Algoma
PUBLIC HEALTH
Santé publique Algoma

BOARD OF HEALTH MEETING

OCTOBER 25, 2017

5:00 PM

SAULT STE MARIE COMMUNITY ROOM A

www.algomapublichealth.com

October 25, 2017 - Board of Health Meeting Book

Algoma Public Health Board of Health Meeting Table of Contents

8, 2017 @ 4:00pm

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15. **Adjournment**

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
OCTOBER 25, 2017 @ 5:00
SAULT STE MARIE ROOM A, SSM
A*G*E*N*D*A

1.0 Meeting Called to Order — Mr. Lee Mason, Board Chair

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda Items — Mr. Lee Mason, Board Chair

Resolution
THAT the agenda items dated October 28, 2017 be adopted as circulated; and
THAT the Board accepts the items on the addendum.

3.0 Adoption of Minutes of Previous Meeting — Mr. Lee Mason, Board Chair

a. September 27, 2017

Resolution
THAT the Board of Health minutes for the meeting dated September 27, 2017 be adopted as circulated.

4.0 Delegations/Presentations.

a. Public Health Emergency Preparedness — Mr. Chris Spooney, Program Manager

5.0 Business Arising from Minutes

a. Response to the Expert Panel Report — Mr. Lee Mason, Board Chair

6.0 Reports to the Board

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

i. October 2017 Report

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

ii. Modernization of Alcohol Sales in Ontario

Resolution
WHEREAS alcohol use is a leading preventable cause of morbidity and mortality in Ontario; and

WHEREAS four-in-five adults in Ontario have used alcohol in the past year and more than 1-in-6 of all drinkers are exceeding Canada's Low-Risk Alcohol Drinking Guidelines; and

WHEREAS in Ontario, nearly 1-in-10 alcohol users report weekly sessions of binge drinking, alarmingly in Algoma, 1-in-5 users report weekly binge drinking sessions; and

WHEREAS since early 2014, the Ontario government, led by the Ministry of Finance, has taken steps to rapidly and fundamentally transform the retail sale and distribution of alcohol; and

WHEREAS it is well established that increased alcohol availability leads to increased consumption and alcohol-related harms; and

WHEREAS it is reasonable to be concerned that actions by the Ontario government to increase access to alcohol may directly contribute to increases in alcohol-related morbidity and mortality in Ontario; and

WHEREAS a comprehensive, provincially led alcohol policy can help mitigate the harms of alcohol

NOW THEREFORE BE IT RESOLVED THAT the Board of Health of Algoma would join the Ontario Public Health Association in calling on the government to both fulfill its promise and prioritize the health and wellbeing of Ontarians by enacting a comprehensive, evidence-based alcohol policy as soon as possible;

AND FURTHER that the Board of Health of Algoma endorse a letter of support to the Government of Ontario encouraging it to fulfill its commitment (as announced in December 2015) to develop a comprehensive, province wide policy to minimize harm and support the safe consumption of alcohol.

b. Financial Report

i. Draft Financial Statements for the Period Ending August 31, 2017 — Mr. Justin Pino, Chief Financial Officer

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

7.0 New Business/General Business

8.0 Correspondence — Mr. Lee Mason, Board Chair

a. Expert Panel
- i Letter to Minister Hoskins from the Council of Ontario Medical Officers of Health (COMOH) dated October 12, 2017
- ii Letter to Minister Hoskins from the Association of Local Public Health Agencies (alPHa) dated October 17, 2017
- iii Letter to Minister Hoskins from Peel Public Health dated October 5, 2017
- iv Peterborough Public Health Board of Health Response to the Report of the Minister's Expert Panel on Public Health
- v Letter to Minister Hoskins from Chatham-Kent Public Health dated October 18, 2017

b. Fluoride Varnish Programs
- i. Letter to Minister Hoskins from Middlesex-London Health Unit dated September 26, 2017

c. Vaccine Recommendations for Child Care Workers
- i Letter to Premier Wynne from Durham Region dated October 12, 2017

9.0 Items for Information

a. alPHa Information Break – September 2017 — Mr. Lee Mason, Board Chair

b. alPHa Fall Meeting – November 3, 2017

c. Report on access to public dental programs in Ontario: An analysis based on interviews with Public Health Units – Ontario Oral Health Alliance

10.0 Addendum

11.0 That The Board Go Into Committee — Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into committee.

Agenda Items:

a. Adoption of previous in-committee minutes dated September 27, 2017
b. Litigation or Potential Litigation
c. Labour Relations and Employee Negotiations

12.0 That The Board Go Into Open Meeting — Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into open meeting.

13.0 Resolution(s) Resulting from In-Committee Session — Mr. Lee Mason, Board Chair

14.0 Announcements: — Mr. Lee Mason, Board Chair

Next Committee Meetings:

Governance Standing Committee	Finance & Audit Committee
October 30, 2017 at 5:00 pm	November 8, 2017 at 4:00 pm
Prince Meeting Room, SSM	Prince Meeting Room, SSM

Next Board Meeting:
November 22 at 5:00pm
Sault Ste. Marie, Room A&B, Sault Ste. Marie

15.0 That The Meeting Adjourn — Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health meeting adjourns.

Public Health Emergency Preparedness

Board of Health Meeting
October 25, 2017

Chris Spooney

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Public Health Emergency Preparedness

- Emergency Preparedness is a program listed in the OPHS
- Public Health Emergency – an imminent threat of a situation, such as an outbreak of an infectious agent, natural disaster or large scale environmental hazard that poses a substantial risk of a large number of deaths or serious harm to a population, and which has the potential to overwhelm routine capabilities to address the threat and/or the health consequences (Public Health Ontario, 2017)
- The goal is to enable and ensure a consistent and effective response to public health emergencies with public health impacts.

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Public Health Emergency Preparedness

The current standard consists of 4 main requirements:

1. Assessment and Surveillance
2. Emergency Planning
3. Risk Communication
4. Education and Training

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Assessment and Surveillance

- Identify hazards that might have public health impacts.
- Assess the risk of the identified hazards using Hazard Identification Risk Assessment (HIRA)
- Rank to highest to lowest (probability and consequence)

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Hazard Probability/Consequence

- Severe Weather Events
- Extreme Temperature
- Hazardous Materials (Transportation)
- Adverse Water Events (including water-borne illness)
- Explosion/Fire
- Disease Outbreaks
- Hazardous Materials (Fixed Site)
- **NEW - Opioid Misuse**
- Flooding
- Severe Influenza Season
- Critical Infrastructure Failures
- Power Outages
- Food Recalls
- Oil/Natural Gas/Propane Events
- Animal Disease
- Food/Water-borne Illness (Large Community Outbreaks)
- Other considerations will be made for Climate Change risks

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Emergency Planning

- Develop a Continuity of Operations Plan (COOP)
- Develop an Emergency Response Plan (ERP)

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Risk Communications and Public Awareness

- Develop a 24/7 notification protocols
- Continue to seek professional development opportunities to build upon our skillset in regards to improving communication
- Increase awareness regarding emergency preparedness activities

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Education, Training and Exercise

- Health unit staff training (EP and ER)
- Board of Health orientation and annual update (Algoma Public Health Emergency Response plan)
- Conduct annual exercise to test plan, COOP and 24/7 notification protocol

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Emergency Preparedness, Response, and Recovery

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Public Health Role in an Emergency

- Assess the impact of the emergency on the health of the public
- Advise the public on matters concerning public health, through communication channels established by the Municipal Emergency Control Group (MECG)
- Control communicable diseases
- Provide advice on the health and safety aspects of emergency water supplies, sanitation, shelters, food supplies, garbage and sewage disposal

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Public Health Role in an Emergency

- Enforce applicable regulations
- Assist in identifying and responding to immediate short and long term situations that affect our vulnerable health unit clients.
- Collaborate with other agencies to determine best possible outcomes for all involved.
- Notify other agencies and senior levels of government of health issues relating to the emergency

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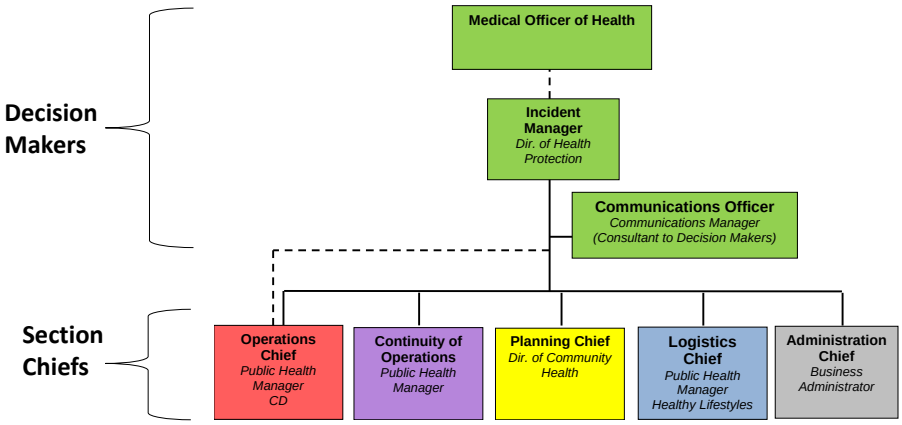
Incident Management System (IMS)

This group is known as the Incident Management Team (IMT)



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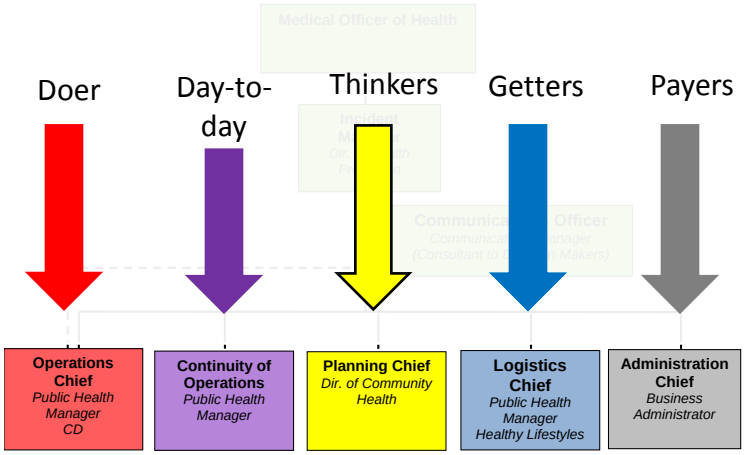
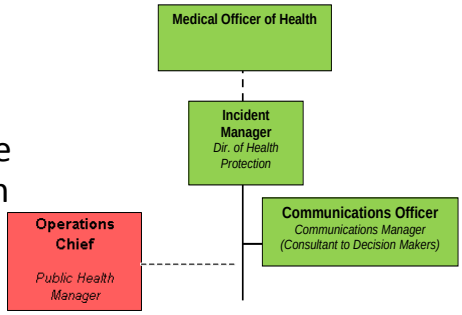


IMS Activation at APH

Once the MOH or Incident Manager is informed of the incident, the "Decision Makers" meet to discuss the immediate key public health issues of concern and determine the scope.



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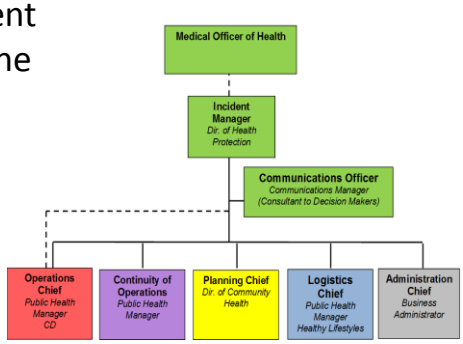
IMS Activation

If IMS is necessary the Incident Manager is responsible for the formation of the Incident Management Team (IMT)



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Exercises

- Rural and Ready
- Forest Fires
- St. Mary's River
- Train derailment
- Public Health Ontario IMS 100/200 Training

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Thank you very much for your time!

QUESTIONS?

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MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER BOARD REPORT OCTOBER 2017

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

and the Leadership Team

APH staff answered the call from the local Soup Kitchen to help stock their shelves. APH staff filled 17 boxes as part of the community wide campaign.

