedure.

FRANCOIS DIONNE is based in the Centre for Clinical Epidemiology and Evaluation in the Vancouver Coastal Health Research Institute. Dr. Dionne completed his doctoral training in the School of Population and Public Health at the University of British Columbia, and also holds a Master's degree in Business from UBC. The focus of his work is on the application of methods to support priority setting and resource allocation decision-making in the public sector. Francois is a principal with Prioritize Consulting Ltd which specializes in assisting public organizations in resource allocation decision-making. He has consulted widely with health care organizations and is one of Canada's leading experts in the application of multi-criteria decision analysis in health care.

CHARLES GARDNER has been the Medical Officer of Health (MOH) for the Simcoe Muskoka Health Unit since 2005, after having served as MOH with the Leeds, Grenville and Lanark District Health Unit for seven years. Prior to that, he worked in general medical practice for four years in communities in Newfoundland and New Brunswick, and a year in Zimbabwe. In the past Dr. Gardner has been the chair of the Council of Ontario Medical Officers of Health, president of the Association for Local Public Health Agencies, president of the Ontario Council for Community Health Accreditation, member of the Ontario Public Health Leadership Council, and co-chair of the Healthy Environments Both Natural and Built Table for the Ontario Public Health Sector Strategic Plan. Most recently Dr. Gardner was a member of the Ontario Tobacco Control System Committee, and is a member of the Smoke-Free Ontario Scientific Advisory Group and of the Ontario Tobacco Research Network. He is also presently on the Modernization of the Smoke Free Ontario Strategy Executive Steering Committee.

GREG SHAW has a science and health administration background and is the Director, International and Corporate Relations for the International Federation of Ageing (IFA). Prior to joining the IFA, he held senior management positions within the Australian Government in the Department Health and Ageing, including responsibility for the regulatory regimes associated with both residential and community care services. He represents the IFA at the United Nations, works closely with government and has responsibility for IFA elder abuse initiatives. Greg also has responsibility for Age-Friendly Cities/Communities (AFCC) initiatives within the IFA that includes providing technical advice and support to government and others engaged in age-friendly program development. His expertise in this field has been recognized through a recent Memorandum of Understanding (MoU) for a new city development in China and ongoing AFCC work with the city of Akita in Japan. More recently, in November 2015 he convened a series of AFCC workshops in the Republic of Iran. Canadian Committee appointments include the Ontario Securities Commission Senior Expert Advisory Committee (SERC), the Toronto Police Service Community Advisory Committee and the City of Toronto Advisory Committee on Long-Term Care & Services.

DAVID COLBY is the Medical Officer of Health in Chatham-Kent and Director of the Travel Immunization Clinic, Middlesex-London and Chatham-Kent Health Units. Originally from Chatham, Ontario, Dr. Colby received his MD from the University of Toronto in 1984. While still a resident at University Hospital in London, he was appointed to Faculty in the University of Western Ontario (UWO) Department of Microbiology & Immunology. Dr. Colby was awarded Fellowship in the Royal College in 1990 (*Medical Microbiology*) and was appointed Chief of Microbiology at University Hospital in 1993. He was President of the Canadian Association of Medical Microbiologists from 1995 to 1997. In 1998, he was appointed as an Ontario Coroner. In 2012, Dr. Colby was promoted to Professor, Departments of Microbiology/ Immunology and Physiology/ Pharmacology at UWO. Dr. Colby lectures locally and internationally on travel medicine, approaches to antibiotic resistance and fungal infections of the critically ill. He is a legally recognized expert on wind turbines and health. Dr. Colby has received numerous citations for teaching, including the Canadian Association for Medical Education Certificate of Merit Award, 2006; the Bank of Nova Scotia/ UWO Alumni Association Award, 2009; and the University Students' Council Award of Excellence in Undergraduate Teaching, 2009.

APRIL RIETDYK is the General Manager, Health and Family Services with the Municipality of Chatham-Kent and the CEO Chatham-Kent Public Health Unit. In addition to Public Health, her portfolio includes Employment and Social Services, Housing Services, Children's Services, and Seniors Services. April has spent the last thirty years working in human services, dedicating her career to promoting and protecting the health of the community. April's doctoral research focused on the impact a sedentary lifestyle can have on a woman's transition through menopause. Her master's work focused on Nursing Professional Practice and the importance of Practice Councils in organizations. She has sat on numerous boards including RNAO, Chatham-Kent Children's Services Board, and the board of the Ontario Association of Children's Aid Societies. April is actively involved in the Chatham-Kent Women's Leadership Council, the Chatham-Kent Leaders' Cabinet and is a member of Sigma Theta Tau International.

ACCREDITATION

This Group Learning program meets the certification criteria of the College of Family Physicians of Canada and has been certified by Continuing Professional Development, Schulich School of Medicine & Dentistry for 8.0 Mainpro+ credits (4.5 credits for June 12, 3.5 credits for June 13).

This event is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification program of The Royal College of Physicians and Surgeons of Canada, approved by Continuing Professional Development, Schulich School of Medicine & Dentistry, Western University. (8.0 hours - 4.5 hours for June 12, 3.5 hours for June 13)

Each participant should claim only those hours of credit that he/she actually spent participating in the educational program.

TELL US HOW WE DID!

Please note that a program evaluation questionnaire will be sent to participants via email immediately following the event. We ask that you please provide us with your feedback on the program as it is essential to the evaluation of the program and the planning of future events.

THANK YOU FOR YOUR PARTICIPATION!

alPHa
Association of Local PUBLIC HEALTH Agencies

Information Break

July 18, 2017

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

2017 Annual Conference Wrap Up

Many thanks to the members, speakers, sponsors and exhibitors who participated at alPHa's 2017 annual conference **Driving the Future of Public Health** last month in Chatham, Ontario. A special shout out to conference co-host Chatham-Kent Public Health who helped organize a successful event. One highlight in particular was the memorable annual awards dinner that was held at the historic Buxton Museum and featured an unforgettable performance by The Friends of Buxton Men's Choir. Our sincerest thanks and gratitude to health unit staffers Lisa Powers, Heather Bakker, Michelle Bogaert and Lyndsay Davidson for making it all happen at the Buxton! For a summary of the conference plenary and breakout sessions, please click on the link below to download proceedings and view slide presentations (login and password required).
2017 alPHa Annual Conference Proceedings & Presentations
Distinguished Service Award 2017 Program

2017-2018 alPHa Executive Committee

At the June annual general meeting, the 2017-2018 slate of officers, the alPHa Executive Committee, were elected as follows:

Carmen McGregor (Chatham-Kent) - President
Dr. Valerie Jaeger (Niagara) - Past President
Dr. Penny Sutcliffe (Sudbury) - Vice President & COMOH Chair
Gilles Chartrand (Porcupine) - Treasurer
Trudy Sachowski (Northwestern) - BOH Section Chair
Paul Sharma (Peel) - Affiliate Representative

For a full list of the 2017-2018 Board of Directors, click here.

Resolutions Passed at Annual Conference

This year, six resolutions were endorsed by the alPHa membership at the June annual conference. Calls to action were made on the following: oral health for low-income Ontarians, Truth and Reconciliation, tobacco endgame, fluoride varnish programs, accessible contraception, and mental health in Ontario workplaces. alPHa will be writing relevant government officials on these resolutions over the summer, and will post responses on the website as they become available.
View the 2017 resolutions here
Visit alPHa's Resolutions home page

Consultation: Cannabis Legalization in Ontario

The Province of Ontario has released a consultation paper on the legalization of cannabis (marijuana) and is currently seeking public input on how it should responsibly approach the regulation and sale of cannabis. Share your health unit's feedback by completing the government's online survey by **July 31, 2017**. Prior to the announcement on Ontario's consultation, alPHa wrote Canada's Attorney General in support of the report *Toward the Legalization, Regulation and Restriction to Access to Marijuana: Submission to Federal Task Force* by the Ontario Public Health Unit Collaboration on Cannabis.
Learn more about Ontario's consultation on cannabis legalization
Read alPHa's letter on cannabis legalization (with report) here

alPHa Website Feature: Correspondence

In the past couple of months, alPHa has sent letters on a number of important public health issues. alPHa submitted its formal response to the province on the draft Public Health Accountability Framework in June, and wrote a congratulatory letter to Ontario health minister Eric Hoskins on expanded access to naloxone. The Association also wrote Ontario's Chief Medical Officer of Health regarding recommendations on public health requirements for *The Child Care and Early Years Act* and *Immunization of School Pupils Act*.
Visit alPHa's Correspondence home page here

Upcoming Events - Mark your calendars!

November 3, 2017* - Fall alPHa Meeting, DoubleTree by Hilton Downtown Toronto Hotel. Details TBA.
** New date (i.e. changed from previously announced date)*

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

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

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

alPHa
Association of Local PUBLIC HEALTH Agencies

Information Break

August 17, 2017
This monthly update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa correspondence and events.

Report of Minister's Expert Panel on Public Health

On July 20, Ontario released the Report of the Minister's Expert Panel on Public Health, *Public Health within an Integrated Health System*. The report advises the government on ways to strengthen and integrate the public health sector with the rest of the provincial health care system. alPHa has prepared a summary of the report's proposals (see link below), which, if implemented, will have significant implications for Ontario's public health system. alPHa has begun to set up processes for members' feedback to inform the association's input and advice to government once consultations are underway. We will keep members updated on developments as they arise.
View the government's announcement on the Expert Panel's report
Download the Expert Panel report here
Read alPHa's summary of the Expert Panel's report here

Government News: Round Up

As part of its Local Food Strategy, the Ontario government recently launched the campaign *Bring Home the World* to expand consumer access and availability of locally-grown foods that reflect the province's cultural diversity. It is presently seeking the public's feedback on its World Foods discussion paper through an online survey. Responses to the survey should be completed by September 23.

On August 3, the province announced that it would be making the abortion pill Mifegymiso available to women at no cost effective August 10, 2017. Women with a valid health card and a prescription from a doctor or nurse practitioner can get the drug at participating pharmacies across Ontario.
Read the Ontario government news release here

ConnectingOntario: Toward a Single Electronic Health Record

eHealth Ontario has established The ConnectingOntario initiative to create electronic health records for all Ontario patients. There are three regional programs: *ConnectingOntario Greater Toronto Area*, *ConnectingOntario Northern and Eastern Region (NER)*, and *Connecting South West Ontario*. Each regional program is being led by a hospital-based delivery partner to provide clinicians with secure and timely access to electronic patient health information across the continuum of care -- hospitals, community and primary care -- through a clinical viewer. Public health is one of the program's target sectors for clinician adoption. As such, alPHa has started working with ConnectingOntario NER to raise awareness of this initiative among health units over the coming months.
Learn more about ConnectingOntario here

Upcoming Events - Mark your calendars!

