Algoma
PUBLIC HEALTH
Santé publique Algoma

March 27, 2019

BOARD OF HEALTH MEETING

SSM Community Room A

www.algomapublichealth.com

March 27, 2019 - Board of Health Meeting Book

Algoma Public Health Board of Health Meeting Table of Contents

Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health Meeting
AGENDA
March 27, 2019 at 5:00 pm
Sault Ste. Marie - Community Room A

BOARD MEMBERS

Lee Mason - Chair
Ed Pearce - 1st Vice Chair
Deborah Graystone - 2nd Vice Chair
Dr. Patricia Avery
Louise Caicco Tett
Randi Condie
Micheline Hatfield
Adrienne Kappes
Dr. Heather O'Brien
Brent Rankin
Karen Raybould
Sergio Saccucci
Matthew Scott

APH EXECUTIVE

Dr. Marlene Spruyt - MOH/CEO
Dr. Jennifer Loo - AMOH & Director of Health Protection
Justin Pino - CFO /Director of Operations
Antoniette Tomie - Director of Human Resources
Laurie Zeppa - Director of Health Promotion & Prevention
Tania Caputo - Board Secretary

1.0 Meeting Called to Order *L. Mason*

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda *L. Mason*

RESOLUTION

THAT the Board of Health agenda dated March 27, 2019 be approved as presented.

3.0 Adoption of Minutes of Previous Meeting *L. Mason*

RESOLUTION

THAT the Board of Health minutes dated February 27, 2019 be approved as presented.

4.0 Delegations / Presentations

a. APH - Mental Health and Addiction Services *A. Brassard & S. Thomas*

5.0 Business Arising from Minutes *L. Mason*

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports *M. Spruyt*

i. MOH Report

RESOLUTION

THAT the report of the Medical Officer of Health and CEO for March 2019 be adopted as presented.

b. Finance and Audit Committee Report

i. Financial Statements *J. Pino*

RESOLUTION

THAT the Financial statements for the period ending January 31, 2019 be approved as presented.

c. Governance Committee *D. Graystone*

i. Committee Chair Report

RESOLUTION

THAT the Governance Committee Chair Report for March 2019 be adopted as presented.

ii. 02-05-075 Election of Chair, Vice Chairs or Committee Members *D. Graystone*

RESOLUTION

THAT the Governance Committee has reviewed and recommends to the Board of Health that policy 02-05-075 Election of Chair, Vice Chairs or Committee Members be approved as presented.

- **No changes to policy 02-05-075 are being brought forward from the review.**

7.0 New Business/General Business *L. Mason*

8.0 Correspondence *L. Mason*

a. Letter to MOH/CEOs and Board Chairs from MOHLTC regarding transformation of our health care system dated March 6, 2019.

b. Correspondence regarding Ministry of Finance Round Tables on Alcohol Retail received March 8, 2019.

c. Letter to the Deputy Premier of Ontario, Minister of Health and Long-Term Care from Renfrew County and District Health Unit regarding Strengthening the Smoke-Free Ontario Act, 2017 to address the promotion of vaping dated March 4, 2019.

d. Letter to the Premier of Ontario from Renfrew County and District Health Unit regarding Support for Provincial Oral Health Program for Low Income Adults and Seniors dated March 4, 2019.

9.0 Items for Information *L. Mason*

a. Call for Board of Health nominations for the alPHa Board of Directors.

b. Presentations to Municipal Councils.

c. June 2019 alPHa Annual Conference - Minding Public Health

d. Connected Communities - Healthier Together , 2017 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario.

10.0 Addendum *L. Mason*

11.0 In Camera *L. Mason*

For discussion of labour relations and employee negotiations, matters about identifiable individuals, adoption of in camera minutes, security of the property of the board, litigation or potential litigation.

- **There are no agenda items for an in camera meeting.**

12.0 Open Meeting *L. Mason*

a. Resolutions resulting from the in camera meeting.

13.0 Announcements / Next Committee Meetings: *L. Mason*

Finance & Audit Committee Meeting
April 10, 2019 @ TBD
Prince Meeting Room, 3rd Floor

Board of Health Meeting:
April 24, 2019 @ 5:00 pm
Sault Ste. Marie, Room A

Governance Committee Meeting
May 29, 2019 @ 4:30 pm
Sault Ste. Marie, Room A

14.0 Evaluation *L. Mason*

15.0 Adjournment *L. Mason*

RESOLUTION

THAT the Board of Health meeting adjourns.

Board of Health Meeting
MINUTES
February 27, 2019 at 5:00 pm
Sault Ste. Marie - Community Room A

PRESENT :

BOARD MEMBERS
Lee Mason - Chair
Deborah Graystone - 2nd Vice Chair
Louise Caicco Tett
Randi Condie
Adrienne Kappes
Dr. Heather O'Brien
Brent Rankin
Matthew Scott

APH EXECUTIVE
Dr. Marlene Spruyt - MOH/CEO
Dr. Jennifer Loo - AMOH & Director of Health Protection
Justin Pino - CFO /Director of Operations
Antoniette Tomie - Director of Human Resources
Laurie Zeppa - Director of Health Promotion & Prevention
Tania Caputo - Board Secretary

T/C : Ed Pearce - 1st Vice Chair

REGRETS : Sergio Saccucci, Dr Patricia Avery, Micheline Hatfield, Karen Raybould

1.0 Meeting Called to Order

L. Mason called the meeting to order at 5:08 pm.

a. Declaration of Conflict of Interest

No conflict of interest was declared.

2.0 Adoption of Agenda

RESOLUTION 2019-11

Moved: D. Graystone
Seconded: H. O'Brien

THAT the Agenda dated February 27, 2019 was reviewed and approved as presented.

CARRIED

3.0 Adoption of Minutes of Previous Meeting

a. January 23, 2019 Minutes

RESOLUTION 2019-12

Moved: L. Caicco Tett
Seconded: R. Condie

THAT the Board of Health minutes for the month of January 2019 were reviewed and approved as presented.

CARRIED

4.0 Delegations / Presentations

a. A Changing Landscape: Cannabis and Public Health presentation was delivered by Kristy Harper, Manager of Community Wellness and Chief Nursing Officer.

5.0 Business Arising from Minutes

This resolution is made to approve the officer positions as acclaimed at the January 23, 2019 Board of Health Meeting.

RESOLUTION 2019-13	**Moved:**	H. O'Brien
	Seconded:	A. Kappes

Be it resolved that the following is the Board of Health slate of officers for the year 2019.

Board of Health Chair:	Lee Mason
1st Vice Chair & Finance and Audit Committee Chair	Ed Pearce
2nd Vice Chair & Governance Committee Chair	Deborah Graystone

CARRIED

L. Mason provided an update on the Governance and Finance and Audit Committee membership. The chairs of each committee discussed and agreed that all members who put forward their names are the membership of the committees. All members have been informed.

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports

i. MOH Report - February 2019

RESOLUTION 2019-14	**Moved:**	D. Graystone
	Seconded:	L. Caicco Tett

THAT the report of the Medical Officer of Health and CEO is adopted as presented.

CARRIED

ii. Briefing Note - Level III Withdrawal Management Services Facility

Responding to the burden of illness of addiction in Sault Ste. Marie and in Algoma by putting adequate treatment in place: support for a regional level III residential withdrawal management services facility.

Edits were noted to dates in the briefing note.

RESOLUTION 2019-15	**Moved:**	E. Pearce
	Seconded:	H. O'Brien

WHEREAS under the Ontario Public Health Standards, the Board of Health for Algoma Public Health has a general mandate to work with community partners to improve overall health and health equity for the population of Algoma, and a specific mandate to reduce the burden of substance use; and

WHEREAS in 2017, the City of Sault Ste. Marie had the 8th highest emergency department visit rate for opioid-poisoning, compared to other cities in Canada with a population of 50,000-99,999; and

WHEREAS in 2017, the death rate from opioid poisonings in Algoma was double the Ontario rate (19.1 versus 8.9 deaths per 100,000 people); and

WHEREAS in 2017, Algoma's hospitalization rate for drug toxicity was double the provincial rate (133.1 versus 62.5 hospitalizations per 100,00 people); and

WHEREAS in 2017, Algoma's hospitalization rate due to mental health or addictions issues was triple the provincial rate (553.9 versus 184.3 hospitalizations per 100,000 people); and

WHEREAS the North East Local Health Integration Network (LHIN) also experiences a higher burden of deaths from opioid poisonings and hospitalizations for mental health and addictions compared to Ontario; and

WHEREAS treatment is one of the four pillars of an evidence-based approach to addressing substance-related harms; and

WHEREAS withdrawal from substances without medical monitoring can be ineffective, dangerous and fatal; and

WHEREAS a level III withdrawal management services facility provides proper medical monitoring; and

WHEREAS there is currently no access to treatment for those requiring level III withdrawal management services in northern Ontario; and

WHEREAS provision of this much needed service would be consistent with the Premier's commitment to ending hallway medicine by matching local needs to an appropriate mix of services and potentially alleviating the burden on hospitals; and

WHEREAS the Sault Area Hospital has worked with the North East LHIN to seek provincial approval and funding for a proposed level III facility that would serve the region of northeastern Ontario; and

WHEREAS in April of 2018,the Council of the City of Sault Ste. Marie endorsed the proposal and committed to working with community partners to collectively address substance use disorder; and

WHEREAS in December of 2018, the Mayor of the City of Sault Ste. Marie wrote to the provincial government to request notification of a funding decision regarding this facility; and

WHEREAS the Sault Ste. Marie & Area Drug Strategy is calling upon community partners to voice clear support for the provincial approval of a level III withdrawal management services facility;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for Algoma Public Health write to the Ontario Minister of Health and Long-Term Care and to local Members of Provincial Parliament in Algoma to request the approval of funding for a regional level III residential withdrawal management services facility, to be located in Sault Ste. Marie; and

BE IT FURTHER RESOLVED THAT correspondence of this resolution be copied to the Federal Minister of Health, Members of Parliament of northeastern Ontario, the Chief Medical Officer of Health of Ontario, the Boards of Health of northeastern Ontario, the councils of Algoma municipalities, the Sault Area Hospital CEO, and the North East LHIN CEO.

CARRIED

iii. Briefing Note - Strategic Planning

RESOLUTION 2019-16	**Moved:**	B. Rankin
	Seconded:	E. Pearce

THAT the Board Chair or a designate commit to work with the Evaluation Team to review and approve the contract with the chosen consultant and;

THAT the BOH authorize the MOH to approve expenditure for this contract which may exceed the current allowable maximum of the MOH ($55K) however, no more than $100K.

CARRIED

b. Finance and Audit Committee Report

i. Committee Chair Report for February 2019

RESOLUTION 2019-17	**Moved:**	D. Graystone
	Seconded:	H. O'Brien

THAT the Finance and Audit Committee Chair Report for February 2019 is adopted as presented.

CARRIED

ii. 2019 Insurance Coverage

RESOLUTION 2019-18	**Moved:**	A. Kappes
	Seconded:	B. Rankin

THAT the Board of Health has reviewed and accepts the recommendation of the Finance and Audit Committee for the renewal of the 2019 Insurance coverage for APH and;

THAT the Board of Health has reviewed and accepts the recommendation of the Finance and Audit Committee and approves the purchase of Network Service Agreement coverage to be added to the Cyber insurance coverage at an incremental cost of $2,000 and;

THAT the Board of Health has reviewed and accepts the recommendation of the Finance and Audit Committee and approves increasing the Cyber insurance liability limit at an incremental cost of $2,000.

CARRIED

iii. Financial Statements

J. Pino presented the Financial Statements

RESOLUTION 2019-19	**Moved:**	M. Scott
	Seconded:	A. Kappes

THAT the Financial statements for the period ending December 31, 2018 was reviewed and approved as presented.

CARRIED

7.0 New Business/General Business

Not Applicable

8.0 Correspondence

a. Letter to the Executive Director Legalization of Cannabis Secretariat, Ministry of the Attorney General from Southwestern Public Health Unit regarding Regulatory Framework for Cannabis Storefronts in Ontario dated January 10, 2019.

b. Letter to the Premier of Ontario from Simcoe Muskoka District Health Unit regarding Support of a Provincial Oral Health Program for Seniors dated February 6, 2019.

c. Letter to the Premier of Ontario from Haliburton, Kawartha, Pine Ridge District Health Unit regarding Support for Provincial Oral Health Program for Low-Income Adults and Seniors dated February 14, 2019.

9.0 Items for Information

Not Applicable

10.0 Addendum

Not Applicable

11.0 In Camera - 6:26 pm

For discussion of labour relations and employee negotiations, matters about identifiable individuals, **adoption of in camera minutes**, security of the property of the board, litigation or potential litigation.

RESOLUTION 2019-20	**Moved:**	L. Caicco Tett
	Seconded:	H. O'Brien

THAT the Board of Health go in camera.

CARRIED

12.0 Open Meeting - 6:33 pm

The Board of Health returned to open meeting without report:

a. Resolutions resulting from in-camera meeting.