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APH AT-A-GLANCE

October has been a busy month. Management is in the midst of 2 sets of union negotiations (ONA and CUPE) and our regular programs all seem to increase activity in the fall. Program staff are busy planning and implementing school immunizations, influenza clinics, and Infection Prevention and Control Week activities. (October 16-20)

I have attended Ministry meetings twice to support Implementation Task Force work for the new Ontario Standards for Public Health Programs and Service (OSPHPS). Presentations to municipalities continued with Dr Jennifer Loo and Justin Pino attending Johnson Township.

As per your request at the last Board meeting I have created a very rough draft of a proposed response to the Recommendations of the Expert Panel. Rather than fine tuning it further I have shared it with you directly so that it can be discussed and further edited during our meeting prior to submission to the Ministry.

PROGRAM HIGHLIGHTS

COMMUNITY MENTAL HEALTH

Director: Sherri Cleaves
Manager: Jan Metheany

Topic: NELHIN Accountability Agreements: Q2

This report addresses the following Strategic Directions: Be Accountable

APH-Community Mental Health Programs (APH-CMH) provides psychiatric case management services for clients that include: intensive psychiatric case management, monitoring of community treatment orders, transitional case management, supports within housing and peer support program. These services are provided throughout the Algoma district and are funded through a NE LHIN multi-sector service accountability agreement.

These programs all contribute to one set of service activity reports. The targets are set by the NE LHIN, and are reported 3 times per fiscal year (April 1st-March 31st) at Q2, Q3 and year end. Q2 being half way to our year end, gives the agency the best opportunity to predict our outcomes for the year. As you can see in the following table all the target projections for the year end indicate that we are meeting and exceeding the expectations set by the NE LHIN for the 5 deliverables listed below. In past years we have always met our targets.

NELHIN Accountability Agreement: Targets 2017/18

Deliverable	NELHIN Target (year-end)	Q2 Report	Outcome Prediction	Year-End Target Prediction
Direct Visits	11,830	6,895	13,790	Exceed target set
Uniquely Identified Individuals Served	840	631	1,262	Exceed target set
Not Uniquely Identified Service Recipients	200	613	1,226	Exceed target set
Group Sessions	200	251	502	Exceed target set
Group Participants	500	1,283	2,566	Exceed target set

In addition, the program delivers Mental Health & Addiction rent supplement administration and transformation supportive housing program (Kingsford Place), through a MOHLTC corporate funding agreement.

The MOHLTC Funding Agreement 2017/18 includes managing the budgets for those receiving housing subsidies and ensuring that the 6 bed supportive housing program at Kingsford is managed and utilized to capacity. The administration of funds includes budgets of $326,900 in mental health and addiction rent supplement(s) per year and $128,000 to house & support 6 individuals in a congregate living environment (Kingsford) which is at capacity.

Q2- number of individual currently receiving housing subsidy

Mental Health	Addiction
111	16

Q2- Supportive Housing Program	**Number of Individuals Residing**
Kingsford	6

APH-CMH appear to be in good position to meet or exceed all yearly program NE LHIN service activity requirements, and are on budget for administration of MOHLTC funding envelopes for housing.

ENVIRONMENTAL HEALTH

Director: Sherri Cleaves
Manager: Chris Spooney

Topic: Public Health Emergency Preparedness

This report addresses the following OPHS requirement: **Requirement #1 -** The board of health shall identify and assess the relevant hazards and risks to the public's health in accordance with the *Identification, Investigation and Management of Health Hazards Protocol, 2008* (or as current); the *Population Health Assessment and Surveillance Protocol, 2008* (or as current); and the *Public Health Emergency Preparedness Protocol, 2008* (or as current).

The following Strategic Directions:

- Collaborate Effectively
- Be Accountable

Public Health Emergency Preparedness is a program under the Ontario Public Health Standards (OPHS). The goal of the program is to enable and ensure consistent and effective response to health emergencies with potential public health impacts.

The OPHS consists of 4 main requirements:

1) Assessment and Surveillance
2) Emergency Planning
3) Risk Communication
4) Education and Training

In the draft document of the modernized standards "Emergency Preparedness, Response, and Recovery" is one of four "Foundational Standards" with specific requirements that underlie and support all Program Standards.

These standards will continue to help provide a consistent approach to preparing and responding to public health emergencies throughout the Province of Ontario.

Algoma Public Health works with all local municipalities to:

- Identify hazards that might occur and may have public health impacts
- Assess each hazard using a Hazard Identification Risk Assessment (HIRA) tool which will rank the potential risk by probability and consequence
- Develop a Continuity of Operations Plan (COOP) which determines places and or methods of operation in the event that the emergency alters the access to or use of community infrastructure. It may also identify which programs must continue to operate during a particular emergency and which programs can have services reduced to reallocate resources to areas of need. (e.g. extended power outages affecting municipal resources, telephone lines are not operational etc.).
- Develop an Emergency Response Plan which is built to address particular emergencies while providing direction in regards to declaring an emergency, establishing roles and responsibilities, establish pathways of communication, establish chain of command, and plans to strategically allocate resources.
- Algoma Public Health collaborates with municipalities and will continue to find opportunities to share resources and experiences across the district of Algoma. Opportunities may be through joint educational sessions, reviewing/updating of emergency plans, table top exercises and real-time events and we have received training and professional development from Public Health Ontario provides us with training and support and we have shared training with our US neighbours at the Rural and Ready conferences.
- During real events such as a train derailment, forest fire and air quality issues, flooding and power outages in the district we work with the municipality as part of their Emergency Operations Committee to support their actions and provide ongoing public health advice.
- Over the last few years some of our district communities have received evacuees from flooding in Northern First Nations communities. This is an opportunity to utilize the processes that would be initiated during a more unexpected opportunity. Our local PHI work with these communities to ensure accommodation and food preparation meets public health standards

Respectfully submitted,
Dr. Marlene Spruyt

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Briefing Note

To: The Board of Health

From: Laurie Zeppa, Director of Health Promotion and Prevention, Chief Nursing Officer

Kristy Harper, Program Manager

Date: October 25, 2017

Re: Modernization of Alcohol Sales in Ontario

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Alcohol is a substance that is intricately integrated into our social environment. Daily, we are inundated with messages about the appropriateness of drinking for all occasions. Unfortunately, rarely does alcohol marketing address the realities of the potential harms associated with alcohol misuse. It is well established that increased alcohol availability leads to increased consumption and alcohol-related harms. Since the December 2015 announcement of the Government of Ontario's plan to create a province-wide alcohol policy, the government has yet to produce or communicate any comprehensive approach to address the harms of increasing access to alcohol. However, the government has continued to advance its alcohol modernization agenda and since 2014 has taken steps to rapidly increase the availability of alcohol in Ontario including changes made at the Liquor Control Board of Ontario, Alcohol and Gaming Commission of Ontario, The Beer Store, farmers' markets, breweries, and winery retail stores.

RECOMMENDED ACTION:

That the Board of Health of Algoma supports the need for a provincial alcohol policy in order to address the health and social harms of alcohol and the impact of increased access by:

1. Joining the Ontario Public Health Association in calling on the government to both fulfill its promise and prioritize the health and wellbeing of Ontarians by enacting a comprehensive, evidence-based alcohol policy as soon as possible

2. Encouraging the Government of Ontario to fulfill its commitment (as announced in December 2015) to develop a comprehensive, province wide policy to minimize harm and support the safe consumption of alcohol, in light of the expansion of alcohol sales in Ontario

BACKGROUND:

Alcohol use is a leading preventable cause of morbidity and mortality in. While 4 in 5 adults in Ontario have used alcohol in the past year, more than 1 in 6 of all those drinkers are exceeding Canada's Low-Risk Alcohol Drinking Guidelines. In Ontario, nearly 1 in 10 alcohol users report weekly sessions of binge drinking. Alarmingly in Algoma, 1 in 5 users report weekly binge drinking sessions. Alcohol is a leading risk factor for death, disease and disability in Ontario and plays a significant role in social disorder, violence and crime.

Since early 2014, the Ontario government has transformed the retail sale and distribution of alcohol. As of the summer of 2017, 206 grocery stores have been authorized to sell alcohol; up to 450 authorizations for grocery stores are planned. Other changes to alcohol distribution have taken place including VQA wine sales at Farmers' Markets and the introduction of the LCBO's e-commerce and delivery platform.

The key public health concerns related to the government's approach to alcohol retail sales and distribution highlights the need for provincial leadership to address the potential harms of increased access to alcohol, and documents the actions that have been taken to date by the government and public health units.

A comprehensive, provincially led alcohol strategy can help mitigate the harms of alcohol.

Alcohol harms extend beyond the user and impacts family, friends, working relationships, and communities. Addressing the harms of alcohol use has major implications for police, emergency medical services, fire services, the health care system, and public health. It is estimated that Ontario incurs a net loss of $456 million from alcohol-related health care and enforcement costs relative to alcohol revenue.

Research has long established that increasing access to alcohol will lead to an increase in alcohol use and misuse. It is reasonable to be concerned that actions by the Ontario government to increase access to alcohol may directly contribute to increases in alcohol-related morbidity and mortality in Ontario. The potential harms from alcohol were, in fact, anticipated by the government in its 2015 Budget, wherein the Ministry of Finance committed to work with the Ministry of Health and Long-Term Care to develop initiatives to support the safe consumption of alcohol.

OPHS STANDARD:

Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables:

- Prevention of Injury and Substance Misuse Program Requirements #2: The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs, and the creation or enhancement of safe and supportive environments that address alcohol and other substances.

STRATEGIC DIRECTION:

Strategic Directions: Collaborate Effectively, Improve Health Equity

CONTACT:

Laurie Zeppa,
Director of Health Promotion and Prevention, Chief Nursing Officer

Kristy Harper, Program Manager
Chronic Disease Prevention, Injury Prevention & Genetics

Timeline of Government of Ontario's Actions to **Modernize Alcohol Sales** and to Develop a Province-wide **Alcohol Policy** to Minimize Harms

Action by Government to **modernize alcohol sales** in Ontario

2014

April 11, 2014
Premier's **Advisory Council** is convened to advise on maximizing value and performance of government assets.

May 1, 2014
VQA wines available at farmers' markets

2015

April 16, 2015
Advisory Council report on beer sales.

April 23, 2015
2015 Ontario Budget: Government commits to implement the Advisory Council's recommendations and to develop initiatives to support the safe consumption of alcohol

December 15, 2015
Beer is available in **58** grocery stores.

2016

February 18, 2016
Advisory Council report on wine and spirit sales.

June 24, 2016
Ciders are available in grocery stores.

July 26, 2016
The **LCBO** launches new e-commerce platform and home deliveries.

October 28, 2016
Wine is available in **67** grocery stores.

2017

February 6, 2017
The Government announces a new round of bidding for alcohol sales in grocery stores.

July 1, 2017
Alcohol will be available in **206** grocery stores.

Total Retail Availability of Alcohol in Ontario

659 LCBO[1]
551 Ferment on Premises[2]
507 ON Winery Retail[3]
447 Beer Store[1]
212 LCBO Agency[1]
206 Grocery Stores[4]
150 On-site Brewery Retail[3]
72 Licensed Delivery Services[5]
69 Farmers' Markets[6]
18 On-site Distillery Retail[3]
15 Duty Free[3,7]
LCBO Online Sales/Delivery

December 18, 2015
Government announces the development of a province-wide **Alcohol Policy** to support their commitment on the safe and responsible consumption of alcohol.

February 2016
MOHLTC[8] consultation on **Alcohol Policy** framework. Proposed launch in spring 2016.

June 20, 2016
Increase in minimum price of wine.[9]

January 1, 2017
Calories are required to be posted on menus (including alcohol).

April 27, 2017
2017 Ontario Budget: Funding for FASD.

Province-wide Alcohol Policy to Minimize Harms
PENDING

Action by Government to develop a province-wide **Alcohol Policy** to minimize harms

Notes: [1] Reporting year, 2016/17. [2] Reporting year, 2014/15. [3] Reporting year, 2015/16. [4] As of May 2017. [5] As of July 1, 2017. Plans for up to 450 locations have been announced. [6] For 2017, 69 farmers' markets are authorized to sell wine; this number may vary each year. [7] Includes airports and land border crossings. [8] MOHLTC = Ministry of Health and Long-Term Care. [9] Implemented over 3 years.