November 3, 2017 - Fall alPHa Meeting, DoubleTree by Hilton Downtown Toronto Hotel. Details TBA.
February 23, 2018 - Winter alPHa Meeting, Novotel Toronto Centre, 45 The Esplanade, Toronto. Details TBA.
March 21-23, 2018 - The Ontario Public Health Convention (TOPHC) 2018, Beanfield Centre, Toronto.
June 10, 11 & 12, 2018 - alPHa Annual General Meeting & Conference, Novotel Toronto Centre, 45 The Esplanade, Toronto.

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alPHa Summary
Public Health within an Integrated Health System:
Report of the Minister's Expert Panel on Public Health

On July 20 2017, the Minister of Health and Long-Term Care released the Expert Panel on Public Health report, Public Health within an Integrated Health System. This report is the product of deliberations that began in January of this year as part of the Government's efforts to increase integration of public health and health care services to achieve the Patients First vision of a transformed and integrated health system that improves access to care and actively promotes health and reduces health disparities.

The first step in this process was the passage of the Patients First Act (alPHa Summary here), which formalized linkages between LHINs and public health units.

The establishment of the Expert Panel was then announced by the Minister on January 18 2017, with the mandate of providing advice on structural and organizational factors required to "improve the integration of population and public health into the health system, deepen the partnerships between local boards of health and LHINs, and improve public health capacity and delivery within a transformed and integrated health system". alPHa provided key messages to the Panel in the early part of its mandate (attached).

The proposed structural, organizational, and governance changes for Ontario's public health sector contained in the report appear to be significant and their implications could be far-reaching. **alPHa strongly encourages its members to read the report carefully and in full** to understand the proposals and the effects that they could have. It is included in this package for your convenience.

It is important to note however that these are recommendations made by the Panel and not decisions that have been made by Government. alPHa has already started work on developing processes to gather feedback from our members to ensure that concerns are articulated and that a complete and thoughtful analysis of the proposals is undertaken during the promised consultation (no information has been made available about format or timing of this).

alPHa is pleased to provide its members with this summary of the Expert Panel report and will keep members informed of new developments and opportunities for input.

Included following the report summary are the following materials:

- alPHa response to the release of the Report, August 1 2017
- alPHa Submission to the Expert Panel, March 15 2017
- The full Expert Panel Report.

We hope you find this information useful.

PUBLIC HEALTH WITHIN AN INTEGRATED HEALTH SYSTEM: REPORT OF THE MINISTER'S EXPERT PANEL ON PUBLIC HEALTH

I. ABOUT THE EXPERT PANEL

The Expert Panel was asked to consider the optimal organizational structure for public health in Ontario to:

- ensure accountability, transparency and quality of population and public health programs and services
- improve capacity and equity in public health units across Ontario
- support integration with the broader health system and the Local Health Integration Networks (LHINs) – the organizations responsible for planning health services
- leverage public health's expertise and leadership in population health-based planning, decision-making and resource allocation, as well as in addressing health equity and the social determinants of health.

Desired Outcome: A Strong Public Health Sector within an Integrated Health System

- Ontario will benefit from a highly skilled and highly visible public health sector at the community level
- Public health will maintain relationships with municipal governments and other local organizations to positively influence the social determinants of health and healthy environments.
- Public Health work will be overseen by boards that reflect the perspectives and diversity of local communities and municipalities. The work will be supported by province-wide efforts to collect and analyze data on health status
- Public health will continue to focus on identifying at-risk populations and Indigenous communities will have an active voice.
- Public health will use Its understanding of local health needs to help identify health system priorities and shape health policy and services.

Principles Guiding the Panel's Work

- The strong independent public health voice and core public health functions will be preserved and leveraged to help reorient the health system.
- The local strengths of public health – including relationships with municipal and other community partners – will be maintained and enhanced to support integrated planning and service delivery.
- Ontario's public health sector has a responsibility to protect and promote Indigenous health and to ensure Indigenous partners have an active voice.
- Being part of an integrated health system will create opportunities to enhance capacity and improve efficiency– some services may be delivered more effectively by or through other parts of the system.
- Structural changes will be based on a clear understanding of the public health sector's role in an integrated health system.

- The organization and distribution of public health expertise, resources and services will reflect local needs and priorities.
- Boundary changes will be necessary to align public health with LHINs, and to support systems planning.

II THE OPPORTUNITY

Public Health is now seen as part of an integrated health system whose component parts will work together to enhance Ontarians' health and well-being at all ages and stages of life.

A stronger relationship between public health and LHINs is expected to integrate a population health approach into local planning and service delivery, so that health services are responsive to population health needs and contribute to promoting health and achieving health equity.

Preparing Public Health for its role in an Integrated Health System

Three public health transformation initiatives that were undertaken in parallel with Patients First are briefly outlined:

- The modernization of the Ontario public health standards
- The Public Health Work Stream, which is a collaboration between public health and LHINs to provide guidance on formal engagement parameters. A report from this group is expected in the early part of the fall.
- The Expert Panel on Public Health

The Impact of Public Health within an Integrated System

- Public health is expected to continue using its relationships outside the health system (municipal governments, community organizations, schools, etc.) to protect and promote health and apply them to broker relationships between health care, social services, municipal governments, and other sectors to create healthier communities.
- Public health is expected to bring a greater focus on the social determinants of health and health equity by embedding a population health approach into health service planning and delivery
- Public health can identify high risk communities and assist in developing comprehensive targeted health interventions to prevent chronic diseases by addressing identifiable risk factors
- Public health can help the health system develop care pathways for patients that incorporate social factors (e.g. food insecurity, precarious housing) that affect health outcomes.
- Public health will enjoy greater public recognition and the importance of investing in health protection and promotion across the life course, and its role in the sustainability of the universal health care system will be more fully understood.

III A STRONG PUBLIC HEALTH SYSTEM IN AN INTEGRATED SYSTEM

The Expert Panel identifies criteria for an optimal structure and governance model for public health to align with the vision of Patients First as well as support more efficient and effective operations of public health within its own mandate. It also agrees with the findings of previous reviews that have concluded that Ontario's public health system would be stronger if there were fewer health units with greater capacity, a consistent governance model and better connections to other parts of the health system. The Panel recommends a new model for public health that would:

- Maintain a strong independent public health sector within an integrated health system
- Relate effectively with the LHINs to influence health system planning
- Enhance public health's strong local presence and effective relationships with municipalities
- Ensure Ontarians continue to have access to public health programs and services in their communities
- Create public health organizations large enough to achieve critical mass and retain public health personnel and resources to efficiently operate services in all parts of the province
- Allow for clear definition of public health functions and roles at the provincial, regional and local levels, to make more effective use of public health expertise and resources
- Enhance public health practice and ensure more consistent implementation of the public health standards across the province
- Foster collaboration/coordination within the public health sector and with the rest of the health system.

A more detailed description of existing public health responsibilities and functions at provincial, regional and local levels is provided in a set of tables and figures on pages 11-15. These are presented with suggestions that they could be redistributed following the implementation of the "proposed end-state", which is presented as an organizational chart on page 16.

Optimal Geographic Boundaries

The Expert Panel has proposed geographic boundaries 14 regions that ensure critical mass by creating larger regional public health entities while supporting effective linkages with LHINs and respecting municipal boundaries and relationships as much as possible. They are therefore not completely aligned with existing LHIN or PHU boundaries. They are mapped against current PHU and LHIN boundaries on pages 18 and 19.

Proposed regions are largely amalgamations of existing Public Health Units, there are exceptions. Parts of the existing catchment areas of Halton, Wellington-Dufferin-Guelph, Toronto, Leeds-Grenville-Lanark, Renfrew, North Bay Parry Sound and Porcupine would be in different regions.

Proposed Model / Leadership Structure

14 REGIONAL BOARDS OF HEALTH / PUBLIC HEALTH ENTITIES, each with a CEO who reports to the Board of Health and a Regional Medical Officer of Health, who may report to Board of Health on matters of public health and safety. Senior public health leadership such as the Chief Nursing Officer, AMOHs, CAOs, CIOs etc. would also be housed here.

LOCAL PUBLIC HEALTH SERVICE DELIVERY AREAS (number TBD), subdivisions of the Regional Entities**,** each with a local MOH who reports to the Regional MOH. Local Program and Service Management staff would be hosed here.

An Optimal Approach to Governance

Following an outline of the current challenges inherent in the current system of variable models, gaps in skills and different appointment processes for Ontario's boards of health, the Expert panel recommends a governance structure that would ensure consistency, maintain autonomy and independence, and maintain a strong municipal voice and representation and ensure the effective performance of the core functions of board governance. A proposed model is presented in a table on page 23.

Key characteristics include autonomy, inclusivity, skills and experience as qualifications and stronger links to the Province and municipalities via their respective appointees.

IV IMPLEMENTATION AND CONSIDERATIONS

The Expert Panel does not make recommendations for implementation, but briefly outlines the required considerations:

- **Legislation**: a detailed analysis will be required to determine how much of the proposed structure and governance model will require legislative amendments.
- **Funding**: the current public health funding model may be a barrier to implementing the proposed structure. The ministry will need to re-visit funding constructs in order to implement the recommendations.
- **Transition Planning/Change Management:** all of the existing 36 public health units will require assistance with change management and the Ministry will need to recognize the complex nature of municipal government and take measures to protect municipal interests. Engaging with consultants to assist with transition and working with the Association of Ontario Municipalities to develop the criteria for municipal representation on the new regional boards.
- **Effective Linkages with LHINs and the Health System:** strategies to enhance linkages could include LHIN / Regional BOH cross appointments, regular meetings between the Chairs of each, and regular meetings between public health and LHIN leadership as well as shared projects and activities.

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

August 2 2017

Dear Minister Hoskins,

Re: Public Health within an Integrated Health System: Report of the Minister's Expert Panel on Public Health

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHa), I am writing to thank you for sharing the Expert Panel on Public Health Report with us so that we can review the recommendations and begin to assess their potential implications.