Not applicable

13.0 Announcements / Next Committee Meetings:

Governance Committee

March 18, 2019 (time to be determined)

Prince Meeting Room, 3rd Floor

Board of Health Meeting:

March 27, 2019 @ 5:00 pm

Sault Ste. Marie, Room A

14.0 Evaluation

L. Mason reminded all members to complete the monthly evaluation.

15.0 Adjournment - 6:45 pm

RESOLUTION 2019-24	**Moved:**	M. Scott
	Seconded:	A. Kappes

THAT the Board of Health meeting adjourns.

CARRIED

Lee Mason, Chair	**Tania Caputo, Secretary**
Date	**Date**

APH – Mental Health and Addiction Services

Name: Alana Brassard – Supervisor Mental Health and Addiction Programs (CMHSS lead)

Shawna Thomas – Supervisor Mental Health and Addiction Programs (CADAP lead)

Date: March 27, 2019

Algoma PUBLIC HEALTH Santé publique Algoma

Objectives

- Mental Health and Addiction Services at APH
  - Community Mental Health Support Services
  - Community Alcohol Drug Assessment Program
    - Budgets
    - Targets
    - Program overviews

Algoma PUBLIC HEALTH
Santé publique Algoma

ALGOMA PUBLIC HEALTH - COMMUNITY MENTAL HEALTH SUPPORT SERVICES

CASE MANAGEMENT SERVICES			RECOVERY SERVICES		HOUSING SERVICES	
Intensive Psychiatric Case Management Program (ICM)	Transitional Case Management Program (TCM)	Community Treatment Order Program (CTO)	Mental Health & Community Wellness Program (MHCW)	Peer Support Program (PSP)	Supports within Housing Program (SWH)	Housing Initiatives - Rent Subsidy Program (HIRS)
District Wide Program	SSM Program	District Wide Program	District Wide Program	SSM Program	District Wide Program	District Wide Program

Algoma PUBLIC HEALTH
Santé publique Algoma

Budget & Service Target Information 2018/2019

- Total Budget: $3.7 Million (Operating year April 1st – March 31st)
- CMHSS Total FTE: 34.7
- Housing Subsidies: Total 116
  - (Wawa 8/SSM 99/Blind River 4/Elliot Lake 5)

	Q3 Data	YE Targets
Total Service Recipients	1,786	1,950
Total Number of Visits	11,435	14,000
Total Number of Groups	665	650

Algoma PUBLIC HEALTH Santé publique Algoma

Intensive Psychiatric Case Management (ICM)

Sault Ste. Marie 10.5 FTE	Wawa 1.7 FTE	Blind River 1 FTE	Elliot Lake 1 FTE

- People diagnosed with a severe, chronic mental health condition with a significant level of disability associated with the mental health condition.
- Assessment, connection to supports (services and natural), system navigation, housing support, advocacy, medication support, etc.
- Support community tenure (reduce hospital visits)
- Over 75% of interactions in the community
- Canadian Standards of Practice for Case Management http://www.ncmn.ca/resources/documents/english%20standards%20for%20web.pdf
- Canadian Core Competency Profile for Case Management Providers http://www.ncmn.ca/Resources/Documents/Final_ncmn_english_report.pdf

47% - Mood Disorder
34% - Schizophrenia and Psychotic Disorders
23% - Concurrent Disorder
12% - Chronic Illness

Algoma PUBLIC HEALTH
Santé publique Algoma

Transitional Case Management (TCM)

Sault Ste. Marie 4 FTE	District Offices Limited services by ICM

- Priority population is those with mental health conditions and addiction/substance use
- Brief support (one time situation) or transitional supports up to 6 months
- Proactive intervention - Avert potential crisis
- Follow-up until ongoing supports are in place (e.g, Intensive Case Management, Outpatient Psychiatry follow-up, Addiction Services, Counselling)
- Extend hours of an individual's existing supports (8:30am-8:00pm)
- Touch Down Spots – CMHA (Canadian Mental Health Association) and NRC (Neighborhood Resource Centre)
- 1FTE located at SAH on the Mental Health and Addiction Unit and Emergency Department (Monday through Friday)

Community Treatment Order Program (CTO)

1 FTE Sault Ste. Marie			
Wawa	**SSM**	**Blind River**	**Elliot Lake**

- Legal document signed by a patient agreeing to adhere to treatment recommendations ordered by a physician
- Program Delivered throughout the district
- Service Model allows for 40 CTOs district wide
- Wawa and Sault Ste. Marie issued from Sault Area Hospital
- Elliot Lake and Blind River issued from the Health Sciences North

Mental Health & Community Wellness Program (MHCW)

District Wide

- Collaborate with APH's Community Wellness Program
  - TEACH Trained staff
  - Groups
    - Community Kitchen
    - Walking Group
    - Fishing Group
    - Summer BBQs
    - Winter Dinners

TOBACCO CESSATION TEACH Training Enhancement in Applied Cessation Counselling and Health ARRÊT DU TABAGISME

Algoma PUBLIC HEALTH Santé publique Algoma

Peer Support Program (PSP)

1FTE Sault Ste. Marie

- Recovery coaching from the perspective of lived experience and following Peer Support Practice
- Intensive one-on-one Recovery Partnerships
- Support and training for the development of workplace skills and employment in Peer Support
- http://peersupportcanada.ca/

Algoma PUBLIC HEALTH
Santé publique Algoma

Supports within Housing Program (SWH)

CRW - 4.5 FTE **CRW – 2 - 0.5 FTE Contract** **HCM (Housing Case Manager) – 1 FTE** **Sault Ste. Marie**	**CRW – 1 FTE** **Elliot Lake**

- Along with Psychiatric Case Managers, services are provided by Community Rehabilitation Workers (CRW's) to support consumers to live in accommodations of their choice.
- CRWs assist in building an individual's activity of daily living skills (ADLs) through one on one and group interventions
- ADL, budgeting, healthy eating, motivation, medication monitoring, public transportation navigation, etc.
- Elgin Place
- Kingsford Place
- 137 East Street

Housing Initiatives – Rent Subsidy Program (HIRS)

District Wide

- Provision of a rental subsidy may be available to enable people with a severe mental illness and/or problematic substance use receiving community supports who are homeless or at risk of becoming homeless to secure safe and affordable accommodation.

Algoma PUBLIC HEALTH
Santé publique Algoma

Service Contracts

Sault Ste. Marie **1 FTE Homelessness Prevention Team** **0.5 FTE (Contract) – CRW East St.** **2 FTE – Garden River Health Centre ICM**	**Sault Ste. Marie** **5 Part Time – Peer Staff – Kingsford Pl.**

- CMHSS provides the service to:
  - DSSAB (District Social Services Administration Board)
  - GRHC – (Garden River Health Centre)
- CMHSS contracts the service from:
  - PEP – (People for Equal Partnerships in Mental Health)

Community Alcohol/Drug Assessment Program Overview

- Service delivery context
- Core services and programs
- budget and targets/ overall staff compliment
- Service user demographics
- Program details
- Summary

Algoma PUBLIC HEALTH
Santé publique Algoma

Service Delivery Context

Regulated:

- In 2018 all Addictions staff are regulated under a professional body in response to Psychotherapy becoming a controlled Act. https://www.crpo.ca/, https://www.ocswssw.org/

Local, Regional and Provincial Leadership:

- Collaboration, System Planning , Evaluation
- SSM and Area Drug Strategy Committee membership
- Algoma Opiate Task Force and Provincial Opioid Case Managers Network,
- Manager/ Supervisor(s) on North/East/and Central Mental Health and Addictions System Planning tables
- Addictions subject matter experts
- Manager Jan Metheany sits on Advisory Committee to the NE LIHN for Mental Health and Addictions.

Community Alcohol/Drug Assessment Program (CADAP)

Core Addiction Services **Harm Reduction Services** **Collaborative Outreach Services**

Assessment & Counselling	Addiction Supportive Housing (ASH)	Methadone Maintenance Treatment Program (MMT)	Stop for Addiction	Overdose prevention Needle syringe program	Mege Zee Wuhsiswun	Ontario Works (DSSMSSAB & ADSSAB) - Addiction Services Initiative (ASI)	Back on Track (BOT)
District Wide	District Wide Rent Subsidy Program Addiction Housing Case Management (SSM only)	SSM	District Wide	District Wide	Garden River	District Wide	District Wide-
(LHIN funded)	(LHIN funded)	(LHIN funded) Service Agreement	(CAMH funded)	APH internal partnership	(Garden River Wellness Centre partnership-funded)	(DSSMSSAB funded) (ADSSAB funded)	(CAMH funded)

Algoma PUBLIC HEALTH Santé publique Algoma

CADAP Budget/ Service Target Information- and FTE: 2018/19

Total Annual Budget 2018/2018 : $955 000 Total FTE compliment across Programs : 11.8	Q3 data : 2018/2019	Fiscal year-end Targets	Progress to Date
Individuals Served by Program Combined	622	921	On target
Number of Groups Offered— includes clinics and groups	91	70	Surpassing target
Number of Group Paraticpant Attendances	1292	1310	Surpassing target
Number of unique Visits	1626	1960	On Target

Algoma PUBLIC HEALTH Santé publique Algoma

CADAP– Substances Clients Identified as Problematic 2018 snapshot

Identified substance of use	Percentage of individuals
Tobacco	63
Alcohol	59
Cannabis	44
Opioids (prescription and non prescription)	35
Cocaine /crack	35
Methamphetamine (crystal Meth)	14 (double previous year)
Benzodiazepines (ativan, clonazepam etc.)	5

Algoma PUBLIC HEALTH Santé publique Algoma

CADAP Basket of Services

1. Core Addictions
2. Harm Reduction
3. Collaborative Outreach Programs

Core Addictions

Assessment/Counselling Services

3 FTE SSM
1 FTE Elliot Lake/BR
.3 FTE Wawa

- ✓ Culturally Sensitive
- ✓ Trauma Informed
- ✓ Culturally Sensitive
- ✓ Harm Reduction Philosophy
- ✓ Provincially Screening /Assessment
- ✓ Group and Individual
- ✓ Pre/Post Tx Case Management

Addiction Supportive Housing (ASH)

(ASH) Program - SSM
2.34 FTE

- ✓ Housing First Model
- ✓ Eligible Rent Subsidy
- ✓ Mobilized Intensive Addiction Case Management
- ✓ Support/advocacy
- ✓ Recovery Model

* *Regional Trainer & Early Adopters of the GAINQ3 & Ontario Perception Of Care Tool*

Algoma PUBLIC HEALTH Santé publique Algoma

Harm Reduction Services

1. Methadone Maintenance
2. Needle Exchange/overdose prevention
3. Tobacco Cessation

Methadone Maintenance Treatment Program -SSM

- Medically Assisted treatment for Opiate use
- Max 40 patients
- Addictions Case Management and Counselling
- Pregnant/HIV positive prioritized
- Harm Reduction/Overdose Prevention Education Naloxone training is available
- No wait list

Needle Exchange Program Support – District Wide

- Staff APH's NEP program across district sites and available for drop ins
- Harm Reduction/Overdose Prevention Education
- Social determinants resources
- Service navigation
- Naloxone available

Stop for Addictions Tobacco Cessation Program

Centre for Addiction & Mental Health Program - aimed at assisting individuals dealing with substance use issues with Tobacco Cessation (all program staff district wide are TEACH and Stop Trained).

- Assessment
- Cessation Planning
- Ongoing Cessation Supports
- Free Nicotine Replacement (up to 26 wks)

CADAP Collaborative Outreach and Service Contracts

1. Ontario Works
2. Back on Track
3. Garden River Wellness
4. Single Session Walk-in Counselling

Algoma PUBLIC HEALTH
Santé publique Algoma

Ontario Works Addiction Services Initiative (ASI) service contract

SSM – 1.0 FTE APH - CADAP Assessment Counsellor DSSMSSAB

District - .25 FTE APH - CADAP Assessment Counsellor ADSSAB

- Assessment, treatment planning, counselling and case management for OW - ASI participants working on recovery
- Collaborative Groups including Options for Wellness (John Howard)

Algoma PUBLIC HEALTH Santé publique Algoma

Back on Track Program-Service Contract

Since 2000 provided Ontario's Remedial Measures Program for convicted impaired drivers:

- Assessment for convicted impaired drivers
- One-day Education Session
- Two-day Treatment Session
- Follow-up Assessment

Groups each have 10-25 participants

Provide services to approximately 125 individuals annually

Algoma PUBLIC HEALTH
Santé publique Algoma

Garden River Wellness Centre Service Contract

Mege Zee Wusiswun

- 1.0 FTE Addiction Assessment Counsellor dedicated to supporting the Garden River First Nations community

Algoma PUBLIC HEALTH
Santé publique Algoma

Single Session Walk-in Counselling Partnership

Are you currently on a waiting list to talk to someone?

Do you feel like you have nowhere else to turn for help?

We are here to help you when you need it.