OPHA
Ontario Public Health Association
Association pour la santé publique de l'Ontario
Established/Établi 1949

WHY ONTARIO NEEDS A PROVINCIAL ALCOHOL STRATEGY

Alcohol is widely consumed in Ontario. But its use is associated with a variety of harms.

Alcohol consumption is widely used and accepted in our society. The majority of us drink, and most of us do so without causing harm to ourselves or others. But alcohol consumption is responsible for a range of harms:

- It is one of the leading risk factors for death, disease and disability in Canada.[1]
- Every year about a quarter of Ontario drinkers engage in high-risk drinking.[2]
- About a third of Ontarians experienced harm as a result of someone else's drinking in the past year.[3]

Alcohol plays an important role in Ontario's economy. But the costs far exceed the revenues.

The annual costs directly attributable to alcohol-related harms in the form of health care, law enforcement, corrections, prevention, lost productivity due to short- and long-term disability and premature mortality, and other alcohol-related problems, have been conservatively estimated at $5.3 billion – well above the alcohol revenue accruing to the provincial government.[4, 5] This means that the economic benefits of alcohol sales are more than offset by the costs, and that our approach to alcohol policy can be improved not only from a health perspective but also from a financial one.

Alcohol-related harms can be mitigated. But this requires a whole-of-government approach.

Research evidence clearly shows that policy tools designed to influence drinking levels and patterns can reduce the burden of death, disease, disability, and social disruption from alcohol.[6] Among the most effective interventions are socially responsible pricing of alcoholic beverages, limits on the number of retail outlets and hours of sale, and marketing controls. These types of policies have been consistently shown to help reduce alcohol-related problems when implemented alongside more targeted interventions such as drinking and driving countermeasures, enforcement of the minimum legal drinking age, as well as screening, brief intervention and referral activities in the primary care setting.

In Ontario, as elsewhere, alcohol policy involves balancing interests – public health, government finances, economic development and consumer preferences for example – that are often at cross-purposes.[7] As a result, alcohol policy can be fragmented and health is sometimes an afterthought. But alcohol-related harms impact all of society and the costs are borne by many government ministries and sectors, from Health and Long-Term Care to Community Safety and Correctional Services. There is a need for coordinated leadership and a comprehensive strategy.

Ontario has been an alcohol policy leader. But we are falling behind.

Historically there has been recognition in Ontario that alcohol is not an ordinary product and that a degree of control over its production and distribution is required in order to mitigate harms. Indeed, Ontario has been a national leader in a number of alcohol policy areas, with many promising practices in place.[8] However, recent developments suggest an ongoing erosion of alcohol controls. Based on what we know from decades of research, we can expect to see an increase in alcohol-related harms as a result.

For example, in British Columbia, the introduction of private sector alcohol outlets was associated with a 3.25% increase in alcohol-related deaths for each 20% increase in private store density.[9] Based on this finding, Ontario's recent decision to sell beer in 450 grocery stores across the province could lead to 100+ alcohol-related deaths per year.[10]

Over the years, many voices from across Ontario's health sector have called for a comprehensive alcohol strategy. A number of provinces are already moving ahead with their own provincial alcohol strategies: Nova Scotia and Alberta have strategies in place and Manitoba is currently developing one. We are falling behind.

Ontario has committed to ensuring a socially responsible approach to alcohol policy. Right now, we are falling short. It is imperative that Ontario commit to an approach to alcohol policy that prioritizes health and safety and considers the costs associated with alcohol consumption. Such an approach is critical to our health and well-being. **Our organizations believe that a provincial alcohol strategy is the best way to achieve this.**

For more information, please contact:

JF Crépault
Senior Policy Analyst, CAMH
416-535-8501 x32127
JeanFrancois.Crepault@camh.ca

Catherine Paradis
Senior Research & Policy Analyst, CCSA
613-235-4048 x253
cparadis@ccsa.ca

Zarsanga Popal
Policy Analyst, CMHA Ontario
416-977-5580 x4123
zpopal@ontario.cmha.ca

Andrew W. Murie
CEO, MADD Canada
1-800-665-6233 x224
amurie@madd.ca

Cathy Edwards
Chair, OPHA's Alcohol Prevention Workgroup
613-549-1232 x1508
Cathy.Edwards@kflapublichealth.ca

Tim Lenartowych
Director of Nursing and Health Policy, RNAO
416-408-5615
tlenartowych@rnao.ca

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[1] Lim et al. (2012). A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: A systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 380, 2224-60.

[2] Ialomiteanu et al. (2014). *CAMH Monitor eReport 2013: Substance use, mental health and well-being among Ontario adults, 1977-2013.* CAMH Research Document Series No. 40. Toronto: Centre for Addiction and Mental Health.

[3] Giesbrecht et al. (2010). Collateral damage from alcohol: implications of 'second-hand effects of drinking' for populations and health priorities. *Addiction* 105, 1323-25.

[4] Rehm et al. (2006). *The costs of substance abuse in Canada 2002*. Ottawa: Canadian Centre on Substance Abuse.

[5] Thomas (2012). *Analysis of beverage alcohol sales in Canada.* Alcohol Price Policy Series: Report 2.Ottawa: CCSA.

[6] Babor et al. (2010). *Alcohol: No ordinary commodity – research and public policy (revised edition)*. Oxford: Oxford University Press.

[7] World Health Organization (2010). *Global strategy to reduce the harmful use of alcohol*. Geneva: WHO.

[8] Giesbrecht et al. (2013). *Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Comparison of Provincial Policies*. Toronto: CAMH.

[9] Stockwell et al. (2011). Impact on alcohol-related mortality of a rapid rise in the density of private liquor outlets in British Columbia: A local area multi-level analysis. *Addiction* 106: 768-76.

[10] Mann (2015). Personal communication. Calculated using data from Stockwell et al. 2011.

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
The Honourable Charles Sousa
Premier Kathleen Wynne
Office of the Minister

Dear Hon. Hoskins:

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

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

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

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

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

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

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

Index	*Page*

Algoma Public Health
Statement of Operations
August 2017
(Unaudited)

Public Health Programs

	Actual YTD 2017	Budget YTD 2017	Variance Act. to Bgt. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017
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	4,872,799	4,872,800	(1)	7,309,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	1,794,161	1,794,133	28	2,691,200	0%	100%
Fees, other grants and recovery of expenditures	397,290	412,251	(14,961)	670,476	-4%	96%
Provincial Grants - Funding for Prior Yr Expenses	0	0	-	-		
Total Public Health Revenue	$ 9,679,776	$ 9,692,773	$ (12,997)	$ 14,155,662	0%	100%
Expenditures						
Public Health 75% Prov. Funded Programs	$ 6,974,156	$ 7,700,322	$ 726,166	$ 11,464,463	-9%	91%
Public Health 100% Prov. Funded Programs	1,631,672	1,777,481	145,809	2,691,200	-8%	92%
Total Public Health Programs Expenditures	$ 8,605,828	$ 9,477,803	$ 871,975	$ 14,155,662	-9%	91%
Excess of Rev. over Exp. 75% Prov. Funded	$ 911,459	$ 198,319	$ 713,140	$ (1)		
Excess of Rev. over Exp. 100% Prov. Funded	162,489	16,652	145,837	1		
Provincial Grants for Prior Yr Expenses	-	-	-	-		
Total Rev. over Exp. Public Health	$ 1,073,947	$ 214,970	$ 858,977	$ (0)		

Public Health Programs - Fiscal 17/18

Provincial Grants and Recoveries	$ -	-	-	-		
Expenditures	0	-	0	-		
Excess of Rev. over Fiscal Funded	(0)	-	(0)	-		

Community Health Programs

Calendar Programs

Revenue						
Provincial Grants - Community Health	$ 712,011	$ 712,007	$ 4	$ 1,068,011	0%	100%
Municipal, Federal, and Other Funding	248,092	225,614	22,478	338,455	10%	110%
Total Community Health Revenue	$ 960,103	$ 937,622	$ 22,481	$ 1,406,466	2%	102%
Expenditures						
Healthy Babies and Children	$ 701,318	$ 712,007	$ 10,689	$ 1,068,011	-2%	98%
Child Benefits Ontario Works	15,399	16,088	689	24,135	-4%	96%
Algoma CADAP programs	195,847	201,546	5,699	302,319	-3%	97%
One-Time Funding programs	11,901	12,000	99	12,000	-1%	99%
Total Calendar Community Health Programs	$ 924,466	$ 941,641	$ 17,176	$ 1,406,465	-2%	98%
Total Rev. over Exp. Calendar Community Health	$ 35,637	$ (4,020)	$ 39,657	$ 1		

Fiscal Programs

Revenue						
Provincial Grants - Community Health	$ 2,338,140	$ 2,331,131	$ 7,009	$ 5,566,099	0%	100%
Municipal, Federal, and Other Funding	315,211	302,826	12,385	734,703	4%	104%
Other Bill for Service Programs	25,011		25,011			
Total Community Health Revenue	$ 2,678,362	$ 2,633,957	$ 44,405	$ 6,300,802	2%	102%
Expenditures						
Brighter Futures for Children	46,727	45,603	(1,124)	109,447	2%	102%
Infant Development	257,547	266,848	9,301	640,434	-3%	97%
Preschool Speech and Languages	263,466	255,940	(7,526)	614,256	3%	103%
Nurse Practitioner	53,764	53,230	(533)	127,753	1%	101%
Genetics Counseling	182,718	153,428	(29,290)	367,806	19%	119%
Community Mental Health	1,376,025	1,436,358	60,333	3,449,498	-4%	96%
Community Alcohol and Drug Assessment	291,004	301,732	10,728	724,157	-4%	96%
Healthy Kids Community Challenge	86,370	87,850	1,480	161,350	-2%	98%
Stay on Your Feet	39,691	41,667	1,976	100,000	-5%	95%
Bill for Service Programs	21,660	-	(21,660)	-		
Misc Fiscal	1,371	2,000	629	6,100		
Total Fiscal Community Health Programs	$ 2,620,342	$ 2,644,655	$ 24,313	$ 6,300,801	-1%	99%
Total Rev. over Exp. Fiscal Community Health	$ 58,020	$ (10,698)	$ 68,717	$ 1		