We understand that the report provides a framework for the government to consider for changes to Ontario's public health system to enhance its effectiveness within its own mandate while augmenting its contributions within the transformed health system as envisioned in the Patients First Strategy.

We remain strongly supportive of bringing our leadership and expertise in health promotion and disease prevention into other areas of the broader health system to ensure a stronger focus on the causes of poor health.

We also remain committed to ensuring that Ontario continues to benefit from a robust, locally relevant and collaborative public health system that maintains its essential relationships with non-health system sectors that have such an important influence on health outcomes.

A careful and considerate analysis of the governance, organizational and structural changes proposed by the Expert Panel will be required to determine their suitability for achieving the stated desired outcome of a strong public health sector within an integrated health system.

We appreciate that no decisions have yet been made and we are already developing processes to gather feedback from our members on the proposals so that we can provide fully-informed and comprehensive advice during the promised consultation process.

We look forward to working with you to ensure that promoting health and reducing health disparities remain central to the Patients First vision.

Yours sincerely,

Carmen McGregor
alPHa President

COPY: Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Division
Sharon Lee Smith, Associate Deputy Minister, Health and Long-Term Care, Policy and Transformation.

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March 15, 2017

Public Health Expert Panel Members
c/o
Dr. David Williams, Chair
Roselle Martino, Executive Sponsor

Dear Panel Members,

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHa), I am writing to share alPHa's perspectives on key issues currently under the Expert Panel's consideration. As the provincial association that provides leadership to Ontario's boards of health and public health units[1], we have long been engaged in the matters within the mandate of the Expert Panel. We hope that the distillation of our years of experience is helpful to you as you pursue this important work.

As you will know, Ontario's local public health system is grounded in a population health approach – focused on upstream efforts to improve health and health equity. Our system is enviable across Canada in that it benefits from: i) a structure that promotes strong municipal and other non-health sector relationships so important to health, and ii) a comprehensive legal and programmatic framework . These assets mean that Ontarians are effectively served by a local public health system that works in partnership to respond to local needs while at the same time ensuring compliance with provincial standards[2].

Such strengths in Ontario's local public health system notwithstanding, there have been a number of occasions to scrutinize and recommend improvements. Many improvements have been made as our system has evolved and recommendations from numerous reports have been implemented over the years.

As the Panel will be aware, since the May 2000 *E. coli* outbreak and tragic deaths in Walkerton there have been numerous opportunities to review the structure, organization, governance, functions and capacity of Ontario's local public health system.

[1] For clarity, please note that each local public health unit in Ontario is governed by a local board of health. For simplicity, the term *local public health* will be used to refer to these entities as a whole in this document.

[2] Local public health works through multiple channels and on multiple issues in order to have an impact on the health of the population. The work is diverse, including individual clinical service delivery, education, inspection, surveillance, and policy development among other activities. What unifies local public health action is its focus on prevention, upstream interventions and societal factors that influence health.

These reviews have afforded alPHa's members with many opportunities to carefully consider how the local public health system could best support the health of Ontarians. Through much participation in the many reviews over many years, a number of consistent messages have been put forward by alPHa that we would like to share with the Expert Panel for your consideration in the current review. These are described in our comments that follow, noting that we would be pleased to discuss any of these items in more detail.

1. PROVINCIAL RELATIONSHIP

Local public health should remain independent of health care structures such as local health integration networks (LHINs). While alPHa views Ontario's LHINs as important partners in community health, and we welcome our new role in supporting population level planning for the health system, it is important for local public health to remain organizationally separate from these structures. Provincial public health funding and accountability agreements must continue to be directly negotiated between local boards of health and the MOHLTC. This direct relationship mitigates against the threat of financial and functional resource allocation to the acute care system as has been evidenced in the experience of the many other regions in Canada and around the world with integrated health systems. Despite the best of intensions in many jurisdictions, over time, the resources available to local public health have been eroded and public health functions have become dispersed and focused more on downstream secondary prevention and treatment.

2. MUNICIPAL RELATIONSHIP

Board of health members should be drawn from the communities the board serves, and should include a balance of municipally elected officials, as well as committed citizens chosen by the Board or appointed by the province. Municipal representation on boards of health ensures valuable connections with decision makers and staff in non-health sectors where there is scope of authority over key determinants of health (e.g., by-laws, built environment, social services, child care, land use planning, long-term care, safe drinking water, recreational facilities, first responders, etc.). Board members should be selected based on their interest in public health issues and the fulfillment of specified competencies through recruitment processes where possible and complemented with training where specific competencies require further development.

3. NUMBERS OF BOARDS OF HEALTH

Changes to health unit boundaries should be considered only in the context of optimizing human and financial resources, and ensuring equitable availability of public health expertise and technical requirements for full local delivery of public health services in all parts of the province. Any such consideration must be undertaken in full consultation with local public health.

4. ALIGNING LOCALLY TO PROMOTE HEALTH

Local public health is responsible to plan for the overall health of the population each board serves. The LHIN boundaries have been established based on referral patterns for patients of acute care institutions. This markedly contrasts with the health promoting approach of local public health that is much broader, reaching people where they live, go to school, work and socialize. alPHa has recommended that when re-thinking LHIN boundaries consideration should be given to the current alignments between local public health, education, municipal and social service boundaries because of the support these sectors provide to local public health, population health and local health systems.

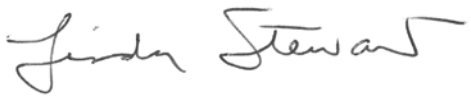
5. LOCAL PUBLIC HEALTH CAPACITY CONSIDERATIONS

There is an important distinction between providing population health information and translating this information into planning, funding and delivery decisions for acute care and other downstream services. It should not be assumed that the latter is a public health competency. It must be recognized that the work for public health as described in the Patients First discussion paper is additional to public health's core functions and mandate and the related resources must be identified to accommodate this work to ensure that public health capacity to promote and protect health and improve health equity is not eroded.

Local public health in Ontario is uniquely mandated and positioned to promote and protect the health of the population. We play a role that is often not well understood and we appreciate the opportunity to provide input based on our many years of experience and wealth of grounded knowledge. We would be pleased to discuss these and related issues further with you and ask that you not hesitate to follow up with us.

On behalf of alPHa, I wish you all the best in your deliberations on these important matters and I look forward to your recommendations.

Yours sincerely,



Linda Stewart
Executive Director

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Ontario

July 20, 2017

Dear Colleagues,

In February 2015, the province launched our *Patients First: Action Plan for Health Care* to transform our health care system into one that puts patients at the center by making our health care system more accessible, equitable and integrated. During the last two years, we have made considerable progress to improve the health care experience and outcomes for patients in Ontario. But we know there is still more work that needs to be done in order to make our system truly integrated.

Improving access to care is one priority of Patients First, but the vision is much broader. Patients First is also about promoting health and reducing health disparities. A key factor in achieving this vision is to strengthen linkages and partnerships within the health system, including public health. Patients First includes a requirement for the public health sector and the province's local health integration networks (LHINs) to work together in an integrated health system: one that actively promotes health and reduces health disparities as well as improves access to health care services. As a first step in realizing this requirement, the Government of Ontario established the Expert Panel on Public Health ("Expert Panel") in January 2017. Over the course of five months, the expert panel met to develop recommendations on proposed structural, organizational, and governance changes for Ontario's public health sector.

I am sharing with you the report of the Minister's Expert Panel on Public Health: "*Public Health within an Integrated Health System."* On behalf of the Ministry of Health and Long-Term Care, I would like to thank the expert panel for its important work. The recommendations of the expert panel's report provide a framework for the government to consider as it continues to implement Patients First. I look forward to engaging with you and other stakeholders to discuss the opportunities offered in this report. Details about consultations will be forthcoming.

This report is an important first step to help us realize the vision for all health programs and services – hospitals, home and community care, primary care and public health – to have strong connections and to work together to enhance Ontarians' health and well-being at all ages and stages of life.

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Yours sincerely,

Dr. Eric Hoskins
Minister

Public Health within an Integrated Health System

Report of the Minister's Expert Panel on Public Health

June 9, 2017

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I. About the Expert Panel

In January 2017, the Minister of Health and Long-Term Care established an Expert Panel on Public Health to provide advice on structural, organizational and governance changes for Ontario's public health sector within a transformed health system.

Mandate

As part of their recommendation, the Expert Panel was asked to consider:

1. The optimal organizational structure for public health in Ontario to:
   - ensure accountability, transparency and quality of population and public health programs and services
   - improve capacity and equity in public health units across Ontario
   - support integration with the broader health system and the Local Health Integration Networks (LHINs) – the organizations responsible for planning health services
   - leverage public health's expertise and leadership in population health-based planning, decision-making and resource allocation, as well as in addressing health equity and the social determinants of health.
2. How best to govern and staff the optimal organizational structure.

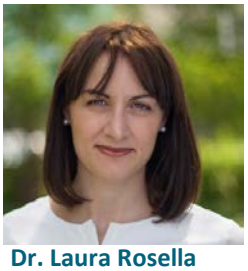
Membership

Members were chosen for their knowledge, expertise and perspectives and appointed by Order in Council. They were appointed as individuals and not as representatives of organizations or associations.

Dr. David Williams
Chief Medical Officer of Health, Ontario

Susan Fitzpatrick
Chief Executive Officer, Toronto Central Local Health Integration Network (LHIN)

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



Dr. Laura Rosella
Canada Research Chair in Population Health Analytics, Assistant professor, Dalla Lana School of Public Health, UofT

Solomon Mamakwa
Health Advisor, Nishnawbe Aski Nation

Dr. Nicola J. Mercer
Medical Officer of Health and CEO, Wellington-Dufferin-Guelph Public Health

Gary McNamara
Mayor of the Town of Tecumseh, Chair of the Windsor Essex Health Unit

Carol Timmings
Director, Child Health and Development, Chief Nursing Officer, Toronto Public Health

Dr. Jeffrey Turnbull
Chief of Staff, The Ottawa Hospital, Chief - Clinical Quality, HQO

Desired Outcome: A Strong Public Health Sector within an Integrated Health System

It is the view of the Expert Panel that Ontario will benefit most from a highly skilled public health sector embedded and highly visible in communities across the province. Public health will continue to nurture strong relationships with municipal governments and other local organizations to positively influence the social determinants of health; and create safe, supportive, healthy environments. Its work will be overseen by boards that reflect the perspectives and diversity of local communities and municipalities and share and promote a strong commitment to public health.