Walk-In Counselling Service

386 Queen Street East
Sault Ste. Marie, ON
P6B 5B4
(705) 759-5989

For More Information Please Contact Our Offices:

Algoma Family Services, Algoma Public Health and the Canadian Mental Health Association are pleased to partner together to make mental health and addictions services more accessible by offering a walk-in counselling service to children, youth, families, adults and couples.

Algoma Family Services
205 McNabb Street
Sault Ste. Marie, ON
P6B 1Y3
(705) 945-5050

Algoma Public Health
294 Willow Avenue
Sault Ste. Marie, ON
P6B 0A9
(705) 942-4646

Canadian Mental Health Association
386 Queen Street East
Sault Ste. Marie, ON
P6A 1Z1
(705) 759-5989

Walk-In Counselling Service

Session at a Time

Algoma PUBLIC HEALTH
Santé publique Algoma

Mental Health & Addiction programs in summary

- 1in 4 Canadians experience MH or Addictions in their lifetime
- Combined our programs support more than 3000 individuals and provide in excess of 16,000 visits to community members in our District
- Both implement Evidence-based best practice
- Governed by Multi-sector Accountability Agreements M-SAA- Current M-SAA 2019-2022
- utilize the provincially mandated tools
- Implemented: The Ontario Perception of Care Tool- OPOC
- Are innovative in expanding services/enhancing partnerships to best meet the needs of community members experiencing mental health and substance use issues
- Consider all social determinants of health
- Incorporate mobilized case management practices
- Focus on the whole person in recovery recognizing housing stability as key element
- Tremendous growth over the last 20 years

Algoma PUBLIC HEALTH
Santé publique Algoma

Thank You

Algoma PUBLIC HEALTH
Santé publique Algoma

March 2019

Medical Officer of Health / CEO

School Health *team members set and ready to immunize at Superior Heights*

CMH *held a "Chase the Cold Away" pasta luncheon with clients*

Prepared by:
Dr. Marlene Spruyt and the Leadership Team

Presented to:
Algoma Public Health Board of Health
03/27/2019

TABLE OF CONTENTS

APH AT-A-GLANCE

What a winter it has been. With the longer days and warming sunshine, we finally see our snow banks recede. Snow drifts were very high on both of the upper decks of the SSM main office location. Many windows were drifted in, and the view from the Communications office had the appearance of an igloo. The amount of snow raised enough concern that we obtained an engineering report to confirm that the structure was capable of supporting the load.
On March 3rd we celebrated Employee Appreciation Day at APH for the first time. This is a national day of recognition occurring the first Friday in March. We provided all employees with an opportunity to come together. Management were present in all the district offices, and we were connected via OTN. Long service awards were presented, and refreshments were provided. In the past, we had celebrated appreciation of some disciplines on identified days (e.g. Nursing Week, Dietitians Day) but this did not provide us with adequate opportunity to appreciate all our unique skill sets and not all staff attended those events, hence the decision to utilize a different approach.

As reported last month APH was requested by SSM City Council to present at their budget information session, and we have followed up with our other municipalities to determine their interest in a similar presentation. To date, eight municipalities have responded, and we are in the process of scheduling. As they are confirmed, we will notify the Board Appointee for that municipality and welcome your attendance when possible.

Things are quiet at APH this week as many employees including our AMOH and Director of Health Promotion are attending The Ontario Public Health Convention (TOPHC) which is an annual conference focused on increasing the knowledge and skills of Ontario's public health workforce. Public health professionals from across Ontario and beyond are gathering to explore how strategy, leadership and practice can align to address changes in the public health sector. It is a time of transformation within public health, with the Ontario Public Health Standards. Collaboration and information sharing will be instrumental in providing high quality public health service throughout Ontario for years to come. Nothing beats in person attendance to support our APH people to network with other professionals across the province. Northern and rural communities are often more isolated from activities occurring in other locations and events such as this conference provide opportunities to be exposed to innovative ideas.

PARTNERSHIPS

Focus on the Algoma Leadership Table (ALT); This group consists of the leaders (CEOs, EDs etc.) of a large number of organizations representing health and social services, police, education and First Nations leaders, which meets approximately monthly. This provides a platform to address issues that may be common to all of us and require collaborative problem solving. Although the table is based in SSM, most of the organizations provide services across the district, and the activities are meant to be inclusive. Over the past year, the group has agreed to take on the work of Social Equity pillar as identified in the strategic directions of the Futures SSM plan. I am sitting at that subcommittee and have identified three priority areas 1) poverty reduction which includes several subcategories, 2) improving child and youth scores and, 3) safe and welcoming community.

PROGRAM HIGHLIGHTS

Topic: Safe Water Program
From: Chris Spooney, Environmental Health Manager

Public Health Goal

- To prevent or reduce the burden of water-borne illnesses related to drinking water.
- To prevent or reduce the burden of water-borne illnesses and injuries related to recreational water use.

Program Standard Requirements

Safe Water OPHS Requirements

1. The board of health (BOH) shall
   a. Conduct surveillance of:
      - Drinking water systems and associated illnesses, risk factors, and emerging trends;
      - Public beaches and water-borne illnesses associated with recreational water, risk factors, and emerging trends; and
      - Recreational water facilities;

   b. Conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations; and
   c. Use the information obtained to inform safe water programs and services
2. The BOH shall provide information to private citizens who operate their own private drinking water supplies (e.g. private wells) to promote awareness of how to safely manage their own drinking water systems.

3. The BOH shall ensure the availability of education and training for owners/operators of small drinking water systems and recreational water facilities.
4. The BOH shall increase public awareness of water-borne illnesses and safe drinking water by working with community partners and by:
   a. Adapting and/or supplementing national/provincial safe drinking water communications strategies, where local assessment has identified a need; and/or
   b. Developing and implementing regional/local communications strategies where local assessment has identified a need.
5. The BOH shall provide all the components of the Safe Water Program.
6. The BOH shall inform the public about unsafe drinking water conditions and provide the necessary information to respond appropriately.
7. The BOH shall review drinking water quality reports for its municipal drinking water supplies where fluoride is added.
8. The BOH shall ensure 24/7 availability to receive reports of and respond to:
   a. Adverse events related to safe water, such as reports of adverse drinking water of drinking water systems;
   b. Reports of water-borne illnesses or outbreaks;
   c. Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and
   d. Safe water issues relating to recreational water use including public beaches.

Key messages:

- Water is protected by strict health-based drinking water standards, comprehensive legislation and strong monitoring, reporting and enforcement that ensure the quality, safety and quantity of our drinking water is held to the highest standard**.**
- APH delivers the Safe Water program through monitoring, inspections, education, and enforcement, related to Algoma's private drinking water systems, public drinking water systems, small drinking water systems, as well as recreational waters.

Safe Water as a Public Health Issue

Access to safe water is vital to public health, and Algoma Public Health (APH) has an important role to play in protecting and promoting safe drinking and recreational water for Algoma communities. As part of APH's Environmental Health Program, the Safe Water Program aims to reduce the incidence of water-related illnesses and injuries in Algoma. APH plays an integral role in supporting a multi-barrier approach to safe drinking water for local communities and citizens (Figure 1).

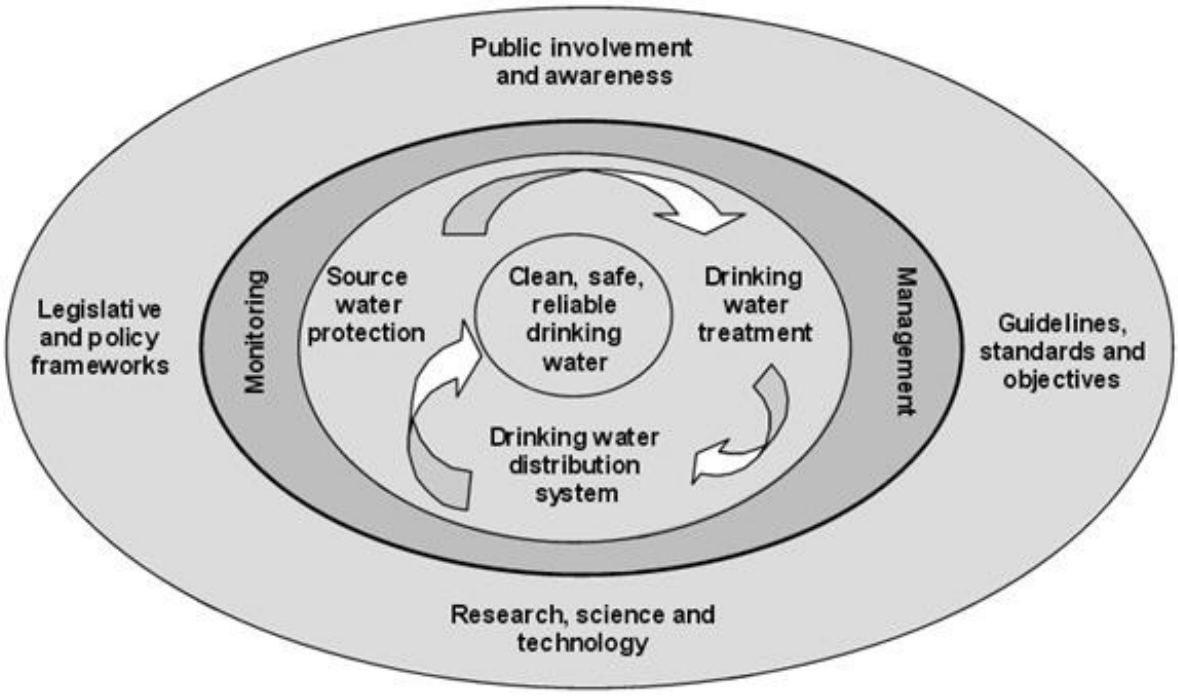


Figure 1. The **multi-barrier approach to drinking water** is an integrated system of procedures, processes and tools that collectively prevent or reduce the contamination of drinking water from source to tap in order to reduce risks to public health[1].

APH has six dedicated public health inspectors (PHIs) who respond to residential, municipal, or small drinking water system complaints, conduct routine inspections, and inspect pools, spas, and beaches. The work of the Safe Water Program is mandated and defined by legislation such as the Health Protection and Promotion Act (HPPA) and the Safe Drinking Water Act, as well as standards, protocols and guidance documents under the Ontario Public Health Standards.

Population Health Snapshot, 2018

Unsafe water conditions can lead to serious population health outcomes that include illness, disease, and even death. In Algoma, the burden of harms related to drinking and recreational water is relatively low.

- In 2017, the rate of food and water-borne illness in Algoma was 48.4 cases per 100,000 people, compared to 66.7 cases per 100,000 people in Ontario.[2]
- Between the years of 2007-2017 there were 23 emergency department visits in Algoma due to drowning.[3]
- Between the years of 2001-2015 there were 6 deaths in Algoma due to drowning.[4]

Note that drowning includes in a swimming pool, natural water, and from unknown conditions.

APH Safe Water Program in the Community

The Safe Water Program works to protect against the health risks associated with water, via four general program areas:

1. **Private Drinking Water,**
2. **Public Drinking Water,**
3. **Small Drinking Water Systems (SDWS), and**
4. **Recreational Water.**

1. Private Drinking Water

- Private drinking water sources (mainly wells or surface water) have the potential to be contaminated with bacteria, viruses, parasites, chemicals, metals and minerals. Any of these may cause illness. APH assists Algoma residents in submitting water samples to the Public Health Ontario (PHO) Laboratory in Sault Ste. Marie for testing.
- **In 2018, the PHO lab notified APH of 278 adverse water samples that were contaminated with either *E. coli* or total coliform bacteria, suggestive of sewage or surface water contamination**. PHIs follow-up with these events to provide education, help homeowners troubleshoot and provide recommendations for corrective action.

2. Public Drinking Water

- PHIs and Ministry of Environment, Conservation and Parks (MECP) inspectors monitor public drinking water systems to ensure a safe water supply. If water supplied by a system is unsafe, a boil water or drinking water advisory will be issued by APH or the system operator to protect the health of the system users.
- **In 2018, 12 boil water advisories (BWAs) were issued to municipal residents** to protect the public from potential risks associated with a specific water system (e.g. water main break in a municipal system may increase the risk of biological or chemical contamination).

3. Small Drinking Water Systems

- Small drinking water systems (SDWS) are regulated under Ontario Regulation 319 Small Drinking Water Systems. PHIs conduct an on-site risk assessment for every SDWS in Algoma. Each system is categorized as low, medium or high risk and the PHI issues a directive outlining what the owner/operator of the system must do to keep the drinking water safe. The directive may include, but is not limited to, water testing requirements, treatment requirements, and operator raining.
- APH inspects each small drinking water system in Algoma every 2 or 4 years, based on risk assessment criteria. There are 285 such small drinking water systems in Algoma, which supply premises which are open to the public and offer overnight accommodations. **APH inspected 54 small drinking water systems in 2018**.
- SDWS are monitored by APH to ensure all requirements are being met and all adverse test results are reported. Boil water or drinking water advisories may be issued by the operator or APH to protect the health of the water system users in the case of an adverse bacteriological result, an adverse observation, or an outbreak associated with the water system. **In 2018, 4 boil water orders were issued to SDWS owners/operators**.