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 Eight Months Ending August 31, 2017
(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	4,753,934	4,753,933	1	7,130,900	0%	67%	4,946,623	4,998,533	(51,910)
MOH Funding Vector Bourne Disease	72,465	72,467	(2)	108,700	0%	67%	72,465	72,467	(2)
MOH One Time Funding Dental Health	0	0	0	0		0%	27,967	22,667	5,300
MOH Funding Safe Water	46,400	46,400	0	69,600	0%	67%	46,400	46,400	0
Total Public Health 75% Prov. Funded	**4,872,799**	**4,872,800**	**(1)**	**7,309,200**	**0%**	**67%**	**5,093,455**	**5,140,067**	**(46,612)**
MOH One Needle Exchange	33,805	33,800	5	50,700	0%	67%	33,805	33,800	5
MOH Funding Haines Food Safety	16,400	16,400	0	24,600	0%	67%	16,400	16,400	0
MOH Funding CINOT/Healthy Smiles	513,266	513,267	(1)	769,900	0%	67%	320,340	273,733	46,607
MOH Funding - Social Determinants of Health	120,335	120,333	2	180,500	0%	67%	120,335	120,333	2
MOH Funding Chief Nursing Officer	81,005	81,000	5	121,500	0%	67%	81,005	81,000	5
MOH Enhanced Funding Safe Water	10,335	10,335	0	15,500	0%	67%	10,333	10,333	(0)
MOH Funding Unorganized	343,405	343,400	5	515,100	0%	67%	333,535	333,533	2
MOH Funding Infection Control	208,270	208,267	3	312,400	0%	67%	208,270	208,267	3
MOH Funding Diabetes	100,000	100,000	0	150,000	0%	67%			
MOH Funding Northern Ontario Fruits & Veg.	78,270	78,270	0	117,400	0%	67%			
Funding Ontario Tobacco Strategy	289,070	289,061	9	433,600	0%	67%	289,067	289,067	0
One Time Funding	0	0	0	0					
Total Public Health 100% Prov. Funded	**1,794,161**	**1,794,133**	**28**	**2,691,200**	**0%**	**67%**	**1,413,090**	**1,366,467**	**46,623**
Funding for Prior Yr Expenses	**0**	**0**	**0**	**0**		**0%**	**139,000**	**0**	**139,000**
Recoveries from Programs	6,660	6,707	(47)	10,061	-1%	66%	23,952	6,707	17,245
Program Fees	159,734	166,496	(6,761)	249,743	-4%	64%	149,948	164,762	(14,814)
Land Control Fees	95,485	106,667	(11,182)	160,000	-10%	60%	75,530	106,667	(31,137)
Program Fees Immunization	106,181	119,667	(13,486)	179,500	-11%	59%	128,812	106,667	22,146
HPV Vaccine Program	8,458	3,300	5,158	12,500	0%	68%	3,018	6,667	(3,649)
Influenza Program	5,490	1,100	4,390	40,000	399%	14%	1,405	40,000	(38,595)
Meningococcal C Program	1,386	1,200	186	8,000	0%	17%	2,849	6,667	(3,818)
Interest Revenue	9,120	7,115	2,005	10,672	28%	85%	7,583	1,333	6,250
Other Revenues	4,777	0	4,777	0	0%	100%	86,533	110,000	(23,467)
Total Fees, Other Grants and Recoveries	**397,290**	**412,251**	**(14,960)**	**670,476**	**-4%**	**59%**	**479,630**	**549,469**	**(69,839)**
Total Public Health Revenue Annual	**$ 9,679,776**	**$ 9,692,773**	**$ (12,997)**	**$ 14,155,662**	**0%**	**68%**	**$ 9,681,444**	**$ 9,605,846**	**$ 75,598**
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 Eight Months Ending August 31, 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	Comparison Prior Year: YTD Actual 2016	YTD BGT 2016	Variance 2016
Salaries & Wages	5,055,971	5,631,998	$ 576,027	$ 8,454,202	-10%	60%	$ 5,217,446	$ 5,541,515	$ 324,069
Benefits	1,341,633	1,327,693	(13,940)	1,993,632	1%	67%	1,285,851	1,385,379	99,528
Travel - Mileage	56,910	85,241	28,331	127,861	-33%	45%	74,222	97,669	23,447
Travel - Other	55,558	51,962	(3,597)	77,942	7%	71%	38,720	63,284	24,564
Program	382,080	478,678	96,598	735,528	-20%	52%	468,866	373,204	(95,662)
Office	75,695	90,000	14,305	135,250	-16%	56%	79,274	61,333	(17,940)
Computer Services	368,503	466,345	97,842	699,518	-21%	53%	521,228	597,272	76,043
Telecommunications	242,338	243,730	1,392	325,994	-1%	74%	164,620	144,989	(19,631)
Program Promotion	51,199	113,865	62,666	170,797	-55%	30%	58,600	142,723	84,123
Facilities Expenses	506,193	533,567	27,373	800,350	-5%	63%	527,400	542,616	15,216
Fees & Insurance	247,007	193,064	(53,943)	242,096	28%	102%	281,023	160,803	(120,220)
Debt Management	307,266	307,267	1	460,900	0%	67%	311,391	304,000	(7,391)
Recoveries	(84,525)	(45,605)	38,919	(68,408)	85%	124%	(62,391)	(93,922)	(31,531)
	$ 8,605,828	$ 9,477,803	$ 871,975	$ 14,155,662	-9%	61%	$ 8,966,249	$ 9,320,865	$ 354,616

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 – August 2017

Reporting Period

The August 2017 financial reports include eight 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 five 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 August 31st, 2017, Public Health programs are reporting an $859k positive variance.

Total Public Health Revenues are indicating a negative $13k 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 $872k related to Total Public Health expenses being less than budgeted. The $576k 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 August 31st, the HR Manager position and the AMOH positions have been filled. Furthermore, the 2017 Public Health Operating budget assumed collectively bargained wage increases for CUPE and ONA staff members from April 2017 through to the end of the calendar year. As of August 31st, 2017, this assumption has not been realized. Travel – Mileage, Program, Office, Computer Services and Program Promotion expenses are also contributing to the positive variance.

As Management is projecting a surplus for the 2017 calendar year, preparations are being made with respect to prioritizing one-time expenditure needs. These include, but are not limited to, building maintenance initiatives, IT and Telecommunication upgrades, and Ergonomic enhancements.

Community Health Calendar programs are operating within budget. Revenues are showing a positive variance as a result of timing of funds received from Other Funding associated with programing with Ontario Works.

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

Genetics Counseling is showing a negative $29k 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 $13k variance.

The municipal levies are within budget.

Provincial Grants are within budget.

There is a negative variance of $11k 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.

There is a negative variance of $13k associated with Program Fees Immunization. This is due to timing of fees received.

Public Health Expenses (see page 3)

Salary & Wages
Salary & Wages expense is indicating a positive variance of $576k. 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 August 31st, the HR Manager position and AMOH positions have now been filled. Furthermore, the 2017 Public Health Operating budget assumed collectively bargained wage increases for CUPE and ONA staff members from April 2017 through to the end of the calendar year. As of August 31st, 2017, this assumption has not been realized.

Travel-Mileage
Travel – Mileage expense is indicating a positive variance of $28k. Management believes a positive variance will be realized at year-end. Management will look to adjust the Travel-Mileage budget for 2018 to more accurately reflect actual Travel-Mileage expenses.

Program
Program expense is indicating a positive variance of $97k 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.

Office
Office expense is indicating a positive variance of $14k variance. This is a result of photocopying expenses being less than budgeted. Management has focused on this area in terms of cost containment by communicating with staff more efficient photocopying methods.

Notes Continued…

Computer Services
Computer Services expense is showing a positive variance of $98k. The noted variance is a result of timing as some general IT equipment purchases have yet to be made. Furthermore, the annual Microsoft License renewal has yet to be purchased but is forthcoming. This will reduce the noted positive variance.

Program Promotion
Program Promotion expense is indicating a positive $63k variance which is due to timing of expenditures not yet incurred. Specifically, staff professional development is below budget by $37k and Promotional expenses are below budget by $20k. Management will continue to monitor this line item to determine if there is opportunity to refine this budget line item for 2018.

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

Recoveries
Recoveries are indicating a positive $39k variance. This is a result of Public Health increasing the charges associated with Genetics and Other Community programs 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 August 31st, 2017. Cash includes $325k in short-term investments.

Long-term debt of $5.61 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $328k 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.

Correction: The July 31st, 2017 Financial Statements indicated long-term debt of $5.34 million. Long-term debt as of July 31st, 2017 should have read $5.67 million. The $5.34 million noted related only to the portion of the long-term debt associated with the 294 Willow Avenue facility.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of August 2017	**August 2017**	December 2016
Assets		
Current		
Cash & Investments	**$ 2,957,393**	$ 2,146,361
Accounts Receivable	**295,771**	509,998
Receivable from Municipalities	**79,083**	9,159
Receivable from Province of Ontario		
Subtotal Current Assets	**3,332,248**	2,665,518
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,306,896**	1,587,880
Payable to Gov't of Ont/Municipalities	**61,854**	321,402
Deferred Revenue	**514,764**	494,864
Employee Future Benefit Obligations	**2,550,458**	2,550,458
Term Loan	**5,903,861**	5,903,861
Subtotal Current Liabilities	**10,337,833**	10,858,466
Net Debt	**-7,005,586**	-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	**14,807,871**	13,620,509

alPHa
Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

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

October 12 2017

Dear Minister Hoskins,

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

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

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

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

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

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

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

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

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

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

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

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

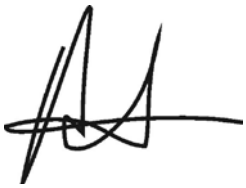
4. **The authority of the medical officer of health position must align with the responsibilities of the position.**

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

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

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

Sincerely,



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

Encl.

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

ATTACHMENT to COMOH Expert Panel Response letter October 12, 2017

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

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

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

OVERALL:

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

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

I - EXPERT PANEL MANDATE

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

The stated principles guiding the panel's work included:

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

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

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

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

II THE OPPORTUNITY

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

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

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

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

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

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

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

III A STRONG PUBLIC HEALTH SECTOR IN AN INTEGRATED SYSTEM

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

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

1. THE OPTIMAL ORGANIZATIONAL STRUCTURE FOR PUBLIC HEALTH

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

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

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

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

2. OPTIMAL GEOGRAPHIC BOUNDARIES

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

This assumes two things:

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

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

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

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

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

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

3. OPTIMAL LEADERSHIP STRUCTURE

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

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

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

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

4. OPTIMAL APPROACH TO GOVERNANCE

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

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

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

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

CONCLUSION:

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

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

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

alPHa
Association of Local
PUBLIC HEALTH
Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

October 17, 2017

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

Dear Minister Hoskins:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Yours truly,

Carmen McGregor,
President

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

Office of the Regional Chair

October 5, 2017

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

Dear Minister Hoskins,

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

Thank you for the opportunity to provide comments on the Expert Panel recommendations. The Expert Panel Report recommends significant structural, organizational, and governance changes to the public health sector in Ontario as part of the Province's overall work on the Patients First Strategy.

The Region of Peel is supportive of a strong Public Health sector in Ontario as noted by the Expert Panel:

- A highly skilled public health sector embedded and highly visible in communities across the province.
- A public health workforce in all parts of the province with access to specialized public health knowledge and resources and a shared commitment to evidence-based practice and achieving population health outcomes.
- A public health sector that nurtures strong relationships with municipal governments and other local organizations to positively influence the social determinants of health; and create safe, supportive, healthy environments.
- A public health sector with capacity to work much more effectively with the rest of the health system to help identify health system priorities and shape health policy and services to deliver population level interventions that will improve health and reduce health inequities.

On September 28, 2017, Region of Peel Council and Board of Health approved submission of key Regional concerns with the Expert Panel recommendations to the ministry (**Resolution 2017-754**). Our analysis reflects the experience and perspective of a Regional government with a public health unit embedded within the Regional government structure, serving a population of about 1.4 million residents, and employing a diverse and skilled workforce. Our analysis is based on the content of the Expert Panel Report, noting that the Report does not speak to important implementation details that need to be better understood and carefully considered.

The key concerns related to the Expert Panel recommendations from the Region of Peel's perspective that require further consideration include:

The mandate of public health should remain unchanged.
The core function of public health is to prevent disease and protect and promote health for the population based on local need. It is imperative that this is maintained, and that public health remains distinct from health care services in terms of both role and oversight, and is not put at risk of being re-oriented to a more clinical perspective.

Consequences for Regional governments that have public health units embedded within their organizational structure should be identified and mitigated.
Separating public health units such as Peel Public Health, which are currently part of the Regional government structure, may have potential unintended negative consequences related to governance, processes and collaboration. Being embedded within the Regional government structure, Peel Public Health is able to work effectively with various Regional departments including Human Services, Planning and Transportation to create healthy public policy and work toward supportive environments for Peel's residents. While the Expert Panel acknowledges continued strong connections with Regional and Municipal governments are important, the impacts of working within a different organizational structure need to be better understood and addressed. While relationships within different Regional departments are already well established, different reporting structures, funding and processes may create challenges for continuing to move this work forward.

Financial implications for municipalities should be mitigated and prevented.
While it was made clear that funding was out of scope for the Expert Panel, it is imperative that the Ministry ensures that public health programs continue to be sufficiently resourced, without increasing funding obligations of municipalities. If the proposed changes are implemented, provincial resources and supports would also need to be made available to implement complex system changes.