The public health workforce in all parts of the province will have access to specialized public health knowledge and resources. Public health practitioners will share a commitment to evidence-based practice and achieving population health outcomes.

The work of public health will be guided by provincial policy and legislation, and supported by province-wide efforts to collect and analyze data on health status. Public health will continue to champion health equity, identifying groups within the population whose health is at risk and developing targeted universal programs so that all Ontarians have equal opportunity for good health outcomes. Public health will also ensure that Indigenous communities have an active voice.

At the same time, the public health sector will have the capacity to work much more effectively with the rest of the health system. Its understanding of local health needs will help identify health system priorities and shape health policy and services. Stronger relationships with other parts of the health system will make it easier to integrate health protection and promotion into all health services. Working with other parts of the heath system, public health will identify more effective ways to deliver population level interventions that will improve health and reduce health inequities.

Ontarians will recognize and value the work of public health and will access local public health programs and services within an integrated health system.

Goals of Patients First

- Effective integration of services and greater equity
- Timely access to, and better integration of, primary care
- More consistent and accessible home & community care
- Stronger links to population and public health
- Inclusion of Indigenous voices in health care planning

Principles Guiding the Panel's Work

To guide its work and deliberations, the Expert Panel developed the following principles:

- The strong independent public health voice and core public health functions will be preserved and leveraged to help reorient the health system.
- The local strengths of public health – including relationships with municipal and other community partners – will be maintained and enhanced to support integrated planning and service delivery.
- The federal government will continue to have responsibility for health services for Indigenous people in Ontario, including First Nations communities; however Ontario's public health sector also has a responsibility to protect and promote Indigenous health and to ensure Indigenous partners have an active voice.
- Being part of an integrated health system will create opportunities to enhance capacity and improve efficiency– some services may be delivered more effectively by or through other parts of the system.
- Form follows function: structural changes will be based on a clear understanding of the public health sector's role in an integrated health system.
- The organization and distribution of public health expertise, resources and services will reflect local needs and priorities.
- Boundary changes will be necessary to align public health with LHINs, and to support systems planning.

Process and Deliberations

To fulfill its mandate, the Expert Panel:

- reviewed background information, including past reports on Ontario's public health sector
- examined the functions of public health at the regional, local, and provincial levels
- reviewed the current organization of the health system
- discussed possible models and scenarios for reorganizing public health based on input received during consultation for Patients First, and various other submissions, letters, etc.
- looked at ways to align services and determine geographical boundaries
- reviewed the literature on various leadership roles and structures and models for governance
- discussed the potential implications for legislation, including the *Health Protection and Promotion Act* and the *Local Health System Integration Act*, and others.

II. The Opportunity

Public Health as Part of an Integrated Health System

As part of Patients First, all health programs and services – hospitals, home and community care, primary care and public health – are strengthening connections and working together to enhance Ontarians' health and well-being at all ages and stages of life.

Historically, public health and health care have operated as distinct systems. Public health largely focuses on the health of populations and providing upstream community-wide interventions, while health care services are designed to diagnose, treat, and improve individual health outcomes. A key goal of Patients First is to strengthen linkages and partnerships between the health care system and public health.

Close collaboration and formalized relationships between public health and LHINs will mean that:

- A population health approach will be integrated into local planning and service delivery across the continuum of health care
- health services will address and be responsive to population health needs and will seek to promote health and achieve health equity
- health promotion, health protection and health care will be more connected
- public health services and other health services will be better integrated

Preparing Public Health for its role in an Integrated Health System

To maximize its impact in the transformed system, public health must change and the health system must adapt to allow and support true integration.

Over the past year, three public health transformation initiatives have been focused on addressing key questions that will help public health be an effective partner in an integrated health system:

1. **What is the work of public health?**
   The **modernization of the Ontario public health standards** will provide a renewed framework for public health programs, services, and accountability in the 21st century.
2. **What is the role of public health in integrated planning?**
   The **public health work stream** is a collaboration between public health and LHINs working to provide guidance on formal engagement parameters for LHINs and public health across the province.
3. **How should public health be organized across the province to function effectively within an integrated system?**
   The **Expert Panel on Public Health** was asked to provide advice on what the structure and governance of public health should be to enhance its capacity to fulfill its health promotion and protection role and work effectively with partners within a transformed health system.

The Impact of Public Health within an Integrated System

What impact will the strengthened relationship between public health and LHINs have on all health system partners and on Ontarians?

Strong relationships outside the health system to protect and promote health.
Public health works with municipal governments, community organizations, schools, and local services outside the health system – to influence the social, environmental and structural factors that can lead to poor health. Public health can broker relationships between health care, social services, municipal governments, and other sectors to create healthier communities.

More focus on the social determinants of health and greater health equity.
Some Ontarians are at greater risk of poor health because of social determinants such as poverty, precarious housing, poor working conditions, and a lack of social support networks. Public health can embed a population health approach into health service planning and delivery to close these health gaps and enhance health equity.

More comprehensive targeted health interventions.
Although chronic diseases are among the most common and costly health problems facing Ontarians, they are also among the most preventable. Interventions targeting chronic disease risk factors can be successful in mitigating and preventing the burden of chronic diseases. Public health can identify high risk communities and offer targeted interventions that can prevent or delay the onset of these diseases and their complications.

Better care pathways and health outcomes.
A person's ability to follow a care pathway after surgery or treatment is affected by factors outside the health system. For example, if an individual is discharged from the hospital and returns to precarious housing and food security challenges, their recovery will be negatively impacted and they may have a higher likelihood of being re-admitted to the hospital than someone who has stable housing and access to healthy food. Public health can help the health system develop care pathways that take into account the social factors that affect health outcomes.

Greater recognition of the value of public health.
With public health as part of an integrated health system, Ontarians will better understand the importance of investing in health protection and promotion across the life course. They will see how public health benefits themselves, their families and their communities and, at the same time, helps contain health care costs and make the universal health care system more sustainable.

Improving access to care is one priority for the integrated system, but the vision of Patients First is much broader. It is also about promoting health, reducing health disparities and helping all Ontarians lead long healthy lives.

III. A Strong Public Health Sector in an Integrated System

The impetus for the Expert Panel's work is the government's Patients First Strategy. The key question for the Expert Panel was how to best organize public health to function effectively within an integrated system. However, the Expert Panel also viewed their task as an opportunity to strengthen the public health sector and support more efficient and effective operations.

Members worked to identify an optimal structure and governance model for public health in Ontario for the 21st century and beyond. In developing recommendations, the Expert Panel did not attempt to "retrofit" the current system.

1. The Optimal Organizational Structure for Public Health

Background

Ontario currently has 36 public health units. They range in size from 630 to 266,291 square kilometres. The smallest serves only 34,246 people dispersed over a geographic area as large as France, while the largest serves 2,771,770 people concentrated within 630 square kilometres. (See Appendix A: map showing current health unit areas and LHIN boundaries)

Public health units are responsible for delivering programs and services in accordance with standards established by the Ministry of Health and Long-Term Care. Public health units are responsible for identifying local health priorities and population needs and addressing those that fall within their mandate. Much of the work in public health is done in close collaboration with municipal partners. There is a cost-sharing relationship between the Ministry of Health and Long-Term Care and municipalities for delivery of public health programs and services.

Key strengths of the public health sector include its focus on health protection, health promotion, and health equity, its local presence, relationship with municipalities, its highly trained workforce, its collaborative relationships outside the health care system, and its in-depth understanding of and capacity to assess population-level health.

Challenges of the current structure – particularly felt in smaller health units – include a lack of critical mass and surge capacity and challenges recruiting and retaining key skilled public health personnel, which make it difficult to deliver equitable services across Ontario. A lack of mechanisms to coordinate across health units and lack of alignment with LHINs also make it challenging to collaborate, share resources and maximize effectiveness both within the public health sector and within the broader health system.

Criteria

The Expert Panel's goal was to recommend an organizational structure for public health that would:

- Maintain a strong independent public health sector within an integrated health system
- Relate effectively with the LHINs to influence health system planning
- Enhance public health's strong local presence and effective relationships with municipalities
- Ensure Ontarians continue to have access to public health programs and services in their communities
- Create public health organizations large enough to achieve critical mass and retain public health personnel and resources to efficiently operate services in all parts of the province
- Allow for clear definition of public health functions and roles at the provincial, regional and local levels, in order to make more effective use of public health expertise and resources
- Enhance public health practice and ensure more consistent implementation of the public health standards across the province
- Foster collaboration/coordination within the public health sector and with the rest of the health system.

Members of the Expert Panel agreed with findings and observations of a series of reviews over the past 20 years, which all determined that Ontario's public health sector would be stronger if:

* there were fewer health units with greater capacity
* there was a consistent governance model
* the sector was better connected to other parts of the health system.

Responsibilities and Functions

To ensure strong local programs and services, every effort should be made to locate the right mix of management and program staff in local communities. Depending on the size of the communities/populations they serve, local service delivery sites may have public health physicians, directors, managers/program leads, front-line staff and staff responsible for using local population health data to develop local initiatives that are reflective of community needs.

The optimal locations for regional and local public health activities should be determined within the region and based on the distribution of the population and geography. The regional public health entity could potentially look for opportunities to co-locate public health services with other health and/or municipal services, thereby increasing the potential for service integration.

Table 1 on pages 12 –15 outlines public health responsibilities and functions at provincial, regional and local levels.