4. Recreational Water

Recreational water use is popular in the district of Algoma. These activities can deliver important benefits to health and well-being. Yet, there is the possibility of injury or illness resulting from recreational use if the water is polluted or unsafe. Human illness and infection can be caused by organisms (bacteria, viruses and parasites) that may be present in pools, spas/hot tubs, and natural bodies of water.

In 2018,

- **24 beaches across the Algoma District were sampled on a weekly basis between June and September to monitor the beach water quality**.
    - In the six instances where samples did not meet quality standards, APH issued media releases and posted educational signage at the site, which indicating a heightened risk to swimmers.

- **44 pool and spa premises were routinely inspected in accordance with annual inspection requirements.**
    - APH also completed an additional 151 compliance inspections to follow up on identified issues and/or complaints.
    - 4 pools were issued orders to close due to infractions that put swimmers at risk.

- **There were 6 water-related complaints associated with blue-green algae (BGA) and two confirmed BGA blooms in Algoma.**

  Lakes that are historically impacted by BGA have permanent signage on site that warns users of the risks associated with using the water in the event of a bloom. APH posts signage on all new lakes that test positive for BGA and provides education via media releases that target the residents living in those affected areas.

Moving forward

APH continues to deliver all components of the Safe Water Program as described above. In 2019, PHIs are finalizing and delivering an educational pool course to Algoma pool operators, based on an identified need for further capacity development in this area. Further work will also be done to expand and optimize the methods by which APH measures the burden of health harms associated with recreational and drinking water.

References

1. The multi-barrier approach to safe drinking water. 2002. Prepared by the Federal-Provincial-Territorial Committee on Drinking Water of the Federal-Provincial-Territorial Committee on Environmental and Occupational Health and the Water Quality Task Group of the Canadian Council of Ministers of the Environment. https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/ewh-semt/alt_formats/hecs-sesc/pdf/water-eau/tap-source-robinet/tap-source-robinet-eng.pdf.

2. Algoma Public Health. (2018). Algoma Community Health Profile. Retrieved from http://www.algomapublichealth.com/stats-reports/community-health-profile-2018/

3. Ambulatory Emergency External Cause. (2007-2017), Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 6, 2019].

4. Ontario Mortality Data (2006-2015), Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 6, 2019].

Topic: APH Health & Safety Report

From: Suzanne Irwin, Manager of Operations and Joint Health and Safety Management Co-Chair
Antoniette Tomie, Director of Human Resources and Corporate Services

Introduction:

Algoma Public Health has a committed and engaged joint health and safety committee that is proactive in promoting health and safety prevention in the workplace. This report will highlight success in reducing workplace injury as well as our participation in a Safety Group Program.

Musculoskeletal incident (MSIs) reports

In 2017 MSI related incidents were the highest of thirty nine (39) employee health and safety incident reports submitted to Human Resources. A total of 11 MSI reports were received - six (6) were workstation related and five (5) were providing clinics (i.e. immunization and/or car seat clinics) either within our offices or in the community. In 2015 and 2016 we received eight (8) MSI reports in each year. Although there wasn't a significant increase of MSI reports received in 2017 compared to past years, it provided an opportunity to investigate various interventions with a goal to decrease MSIs.

A significant intervention that was implemented included performing ergonomic assessments of workstations and in our internal clinic room(s). A workstation assessment is conducted with newly hired employees to determine if modifications are needed. Also, any employee can request an ergonomic assessment of their workstation or in clinic room(s) at any time. Some employees that have the experience and knowledge to make recommendations will perform the assessment including workstation design, proper chair, keyboard setup etc. An external ergonomist is used for issues of a complex nature. Once recommendations are made and implemented, follow-up continues until issues are resolved.

Other measures regarding workstations and/or clinic rooms that have been implemented include:

- Some workstations equipped with two monitors which reduces toggling between screens and thus the need for mouse clicking;
- An increase in the number of headsets for those that spend some time on the telephone.

Employees are encouraged to share ergonomic issues during monthly workplace inspections. As this was a fairly common request, ergonomics is now included on the inspection form. Positive outcomes from these assessments have enabled employees to share tips amongst themselves.
A number of awareness campaigns from either the employee wellness or joint health and safety committees occurred during 2018. Employees were encouraged to move more often during the work day including taking breaks, doing short stretches, taking stairs instead of the elevator etc.
Interventions as the ones described above were successful in reducing MSI related incident reports. In 2018 only five (5) MSI related incident reports were received of which one each for workstations and providing clinics.

Safety Group Program (SGP)

This year we enrolled in the Workplace Safety and Insurance Board's (WSIB) Safety Groups Program (SGP). The SGP is designed to recognize organizations that make the prevention of workplace injuries and illnesses a daily habit by building it into their health and safety management system (HSMS).
The SGP affords networking opportunities and resources for participants as well as WSIB financial incentives. In order to participate in the program we were required to develop an action plan and implement at least five (5) health and safety program elements. The five elements selected are:

1. Supervisor Competency,
2. Networking,
3. Workplace Inspections,
4. Health and Safety Policy, and
5. Return To Work.

Within each element we are to have a written standard, communicate and train employees, evaluate each element and acknowledge success and making improvements.
Participating in the SGP is one element of our objective to eliminate or reduce workplace injuries and promote health and safety prevention in the workplace.

Algoma Public Health
(Unaudited) Financial Statements January 31, 2019

Algoma Public Health
Statement of Operations
January 2019
(Unaudited)

	Actual YTD 2019	Budget YTD 2019	Variance Act. to Bgt. 2019	Annual Budget 2019	Variance % Act. to Bgt. 2019	YTD Actual/ YTD Budget 2019
Public Health Programs						
Revenue						
Municipal Levy - Public Health	**$ 887,705**	$ 879,923	$ 7,783	$ 3,519,690	1%	101%
Provincial Grants - Cost Shared Funding	**626,934**	626,933	1	7,523,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	**249,748**	249,745	3	2,996,950	0%	100%
Fees, other grants and recovery of expenditures	**34,149**	44,388	(10,239)	695,214	-23%	77%
Total Public Health Revenue	**$ 1,798,537**	$ 1,800,989	$ (2,452)	$ 14,735,054	0%	100%
Total Public Health Programs Expenditures	**$ 1,222,634**	$ 1,209,669	$ (12,965)	$ 14,735,055	1%	101%
Total Rev. over Exp. Public Health	**$ 575,902**	$ 591,319	$ (15,417)	$ (1)		
Healthy Babies Healthy Children						
Provincial Grants and Recoveries	**$ 89,000**	89,001	1	1,068,011	0%	100%
Expenditures	**98,797**	88,818	9,980	1,068,011	11%	111%
Excess of Rev. over Exp.	**(9,797)**	183	(9,981)	-		
Public Health Programs - Fiscal 18/19						
Provincial Grants and Recoveries	**$ 189,751**	189,756	5	227,700		
Expenditures	**158,633**	226,700	(68,067)	227,700		
Excess of Rev. over Fiscal Funded	**31,118**	(36,944)	68,062	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	**$ -**	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	**15,733**	25,899	(10,167)	335,290	-39%	61%
Total Community Health Revenue	**$ 15,733**	$ 25,899	$ (10,167)	$ 335,290	-39%	61%
Expenditures						
Child Benefits Ontario Works	**119**	2,042	1,923	24,500	-94%	6%
Algoma CADAP programs	**25,130**	25,899	769	310,790	-3%	97%
Total Calendar Community Health Programs	**$ 25,249**	$ 27,941	$ 2,691	$ 335,290	-10%	90%
Total Rev. over Exp. Calendar Community Health	**$ (9,517)**	$ (2,042)	$ (7,475)	$ 0		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	**$ 4,732,642**	$ 4,754,753	$ (22,111)	$ 5,719,161	0%	100%
Municipal, Federal, and Other Funding	**648,075**	666,952	(18,878)	733,905	-3%	97%
Other Bill for Service Programs	**45,336**		45,336			
Total Community Health Revenue	**$ 5,426,052**	$ 5,421,705	$ 4,347	$ 6,453,066	0%	100%
Expenditures						
Brighter Futures for Children	**73,794**	95,372	21,579	120,099	-23%	77%
Infant Development	**527,227**	536,819	9,592	643,783	-2%	98%
Preschool Speech and Languages	**506,963**	512,046	5,083	614,256	-1%	99%
Nurse Practitioner	**118,393**	121,544	3,151	145,452	-3%	97%
Genetics Counseling	**381,827**	306,505	(75,323)	367,806	25%	125%
Community Mental Health	**2,864,647**	3,002,081	137,434	3,607,765	-5%	95%
Community Alcohol and Drug Assessment	**603,273**	614,135	10,862	737,406	-2%	98%
Healthy Kids Community Challenge	**93,321**	112,500	19,179	112,500	-17%	83%
Stay on Your Feet	**77,206**	83,333	6,127	100,000	-7%	93%
Bill for Service Programs	**26,461**	-	(26,461)	-		
Misc Fiscal	**-**	4,000	4,000	4,000		
Total Fiscal Community Health Programs	**$ 5,273,112**	$ 5,388,335	$ 115,223	$ 6,453,066	-2%	98%
Total Rev. over Exp. Fiscal Community Health	**$ 152,940**	$ 33,370	$ 119,570	$ (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

Revenue Statement

For One Month Ending January 31, 2019

(Unaudited)

	Actual YTD 2019	Budget YTD 2019	Variance Bgt. to Act. 2019	Annual Budget 2019	Variance % Act. to Bgt. 2019	YTD Actual/ Annual Budget 2019	*Comparison Prior Year:* YTD Actual 2018	YTD BGT 2018	Variance 2018
Levies Sault Ste Marie	609,525	609,525	0	2,438,100	0%	25%	606,441	606,441	0
Levies Vector Bourne Disease and Safe Water	14,858	14,858	0	59,433	0%	25%	14,858	14,858	0
Levies District	263,322	255,539	7,783	1,022,157	3%	26%	254,246	254,246	0
Total Levies	**887,705**	**879,922**	**7,783**	**3,519,690**	**1%**	**25%**	**875,545**	**875,545**	**0**
MOH Public Health Funding	612,076	612,075	1	7,344,900	0%	8%	594,242	594,242	0
MOH Funding Vector Borne Disease	9,058	9,058	(0)	108,700	0%	8%	9,058	9,058	0
MOH Funding Safe Water	5,800	5,800	0	69,600	0%	8%	5,800	5,800	0
Total Public Health Cost Shared Funding	**626,934**	**626,933**	**1**	**7,523,200**	**0%**	**8%**	**609,100**	**609,100**	**0**
MOH Funding Needle Exchange	5,392	5,392	0	64,700	0%	8%	4,226	5,392	(1,167)
MOH Funding Haines Food Safety	2,050	2,050	0	24,600	0%	8%	2,050	2,050	0
MOH Funding Healthy Smiles	64,158	64,158	(0)	769,900	0%	8%	64,158	64,158	0
MOH Funding - Social Determinants of Health	15,042	15,042	0	180,500	0%	8%	15,042	15,041	1
MOH Funding - MOH / AMOH Top Up	10,538	10,538	0	126,450	0%	8%	9,236	10,537	(1,301)
MOH Funding Chief Nursing Officer	10,126	10,125	1	121,500	0%	8%	10,126	10,125	1
MOH Enhanced Funding Safe Water	1,292	1,292	0	15,500	0%	8%	1,292	1,291	1
MOH Funding Unorganized	44,200	44,200	0	530,400	0%	8%	44,200	44,200	0
MOH Funding Infection Control	26,034	26,033	1	312,400	0%	8%	26,034	26,034	0
MOH Funding Diabetes	12,500	12,500	0	150,000	0%	8%	12,500	12,500	0
MOH Funding Northern Ontario Fruits & Veg.	9,782	9,783	(1)	117,400	0%	8%	9,784	9,784	0
Funding Ontario Tobacco Strategy	36,134	36,133	1	433,600	0%	8%	36,134	36,134	0
MOH Funding Harm Reduction	12,500	12,500	0	150,000	0%	8%	0	12,500	(12,500)
One Time Funding	0	0	0	0		0%	0	0	0
Total Public Health 100% Prov. Funded	**249,748**	**249,746**	**2**	**2,996,950**	**0%**	**8%**	**234,782**	**249,746**	**(14,965)**
Recoveries from Programs	838	838	0	27,621	0%	3%	838	833	5
Program Fees	17,126	19,883	(2,757)	238,593	-14%	7%	19,568	20,314	(746)
Land Control Fees	1,415	5,000	(3,585)	160,000	-72%	1%	500	13,333	(12,833)
Program Fees Immunization	10,447	12,917	(2,470)	155,000	-19%	7%	10,396	15,417	(5,021)
HPV Vaccine Program	0	0	0	12,000	0%	0%	0	0	0
Influenza Program	0	0	0	25,000	0%	0%	0	0	0
Meningococcal C Program	0	0	0	8,000	0%	0%	0	0	0
Interest Revenue	3,573	2,667	906	32,000	34%	11%	2,448	1,167	1,281
Other Revenues	750	3,083	(2,333)	37,000	0%	2%	0	1,167	(1,167)
Total Fees, Other Grants and Recoveries	**34,149**	**44,388**	**(10,239)**	**695,214**	**-23%**	**5%**	**33,750**	**52,231**	**(18,481)**
Total Public Health Revenue Annual	**$ 1,798,536**	**$ 1,800,989**	**$ (2,453)**	**$ 14,735,054**	**0%**	**12%**	**$ 1,753,176**	**$ 1,786,622**	**$ (33,446)**
Public Health Fiscal									
Panorama	0	0	0	0	0%	0%	61,749	52,050	9,699
Smoke Free Ontario NRT	0	0	0	0	0%	0%	25,000	15,000	10,000
Practicum	8,334	8,334	0	10,000	0%	83%	8,332	5,000	3,332
Other One Time Fiscal Funding	181,417	181,417	0	217,700	0%	83%	16,747	10,050	6,697
Total Provincial Grants Fiscal	**$ 189,751**	**$ 189,751**	**$ -**	**$ 227,700**	**0%**	**83%**	**$ 111,828**	**$ 82,100**	**$ 29,728**