Further consideration of optimal geographic boundaries that support system and service integration is warranted.
The Region of Peel has previously advocated for LHIN boundaries to be realigned to municipal boundaries to support further integration, administrative efficiency, and linkages between health services and programs and services that influence the social determinants of health. Based on the recommended boundaries in the report, Peel is one of the jurisdictions where alignment with LHIN boundaries will result in misalignment with municipal boundaries. This may present challenges for collaborative work and service delivery related to the social determinants and supportive environments, which are typically delivered by Regional and municipal governments (e.g., Housing, employment, transportation), as well as navigation challenges for residents navigating the health and social services system. Further, partnerships with local stakeholders such as School Boards that also use municipal boundaries may also become more challenged.

Any changes that are considered by the Ministry should be evidence-informed to achieve population health outcomes.
Recommendations of the Expert Panel propose significant dismantling of the current system. Evidence that this is the right approach to achieve the desired outcomes are required. Further, the benefits for Peel residents and public health units such as Peel Public Health, which already have well demonstrated organizational capacity, are unclear. Alternative or hybrid models that benefit each of the 36 public health units across Ontario and the populations they serve should be identified and considered. Exploration of

Board of Health models that ensure inclusivity, diversity and citizen representation while maintaining the benefits of municipal council representation is also warranted.

We hope that the above input is helpful as you consider the Expert Panel recommendations. The Region of Peel and Peel Public Health are committed to a robust and effective public health sector that is well integrated and serves the unique needs of Peel residents. We look forward to continued engagement and discussion on these important recommendations related to the future of public health in Ontario. Please contact Dr. Jessica Hopkins, Medical Officer of Health for any questions or follow-up items – Jessica.Hopkins@peelregion.ca 905-791-7800 ext. 2856.

Sincerely,

Frank Dale
Regional Chair

Jessica Hopkins, MD MHSc CCFP FRCPC
Medical Officer of Health
Peel Public Health

c:
Nancy Polsinelli, Commissioner, Health Services, Region of Peel
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
Ontario Board of Health Chairs
Lynn Dollin, President, Association of Municipalities of Ontario
Pat Vanini, Executive Director, Association of Municipalities of Ontario
Carmen McGregor, President, Association of Local Public Health Agencies
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Carmine Domanico, Board Chair, Central West Local Health Integration Network
Scott McLeod, Chief Executive Officer, Central West Local Health Integration Network
Neil Skelding, Board Chair, Mississauga Halton Local Health Integration Network
Bill MacLeod, Chief Executive Officer, Mississauga Halton Local Health Integration Network

APPROVED AT REGIONAL COUNCIL
September 28, 2017

9.1. **Response to the Report of the Minister's Expert Panel on Public Health**
Presentation by Dr. Jessica Hopkins, Medical Officer of Health; and Nancy Polsinelli, Commissioner of Health Services

Received 2017-753

Moved by Councillor Parrish,
Seconded by Councillor Gibson;

That the submission to the Minister of Health and Long-Term Care, in response to the Minister's Expert Panel on Public Health Report outlined in Section 2b of the report of the Commissioner of Health Services and Medical Officer of Health, titled "Response to the Report of the Minister's Expert Panel on Public Health", be endorsed;
And further, that the submission, incorporating Region of Peel Council and Board of Health input as directed, be sent to the Ministry of Health and Long-Term Care as the Region of Peel's official response to the consultation regarding the Minister's Expert Panel on Public Health Report;

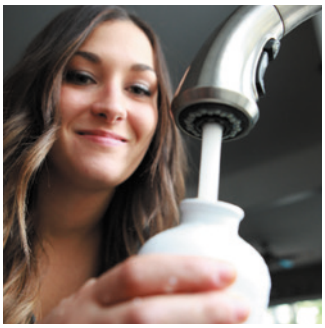
And further, that a copy of the Region of Peel submission to the Minister of Health and Long-Term Care, in response to the Minister's Expert Panel on Public Health Report be shared with the Association of Municipalities of Ontario, the Association of Local Public Health Agencies, the other 36 Boards of Health in Ontario, the Central West Local Health Integration Network and the Mississauga Halton Local Health Integration Network for their information.

Carried 2017-754

Peterborough Public Health

Peterborough Public Health Board of Health Response to the Report of the Minister's Expert Panel on Public Health

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



Serving the residents of **Curve Lake** and **Hiawatha First Nations**, and the **County** and **City of Peterborough**

Peterborough Public Health Board of Health Response to the Report of the Minister's Expert Panel on Public Health (October 2017)

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

Our board of health believes that the recommendations as outlined in the expert panel report would jeopardize the relations that boards like ours have cultivated with local governments and the communities in which we are located.

We find ourselves at a time of transition. Investments made so far as a result of Patients First (Modernization of the standards, Accountability Framework, greater collaboration with LHINs, LHIN mandate to include health promotion and health equity, etc.) still need more time to become fully realized. It is our expectation and hope that these changes will achieve much of the desired outcome of a strong Public Health sector within a more integrated system without unnecessary disruption to public health structure and governance.

As we elaborate in our response, we hope to help you understand how and why the change to regional governance would displace and threaten the local participation and engagement of Indigenous communities that has been cultivated over several decades. Currently, the HPPA allows for First Nations to decide whether to enter into agreements with their local boards of health. We fear that the proposed regional structure does not create a space for First Nation representation.

Why are you so dedicated to serving on a local board? "Maintaining a working relationship with PPH and the Board of Directors assures the collective voice. While on this Board the two First Nations affiliated have a voice and representation for our citizens whether in the First Nation, living in the city or county. Indigenous people must have the equity of services and being on the board guarantees that our people are represented and culturally understood. We can all appreciate that First Nations and Indigenous people have unique and complicated issues, therefore it is important that the First Nation voice is present to articulate the issues or challenges that are faced in community." *Chief Phyllis Williams, Curve Lake First Nation Representative, PPH Board of Health Member*

The health system priorities and the public health sector's priorities exist within a tension – while we support the concept of bringing them closer together, the health system has the potential to distract public health so that we lose our current focus and potentially miss opportunities for meaningful interventions and change. For example, funding has always been made available for an epidemic or crisis, but not for health promotion interventions like the Healthy Babies Healthy Children home visiting program for high risk families or for interventions like violence prevention.

Our board strongly agrees with the vision that is promoted by the expert panel because it has been our vision and we believe we have accomplished, if not excelled in many of its aspects. We will elaborate by referring more specifically to aspects of your articulated desired outcome:

"Ontario will benefit most from a highly skilled public health sector embedded and highly visible in communities across the province". *(Page 5)*

- We believe we have that now!
- Recent proliferation of post-secondary training in relevant public health fields has addressed many if not most of our recruitment issues for small boards of health like Peterborough. For example, we recently interviewed 4 candidates for a vacant epidemiology position.
- The current placement and structures of local public health agencies provides diversity of options to maximize partnerships, community collaboration and visibility. (Some are within local governments and others are free-standing).
- Currently, local public health is tied geo-politically to existing boundaries and identities that resonate and make sense to the communities we serve. For example, our branding and tagline states "Serving the residents of Curve Lake and Hiawatha First Nations, and the County and City of Peterborough".

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." *(Page 5)*

- We do that now! Those relationships exist currently.
- We have worked hard for many years to develop a strong and credible reputation. We are highly respected and we can leverage this to achieve healthy outcomes for our communities.
- Local governments see public health as a valued partner, and their key contact for health writ large, for example emergency response, health protection, healthy public policy, health system navigation.
- Local government is invested in the board and has a sense of ownership over its work.
- Recreating meaningful representation at a regional rather than a local level will be a challenge.
- Proposed recommendations to dismantle local boards and create regional ones will seriously handicap the ability of the board to influence local social determinants of health.

"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." *(Page 5)*

- We have that now!
- Current Section 50 agreements with two First Nations have led to authentic commitment, not tokenism. This has had a profound influence on organizational strategic priorities and operations. This has also ensured that First Nations are regarded as peers in relation to other obligated municipalities.
- Despite the existing provincial barriers to board recruitment, we have a pro-active approach that has allowed Peterborough to create a diverse and skill-based board. In fact, the Province could make this easier for all boards (see additional comments)
- The HPPA requires a majority of municipal board members and this makes the board accountable to its local communities. This would be lost under the proposed regional governance model.

How would this impact your community? "For Curve Lake First Nation – what replaces this unique and special attention, relationship, and support? Why break what isn't broken or in other words, what can be in its place to be equal to or better? Let's consider that first. There is already a trusting and responsive understanding of our needs. Curve Lake as a First Nation will become once again "lost" in the complication of transition, leaving our citizens vulnerable –and their well-being and stability cannot be at the detriment of risk or such drastic change." *Chief Phyllis Williams, Curve Lake First Nation Representative, PPH Board of Health Member*

"At the same time the public health sector will have the capacity to work much more effectively with the rest of the health system." *(Page 5)*

- "Patients First" planned transformation will achieve this!
- The health care system only contributes about 25% to health outcomes, and the majority of the work of public health needs to be outside of this system. Working with LHIN partners to plan health care delivery should not consume our time and energy so that our capacity to work with other sectors and partners is eroded.
- For example:
    - Municipal by-laws banning exposure to second hand smoke have been demonstrated to effectively and immediately reduce hospital admissions in published research.[1]
    - The community fluoridation of water (CWF) effectively reduces the need for expensive dental treatment and we are actively engaged in fighting to protect CWF where it currently exists.

- Many of us are working closely with municipal transportation and planning departments to ensure that communities are liveable and walkable for future generations.
- Peterborough Public Health staff help lead and broker a community-wide response to food insecurity.

The Optimal Organizational Structure for Public Health *(Pages 9 to 16)*

We agree that regionalization of some organizational functions and services offers efficiencies but we are skeptical that there are enough additional ones to warrant the cost and disruption that implementation of the expert panel recommendations would entail. Since the Capacity Review Committee's report in 2006[2] many issues faced by smaller local public health agencies like ours have been resolved.

Public Health Ontario has been established and it is able to support local public health agencies with resources such as central analytics and interactive data dashboards, environmental health consultations, and infection prevention and control supports. Given the technical and scientific resources now available at PHO, there is less need for regionalization to access this type of expertise that was once only available in larger public health units.

In addition, many local public health agencies are entering into mutual aid agreements to provide surge capacity for one another. Our staff has been engaged with other neighbouring public health agencies to develop an agreement that is now ready for signature.

Efficiencies can be found at all levels, not strictly regional. For example provincial buying of contraceptives has enhanced our ability to provide low cost birth control; regional sharing of technical epidemiology and research capacity (e.g., Locally Driven Collaborative Projects) has produced valuable public health applied research; and our local procurement agreements with municipal partners assist us in achieving cost savings in transportation.

More provincial leadership is needed in areas that can/should be standardized for the sake of efficiencies. For example, the Business Administrators recently had presentations from Peel Public Health on the development of an organizational IT strategy and from Ottawa Public Health on a procurement model. These collaboratives should be fostered and then developed into policies or strategies so that all local public health agencies can benefit. A regional entity for the Central East LHIN would fail to add much to the strategies we've described or desire in order to achieve a better return on investment by both levels of government.

Rather than creating new regional entities, provincial support for voluntary and strategic amalgamations where they make sense, based on a set of criteria and appropriate funding formula, is a more viable and sustainable solution. Hence, we support more of a "retrofit" approach rather than a disruptive, costly, risky and inappropriate overhaul as recommended by the panel.

The proposed end state that is described on page 16 of the expert panel report reflects our current operations:

- ✓ We have centralized our program delivery to one office (down from two sites);
- ✓ We have a proven record of accountability for the majority of provincial standards. Modernization of the standards to provide greater local flexibility will only enhance our accountability;
- ✓ We have a long history of strong collaboration with both the CE-LHIN and local health partners to tailor our delivery;
- ✓ Our current public health unit corresponds completely with the proposed sub-LHIN planning regions; and
- ✓ Peterborough's public health programs and services are visible and accessible across our many communities, including our two local First Nations.

Rather than dismantling local boards, rupturing their local ties and upheaving their organizations, the emphasis of any proposed change should be on strengthening those boards that are having difficulty in meeting the standards and their performance targets. That is the goal of performance management.

Optimal Geographic Boundaries *(Pages 17 to 19)*

Clearly the expert panel recommendations do not solve the ongoing challenges with trying to marry health care utilization with geo-political and historic realities and community identities. For Peterborough, we easily align with one of the CE-LHIN proposed sub-planning regions but this is not the case for all boards of health and we cannot support a change that ultimately fails to address boundary issues.