Figure 1: Organizations Described at Each Level

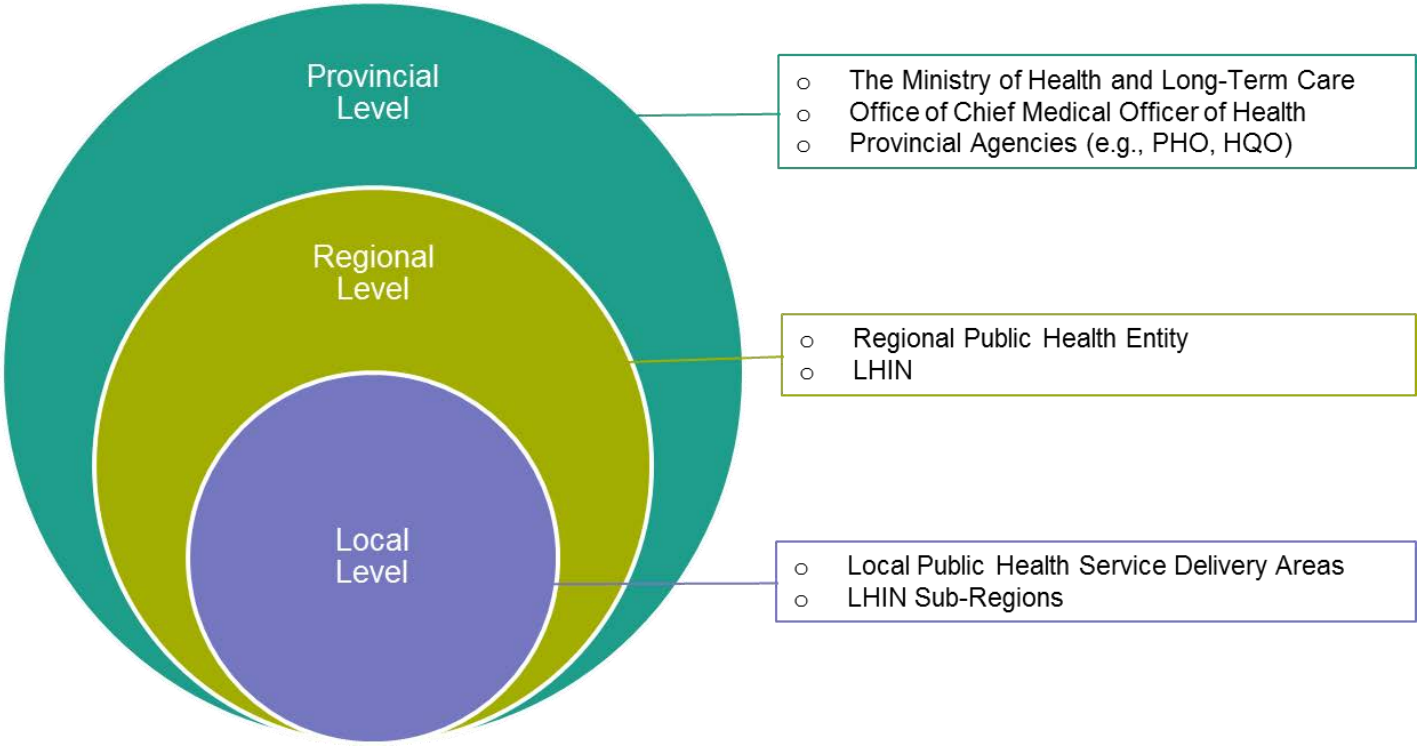


Table 1: Public Health Responsibilities and Functions

Category	Function	Regional	Local	Provincial	LHIN
Corporate Services	**Funding and Accountability**	• Accountability agreements with province • Performance management approach • Accountability for local public health entities	• Continuous quality improvement • Performance management initiatives	• Transfer payments • Overall provincial accountability with 14 regions	
	Human Resource Management	• Workforce strategy • Human resource policies and procedures	• Local oversight • Staff development	• 100% funded positions (e.g., social determinants of health nurses) • Medical Officer of Health/ Associate compensation	
	Administrative	• Risk management • Procurement • Service level agreements • Facilities planning and administration	• Local facilities management and input		
	Communications	• Strategic communication planning • Guidelines for use of relationships with media channels • Guidelines for public reporting	• Local issues management and correspondence with the media • Strategies for educating community partners and the public		
	Information tech-nology	• Corporate IT			

Table 1: Public Health Responsibilities and Functions (continued)

Category	Function	Regional	Local	Provincial	LHIN
Performance, Quality, and Analytics	**Surveillance and Monitoring**	• Collect and consolidate pertinent health-related data • Detect and notify of health events • Appropriate reporting of data to province, local offices, LHINs, etc.	• Apply surveillance data to guide public health policy and strategies • Document impact of an intervention or progress towards specified public health targets/goals • Investigation and confirmation of cases or outbreaks • Coordination and sharing of information with LHIN sub-regions	• Ongoing, systematic collection, analysis and interpretation of health-related data	• Receive surveillance information and assist with dissemination
	Information Management	• Responsible for common regional systems • Decision making • Data governance	• Systems designed to address local needs	• Centralized data systems • Data governance	• Potential integrated databases
	Performance and Evaluation	• Regional metrics and dashboards • Data repository • Inform /contribute to LHIN planning	• Local data collection and insights • Application of data in local planning and delivery • Program accountability • Quality of practice	• Provincial dashboards • Provincial level data • Coordination of data sharing with other jurisdictions and First Nations	• Coordination/ bridging work with public / population health data
	Research	• Set research priorities • Lead and/or participate in regional research projects • Review and incorporate research and evaluation findings into planning	• Conduct research projects • Help inform research proprieties • Partner with other organizations undertaking research • Stay up to date on latest studies • Ongoing program review and evaluation	• Set research priorities • Research grants	• Interpretation of population health research to inform planning

Table 1: Public Health Responsibilities and Functions (continued)

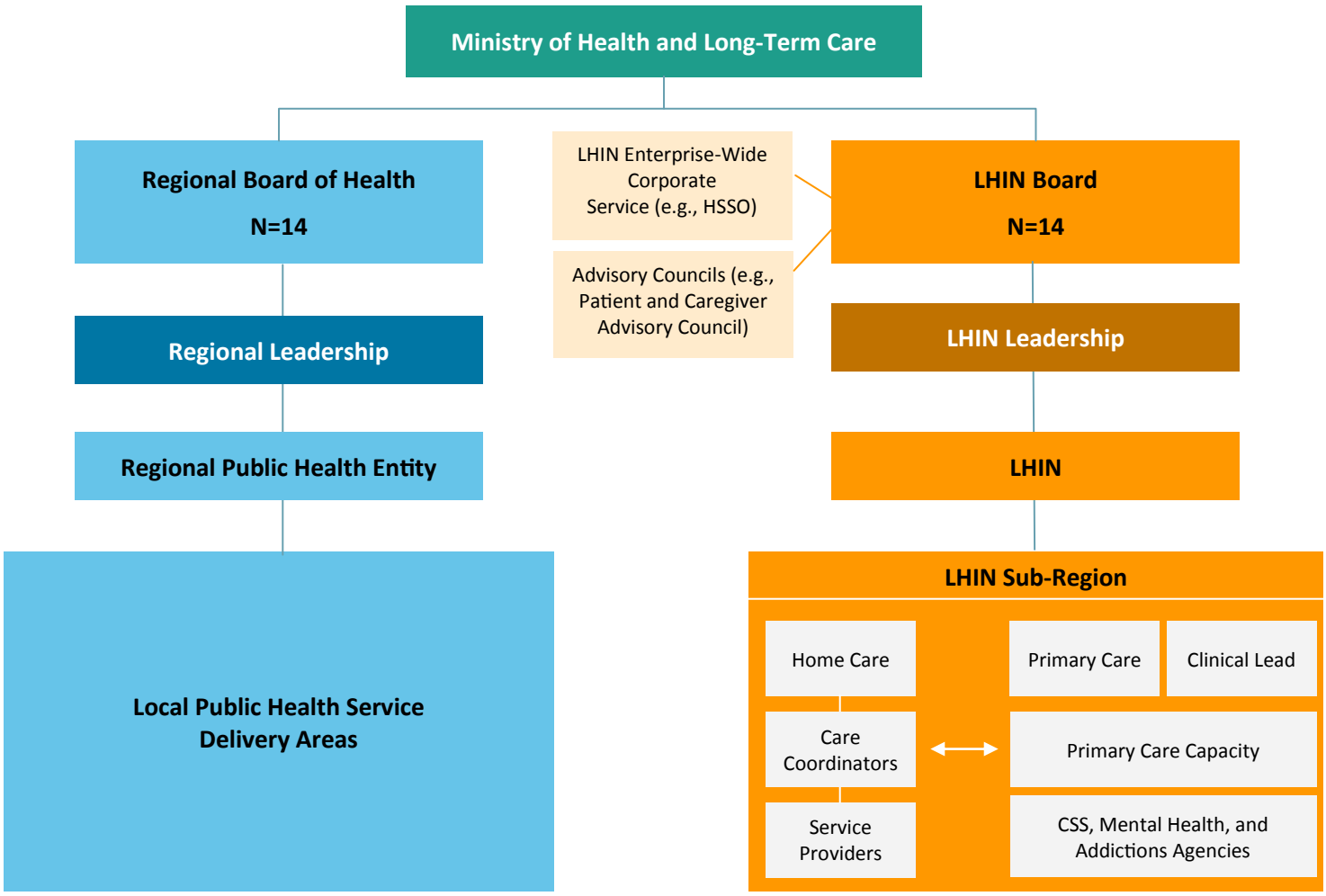
Category	Function	Regional	Local	Provincial	LHIN
Public Health Practice (Programs and Services)	**Planning**	• Annual service plan • Strategic plan • Health equity lens • Corporate planning • Resource allocation planning	• Operational plans • Implementation plans • Provide context, data, and costing inputs • Local perspective and considerations (including First Nations)	• Review and approve annual service plan • Mandate letters • Program and policy planning	• Regional input and alignment with other health services • Service planning
	Delivery	• Management of after-hours on-call system	• Implementation • Ongoing program and service delivery • Coordination of after-hours on-call system	• Provincial program implementation and oversight	• Coordinated delivery / optimization of services
	Coordination	• Work with leadership at all levels of government, throughout the public health organization, the 13 other regional MOHs, the LHIN, and across sectors • Functional integration and consistency with LHIN business plan	• Work with local leadership to execute public health services and delivery • Participation on local committees and in community meetings	• Chair provincial public health table with MOHs • Provide guidance and leadership on public health topics and issues	• Functional integration and consistency with public health business plan

Table 1: Public Health Responsibilities and Functions (continued)

Category	Function	Regional	Local	Provincial	LHIN
Strategic Engagement	**Health System**	• LHIN (cross-linkages) • Health regulatory colleges	• LHIN sub-regions (when applicable) • Primary care • Hospitals	• Public health accountability and reporting to province • Receive information/ direction/ mandates from province (when applicable)	• Information sharing • Inform planning at a LHIN and LHIN sub-region level • Consultation through LHIN committees (when applicable) • Routine collaboration between public health and LHIN leadership (at both regional and local/ LHIN sub-region levels) • Other health service providers e.g., hospitals, Community Health Centres and Family Health Teams
	Public Health System	• Chief Medical Officer of Health • Other MOHs and CNOs • Academic / research institutions • Public Health Ontario • Associations	• Regional public health • Other public health units • Academic / research institutions	• Regional MOHs (e.g., standing meetings)	• MOHs
	Governments	• Province	• Municipality	• Federal government • First Nations • Agencies	• Province
	Cross-Sector	• Leadership from all social deter-minants of health disciplines (e.g., environment, transportation, housing, children and youth services)	• Local community and social services • Education, transportation, housing, settlement, etc.	• Health in all policies approach	• Social services • Community and home care • Family services • Community and recreation services

Figure 2: Proposed End State — Public Health within an Integrated Health System

The Expert Panel recommends that Ontario establish 14 regional public health entities .