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 One Month Ending January 31, 2019

(Unaudited)

	Actual YTD 2019	Budget YTD 2019	Variance Act. to Bgt. 2019	Annual Budget 2019	Variance % Act. to Bgt. 2019	YTD Actual/ YTD Budget 2019	*Comparison Prior Year:* *YTD Actual 2018*	*YTD BGT 2018*	*Variance 2018*
Salaries & Wages	$ 745,963	$ 752,617	$ 6,654	$ 9,031,426	-1%	8%	$ 712,842	$ 736,313	$ 23,471
Benefits	203,647	182,091	(21,556)	2,185,088	12%	9%	188,110	175,318	(12,792)
Travel	11,867	15,922	4,055	191,069	-25%	6%	12,998	16,222	3,224
Program	43,205	52,619	9,414	631,433	-18%	7%	48,381	53,918	5,537
Office	10,750	8,629	(2,122)	103,544	25%	10%	17,569	9,742	(7,826)
Computer Services	66,438	63,160	(3,278)	806,927	5%	8%	87,358	56,323	(31,035)
Telecommunications	23,666	18,974	(4,692)	267,685	25%	9%	1,797	25,275	23,478
Program Promotion	3,282	5,244	1,963	62,930	-37%	5%	0	5,087	5,087
Professional Development	4,335	8,059	3,724	96,702	-46%	4%	2,949	8,571	5,623
Facilities Expenses	67,218	63,333	(3,885)	760,000	6%	9%	59,648	66,250	6,602
Fees & Insurance	12,583	9,340	(3,243)	242,080	35%	5%	9,198	9,038	(161)
Debt Management	38,408	38,408	0	460,900	0%	8%	38,408	38,408	0
Recoveries	(8,728)	(8,727)	0	(104,730)	0%	8%	(8,691)	(8,691)	(0)
	$ 1,222,635	$ 1,209,669	$ (12,966)	$ 14,735,054	**1%**	**8%**	$ 1,170,567	$ 1,191,773	$ 21,207

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 – January 2019

Reporting Period

The January 2019 financial reports include one month 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 ten 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 January 31st, 2019, Public Health programs are reporting a $15k negative variance.

Actual Public Health Revenues are aligned with budgeted revenues. The negative $2k variance is a result timing of receipts of associated with Fees, Other Grants & Recoveries.

APH's Public Health programs are early in the calendar year and as such actual expenses are relatively aligned with budgeted expenses.

There is a negative variance of $13k related to Total Public Health expenses being more than budgeted. This is a result of timing of expenses incurred. Benefits expense is indicating a negative $22k variance as a result of employee health benefit expenses (Green Shield) being higher than budgeted for the month of January. Additionally, employer contributions associated with Canada Pension Plan and Employment Insurance are higher than budgeted however as the year progresses this negative variance is expected to reduce.

Community Health Calendar programs are operating within budget.

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

Brighter Futures for Children Program is indicating a positive $22k variance. This is a result of timing of expenses not yet incurred.

Genetics Counseling is showing a negative $75k variance. APH management continues to use deferred revenue associated with the program to ensure actual program costs are fairly reflected. The general administration support Public Health Provides to the Genetics Program more accurately reflects actual usage. As APH makes plans to transition the program to Health Science North, funding associated with the program will end March 31st, 2019. The plan is for APH to continue to use deferred revenue after March 31st, 2019, as the transition continues.

Healthy Kids Community Challenge is showing a $19k positive variance. The Healthy Kids Community Challenge Program ended September 30th, 2018. This program has now come to its conclusion.

Notes Continued…

Public Health Revenue (see page 2)

Overall, Public Health funding revenues are within budget.

The municipal levies are showing a positive $7k variance. This is a result of timing of receipts from some smaller municipalities.

Cost Shared Funding is within budget.

100% Provincially Funded Grants are within budget.

Fees, Other Grants & Recoveries are showing a negative variance of $10k. This is primarily a result timing of receipts of Fees, Other Grants & Recoveries. APH typically captures the bulk of its fees between the spring and fall months.

Public Health Expenses (see page 3)

For 2019, changes to the format of the Public Health Expense Statement include:

- Travel (Mileage) and Travel (Other) line items have been consolidated to one Travel line item
- Professional Development now has its own line item as opposed to being included in the Program Promotion line item

As Public Health programs are only one month into their operating year, variances noted are a result of timing of expenses incurred. All variances noted fall under the Board of Health threshold of explanation for the first 6 months of the year. Benefits expense is highlighted below as it was relatively close to the threshold.

Benefits
Benefits expense is indicating a negative $22k variance as a result of employee health benefit expenses (Green Shield) being higher than budgeted for the month of January. Additionally, employer contributions associated with Canada Pension Plan and Employment Insurance are higher than budgeted however as the year progresses this negative variance is expected to reduce.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of January 31st, 2019. Cash includes $835k in short-term investments plus $2.9M in APH's operating account.

Long-term debt of $5.11 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $299k 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.

Notes Continued…
There are no collection concerns for accounts receivable.

NOTE:
Similar to previous years, the Balance Sheet as of January 31st, 2019 (page 7) is not included as APH is currently completing year-end audit requirements. Once the 2018 annual audited Financial Statements are completed, the Balance Sheet will be provided.

Governance Committee Chair Report

March 18, 2019

Attendees:

Deborah Graystone - Chair
Lee Mason
Karen Raybould
Adrienne Kappes
Heather O'Brien
Louise Caicco Tett

APH Executive

Marlene Spruyt - MOH/CEO
Tania Caputo - Board Secretary

The Bylaw and Policy Review Schedule was reviewed by the committee. No amendments were made.

A discussion of Governance Recommendations regarding Board member skill mix and term limit review to ensure experience in combination with healthy turnover. A discussion regarding previous Governance Committee recommendations and how the board is limited in implementing policy. A past governance recommendation will be reviewed by Lee Mason and Marlene Spruyt and will provide feedback when available.

The Travel Policy and Board Remuneration Policy were discussed with new information required before moving forward. Marlene will review their alignment to the employee policy. The Board Employee Retirement Recognition Policy was transferred to the leadership team's accountability with acknowledgement that the practice continue. The Reserve Fund Policy and Procurement Policy were discussed and a decision was made to refer back to the Finance Committee for review and recommendations.

A discussion regarding the Provincial Appointee re-appointment process and whether the board needs to provide a letter of recommendation if member is seeking re-appointment. A chart with all board members and their dates of appointment and term limits was discussed and determined to be helpful information to share with the board.

Terms of Reference for the Finance and Audit and Governance Committees were deferred to the June meeting.

Deborah Graystone,
Governance Committee Chair

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-075
DATE:	Original: September 27, 2017 Reviewed: March 18, 2019	**SECTION:**	Board
		SUBJECT:	Election of Chair, Vice-Chairs or Committee Members

POLICY:

The purpose of this policy is:

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

Reference Bylaw 95-1

Nominations

The Secretary to the Board will send a callout for expressions of interest for nominations prior to the first Board meeting of the new year.

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

PROCEDURES:

Call for Nominations

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

2) Once nomination call is completed, nominees will be asked if they accept the nomination.
"_____, you have been nominated for the position of _____. Do you accept the nomination to stand?" Any nominee that does not accept will have their name removed from the nomination call list.

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

Election of Board Chair

MOH/CEO or Delegate:

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

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

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

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

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

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

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

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

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

Election of Board Vice-Chairs

Elected Board Chair

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

2) Follow same procedure for electing chair.

Selection Procedure for Committee Members

Board Chair

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

Board Members	2) Submit a form with their name and any information they believe is pertinent to being selected for a committee.
Board Chair and Vice-Chairs	3) Collect completed forms of interested board members and discuss who will be place on which committee. Members will be placed on one committee to allow for the most possible people to take part.
	4) Should there remain any vacancies on the committees, they will be filled by appointment through application to the Chair and Vice-Chairs and serve the remainder of the term of the committee.

Ministry of Health and Long-Term Care

Office of Chief Medical Officer of Health, Public Health
393 University Avenue, 21st Floor
Toronto ON M5G 2M2

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

Bureau du médecin hygiéniste en chef, santé publique
393 avenue University, 21e étage
Toronto ON M5G 2M2

Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

March 6, 2019

MEMORANDUM:

TO: Medical Officers of Health, Chief Executive Officers and Board Chairs

Dear Colleagues,

By now I am expecting you will have seen and heard the recent announcement on the transformation of our health care system.

At a high level, the announcement focused on the Ministry's plan to improve the patient experience and enable better connected care by:

- Supporting the establishment of Ontario Health Teams across the province and in every community, and
- Integrating multiple existing provincial agencies into a single health agency – Ontario Health.

While the main focus of the government's plan is currently on improving patient experience and fostering better connected care, as always, there is a significant role for the public health sector to play within the larger system. I want to assure you that the public health sector, as always, is a valuable partner and key piece of the health care system.

I look forward to hearing your input and collaborating as a sector as we work to understand what these changes mean for us. As we wait to hear more from the government, it will require us to remain nimble and adapt while we continue our work to best serve our communities. These are early days and more information will follow in the weeks/months ahead. And, my commitment is to share what I know with you when I am able to share it.

I have included the following information, for your reference, with respect to this week's announcement.

- News Release
- Backgrounder
- Minister's Remarks
- Connected Care Stakeholder Webinar
- Bill 74

Sincerely,

Original signed by

Dr. David Williams

Chief Medical Officer of Health
Office of Chief Medical Officer of Health, Public Health
Ministry of Health and Long-Term Care

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. Vic Fedeli
Minister of Finance
Room 281, Main Legislative Building,
Queen's Park
Toronto, Ontario M7A 1A1

January 31 2018

Dear Minister Fedeli,

Re: Alcohol Choice & Convenience and a Provincial Alcohol Strategy

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health, and Affiliate organizations, I am writing to provide our input to your Government's plans for modernizing the rules for the sale and consumption of alcohol in Ontario. We are especially interested in helping you achieve the stated goal of ensuring safe and healthy communities by reiterating our call for a Provincial Alcohol Strategy.

Over the past few years, Ontario has been steadily increasing the availability of and access to beverage alcohol by relaxing long-standing controls over its sale and distribution, such as expanding the number and type of retail outlets, extending hours of service, allowing online ordering with home delivery and reducing over-the-counter prices. Your Government's plan to expand the sale of alcohol to corner stores, additional grocery stores and big-box stores would be a significant move towards further loosening these controls.

While we understand the consumer convenience aspect of these decisions, we are very concerned that the negative societal and health impacts of increasing the availability of alcohol continue to be overlooked.

Alcohol is no ordinary commodity. It causes injury, addiction, disease, and social disruption and is one of the leading risk factors for disability and death. Its contributions to liver disease, fetal alcohol spectrum disorder, acute alcohol poisoning and various injuries owing to intoxication are well known and evidence of its links to mental health disorders and a range of cancers continues to mount. In fact, a recent study by the Canadian Institute for Health Information (CIHI) estimated that there were over 25,000 hospitalizations in one year in Ontario that were entirely caused by alcohol[1].

In addition to the personal health impacts, alcohol is a significant factor in the public costs associated with health care, social services, law enforcement and justice, and lost workplace productivity.

We have expressed our opposition to expanding the nature and number of retailers permitted to sell alcohol in the past, based on clear evidence that increasing access is detrimental to public health, and this remains our position. Given that such expansion continues to proceed in Ontario however, we must reinforce the importance of developing a comprehensive, provincially led alcohol strategy that can help mitigate the otherwise entirely preventable negative impacts of increased alcohol availability, which include increasing hallway medicine and waste of taxpayers' money.

It is well-established that increasing alcohol availability is directly related to increased consumption and alcohol-related harms. A comprehensive, evidence-based approach to alcohol policy is therefore critical to limiting these harms.