Currently, public health is under resourced and what is being proposed by the expert panel would be cost prohibitive for just such a restructure. Money could be better used in actually fully funding public health programs and services.

It is our assessment that the dissolution of local boards of health and the creation of regional entities would be a lot of pain for very little gain, if any.

Why is it important to keep boards connected to their local communities and councils? "From a municipal standpoint, it has been less than twenty years since the most recent round of municipal amalgamations, both voluntary and forced. That is not a long time in terms of peoples' lives, although it may seem to be with respect to government administrations. In the Peterborough area, the City and the County are continuing to learn to work together. Nowhere is this more evident than in public health. The proposed regional board structure will only diminish the feeling that municipalities are a respected part of the public health system, and that once again the Province wants to blur the lines of responsibility for what we realize and appreciate has had such a meaningful impact on our communities. *Deputy Mayor John Fallis, Township of Cavan Monaghan, PPH Board of Health Member*

Optimal Leadership Structure *(Pages 20-21)*

The criteria listed on page 20 is the current responsibility of a board of health and any other organization that is hiring its senior leader. The proposed structure of four functional departments also represents how many organizations divide up the responsibility for optimal performance. What does not make sense to us is why the senior leader of the proposed regional entities has been divided into two, a CEO and an MOH. The report fails to make this argument, and in fact on page 20, states that a "single leader" is "more effective". It should be up to local boards to decide whether or not these two functions are best suited to a single MOH or are better being shared.

Rather than creating a large regional entity with regional leadership, we would prefer smaller amalgamations to be incentivized by the Province to build on existing governance and leadership models.

An Optimal Approach to Governance

The recommendations contained in this section feel to us like using an atomic bomb to blow up a mosquito.

We believe that governance of public health, for the most part, has a great deal of strength and rather than abolishing local boards, the province could improve local governance through better training, more policy direction, and a more responsive and proactive process of member recruitment.

Why is a local board important? "A large part of what determines the health status of any individual happens outside of their doctor's office or the hospital. Local policy/decision making and the services provided at the local level are very important to population health, especially for marginalized groups. Eliminating local public health boards removes an important local voice that has a close connection to the community and better understanding of its needs." *Michael Williams, Provincial Appointee, PPH Board of Health Member*

Boards need to have more control or input into provincial board appointments.

We are extremely concerned that the proposed regional board governance model will result in a silencing of the local board of health voice that has proven to be an effective advocate for healthy public policy in this province.

Recommendation that key leadership roles would only be open to provincial appointments flies in the face of our experience where municipal members have often provided strong leadership. The board as a whole should have the ability and freedom to determine its key positions, as it sees fit.

Conclusion

Peterborough's board of health is very concerned about many of the recommendations made by the expert panel. We believe that local boards, connected to their local governments, be they First Nations or municipalities, have provided a strong and effective anchor for the work of the public health sector. This accounts for the stability Ontario has experienced over the years in its public health sector, relative to other provinces and territories. The panel's recommendations threaten this.

Rather than the overhaul that is recommended, we would support a more modest approach led by boards of health and supported by the Province to encourage amalgamations where desired and appropriate. In our opinion, a more sustainable approach would be to implement those changes that would support existing governance to function more effectively. The panel recommendations assume that there is a discord in the public health system. We would argue that this is not the case. Public health in Ontario suffers from a limited funding envelope which requires attention rather than resourcing the proposed governance and geographic changes.

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[1] Naiman A, Glazier RH and Moineddin R Association of anti-smoking legislation with rates of hospital admission for cardiovascular and respiratory conditions. CMAJ 2010 May 18;182(8):761-767

[2] The Final Report of the Capacity Review Committee Revitalizing Ontario's Public Health Capacity. MOHLTC May 2006 accessed at http://neltoolkit.rnao.ca/sites/default/files/1._Capacity_Review_Committee_Full_Report_2006%20(1).pdf, Oct. 4, 2017.

Municipality of Chatham-Kent
Public Health Unit
PO Box 1136, 435 Grand Avenue West, Chatham, ON N7M 5L8
Tel: 519.352.7270 Fax: 519.352.2166
Email ckhealth@chatham-kent.ca

October 18, 2017

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

Dear Minister Hoskins,

RE: RESPONSE TO THE REPORT OF THE MINISTER'S EXPERT PANEL ON PUBLIC HEALTH

Thank you for the opportunity to provide feedback on the *Report of the Minister's Expert Panel on Public Health*. Chatham-Kent operates under a single tier municipal governance structure following the amalgamation of 23 distinct communities in 1998, covering a land mass of 2,458 square kilometers. Chatham-Kent is classified as predominately rural, having a population of 104,000 people. The local economy is supported largely through agriculture and as in many rural communities, older adults and seniors outnumber children, youth, and younger adults. Cardiovascular Disease, Ischemic Heart Disease, and Diabetes continue to be Chatham-Kent's leading causes of mortality. As the local public health unit, Chatham-Kent Public Health knows, and more importantly, understands Chatham-Kent and is best situated to address the needs of the communities served within its border.

The Chatham-Kent Board of Health has always functioned in a manner that ensures accountability, addresses capacity, improves equity, supports integration and leverages the significant amount of public health expertise collectively held by Chatham-Kent's public health team. As an autonomous-integrated board this is accomplished through partnerships and collaboration with numerous community groups and organizations but more importantly through the strong bonds that exist between the Chatham-Kent Public Health Unit and the Municipality of Chatham-Kent. When reviewing the panel's recommendations, emphasis was placed on looking at Public Health from a local and provincial perspective while recognizing potential benefits to the public health system if recommendations were implemented. The Chatham-Kent Board of Health supports health units and their respective municipalities struggling to fulfill their public health mandate and acknowledge that the recommendations in the report may assist some communities to meet their provincial obligations. While Chatham-Kent Board of Health is not supportive of the report in its entirety, there are recommendations that might improve public health depending on how, where, and when they are implemented, but a single organizational model is unlikely to be optimal for all geographic areas in Ontario.

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The Chatham-Kent Board of Health is comprised of seven members. Four are municipal counsellors who submit an expression of interest following each municipal election to sit as a member of the board. The two community representatives are selected by open competition where candidates apply and are screened, interviewed as required, and ultimately appointed by Council. These positions have four year terms with terms staggered opposite the municipal election appointments thus ensuring continuity of the board and its support to the health unit's leadership team. The final member of the board is a provincial appointee, currently serving her second three-year term. Chatham-Kent Public Heath's leadership team consists of a full-time Medical Officer of Health, Chief Executive Officer, Director, and five Program Managers, three who share responsibilities of the Chief Nursing Officer. The team is supported by one administrative assistant and two epidemiologists. Service Level Agreements exist with the Municipality of Chatham-Kent for Human Resource and Organizational Development, Legislative, Finance, Information Technology, and Building Services.

The Chatham-Kent Board of Health would like to express concern that more consultation was not undertaken prior to the writing of the report. Some of the recommendations outlined in the report reflect best practice and are occurring in many health unit areas, including Chatham-Kent, without the need to overhaul and disrupt the entire provincial public health system. When local capacity is potentially compromised, health unit staff contact a neighbouring health unit or community partner for support, advice and assistance. Health units experiencing ongoing capacity issues and demonstrate the need for amalgamation should be provided resources, support, and guidance to do so. Addressing local needs and responding to those needs in a way that makes sense to the community, has always been a fundamental belief of public health. Forcing health units to report to a regional Board of Health strips the local leadership of the ability to meet local needs in a way the community desires those needs to be met. By removing public health oversight and governance from the local community it further silos public health from the local community health, education, and social services networks. In Chatham-Kent, this move would significantly impact the work completed over the last several decades to build community, working together collectively to improve the quality of life for all Chatham-Kent citizens.

The expert panel has indicated *that the current organization of public health units has a negative impact on the capacity of smaller health units, further indicating that 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*. Evidence to support this broad assertion is not provided. In conversation with numerous other small health units, none were contacted by a member of the expert panel to assess needs or concerns regarding capacity or integration with the local health system. Chatham-Kent has made great strides, working collaboratively with the Municipal Human Resources and Organizational Development Department to ensure the recruitment, onboarding, and retention of skilled public health workers and provides quality services tailored to local needs.

Working effectively within the health system, Chatham-Kent Public Health sits on numerous committees and works on multiple projects together, sharing and contributing both human and financial resources. The expert panel has not acknowledged the significant work public health does in partnership and collaboration with all sectors in the community. Meeting the public heath mandate would not be possible if health units focused on integration and partnership with only the health care sector. The benefits of local municipal integration in addressing all aspects of public health is absent from the analysis. Chatham-Kent Public Health partners and collaborates

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with organizations from the public, private, and non-profit sectors to address the social determinants of health. Chatham-Kent Public Health supports the fundamental underpinning of public health – public health is not primarily about health care, it is about improving the well-being of everyone.

Organizationally, Chatham-Kent Public Health is a municipal department, with health unit leadership participating in all levels of municipal operations. Service Level Agreements acknowledge the services provided to Chatham-Kent Public Health and public health employees. Everything from recruitment and onboarding to procurement and accounts payable. From legal support to snow removal, all support and administrative services are provided by employees from other municipal departments. As experts in their field, employees working in the public health department are afforded the ability to focus on the work of public health, knowing their municipal colleagues are there to provide support services. While the Board acknowledges the report is not just about one health unit or one region, any type of organizational structure change will have significant implications to Chatham-Kent.

Synergies between public health and numerous municipal departments allow the delivery of programs and services with significantly greater reach, serving more citizens than public health would be able to do on their own. The greater the reach of services, the greater number of clients served. While synergies may also be found in a regional system, the Chatham-Kent Board of Health firmly believes that the benefits of a centralized regional system do not outweigh the negative impact on local planning and collaboration. Creating a regional board of health for Erie St. Clair that will oversee public health programs and services in twenty municipalities, creates amalgamation issues and concerns that will be discussed and potentially remain unresolved for decades, despite the establishment of local public health service delivery areas. Although one of the guiding principles of the Expert Panel's report is to maintain and enhance local relationships, history has demonstrated that moving towards any type of regionalized structure impacts the close relationships that municipalities and other community partners have with public health.

The report does not identify any consultation with health units currently embedded in a municipal structure. While the Chatham-Kent Board of Health acknowledges that the implementation of recommendations was not the mandate of the expert panel, recommendations indicating such a monumental shift in organizational structure would have benefitted from an in-depth analysis regarding the unintended consequences of the recommendations. Something as simple as bringing together Information Technology departments as part of centralizing administrative services creates challenges as IT systems, processes, information management, infrastructure and system capabilities vary between health units. Chatham-Kent Public Health Unit's Information Technology systems are embedded in the municipal system and totally supported by the Municipal IT Department. The potential for significant data loss and security risks occur when health units are separated from their current IT system and amalgamated into the designated host system. If administrative functions are centralized, considerations on the impact of disentangling these services from the municipal fold must be addressed.

The panel indicates that, *Public health units of the future will require leaders with broad-based skills that encompass strong demonstrated organizational and business management,*

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relationship management, strategic planning and performance management skills as well as extensive public health experience. The Chatham-Kent Board of Health is proud of the extensive background and experience held by their leadership team. Senior staff hold Master's Degrees in public health, nursing, business, epidemiology, and leadership, with one member having a Doctorate in Public Health. Significant skills and competencies also exist with Chatham-Kent's front-line workforce with half of the employees having at least 10 years of public health experience. Once again, the Board is concerned that recommendations have been made without significant consultation regarding staffing capacity, experience, and competencies of current public health employees, many who have dedicated their careers to public health and their communities.

Just over five years ago Chatham-Kent secured a full-time Medical Officer of Health who works with the Chief Executive Officer in a shared leadership model. The Expert Panel recommends this type of leadership at the regional level with the hiring of 14 additional Medical Officers of Health. While the Chatham-Kent Board of Health supports a shared leadership model they are not supportive of the hiring of 14 additional Medical Officers of Health without the ability to review and assess the evidence used by the Expert Panel to make this recommendation. Formalizing senior leadership relationships between health units would be a cost-effective way to maximize skills and expertise, facilitate knowledge transfer, and encourage shared services.