The proposed structure of 14 regional public health entities will allow public health to:

Centralize administrative and specialized public health functions at the regional level

Be Accountable for public health standards set provincially

Collaborate with LHINs and other partners to plan and tailor health services in their regions

Establish local public health service delivery areas within regions, based on population and geography

Locate public health programs and services in local communities to maintain local engagement

The Expert Panel believes that having fewer regional public health entities will result in more frequent and effective interactions among regional medical officers of health and between regional medical officers of health and the province. At the same time, maintaining local public health delivery areas will ensure a strong local presence and effective relationships with municipalities.

For the proposed structure to succeed, it will be essential to establish strong working relationships, develop effective communication mechanisms and undertake shared projects and activities:

- within each regional public health entity
- between the regional public health entity and the municipalities in the region
- between the regional public health entity and the LHIN
- among the regional public health entities
- with the province.

2. Optimal Geographic Boundaries

Background

Ontario's existing 36 public health units are organized based mainly on municipal boundaries. The current configuration of health unit areas make it difficult to operate as a unified system with LHINs and other health system partners following LHIN boundaries.

The current organization of public health units has a negative impact on the capacity of smaller health units. Boundary changes are necessary to enhance public health capacity and effectiveness, and to help public health be more integrated with the rest of the health system. At the same time, it is important to maintain the strengths associated with public health's close relationship with municipalities.

Criteria

To determine the number of regional public health entities and their recommended geographic boundaries, the Expert Panel used the following criteria:

- create regional public health entities that would serve a large enough population to achieve critical mass to be able to operate efficiently and effectively and attract skilled staff
- support effective linkages with LHINs by aligning with LHIN boundaries
- respect municipal boundaries and relationships as much as possible
- whenever feasible, move existing health units in their entirety into the same regional health entity catchment area
- when it is not feasible to move entire existing health units together, divide health units based on municipal boundaries

Proposed Geographic Boundaries

The Expert Panel recommends that Ontario establish catchment areas for the 14 regional public health entities that are consistent with LHIN boundaries and respect existing municipal boundaries.

Figure 3: Proposed Boundaries Mapped Against Current Public Health Unit Boundaries

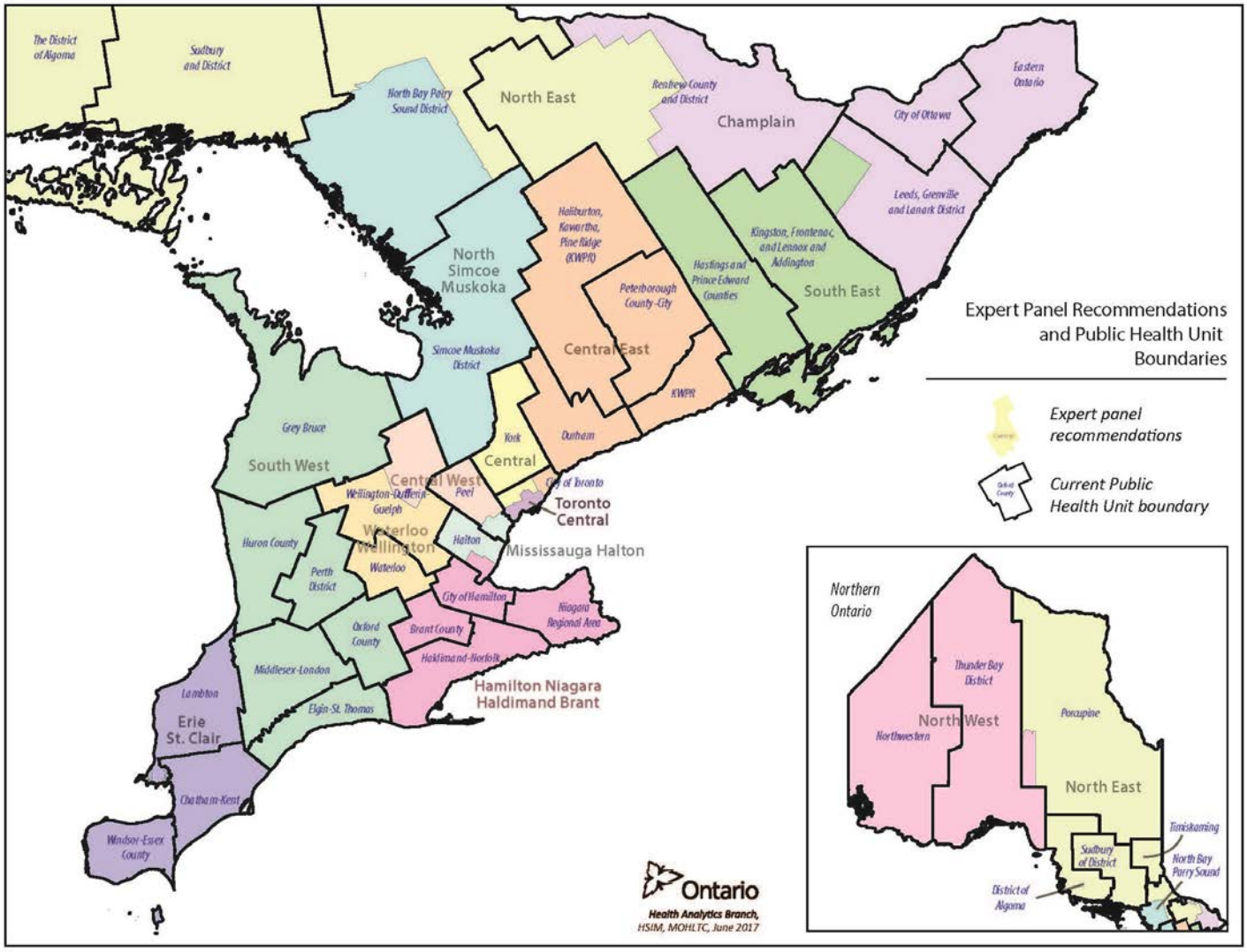
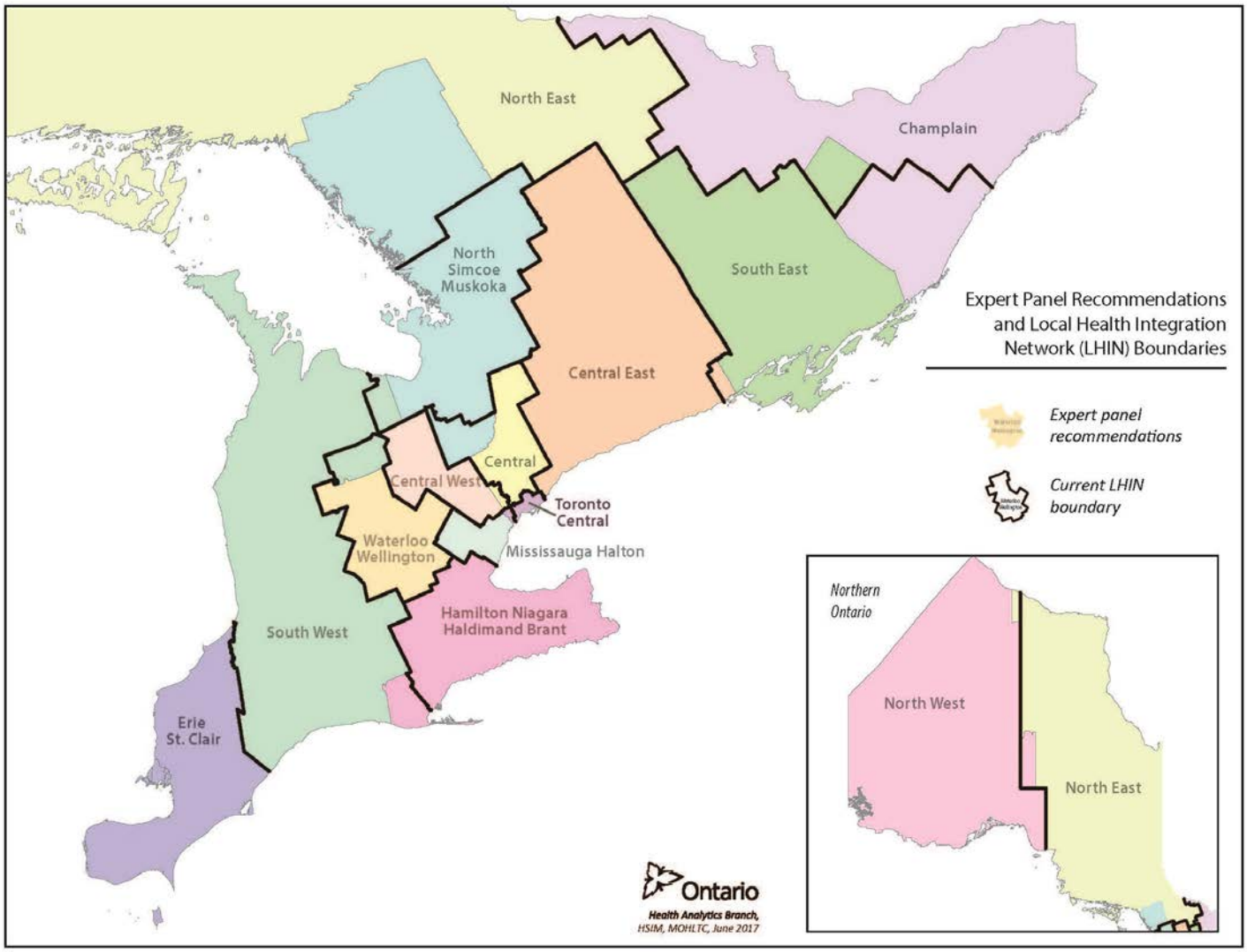


Figure 4: Proposed Boundaries Mapped Against Current LHIN Boundaries



With the recommended boundaries, the populations served by the regional public health agencies would range from about 0.25 million to 1.8 million.