We would be pleased to meet with you to further discuss our views on the public health impacts of alcohol availability and to lend our expertise to the development of a made-in-Ontario alcohol strategy. To schedule a meeting, please have your staff contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Sincerely,

Dr. Robert Kyle,
alPHa President

COPY: Hon. Doug Ford, Premier of Ontario
Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health

Encl.

1. *Canadian Institute for Health Information. Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm. Ottawa, ON: CIHI; 2017.*

alPHa Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A11-1

TITLE: **Conduct a Formal Review and Impact Analysis of the Health and Economic Effects of Alcohol in Ontario and Thereafter Develop a Provincial Alcohol Strategy**

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

WHEREAS There is a well-established association between easy access to alcohol and overall rates of consumption and damage from alcohol; and (Barbor et al., 2010)

WHEREAS Ontario has a significant portion of the population drinking alcohol (81.5%), exceeding the low risk drinking guidelines (23.4%), consuming 5 or more drinks on a single occasion weekly (11.2%), and reporting hazardous or harmful drinking (15.6%); and (CAMH Monitor)

WHEREAS Ontario youth (grades 9-12) have concerning levels of alcohol consumption with 69.4% having drank in the past year, 32.9% binge drinking (5 or more drinks), and 27.5% of students reporting drinking at a hazardous level; and (OSDUHS Report)

WHEREAS Each year alcohol puts this province in a $456 million deficit due to direct costs related to healthcare and enforcement; and (G. Thomas, CCSA)

WHEREAS Billions of dollars are spent each year in Canada on indirect costs associated with alcohol use (illness, disability, and death) including lost productivity in the workplace and home; and (The Costs of Sub Abuse in CAN, 2002)

WHEREAS Nearly half of all deaths attributable to alcohol are from injuries including unintentional injuries (drowning, burns, poisoning and falls) and intentional injuries (deliberate acts of violence against oneself or others); and (WHO – Alcohol and Injury in EDs, 2007)

WHEREAS Regulating the physical availability of alcohol is one of the top alcohol policy practices in reducing harm; and (Barbor et al., 2010)

WHEREAS The World Health Organization (WHO, 2011) has indicated that alcohol is the world's third largest risk factor for disease burden and that the harmful use of alcohol results in approximately 2.5 million deaths each year. Alcohol is associated with increased levels of health and social costs in Ontario and is causally related to over 65 medical conditions;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the Ontario government to conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and develop a provincial Alcohol Strategy.

ACTION FROM CONFERENCE: **Resolution CARRIED**

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

Retail Expansion Roundtable
Ontario Ministry of Finance

375 University Ave, 7th Floor, Toronto, ON M5G 2J5
Wednesday, March 6, 2019
Speaking Notes

Introduction

- alPHa represents all 35 boards of health and all associate/medical officers of health
- Thank you for inviting us to attend today's roundtable
- The focus of our remarks is on:
    - Rules for sale and consumption
    - Safe and healthy communities
- Alcohol is responsible for the second highest rate of preventable death and disease in Canada, following tobacco. Additionally, alcohol is responsible for the greatest proportion of costs attributed to substance use in Ontario;[i] it is well-established that increasing alcohol availability is directly related to increased consumption and alcohol-related harms. It is necessary to balance consumer demand for convenience with policy supports aimed at ensuring the health of Ontarians remains a priority.

Background

- Alcohol availability in Ontario has increased 22 percent from 2007 to 2017 and will continue to increase under the government's proposed sale expansion plan.[ii]
- Ontario has committed to making wine, beer and cider available in up to 450 grocery stores.
- In August 2018, there was a reduction in the minimum retail price of beer (below 5.6% ABV) from 1.25 to $1.00; participating manufacturers were given enhanced promotion in LCBO retail stores.
- In December 2018, alcohol retail hours of sale were extended to 9 – 11 AM, seven days a week.

Current State

- Alcohol use is associated with addiction, chronic diseases, violence, injuries, suicides, fetal alcohol spectrum disorder, deaths from drunk driving, increased HIV infections, unplanned pregnancies, violence, assaults, homicides, child neglect and other social problems.
- Alcohol causes cancers of the mouth, esophagus, throat, colon and rectum, larynx, breast and liver.
- Even low to moderate alcohol consumption can cause cancer and damage to the brain.
- Alcohol outlet density has been shown to be related to heavy episodic drinking by youth and young adults.[iii] [iv]

- Privatized liquor sales, often associated with high density and increased sales to minors, can have troubling results for youth, including significantly more hospital visits, increased theft, increased acceptance of drinking among youth, and an increase in the number of "drinking days" among youth who were already drinking.[v]
- 1 in 3 Ontarians experience harms because of someone else's drinking.
- Evidence shows a consistent and positive association between alcohol outlet density and excessive alcohol consumption and related harms. The largest effect sizes were seen between outlet density and violent crime.[vi]
- Evidence shows that restricting the physical availability of alcohol by regulating the times when alcohol can be sold and limiting outlet density will decrease alcohol harm e.g., road traffic casualties, alcohol related disease, injury and violent crime.
- Increasing the hours of sale by greater than 2 hours has been shown to be related to increases in alcohol-related harms, such as an 11% relative increase in traffic injury crashes and a 20% relative increase in weekend emergency department admissions.[vii]
- A recent study by the Canadian Institute for Health Information estimated that there were over 25,000 hospitalizations in one year in Ontario that were entirely caused by alcohol; there were more hospital admissions in Canada in 2017 for alcohol-related conditions than heart attacks.[viii]
- Increasing access to alcohol works against the government's efforts to reduce health care costs and end "Hallway Medicine".
- Alcohol-related costs currently exceed alcohol-related net income within Ontario.
- Alcohol-related costs in Ontario amount to at least $5.3 billion annually:[ix]
    - $1.5billion in healthcare
    - $1.3 billion in criminal justice
    - $2.1 billion related to lost productivity
    - $500 million in other direct costs
- In the United States, growth in life expectancy has stagnated and even decreased slightly in recent years, owing mainly to deaths attributed to alcohol and drug use or to suicide in lower socioeconomic strata; in Canada, rates of "deaths of despair" have also increased, particularly for opioid overdoses and alcoholic liver cirrhosis; as such, it is important for Canada to avoid further inequalities in income, to reduce rates of opioid prescribing and to strengthen alcohol control policies.[x]

Recommended Risk Mitigation Actions/Options:

Retail Siting and Setbacks

- Consider implementing the following setbacks, density and sensitive land use measures related to alcohol retailers:
    - Child care centres
    - Post-secondary schools
    - Elementary and secondary schools
    - Gaming facilities/casinos
    - Health care facilities, such as hospitals

- Long-term care homes
- Recreation and sports facilities
- Arcades, amusement parks, and other places where children and youth congregate
- Separation distances between retailors
- High priority neighbourhoods where there is more crime or higher socioeconomic disparity. DRHD priority neighbourhood data can be found at the following link: https://www.durham.ca/health.asp?nr=/departments/health/health_statistics/health_neighbourhoods/index.htm

Retail Density and Hours of Operation

- Take an incremental approach to alcohol sales expansion, including retail density and hours of sale, which will allow the government to monitor and evaluate the impact of any changes or increase in harms gradually.[xi]

Public Education, Prevention Strategies and Treatment Services

- Provide financial assistance to public health agencies to implement comprehensive and sustained prevention and harm reduction approaches that promote awareness of alcohol related harms and delay age of initiation amongst youth and young adults.
- Allocate a portion of additional revenue generated by increased alcohol availability directly to mental health and addictions services, which would assist in meeting current gaps in funding for direct service provision.

Pricing

- Adopt alcohol pricing policies that more effectively target hazardous patterns of drinking. These policies include:[xii]
  - setting and enforcing a minimum price per standard drink and applying it to all products
  - altering markups to decrease the price of low alcohol content beverages and increase the price of high alcohol content beverages
  - indexing minimum prices and markups to inflation to ensure that alcohol does not become cheaper relative to other commodities over time.

Note: Saskatchewan has demonstrated an effective strategy to bring revenue to the province while reducing alcohol related harms:

- increasing alcohol pricing can achieve the financial goal of increased revenues while realizing the health benefits of reduced alcohol consumption; Saskatchewan increased minimum prices and saw a decline in alcohol consumption of 135,000 litres of absolute alcohol and a revenue increase of $9.4 million last year.[xiii]

Youth

- Maintain a government monopoly for off premise sales, including strong compliance checks.
- Limit retail density in areas frequented by youth.
- Ban the use of alcohol advertising, marketing and power walls in retailers that permit youth access.

Conclusion

- Notwithstanding competing pressures and priorities, government policies should strive to work in concert to support the health of all Ontarians.
- There are a number of options available to the government as in proceeds with alcohol retail expansion to mitigate the risks, especially to youth and vulnerable populations and to ensure safe and healthy communities.
- alPHa asks the government to fully consult with health experts, including the Association of Local Public Health Agencies, Centre for Addiction and Mental Health, and Ontario Public Health Association before making changes to the availability of alcohol.
- In addition, alPHa asks the government to develop, implement and evaluate a provincial alcohol strategy in consultation with the same experts cited above.

About alPHa: The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to the boards of health and public health units in Ontario. Membership in alPHa is open to all public health units in Ontario and we work closely with board of health members, medical and associate medical officers of health, and senior public health managers in each of the public health disciplines – nursing, inspections, nutrition, dentistry, health promotion, epidemiology and business administration. The Association works with governments, including local government, and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention, and surveillance services in all of Ontario's communities. Further information on alPHa can be found at: www.alphaweb.org

For further information contact:
Loretta Ryan
Executive Director, alPHa
647-325-9594 loretta@alphaweb.org

References

[i] The Canadian Centre for Substance Use and Addiction. (2018). Canadian Substance Use Costs and Harms in the Provinces and Territories. Retrieved from: http://www.ccdus.ca/Resource%20Library/CSUCH-Canadian-Substance-Use-Costs-Harms-Provincial-Territorial-Report-2018-en.pdf

[ii] Centre for Addiction and Mental Health (CAMH). (2017). Alcohol Availability in Ontario: The Changing Landscape. Retrieved from: http://eenet.ca/sites/default/files/2018/Alcohol%20Availability%20in%20Ontario%20Infographic.pdf

[iii] Babor, T., Caetano, R., Cassell, S., Edwards, G., Giesbrecht, N., Graham, K., Rossow, I. (2010). Alcohol: No Ordinary Commodity: Research and public policy (Second Ed.). New York, USA: Oxford University Press.

[iv] Bryden, A., Roberts, B., McKee, M., & Petticrew, M. A Systematic Review of the Influence on Alcohol use of Community Level Availability and Marketing of Alcohol. Health & Place: 2012, 18 (349-357). Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/22154843

[v] Becker, L., & Dilley, J. Studying the Impact of Washington State Initiatives: I-1183 (alcohol privatization) and I-502 (marijuana legalization)". Presentation to Joint House Committees on Early Learning and Public Safety, Washington State Legislature, February 19, 2014 Retrieved from: http://media.oregonlive.com/politics_impact/other/wash.priv.study.pdf

[vi] Campbell, C.A., et al., The Task Force on Community Preventative Services. (2009). The Effectiveness of Limiting Alcohol Outlet Density as a Means of Reducing Excessive Alcohol Consumption and Alcohol Related Harms. The American Journal of Preventative Medicine., 37 (6), 556.

[vii] Canadian Institute for Health Information. (2017). Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm. Ottawa, ON: CIHI. Retrieved from: https://www.cihi.ca/sites/default/files/document/report-alcohol-hospitalizations-en-web.pdf

[viii] ibid

[ix] Thomas, G. (2012). Analysis of beverage alcohol sales in Canada. Alcohol Price Policy Series: Report 2. Retrieved from: http://www.ccsa.ca/Resource%20Library/CCSA-Analysis-Alcohol-Sales-Policies-Canada-2012-en.pdf

[x] Probst, Charotte and Rehm, Jürgen (2019) Alcohol Use, Opioid Overdose and Socioeconomic Status in Canada: A Threat to Life Expectance? Retrieved from: http://www.cmaj.ca/content/190/44/E1294

[xi] Canadian Mental Health Association Ontario (2019). Expansion of Alcohol Sales in Ontario. Perspectives from the Canadian Mental Health Association, Ontario. Retrieved from: https://ontario.cmha.ca/wp-content/uploads/2019/02/CMHA-Alcohol-submission.pdf

[xii] Thomas, G., Stockwell, T., & Reist, D. (2019). Alcohol Pricing, Public Health and the HST: Proposed Incentives for BC Drinkers to Make Healthy Choices. Retrieved from: https://www.researchgate.net/publication/242463777_Alcohol_Pricing_Public_Health_and_the_HST_Proposed_Incentives_for_BC_Drinkers_to_Make_Healthy_Choices

[xiii] Thomas, G. (2012). Analysis of beverage alcohol sales in Canada. Alcohol Price Policy Series: Report 2. Retrieved from: http://www.ccsa.ca/Resource%20Library/CCSA-Analysis-Alcohol-Sales-Policies-Canada-2012-en.pdf

Appendix

Summary of alPHa's Submissions Related to Alcohol

- Alcohol is an important public health issue.
- Alcohol is not an ordinary commodity and should not be treated as such.
- Decisions how it is regulated, promoted and sold must be made within the broader context of its known and measurable societal harms, negative economic impacts and most importantly, public health.
- Alcohol is the most commonly used drug among Ontarians and one of the leading causes of death, disease and disability in Ontario.
- Alcohol is responsible for the second highest rate of preventable death and disease in Canada, following tobacco.
- Ontario has a significant portion of the population drinking alcohol and exceeding the low risk drinking guidelines.
- Expenditures attributed to alcohol consumption cost Ontarians an estimated $1.7 billion in direct health care costs and $3.6 billion in indirect costs in 2011, for a total of $5.3 billion.
- Direct health problems include chronic diseases such as liver diseases, diabetes, cardiovascular disease, cancer and other chronic illness along with deaths from drunk driving, homicides, suicides, assaults, fires, drowning and falls. These are but some of the more obvious examples of the adverse impacts of alcohol use and abuse.
- Indirect costs are also substantial due to alcohol-related illness, disability and death along with lost productivity in the workplace and at home.
- There is a well-established association between easy access to alcohol and overall rates of consumption and damage from alcohol.
- Increasing access works against the government's efforts to reduce health care costs. A recent study by the Canadian Institute for Health Information estimated that there were over 25,000 hospitalizations in one year in Ontario that were entirely caused by alcohol. There were more hospital admissions in Canada in 2017 for alcohol-related conditions than heart attacks. Significant health care savings could be achieved through reduced health care burden from alcohol-related diseases and death.