The expert panel report recommends OIC appointments, implying that the Province will be choosing Board Chairs and other key positions for the regional boards, completely removing local and even regional input. These positions are typically held by local public health champions. The Chatham-Kent Board of Health cannot support the establishment of 14 Regional Boards of Health coupled with the disintegration of 36 Local Boards of Health without significant discussion on municipal representation and financial responsibilities at this regional level. Programs and services that are based on local assessment and surveillance, address local needs, decrease gaps in local service and are delivered in community partnership deserve local oversight and governance. Public Health prides itself with protecting and promoting the health of its local community. Health happens at a local level, where we live, learn, work, and play.

As indicated previously, the Chatham-Kent Board of Health operates as an autonomous integrated board. It benefits from being integrated into the municipal organizational structure while maintaining its requisitioning and authoritative powers like all other autonomous boards. The Chatham-Kent Board of Health supports a board that is comprised of municipal, provincial, and citizen appointments, based on skills and competencies, with terms adjusted to ensure continuity of services.

Prior to the development of an implementation plan, we trust that local health units will be consulted for feedback. The Chatham-Kent Board of Health continues to provide programs and services in a time of significant fiscal restraint that meet the specific needs of our local community. If the Board of Health and the Municipality of Chatham-Kent are expected to contribute financially toward the implementation of the recommendations, local programs and services will be impacted, and our community will suffer.

In the Erie St. Clair LHIN catchment area, the current public health climate is one of collaboration and cooperation. This has led to innovative service delivery models to address specific local issues. We look forward to the opportunity to share these successes to help

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strengthen public health across the Province. We hope that the concerns shared in this letter demonstrate the need and importance of the local voice before any of the recommendations are implemented and changes are made to the Provincial public health system.

Sincerely,

Joe Faas
Chair
Chatham-Kent Board of Health

C: Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Health and Long-Term Care, Population and Public Health Branch
Sharon Lee Smith, Associate Deputy Minister, Health and Long-Term Care, Policy and Transformation
Dr. David Williams, Chief Medical Officer of Health
Pat Vanini, Executive Director, AMO
Ralph Ganter, Chief Executive Officer, Erie St.Clair LHIN
Dr. Penny Sutcliffe, Chair, COMOH
Association of Local Public Health Agencies
Chairs, Ontario Boards of Health

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

September 26, 2017

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

Dear Minister Hoskins,

Re: Fluoride Varnish Programs for Children at Risk for Dental Caries

At its September 21, 2017 meeting, under Correspondence item c), the Middlesex-London Board of Health considered the attached correspondence from the Association of Local Public Health Agencies (alPHa) regarding *alPHa Resolution A17-6, Fluoride Varnish Programs for Children at Risk for Dental Caries* and voted to endorse the following:

c) Date: 2017 July 21
Topic: Fluoride Varnish Programs for Children at Risk for Dental Caries
From: Association of Local Public Health Agencies
To: The Honourable Eric Hoskins

Background:
The Association for Local Public Health Agencies (alPHa) adopted a resolution that called on the Government of Ontario to provide funding through the Healthy Smiles Ontario Program for the implementation of school and community-based fluoride varnish for children at risk of dental caries.

Recommendation:
Endorse.

It was moved by Mr. Trevor Hunter seconded by Ms. Maureen Cassidy, *that the Board of Health endorse item c).*
Carried

The Middlesex-London Board of Health calls on the Government of Ontario to consider providing funding through Healthy Smiles Ontario for the implementation of school and community-based fluoride varnish programs for children at risk for dental caries.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc: Carmen McGregor, alPHa President
Linda Stewart, Executive Director, alPHa
Ontario Boards of Health

alPHa
Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

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

alPHa Sections:

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

Affiliate Organizations:

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

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 30 YEARS 1986-2016 Association of Local PUBLIC HEALTH Agencies

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**

DURHAM REGION

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 ROSSLAND ROAD EAST
PO BOX 623
WHITBY, ON L1N 6A3
CANADA

905-668-7711
1-800-372-1102
Fax: 905-668-9963

durham.ca

Don Beaton, B.A.S., M.P.A.
Commissioner of
Corporate Services

October 12, 2017

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

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

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

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

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

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

Ralph Walton
Regional Clerk/Director of Legislative Services

RW/np

Attach.

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

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

DURHAM REGION

The Regional Municipality of Durham

HEALTH DEPARTMENT

Street Address
605 Rossland Rd.E.
Whitby ON
Canada

Mailing Address
P.O. Box 730
Whitby ON
Canada L1N 0B2

905-668-7711
: 905-666-6214
1-800-841-2729

www.durham.ca

An Accredited Public Health Agency

MEMORANDUM

To: Committee of the Whole

From: Dr. Robert Kyle

Date: October 4, 2017

Re: Vaccine Recommendations for Child Care Workers

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

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

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

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

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

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

Respectfully submitted,

Original signed by

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

alPHa
Association of Local
PUBLIC HEALTH
Agencies

2 Carlton Street, Suite 1306
Toronto, Ontario M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

July 18 2017

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

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

Dear Dr. Williams and Ms. Martino,

Re: COMOH Recommendations – ISPA and CCEYA

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

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

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

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

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

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

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

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

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

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

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

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

In particular, the following features should be considered:

- The early dose should be accepted as valid meaning no exemption is required, similar to the estimated vaccination date. There should be no increase to the number of exemptions in the database and no need to analyze these numbers in local/provincial coverage reports.

- There are no impacts to the forecaster and the client will proceed through screening activities without any follow up required.

- These clients will not appear on at-risk reports during an outbreak. If an administrative exemption is used, these clients will appear on 'at risk' reports during an outbreak and staff involved with outbreak management need to asses these records individually prior to contact/case management.

- There is less risk for errors in forecasting and/or screening practices if a separate Panorama function is created.

II) Communication Campaign for Health Care Providers by Ministry

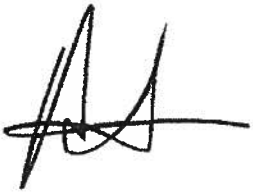
As part of Immunization 2020 Action #8, the Ministry has agreed to launch a coordinated immunization communication strategy. COMOH is requesting the Ministry to work closely with health care partners to share important immunization information to make informed immunization decisions.

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

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

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

Sincerely,



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

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

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

alPHa
Association of Local PUBLIC HEALTH Agencies

Information Break

September 19, 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

Stakeholder consultations are underway regarding the Report of the Minister's Expert Panel on Public Health, *Public Health within an Integrated Health System*, which makes major recommendations on public health's integration within the provincial health system. Feedback on the report's content is to be emailed to the province by **October 31st**. alPHa has arranged a number of meetings among its various constituent members and the Board of Directors to facilitate an association response to the report. COMOH will meet on September 13 to discuss the report; Board of Health Chairs and Affiliate groups have been asked to submit feedback to their representatives on the alPHa Board; and alPHa's Board will convene at the end of this month to collate and review members'comments. In October alPHa staff will work on drafting a response for submission. In the meantime, staff and members are attending the Ministry information sessions on the report on September 15 and 29. We will keep members updated on developments as they arise.
Download the Expert Panel report here
Read alPHa's summary of the Expert Panel's report here

Government News: Round Up

Federal committee releases preliminary national data on opioid-related deaths (Sept. 14)

Canada invests $7.5M into opioids research (Sept. 14)

PHAC launches Infectious Diseases and Climate Change Fund (Sept. 13)

Ontario releases cannabis legislation framework (Sept. 8)

Canada announces $274M in funding for law enforcement to support new cannabis legalization (Sept. 8)

Minister Hoskins' statement on Ontario Opioid Strategy (Sept. 7)

Ontario invests $222M to enhance Ontario's Strategy to Prevent Opioid Addiction and Overdose (Aug. 29)

Law firm article on recent changes to PHIPA and new regulation coming into force Oct. 1, 2017 (Aug. 17)

Central West Board of Health Nominations Sought

The alPHa Board of Directors is seeking nominations from the following Central West boards of health to fill a position on the Board and BOH Executive Committee for a 2-year term: *Brant, Haldimand-Norfolk, Halton, Hamilton, Niagara, Waterloo, and Wellington-Dufferin-Guelph*. Interested candidates must submit a completed form, a short biography, and a copy of a motion passed by the sponsoring board of health approving the nomination by **October 27th**.
Click here for more information, including form

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alPHa Website Feature: Risk Management Resources

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

Group Insurance Offer for Members & Health Unit Staff

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

Upcoming 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
Association of Local
PUBLIC HEALTH
Agencies

2 Carlton Street, Suite 1306
Toronto ON M5B 1J3
Tel: (416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

Providing leadership in public health management

FALL 2017 MEETINGS

NOVEMBER 3, 2017 | DOUBLETREE BY HILTON HOTEL
108 CHESTNUT ST., DOWNTOWN TORONTO

BOARDS OF HEALTH SECTION MEETING (full day; times TBA)

Governing Through Change - A meeting for Ontario board of health members

Board of health members and senior managers are encouraged to participate in this interactive day that will help prepare public health leaders for known and proposed changes to Ontario's local public health sector. Come and share your views on the accountability framework, Expert Panel on Public Health recommendations and governance considerations in times of transformation.

$295 + HST per person; agenda details to come

Click this button to register for the BOH meeting

COMOH SECTION MEETING (full-day; times TBA)

A meeting for Medical/Associate Medical Officers of Health & PHPMRs

$295 + HST per person; agenda details to come

Click this button to register for the COMOH meeting

A limited block of DoubleTree by Hilton hotel guestrooms has been booked for alPHa attendees – RESERVE TODAY!

Hotel booking options:

1. ***Call*** **(416) 599-0555 / 1-800-668-6600 &** ***request "Association of Local Public Health Agencies" to get the group rate***
2. ***Email:*** **reservations@torontodoubletree.com**

Report on access to public dental programs in Ontario: An analysis based on interviews with Public Health Units

August 2017

Prepared by the Ontario Oral Health Alliance

The Ontario Oral Health Alliance is committed to expanding access to affordable, accessible public dental programs for people in Ontario living on low incomes.

For further information:
Jacquie Maund jacquie@aohc.org

Executive Summary

Background

Tooth decay is the most prevalent and preventable chronic disease but not everyone in Ontario has access to oral health care. Studies have found that an estimated 17 per cent of people in Ontario have not visited a dentist in the past year, with the main reason being the cost of private dental care.[1]

Ontario has a very limited patchwork of provincial public dental programs. The Healthy Smiles Ontario (HSO) program covers children and youth under age 18 from low income families and provides preventive, treatment and emergency dental services. Adults on social assistance have very basic oral health coverage depending on where they live. Ontario Works (OW) coverage ranges from nothing at all, to basic extraction of teeth for relief of pain. It varies by municipality. People on the Ontario Disability Support program (ODSP) have access to a wider range of basic services, but typically it doesn't include dentures. There are federal government dental programs for First Nations and recognized Inuit under the Non Insured Health Benefits (NIHB) program, and for refugees under the Interim Federal Health (IFH) program. There are no provincial programs for low income adults and seniors who are not on social assistance.

These public dental programs are delivered by both private dentists/dental hygienists and those working in the public sector. But many private dentists choose not to participate in the public programs which reimburse dentists at a lower rate than private insurance programs. Dentists, like all privately owned businesses, are not obligated to provide care to all people who are seeking care.

In the public health sector only twelve of the thirty six public health unit (PHU) regions in Ontario have full dental suites with capacity to deliver a full range of preventive and treatment services. There are twenty-four Community Health Centres and two Aboriginal Health Access Centres with full dental suites. Most of these dental suites in public health units and Community Health Centres are in urban areas.

The Problem

Ontario Oral Health Alliance (OOHA) members were getting anecdotal information indicating that although there are some public dental programs for low income children/youth and people on social assistance there remains a geographical access problem because not all dentists participate, and not all regions of the province have PHUS or Community Health Centres with full dental suites. We were hearing that many people on social assistance are having difficulty finding a dentist to accept them, and some low income parents could not find a local dentist who participated in HSO.