3. Optimal Leadership Structure

Background

The proposed regional public health entities will be complex multi-million dollar organizations with staff spread across multiple local sites. The leadership structure and the quality and competence of public health leaders will be critical to the success of the proposed organizational structure.

Public health units of the future will require leaders with broad-based skills that encompass strong demonstrated organizational and business management, relationship management, strategic planning and performance management skills as well as extensive public health experience.

The literature indicates that, for large health organizations, a single leader as opposed to a joint leadership model is more effective – when the leader has the right mix of experience and competencies. It also indicates that it is essential for that single leader to have both content expertise – in this case, public health knowledge – and management expertise.

Criteria

The Expert Panel's goal was to propose a leadership structure that would:

- Reflect best practices in the leadership of health organizations
- Reinforce and capitalize on strong public health/clinical skills
- Be able to support geographically distributed programs and staff
- Maintain strong expertise and skills at both the regional and local levels
- Capture all the roles and functions of current leaders
- Operate efficiently and effectively

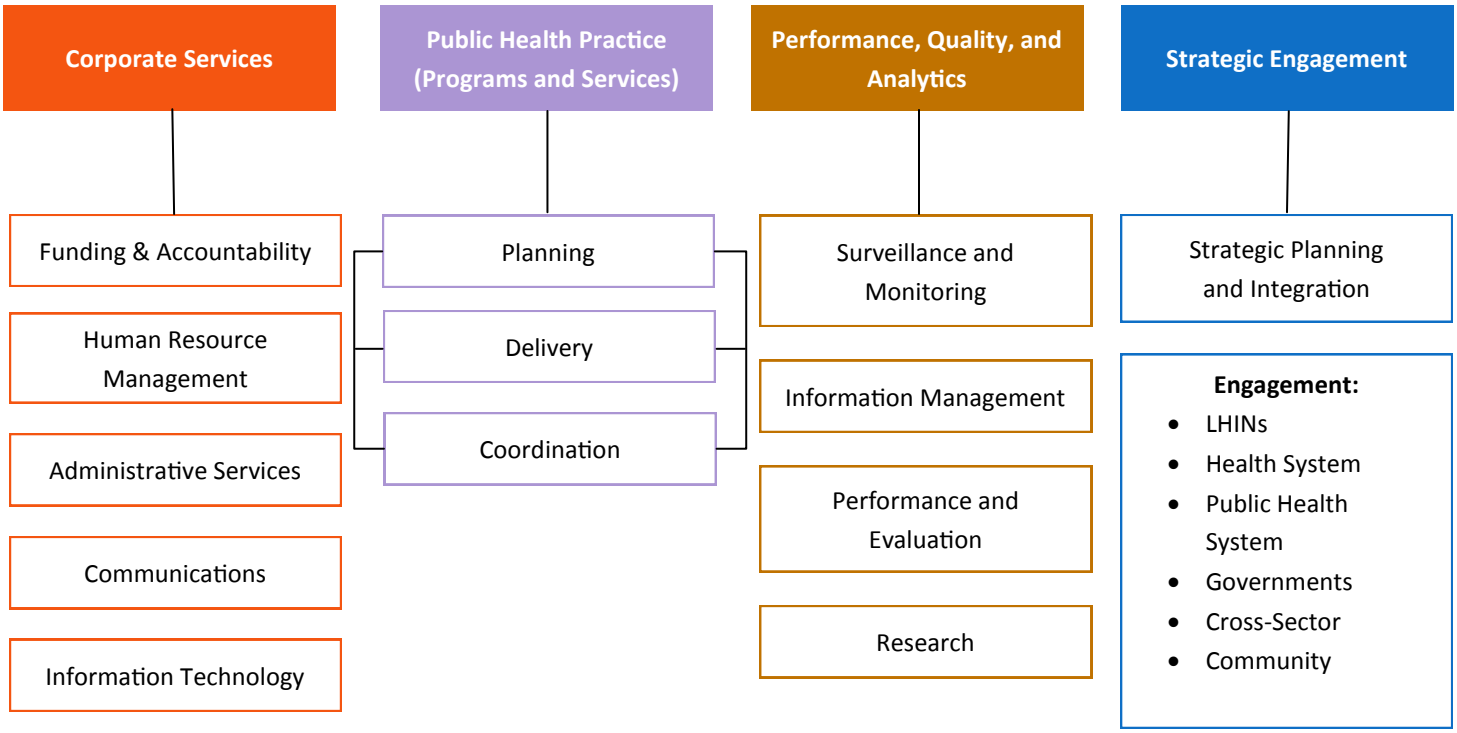
Proposed Leadership Structure

Figure 5: Proposed Leadership Considerations

Regional Public Health Entity	
CEO	• Direct report to the Board of Health
Regional Medical Officer of Health	• Public health physician • Ability to report directly to the Board of Health on matters of public health and safety
Senior Public Health Leadership	• E.g., nursing (Chief Nursing Officer), associate medical officers of health, other content-specific leaders, corporate management (e.g., Chief Administrative Officer, Chief Operating Officer, Chief Information Officer, etc.)

Local Public Health Service Delivery Areas	
Local Medical Officer of Health	• Local public health physician • Report to regional Medical Officer of Health • Number—variable, e.g., based on population and geography
Local Public Health Program and Service Management	• E.g., nursing leadership, public health inspection management, etc. • Program managers • Multi-disciplinary teams

Regional Public Health Entity—Functional Departments



4. An Optimal Approach to Governance

Background

All public health units are governed by a board of health. While the *Health Protection and Promotion Act (HPPA)* requires that all health units be governed by a board of health, the legislation does not set out a specific model of governance. Currently, public health governance models vary considerably across the province (i.e., some are autonomous boards, others are part of the structure of the municipal or regional government). While variation is not necessarily a problem in and of itself, it can result in inequities.

A number of reviews and reports have highlighted challenges with current public health governance, including the wide variety of governance models, gaps in skills on some boards and challenges with both provincial and municipal appointments to the boards. Over time, this may affect public health's ability to work effectively with the LHIN boards, which have a consistent governance model.

Although the HPPA sets out a process for appointing members of the boards of health that reflect both the municipal and provincial responsibility for public health (i.e., some members are appointed by the municipalities and some by the Ministry of Health and Long-Term Care through orders in council), there are no specific requirements related to the skills or experience that board members should have. As a result, there are significant skill gaps on some boards of health.

In terms of appointing board members, boards of health experience high vacancy rates among provincial appointees. Vacant seats can make it difficult for boards to optimally function. Furthermore, there can be gaps in appointment of elected municipal officials as a result of elections.

Criteria

The Expert Panel's goal was to recommend a public health governance structure that would:

- Ensure greater consistency in governance of public health
- Maintain public health autonomy and independence
- Maintain a strong municipal voice and representation
- Relate effectively to LHIN boards
- Reflect best practices in governance
- Address issues related to board vacancies
- Reinforce the roles and responsibilities of board members
- Ensure accountability and effective oversight

Proposed Governance Model

The Expert Panel recommends that Ontario establish a consistent governance structure for regional boards of health in Ontario with the following features:

	Board of Health Governance Characteristics
Governance	Free-standing autonomous board
	Consideration for appropriate secretariat support for board operations
Appointees	Municipal members (formula for representation to be defined in Regulations – e.g., by population, by upper tier etc.)
	Provincial appointees (including OIC appointments for specific position(s) such as board chair, vice chair, finance – to be nominated by the board)
	Citizen members (municipal appointees)
	Other representatives (e.g., education, LHIN, social sector, etc.)
Size	Varied: 12-15 members
Indigenous Representation	Meaningful opportunity for representation to ensure Indigenous partners have an active voice (based on population demographics)
Francophone Representation	Representation for the Francophone community (based on population demographics)
Diversity and Inclusion	Boards should reflect the communities which they serve, including but not limited to inclusion of: • Gender and sexual orientation • Visible minorities • Lived experience • Diverse ages
Qualifications	Skills-based
	Experience
Appointment Process	Flexibility for combination of provincial and local appointments (for non-specific positions) to address varying capacity across province
Board Compensation	Apply consistent approach for board member compensation
	Consideration of equitable compensation across public boards (e.g., public health, LHINs, agencies, etc.)
Committees	Establishment of standing committees (e.g., good governance and nomination committees, finance and audit, HR, etc.) to be defined in Regulations
	Committees are responsive to community needs
Succession Planning and Implementation	Staggered transition/appointments for new board structures
	Tenure
	Targeted recruitment

Considerations for Proposed Regional Board of Health

The regional board of health should be small enough to be efficient but large enough to support strong standing committees (i.e., governance, finance/audit, quality). The literature shows that doing certain work in standing committees is more functional and effective than doing it as an entire board.

The goal is to attract highly skilled and competent individuals who will speak for the interests of public health to serve on the board. It is critical that:

- the board have the right mix of skills, competencies, and diverse perspectives
- all board members understand and accept their role
- the boards have a process to manage attendance and to remove people from the board who are not fulfilling their responsibilities.

Furthermore, when recruiting members to the regional board of health, the governance committee should look specifically for people who want to work on a team and share a commitment to improving the health of the population.

Because of past challenges with timing Order in Council (OIC) appointments, the Expert Panel recommends a smaller number of provincial appointees; however, to ensure accountability to the provincial government, those seats should be key positions (e.g., chair, vice-chair, chair of the finance/ audit committee). The governance committee should recommend the candidates for OIC appointments, and those candidates should be able to include elected municipal officials.

To address continuity of service challenges with municipal officials, the Expert Panel recommends that when an elected official appointed to the board of health is not re-elected, he or she continue to serve on the board of health until the municipality makes a new appointment. Municipalities should also be encouraged to appoint a mix of elected officials and members of the community to ensure diversity and continuity, and to reduce the challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health.

IV. Implementation Considerations

The Expert Panel recognizes that if implemented, the recommendations will mean large organizational change for the sector. The Expert Panel was not asked to make specific recommendations about implementation, however, they have identified elements that should be considered in developing an implementation plan.

Legislation

The proposed health unit boundary changes and implementation of regional public health entities will have implications for public health and other related legislation. A detailed analysis will be required to determine how much of the proposed structure and governance model will require legislative amendments.