- It is well-established that access increases consumption, which in turn increases the numerous alcohol-related harms as well as societal costs to the Province related to law enforcement. It is estimated that law enforcement related to alcohol costs Ontarians $3.18 yearly.

- We have expressed our opposition to expanding the nature and number of retailers permitted to sell alcohol in the past, based on clear evidence that increasing access is detrimental to public health, and this remains our position. Given that such expansion continues to proceed in Ontario however, we must reinforce the importance of developing a comprehensive, provincially led alcohol strategy that can help mitigate the otherwise entirely preventable negative impacts of increased alcohol availability, which include increasing hallway medicine and waste of taxpayers' money.

- It is well-established that increasing alcohol availability is directly related to increased consumption and alcohol-related harms. A comprehensive, evidence-based approach to alcohol policy is therefore critical to limiting these harms.

EXCERPTS FROM AGO REPORT, CHAPTER 3.10 PUBLIC HEALTH: CHRONIC DISEASE PREVENTION

1.0 Summary

OVERALL MINISTRY RESPONSE

The Ministry and public health units are actively involved in promoting the Low-Risk Alcohol Drinking Guidelines to support a culture of moderation and provide consistent messaging about informed alcohol choices and responsible use. Over 65 stakeholders have been consulted to inform the development of a provincial Alcohol Strategy (p. 531).

4.1.3 Comprehensive Policy Developed and Dedicated Funding Provided for Tobacco Control but Not Physical Activity, Healthy Eating and Alcohol Consumption

Alcohol Consumption

In the case of ensuring effective controls on alcohol availability, we found that while public health is tasked with promoting Canada's Low-Risk Alcohol Drinking Guidelines to reduce the burden of alcohol-related illness and disease, in 2015 the Province expanded alcohol sales in grocery stores, farmers' markets, and LCBO e-commerce sales channels. One public health unit released a public statement noting that this move undermines the objective of public health units' work to reduce the burden of alcohol-related illness and disease.

Similarly, in their report mentioned earlier, Cancer Care Ontario and Public Health Ontario noted that the evidence shows that increased availability of alcohol is associated with high-risk drinking and alcohol-related health problems (pp. 546-547).

RECOMMENDATION 3

To better address the risk factors that contribute to chronic diseases, we recommend that the Ministry of Health and Long-Term Care develop comprehensive policies to focus on the key risk factors of chronic diseases—physical inactivity, unhealthy eating and alcohol consumption—in addition to tobacco control (p. 547).

MINISTRY RESPONSE

The Ministry and public health units are actively involved in promoting the Low-Risk Alcohol Drinking Guidelines to support a culture of moderation and provide consistent messaging about informed alcohol choices and responsible use. Over 65 stakeholders have been consulted to inform the development of a provincial Alcohol Strategy.

Building on these achievements, the Ministry is currently developing an integrated provincial strategy to further increase adoption of healthy living behaviours across the lifespan to reduce risk factors for chronic diseases including unhealthy eating, physical inactivity, harmful use of alcohol, and tobacco use, while recognizing the impact of social determinants of health.

EXCERPTS FROM AGO NEWS RELEASE DECEMBER 6, 2017: *SUCCESS OF PUBLIC HEALTH PROGRAMS IN PREVENTING CHRONIC DISEASES UNKNOWN: AUDITOR GENERAL*

The audit found that although the Ministry of Health and Long-Term Care (Ministry) has made progress in reducing smoking, a chronic disease risk factor, more work is needed to address the other risk factors such as physical inactivity, unhealthy eating and heavy drinking (3rd ¶)

A 2016 research report from the Ontario-based Institute for Clinical Evaluative Sciences, says that four modifiable risk factors that contribute to chronic diseases—physical inactivity, smoking, unhealthy eating and excessive alcohol consumption—cost Ontario almost $90 billion in health-care costs between 2004 and 2013. One of public health's functions is to prevent chronic diseases, such as cardiovascular and respiratory diseases, cancer and diabetes. In Ontario, the number of people living with these diseases has been rising (4th ¶).

The Regional Municipality of Durham

Health Department

605 ROSSLAND ROAD EAST
LEVEL 2
PO BOX 730
WHITBY, ON L1N 0B2
CANADA

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

durham.ca

An Accredited Public Health Agency

facebook.com/DurhamRegionHealth

twitter.com/DurhamHealth

February 20, 2019

Christopher Tyrell
Standing Committee on Public Accounts
Committee Clerk
Procedural Services Branch
Legislative Assembly of Ontario
1405-99 Wellesley Street West
Toronto, Ontario M7A 1A2

Dear Chair and Members:

Re: Public Health – Chronic Disease Prevention Audit

On behalf of my colleagues Drs. David Colby (Municipality of Chatham-Kent), Eileen de Villa (Toronto Public Health) and Janet DeMille (Thunder Bay District Health Unit), we are pleased to appear before you today to answer any questions you may have with respect to the Public Health – Chronic Disease Prevention audit of the 2017 Auditor General of Ontario's Annual Report.

Our respective biographies are listed below, and our speaking points are attached to this letter. We respectively recommend that questions related to the Ministry of Health and Long-Term Care, including the status of the audit's recommendations, and Public Health Ontario (PHO) be directed to the appropriate officials within the Ministry or PHO. In addition, if we are unable to answer your questions, we are happy to take them back to our respective public health units and report back to the Committee.

Sincerely,

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

If this information is required in an accessible format, please contact 1-800-372-1102 ext. 3324.

100% Post Consumer

Dr. David Colby

Originally from Chatham, Dr Colby received his MD from the University of Toronto in 1984. Dr Colby was awarded Fellowship in the Royal College in 1990 (Medical Microbiology) and was appointed Chief of Microbiology at University Hospital, London in 1993. He was President of the Canadian Association of Medical Microbiologists from 1995 to 1997. Dr Colby is a Coroner for the province of Ontario and Professor of Microbiology/ Immunology and Physiology/ Pharmacology at Western. His research interests include antimicrobial resistance and wind turbine sounds. Dr Colby is the Medical Officer of Health in Chatham-Kent.

Dr. Eileen de Villa

Dr. Eileen de Villa is the Medical Officer of Health for the City of Toronto. Dr. de Villa leads Toronto Public Health, Canada's largest local public health agency, which provides public health programs and services to 2.9 million residents. Prior to joining Toronto Public Health, Dr. de Villa served as the Medical Officer of Health for the Region of Peel serving 1.4 million residents.

Dr. de Villa received her degrees as Doctor of Medicine and Master of Health Science from the University of Toronto and holds a Master of Business Administration from the Schulich School of Business. Dr. de Villa is also an Adjunct Professor at the Dalla Lana School of Public Health at the University of Toronto.

Dr. de Villa has authored, published and presented research on issues including public health considerations for city planning and emergency preparedness, communicable and infectious disease control, and public health policy development.

Dr. Janet DeMille

Dr. Janet DeMille is the Medical Officer of Health and CEO of the Thunder Bay District Health Unit (TBDHU), one of two provincial public health units covering all of Northwestern Ontario.

Dr. DeMille has lived and worked in Northwestern Ontario (NWO) for over 20 years, initially training and then practicing in Family Medicine in rural communities in NWO as well as in the City of Thunder Bay. In 2009, she entered the post-graduate medical training at the Northern Ontario School of Medicine and successfully completed her Master of Public Health degree and her Royal College certification in Public Health and Preventive Medicine in 2012. She started working at the TBDHU after this, first in the role of Associate MOH before officially taking on the role of MOH in early 2016.

Dr. Robert Kyle

Dr. Robert Kyle has been the Commissioner & Medical Officer of Health for the Regional Municipality of Durham since 1991. He obtained his Bachelor of Science degree in chemistry from Western University and medical degree and Master of Health Science degree from the University of Toronto. He is a certificant in the Specialty of Community Medicine from the Royal College of Physicians and Surgeons of Canada and holds a certificate in Family Medicine from the College of Family Physicians of Canada.

Dr. Kyle is a Fellow of the Royal College of Physicians and Surgeons of Canada and of the American College of Preventive Medicine and is a former Medical Officer of Health for the Peterborough County-City Health Unit. He is an Adjunct Professor, Dalla Lana School of Public Health, University of Toronto and a member of the medical staffs of Lakeridge Health Corporation and Markham-Stouffville Hospital.

Dr. Kyle is an active member of many provincial and regional health groups and organizations. For example, he is currently Chair of Public Health Ontario's Board of Directors, President of the Association of Local Public Health Agencies, and Chair of the Public Health and Preventive Medicine Exam Board for the Royal College of Physicians and Surgeons of Canada.

Standing Committee on Public Accounts
Room 151, Main Legislative Building

February 20, 2019

Speaking Points

- Good morning; I am Dr. Robert Kyle, Commissioner & Medical Officer of Health, Regional Municipality of Durham
- With me are Drs. David Colby, Eileen de Villa and Janet DeMille, Medical Officers of Health for Chatham-Kent, Toronto, and Thunder Bay District, respectively
- Our bios are attached to our transmittal letter, together with these speaking points, which we would be happy to leave with the Committee Clerk
- Thank you for the invitation to appear before you today
- Thanks to the Audit Team for working with us in researching and preparing its audit report
- Before proceeding, it should be noted that section 2.1.2 of the audit (p 533) refers to the previous Ontario Public Health Standards, 2008 (revised March 2017) that were replaced by the new Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, 2018 (OPHS), which are described in more detail below
- We acknowledge the public health significance of chronic diseases, in that:
    - Most chronic diseases (e.g., diabetes, cancer, etc.) are preventable, or their onset can be delayed by limiting four modifiable risk factors:
        - Physical inactivity
        - Smoking
        - Unhealthy eating
        - Excessive alcohol consumption (p 527)

    - The MOHLTC estimated that major chronic diseases and injuries accounted for 31% of direct, attributable health care costs in Ontario (p 534)
    - Preventing chronic diseases helps reduce the burden on the health-care system and promotes a better quality of life (p 534)

- Accordingly, the focus of our remarks is on the public health system and its role in chronic disease prevention

- Questions about the Ministry of Health and Long-Term Care (Ministry), the status of the Audit's recommendations, and Public Health Ontario (PHO) are best directed to Ministry and PHO officials, respectively

- Public health focuses on the health and well-being of the whole population through the promotion and protection of health and prevention of illness (p 531)

- The *Health Protection and Promotion Act* (Act) is the primary legislation that governs the delivery of public health programs and services; its purpose is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease, and the promotion and protection of the health of the people of Ontario (p 532)

- The public health system is an extensive network of government, non-government and community organizations operating at the local, provincial and federal levels (p 532)

- The key provincial players are the Ministry and PHO (p 532)

- The Ministry co-funds with obligated municipalities 35 public health units (PHUs) to directly provide public health programs and services (p 532)

- The Population and Public Health Division (Division) is responsible for developing public health initiatives and strategies, and funding and monitoring public health programs and services delivered by PHUs (P 532)