To explore this issue and better understand where the service gaps are geographically, OOHA undertook an informal telephone survey in 2016 with oral health staff at Ontario PHUs.

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[1] Canadian Academy of Health Sciences. *Improving Access to Oral Health Care for Vulnerable People Living in Canada.* 2014 http://cahs-acss.ca/improving-access-to-oral-health-care-for-vulnerable-peopleliving-in-canada/ and College of Dental Hygienists of Ontario, *Review of Oral Health Services in Ontario*, 2014. Prepared by Optimus/SBR. http://www.cdho.org/otherdocuments/OHSReview.pdf

Summary of findings

- Twelve of the 35 PHUs who participated in the survey have full dental suites that provide both preventive and treatment services (34%). Some of these have multiple sites (e.g. Toronto, Ottawa). Other PHUs partner with local Community Health Centres who have full dental suites.

- Some PHUs indicated they do keep a list of providers accepting HSO/OW/ODSP clients or not, but are not permitted to use the list to directly refer clients to dentists. Only two PHUs indicated that they are able to provide direct referrals for clients.

- Most PHUs are not able to keep a specific list of local dentists who accept people on OW/ODSP or the HSO program for a variety of reasons. So clients may be provided with a list of dental offices in their area or are advised to check phone books, call around, ask friends or family for referral to find a dentist that will provide treatment for people on public programs.

- HSO: Most PHUs reported that they do have local dentists participating in the HSO program.

- A few PHUs commented that now that Accerta administers HSO, it is difficult for them to track how many of the eligible children/youth each year are participating in the program and getting treatment. They no longer know who has got the HSO dental card and used it, so cannot call to follow up and check if the child is accessing the services.

- OW/ODSP: About half of the PHUs indicated that they had difficulty finding local dentists willing to take adults on OW/ODSP programs.

- Other Findings: A number of PHUs stated that the big problem is finding dental care for low income people and seniors who are not on OW/ODSP and do not have private dental insurance. E.g. in Thunder Bay PHU they get a call almost daily from an adult in dental pain without insurance needing help. In Timiskaming the PHU used to screen seniors for oral health but stopped in 2016 as they have no affordable/free services to which they can refer seniors who need dental treatment.

- Pediatric services: Staff from a number of PHUs noted the lack of pediatric dentists in their areas, or pressures due to high demand.

Report on Access to public dental programs in Ontario: Analysis by Public Health Unit

The Ontario Oral Health Alliance is committed to expanding access to affordable, accessible public dental programs for people in Ontario living on low incomes.

Anecdotal information indicates people on social assistance cannot always find a local dentist to accept them even though they have some dental coverage. In addition, low income parents are not always able to find a local dentist who will deliver the Healthy Smiles Ontario (HSO) program for their children. The

Ministry of Health and Long Term Care does not have a list of dentists participating in these public dental programs.

To investigate this access problem, inform our advocacy work on equitable access to public dental programs and gain a better understanding of where the gaps in service are geographically in Ontario, oral health staff at each of the 36 public health units (PHU) were contacted over the summer and fall of 2016 and asked to participate in a short telephone survey. Representatives from 35 PHUs responded to the survey.

Findings suggest that private dentists appear more willing/interested to take on children who are HSO clients than adults who are on OW/ODSP programs. Some PHUs commented that the private dentists cited their reasons for unwillingness to take on these clients included: high no-show rates, and the low reimbursement rates for public dental programs

Health Units with Dental Clinics that offer full dental services by a dentist

Health Unit Name	**Treats children on HSO**	**Treats some adults**
Simcoe Muskoka (Fixed site and Mobile)	Yes	Yes (Seniors, OW/ODSP, unemployed low income, NIHB , IFH
Hamilton (Fixed and Bus)	Yes	Yes (OW cleaning only, treatment for low income adults)
Windsor Essex (Fixed)	Yes	No
Peterborough (Fixed and Bus)	Yes	Yes (OW/ODSP)
Middlesex London (Fixed)	Preventive only (2017)	Yes (Parents of HSO kids , OW adults, NIHB, IFH)
Ottawa (3 Fixed sites)	Yes	Yes (all except youth over 18 on ODSP & spouses over 65 in ODSP families)
Toronto (23 Fixed sites, 1 bus)	Yes	Yes (OW adults)
North Bay Parry Sound (fixed)	Yes	Plan to in 2017
Waterloo (Fixed)	Yes (and kids just above HSO cut off)	Yes (limited emergency for low income adults not on OW/ODSP)
Northwestern (Fixed and Mobile)	Yes	Yes (OW/ODSP & NIHB)
Durham (Fixed)	Yes	No
Eastern Ontario Health Unit (Fixed)	Yes	Yes. (OW/ODSP, also do some pro-bono)

Survey Questions and Methodology

One staff member at each PHU was asked whether the Public Health Unit had full dental clinics equipped and staffed to provide dental treatment services (not just prevention) for children/youth on HSO and for adults on OW/ODSP. They were also asked if they had a list of local dentists who accept people on OW/ODSP/HSO. This was asked to find out how the PHU helped connect people to private dentists where the PHU could not offer the service. Additionally, they were asked if there were challenges finding local dentists to take clients on OW/ODSP/HSO programs in their PHU area, or certain parts of their area.

Phone calls were made to the 36 public health units in Ontario and 35 responded to our request for an interview. Three specific questions were asked:

- Do you have a dental clinic where you provide treatment services by dentists for (i) people on Ontario Works (OW) and ODSP, and (ii) children and youth eligible for HSO?
- Do you have a list of dentists in your PHU that will accept (i) patients who are on OW/ODSP YES/NO and/or (ii) children eligible for HSO? YES/NO
- Do you have difficulties in parts of your PHU finding dental providers to take people on (i) OW/ODSP Y/N and (ii) HSO? Y/N. If so, in which areas/communities do you have difficulty finding providers?

While each interviewer kept to the script of these questions, one limitation to this methodology is that there would be room for differences in how each person conducted the interview and potential prompting questions, which would then result in potentially a different set of details in the results.

A manual thematic analysis was carried out and some general themes emerged. A caveat is that while the qualitative data yields important results, they rely on the individual respondents' knowledge which may not be consistent within and / or between the other respondents' knowledge about the issue at hand.

Analysis

Do you keep a list of dental offices that accept dental programs?

Most health units surveyed did not keep a list of dentists that accepted people on public dental programs. Reasons for this included: not being allowed to do so, not wanting to upset dental offices, dental offices putting a cap on the clients they accept on programs each week or month, and/or lists would be ever changing, inconsistent and unhelpful. Many respondents said they had knowledge of which dentists accept people on public programs and which do not. Several health units provide clients with a list of all dentists in the area and/or encourage clients to consult with friends, family or the yellow pages to find a dentist.

Healthy Smiles Ontario (HSO) Program

Most communities reported that there are at least some dentists that participate in HSO in their community and that more providers accept children/youth on HSO then other government dental programs. Many also mentioned that some dentists only take a certain number of children on HSO each month or only see pre-existing clients. Some respondents noted that there are dentists that say they

accept HSO, then refuse to take them when parents call and are "hit or miss" on how many families they will accept, regularly changing how many children they will accept.

Others talked about the small number of dentists in some of their communities that accept HSO. For example, one health unit noted that out of 30 dentists, only 9 accepted children on HSO. Other health units noted that fewer dentists accept children on HSO in parts of their regions (E.g., the more Northern parts of their health unit area, or the highest income communities where in one health unit area only 19 out of 70 providers accepted HSO clients). This lack of acceptance in specific areas force families to go out of town to try to find a dentist that will accept them, leading to barriers with transportation costs.

Some respondents talked about how difficult it is to track who is on the HSO program, whether the uptake has increased and whether families are using their HSO dental cards, since health units no longer administer the program and do not have access to this data. One health unit noted having to turn some parents away due to the HSO Core program's low financial cut-off and were concerned that some parents do not call the health unit to inquire about HSO because of this income cut-off. This health unit has also seen a reduction in take up of preventive services from 41% in 2015 to 9% in 2016, saying this is due in part to the stigmatizing wording of the HSO forms that parents must complete in order to get access (i.e. "paying for dental care would result in food back visit to get food"). This is another barrier for the people that rely on the public program funding for their oral health care.

Ontario Works (OW)/Ontario Disability Support Program (ODSP)

Several health units noted that they refer OW/ODSP clients looking for dental care to their caseworkers since they do not have a lot of information about social assistance programs for adults. Many talked about how it is always harder for an adult than a child on a government program to find a dentist to accept them, and how variable dental offices could be with the number of OW/ODSP clients they accept. Some only accept a certain number per month or serve only current clients.

Some health units offer clients a list of dentists they know are accepting people on social assistance programs, or use personal connections to get a client an appointment, while others suggest for them to "shop around" and/or find out by "word of mouth" which dentists are accepting OW/ODSP clients. According to respondents, many social assistance recipients struggle to find a provider that will accept them and have reported being 'blacklisted' if they miss or must cancel an appointment.

About half of the PHUs reported difficulty finding dental providers who will accept adults on OW/ODSP. Several health units said that only a few dentists will accept adults on social assistance programs (e.g. the non-franchise dental offices in one community, the older dental providers in another community). Some PHUs had surveyed local dentists.

Apparently in some cases even when dentists say they will accept adults on government programs clients report being turned away. A few respondents talked about how dental coverage through OW/ODSP was inadequate, leading to limited treatment options. This appears to be a systemic barrier that discriminates against people on social assistance.

Problems for others not eligible for government dental programs

Many respondents reported getting calls from low income working adults and seniors daily and weekly looking for help accessing affordable/free dental care. One health unit noted that they used to offer

seniors a dental screening but stopped because they had nowhere to refer them to for dental treatment afterwards. Several health units talked about how they did not have a Community Health Centre (CHC) with a dental clinic in their community, or had nowhere to refer low income adults and seniors seeking dental care. Some respondents talked about giving adult callers a list of dentists in their area, the number of a local CHC dental program, the number for dental schools that offer low cost care or talking to them about priorities (i.e. getting the most serious tooth treated first). Others said they would encourage these clients to try to find assistance from service clubs, charities, dentists that offer payment plans, and or any limited municipal funding or special programs that may be available in some communities.

Other Comments

Dental Reimbursement rates for government programs are lower than private insurance programs –this discourages private dentists from participating.

In many communities there is a need for a community based clinic with stable provincial funding. Eg in Sudbury there is no dental clinic at the PHU or Community Health Centre, no dental facility in the hospital. Seniors are particularly struggling. Low income people have to rely on spotty free dental care where dentists provide volunteer work at their discretion.

There is a lack of paediatric dentists in some areas- one is starting to charge a $500-$700 facility fee.

High rate of dental decay among children in the North. Eg Thunder Bay PHU sees three times the rate of children going to ER for dental decay than in southern Ontario

Concerns were expressed by respondents about how oral health services to seniors in Long Term Care Facilities are being provided.

Conclusion

There are a number of areas in the province where there are no public dental suites at PHUs or CHCs to deliver full preventive and treatment services under public dental programs. In these areas people who are eligible for HSO, OW/ODSP dental services must rely on private dental providers.

Most PHUs are not permitted to provide direct referrals to dental offices, though they generally know where there is and is not difficulty finding private dentists to serve people on public programs. Access challenges are not experienced evenly across the province. Challenges appear to be higher in northern and rural areas, but in some parts of urban PHUs staff report difficulties finding private dentists willing to serve people on public programs.

It is more difficult for adults on social assistance programs than children/youth eligible for HSO to find a dentist that will accept them. Dentists who say they will accept clients on HSO, OW/ODSP may have caps on how many people they are willing to accept.

Most health units report that adults on social assistance programs and low income people have difficulty accessing dental care because there is no local low cost/free clinic to which PHU staff can refer them and many private dentists do not accept adults on government dental programs.

In conclusion, while access to optimal heath care services is a basic principle of Ontario government health policy this tenet does not apply to oral healthcare. Access for people living on low incomes depends on: eligibility for very limited public dental programs; sporadic public dental clinics at PHUs, CHCs and AHACs that deliver full treatment; and the willingness of private dentists to accept people on public programs.

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