Funding

While public health funding was not within the scope of the Expert Panel's mandate, they have flagged that the current public health funding model may be a barrier to implementing the proposed structure.

Under the HPPA, municipalities have legislated authority for public health and provincial funding for public health is discretionary. Public health units receive an annual grant from the Ministry of Health and Long-Term Care– and the amount the province contributes has varied over the years.

The Ministry of Health and Long-Term Care provides funding for:

- up to 75% of ministry approved allocations

- 100% of certain programs, such as Healthy Smiles Ontario, the Infectious Disease Control Initiative, nursing initiatives and the Smoke-Free Ontario Strategy

- 100% of services in unorganized territories (i.e., areas without municipal organizations)

Municipalities provide funding for:

- at least 25% of ministry approved allocations (many provide more)

- other public health programs and services– beyond those provincially mandated

The ministry's contribution recognizes the challenges many municipalities – particularly smaller ones – face in funding public health services.

The proposed shift from local health units, whose costs are shared by local municipalities, to a regional public health entity will likely raise questions about the funding obligations of each municipality in the region.

As part of implementation planning, the ministry will need to re-visit funding constructs in order to implement the recommendations.

Transition Planning/Change Management

The proposed structure will have a significant impact on the 36 existing health units and boards of health. Although the transition may be more straightforward for the public health units that move in their entirety into a regional health entity than for those divided across two or more regional agencies, all will require assistance with change management. Given the complex nature of municipal government (i.e., upper tier, lower tier, independent), it may be helpful to engage consultants with a strong track record in change management to help with transition planning.

The transition from the current 36 local boards of health to a smaller number of regional boards of health will have particular implications for municipalities and municipal members. It is important that the new board structure recognize and protect municipal interests, while recognizing the potential for competition for municipal seats.

To ensure greater consistency across the province, it may be helpful to work with the Association of Ontario Municipalities to develop the criteria for municipal representation on the new regional boards.

Effective Linkages with LHINs and the Health System

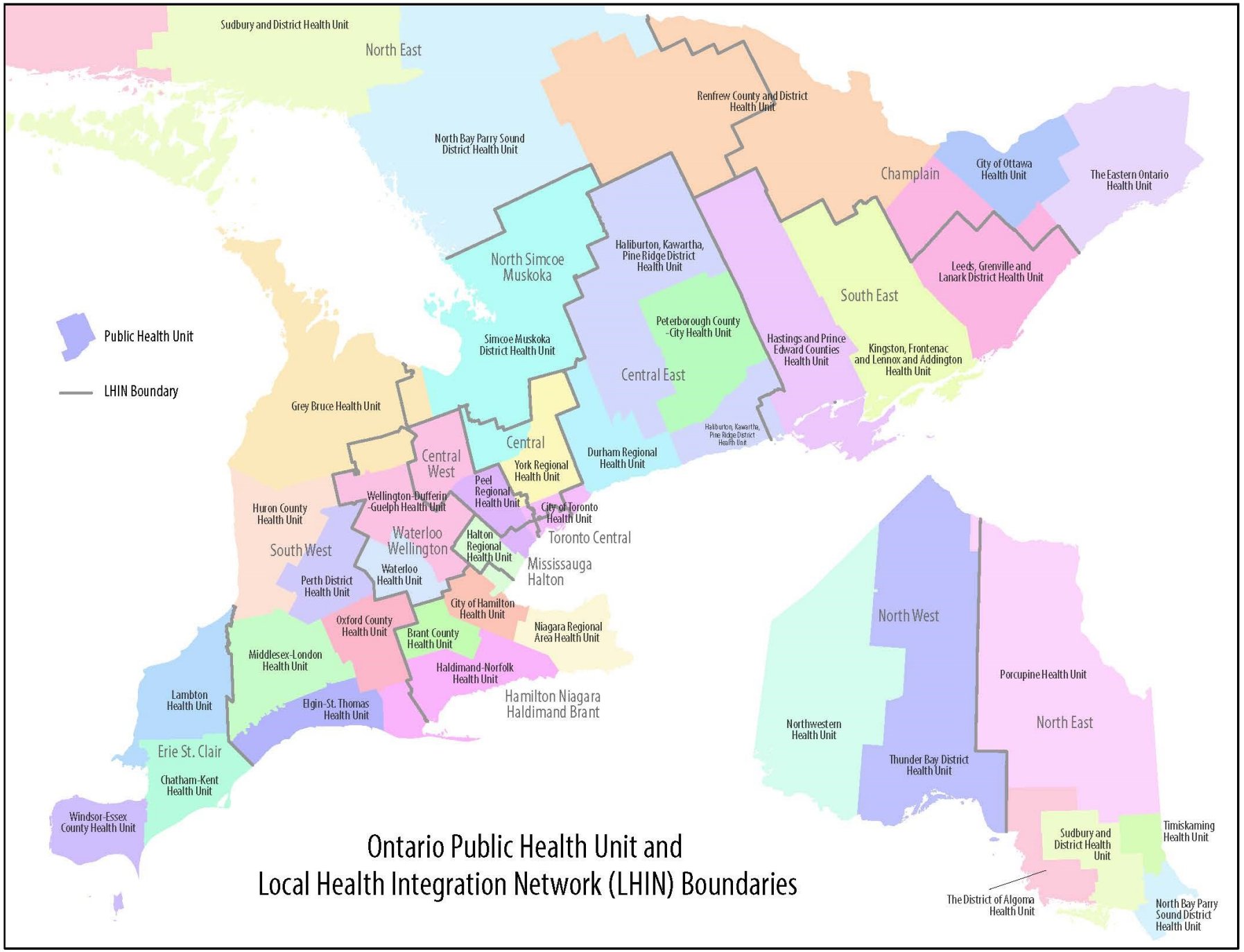
During its deliberations, the Expert Panel identified a number of strategies that, in its view, could enhance linkages with LHINs, such as:

- potential cross appointments (or ex-officio) to the regional Board of Health and the LHIN board
- regular meetings between the Regional Board of Health chair and the LHIN board chair
- regular meetings between public health and LHIN leadership as well as shared projects and activities.

Structured relationships will also be necessary with all health system partners including primary care, hospitals, and home and community care to develop stronger linkages between disease prevention, health promotion and care, maximize system efficiencies and support a fully integrated health system.

Appendix

Appendix A: Current LHIN and PHU Boundaries



Bibliography

Baker, G. Ross, et al. *High-Performing Healthcare Systems: Delivering Quality by Design.* Longwoods Publishing Corporation. Toronto, Ontario, 2008.

Baker, G. Ross and Renate Axler. *Creating a High Performing Healthcare System for Ontario: Evidence Supporting Strategic Changes in Ontario* Institute of Health Policy, Management and Evaluation, University of Toronto. Toronto, Ontario, 2015.

Berwick, Donald M., et al. "The Triple Aim: Care Health and Cost." *Health Affairs* 27, no. 3: 759-769. 2008.

Campbell, Archie G, *The SARS Commission interim report: SARS and public health in Ontario* SARS Commission. Toronto, Ontario, 2004.

Commission on the Reform of Ontario's Public Services. *Enabling Transformation. Confidential Advice to the Minister of Health and Long-Term Care*. Local Health Integration Networks. Draft version, April 2012.

Commission on the Reform of Ontario's Public Services. *Commission on the Reform of Ontario's Public Services: Public services for Ontarians: a path to sustainability and excellence.* Toronto: Queen's Printer for Ontario. (2012). http://www.fin.gov.on.ca/en/reformcommission/chapters/report.pdf

Manuel DG, et al. *A $4.9 Billion Decrease in Health Care Expenditure: The Ten-Year Impact of Improving Smoking, Alcohol, Diet and Physical Activity in Ontario*. ICES: April 2016. http://www.ices.on.ca/flip-publication/A-4-9-Billion-Decrease-in-Health-Care-Expenditure/index.html

Meacher-Stewart, Donna, PH, PhD., et al *Building Canadian Public Health Nursing Capacity: Implications for Action.* Hamilton, ON: McMaster School of Nursing and the Nursing Health Services Research Unit. Series Number 15. 2009.

Ministry of Health and Long-Term Care. Capacity Review Committee. *Revitalizing Ontario's public health capacity: The final report of the Capacity Review Committee.* Toronto, Ontario, 2006.

Ministry of Health and Long-Term Care Expert Panel on SARS and Infectious Disease Control. *For the public's health initial report of the Ontario Expert Panel on SARS and Infectious Disease Control.* Toronto, Ontario, 2003. http://www.health.gov.on.ca/en/common/ministry/publications/reports/walker_panel_2003/walker_panel.aspx

Ministry of Health and Long-Term Care. Expert Panel on SARS and Infectious Disease Control. *For the public's health: a plan of action: Final Report of the Ontario Expert Panel on SARS and Infectious Disease Control.* Toronto, Ontario, 2004. http://www.health.gov.on.ca/en/common/ministry/publications/reports/walker04/walker04_mn.aspx

Moloughney, Brent W. *Defining "Critical Mass" for Ontario Public Health Units*. Ministry of Health and Long-Term Care, Toronto, 2005.

Moloughney, Brent W. *A discussion paper on public health, local health integration networks, and regional health authorities.* Ontario Public Health Association**.** Ottawa, Ontario, 2007.

O'Connor, Dennis R. "Chapter 15: Summary of Recommendations." *Part One Report of the Walkerton Inquiry: The Events of May 2000 and Related Issues*. Ontario, 2001.

Office of the Auditor General of Ontario. *Annual Report of the Auditor General of Ontario*. Toronto Ontario, 2003.

Office of the Auditor General of Ontario. *Annual Report of the Auditor General of Ontario*. Toronto, Ontario, 2014.

Ontario Public Health Association. *Enhancing our Capacity: A consultative report from the OPHA and its constituent societies to the Capacity Review Committee*. Ontario, 2005. http://opha.on.ca/getmedia/f2d20044-763b-41fe-b5df-349c5f581d45/OPHA-CRCinput-Report.pdf.aspx?ext=.pdf

Primary Health Care Expert Advisory Committee. *Patient Care Groups: A new model of population based primary health care for Ontario.* Toronto, Ontario, May 2015.

Registered Nurses Association of Ontario. *Enhancing Community Care for Ontarians: EECO 1.0.* Toronto, Ontario, October 2012