- The Division is currently led by the Chief Medical Officer of Health (CMOH) who reports directly to the Deputy Minister; his other duties include those listed on p 532
- PHO provides scientific and technical advice and support to the CMOH, Division and PHUs; it also operates Ontario's 11 public health laboratories (p 532)
- PHUs deliver a variety of program and services in their health units; examples are listed on p 533
- Health unit populations range in size from 34,000 (Timiskaming) to 3 million (Toronto) (p 533)
- Each PHU is governed by a board of health (BOH), which is accountable for meeting provincial standards under the Act (p 533)
- Each BOH appoints a medical officer of health (MOH) whose powers and duties are specified in the Act and include reporting directly to the BOH on public health and other matters (P 533)
- Governance models vary considerably across the 35 PHUs; all are municipally controlled to varying degrees (p 533)
- Each BOH has a Public Health Funding and Accountability Agreement with the Ministry, which sets out the terms and conditions governing its funding (p 533)
- The Ministry develops standards for delivering public health programs and services as required by the Act; each BOH is required to comply with these standards (p 533)
- On January 1, 2018, each BOH began implementing the new OPHS, Protocols and Guidelines
- The OPHS set out the minimum requirements that PHUs must adhere to in delivering programs and services

- The OPHS consist of the following nine Program Standards:
    - Chronic Disease Prevention and Well-being
    - Food Safety
    - Healthy Environments
    - Healthy Growth and Development
    - Immunization
    - Infectious and Communicable Diseases Prevention and Control
    - Safe Water
    - School Health
    - Substance Use and Injury Prevention

- The OPHS also consist of the following four Foundational Standards that underlie and support all Program Standards:
    - Population Health Assessment
    - Health Equity
    - Effective Public Health Practice, which is divided into 3 sections:
        - Program Planning, Evaluation, and Evidence-Informed Decision-Making
        - Research, Knowledge Exchange, and Communication
        - Quality and Transparency
    - Emergency Management

- 23 Protocols provide direction on how BOHs shall operationalize specific requirement(s) identified within the OPHS; the aim is to have consistent implementation of specific requirements across all 35 BOHs; in the past and now, BOHs must comply with these Protocols

- 20 Guidelines provide direction on how BOHs shall approach specific requirement(s) identified within the OPHS; the aim is to provide a consistent approach to/application of requirements across all BOHs while also allowing for variability in programs and services across PHUs based on

local contextual factors as defined in the guidelines; now, BOHs must comply with these Guidelines

- It should be noted that although there are fewer Program Standards, there are more Foundation Standards and taken together with the Protocols and Guidelines, more requirements with which BOHs must comply
- Under the Act, provincial funding of PHUs is not mandatory but rather is provided as per Ministry policy; the Act requires obligated (upper-tier or single-tier) municipalities to pay the expenses incurred by or on behalf of the PHUs to deliver the programs and services set out in the Act, the regulations and the OPHS (p 534)
- Currently, the Ministry funds up to 75% of mandatory programs and up to 100% of priority programs (p 534)
- The Ministry updates the schedules in the Public Health Funding and Accountability Agreement annually (p 534)
- The new OPHS takes a coordinated approach to the Standards listed above and a more robust Accountability Framework that covers the following domains:
    - Delivering of Programs and Services
    - Fiduciary Requirements
    - Good Governance and Management Practices
    - Public Health Practice
    - Common to All Domains
- Accordingly, beginning in 2018, each BOH submits a prescribed Annual Service Plan and Budget Submission to the Division for approval
- It should be noted that BOHs are now providing the PPHD with far more information; moreover, beginning in the fall of 2018, BOHs must report on their risk management activities; finally, commencing with the 2019 ASPBS,

BOHs must report on their 2018 program activities, as specified by the PPHD

- With respect to chronic disease prevention, the OPHS require each BOH to develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic disease risk and protective factors

- The following topics (by program) are considered based on an assessment of local needs:

    - Built environment (Chronic Disease Prevention and Well-being {CDP})
    - Comprehensive tobacco control (Substance Use and Injury Prevention {SUIP})
    - Healthy eating behaviours (CDP, School Health {SH})
    - Mental health promotion (CDP, SH, SUIP)
    - Oral health (CDP, SH, SUIP)
    - Physical activity and sedentary behaviour (CDP, SH)
    - Substance use (SH, SUIP) and harm reduction (SH)
    - UV exposure (CDP, SH)

- Several Guidelines (i.e., *Chronic Disease Prevention*, *Health Equity*, *Mental Health Promotion*, and *Substance Use Prevention and Harm Reduction*) and one Protocol (*Tobacco, Vapour and Smoke)* guide the work in this area

- For these three (CDP, SH, SUIP) programs, each BOH shall collect and analyze relevant data and report and disseminate the data and information in accordance with the *Population Health Assessment and Surveillance Protocol, 2018*

- As regards program evaluation, each BOH is required to:

    - Routinely monitor program activities and outcomes to assess and improve the implementation of programs and services

    - Ensure a culture of on-going program improvement and evaluation, and conduct formal program evaluations where required
    - Ensure all programs and services are informed by evidence

- Each BOH must comply with 2 research and knowledge exchange (KE) requirements:

    - Engage in KE activities with public health practitioners, etc. regarding factors that determine populations health
    - Foster relationships with researchers, academic partners and others to support research and KE activities

- In closing, Ontario has a mature, inter-connected, and well-regulated public health system
- The system is capably led by the Ministry and ably assisted by the CMOH and the Division
- PHO provides the Ministry and PHUs with superb scientific, technical and laboratory support
- PHUs are governed by BOHs each of which appoints a MOH who ensures the delivery of a wide array of public health programs and services, including chronic disease prevention, in accordance with the Act, regulations, OPHS, Protocols and Guidelines
- As with all well-functioning health systems, there is always room for continuous quality improvement
- With the foregoing in mind, we would be happy to answer your questions

March 04, 2019

The Honourable Christine Elliott
Deputy Premier of Ontario
Minister of Health and Long-Term Care
christine.elliottco@ola.org

Dear Minister Elliott,

Re: Strengthening the Smoke-Free Ontario Act, 2017 to address the promotion of vaping

At the February 26, 2019 regular meeting of the Board of Health for the Renfrew County and District Health Unit (RCDHU) the Board considered the attached correspondence from Peterborough Public Health urging the Ontario government to strengthen the Smoke-Free Ontario Act, 2017 to prohibit through regulation, the promotion of vaping products.

The following motion was recommended by the Stakeholder Relations Committee and accepted by the Board on February 26, 2019:

Resolution: # 3 SRC 2019-Feb-08
A motion by M. A. Aikens; seconded by J. Dumas; be it resolved that the Stakeholder Relations Committee recommend to the Board that the RCDBH support the correspondence from Peterborough Health Unit urging the province to strengthen the Smoke-Free Ontario Act 2017 and prohibit the promotion of vaping products and further that it be cc as per the Sudbury letter.

Carried

Sincerely,

Janice Visneskie Moore
Chair, Board of Health
Renfrew County and District Health Unit

cc (via email): The Honourable Doug Ford, Premier of Ontario
Dr. David Williams, Chief Medical Office of Health
The Honourable John Yakabuski, MPP, Renfrew-Nipissing-Pembroke

Ontario Boards of Health
Loretta Ryan, Executive Director, association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Associations
Association of Municipalities of Ontario
Jacquie Maund, Alliance for Healthier Communities

Peterborough Public Health

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

November 5, 2018

The Honourable Christine Elliott
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
christine.elliott@pc.ola.org

Dear Minister Elliott,

Re: Strengthening the Smoke-Free Ontario Act (2017) to address the promotion of vaping

At its meeting on October 10, 2018, the Board of Health for Peterborough Public Health passed a motion to urge the Ontario government to strengthen the Smoke-Free Ontario Act (2017) and prohibit through regulation, the promotion of vaping products.

By and large the changes in the updated Act and regulations are viewed favorably by Peterborough Public Health as it harmonizes medicinal cannabis, recreational cannabis, conventional cigarettes, and e-cigarette laws into one piece of legislation. However, health experts conclude that allowing retail vaping displays and promotion will put thousands of children and youth at risk of nicotine addiction. The legislation only bans actual vaping product displays at retail outlets and does not restrict other types of retail promotion for vaping products. It permits the widespread promotion of vaping products in convenience stores, gas bars and other retail locations across Ontario. This includes freestanding brand promotions now located inside and outside retail locations like gas bars, posters including pictures of products, video product promotion, and many other types of promotion including those featuring actual vaping products, are all allowed. Mass media promotion of vaping produces (i.e., television advertising) has already been seen in Ontario.

Public health representatives are very concerned about the outcome of nicotine exposure on the adolescent brain. There is also more evidence of respiratory health impacts among young vapers. We are sure that these serious health impacts must be of concern to you and the Government of Ontario as well. We agree with a federal commitment to reducing tobacco use to 5% in Ontario by 2035[1] and fear that current promotion of vaping will actually lead to increased tobacco use among youth. Recently released results from the Canadian Tobacco, Alcohol and Drugs Survey (CTADS) shows that current smoking rates for Canadians aged 15 years and over have actually increased to 15.1% in 2017 from 13.0% in 2015.[2] Your action is urgently needed to protect the health of youth in Ontario and avoid an epidemic of vaping and nicotine addiction. We must work collaboratively to ensure that young people do not start smoking or vaping.

In conjunction with the above actions, the Board of Health requests that the Province invest in a timely evaluation of the implementation of the Smoke-Free Ontario Act to monitor the impacts of the limited promotion of vaping products with a commitment to make the required amendments as soon as possible.

Sincerely,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

cc: Hon. Doug Ford, Premier of Ontario
Local MPPs
Ontario Boards of Health
Association of Local Public Health Agencies

---

[1] Health Canada (2018). Canada's Tobacco Strategy. Retrieved from https://www.canada.ca/content/dam/hc-sc/documents/services/publications/healthy-living/canada-tobacco-strategy/overview-canada-tobacco-strategy-eng.pdf

[2] Statistics Canada (2018). Canadian Tobacco, Alcohol and Drugs Survey (CTADS): Summary of results for 2017. Retrieved from https://www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2017-summary.html

Renfrew County and District Health Unit

"Optimal Health for All in Renfrew County and District"

March 04, 2019

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

Dear Premier Ford,

Re: Support for Provincial Oral Health Program for Low Income Adults and Seniors

At the February 26, 2019 regular meeting of the Board of Health for the Renfrew County and District Health Unit (RCDHU) the Board considered the attached correspondence from Sudbury & Districts Public Health regarding support for the oral health program for low income seniors and encouraging the government to expand access to include low income adults.

The following motion, recommended to the RCDHU Board of Health by the Stakeholder Relations Committee, was accepted by the Board on February 26, 2019:

Resolution: # 3 SRC 2019-Feb-08
A motion by J. Dumas; seconded by M. A. Aikens; be it resolved that the Stakeholder Relations Committee recommends that the Board endorse correspondence from Sudbury and Districts Public Health regarding support for a provincial oral health program for low income adults and seniors and further that it be cc'd as per the Sudbury Board of Health letter with the addition to alPHa and the Honourable MPP John Yakabuski.

Carried

Sincerely,

Carolyn Watt

for Janice Visneskie Moore
Chair, Board of Health
Renfrew County and District Health Unit

cc (via email): The Honourable Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health

The Honourable John Yakabuski, MPP, Renfrew-Nipissing-Pembroke
Ontario Boards of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Municipalities of Ontario
Jacquie Maund, Alliance for Healthier Communities

Public Health
Santé publique
SUDBURY & DISTRICTS

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Rainbow Centre
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
101 rue Pine Street E
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

Toll-free / Sans frais
1.866.522.9200

phsd.ca

December 7, 2018

VIA ELECTRONIC MAIL

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

Dear Premier Ford:

Re: Support for Provinical Oral Health Program for Low Income Adults and Seniors

I am very pleased to write to you on behalf of the Board of Health for Public Health Sudbury & Districts to share our sincere appreciation for the provincial government's support of a provincial oral health program for low-income seniors. This is a welcome addition to oral health programs already available for children and youth in low-income families through Healthy Smiles Ontario.

The Board of Health for Public Health Sudbury & Districts has a keen interest in oral health. In reviewing our 2018 data on oral health, we identified that to further support oral health for all Ontarians, programs are needed for low-income adults, in addition to those in place or planned for children, youth and seniors.

At its meeting on November 22, 2018, the Board of Health carried the following resolution #42-18:

WHEREAS as compared with other provinces, Ontario has the lowest rate of public funding for dental care, as a percentage of all dental care expenditures and the lowest per capita public sector spending on dental services, resulting in precarious access to dental preventive and treatment services, especially for low-income Ontarians; and

WHEREAS the Ontario Progressive Conservative party pledged to implement a comprehensive dental care program that provides low income seniors with quality care by increasing the funding for dental services in Public Health Units, Community Health Centres, and Aboriginal Health Access Centres and by investing in a new dental services in underserviced areas including increasing the capacity in public health units and investing in mobile dental buses;

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts fully support the Premier's plan to invest in oral health programs for low income seniors and further encourage the government to expand access to include low income adults; and

FURTHER that this motion be shared with area municipalities and relevant dental and health sector partners, all Ontario Boards of Health, Chief Medical Officer of Health, Association of Municipalities of Ontario (AMO), and local MPPs.

Thank you for your attention to this matter and I look forward hearing more about the role public health can take in support of a new oral health program for low income adults and seniors that is cost effective and accessible.

Sincerely,

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

cc: Honorable Christine Elliott, Minister of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health, Minister of Health and Long-Term Care
Mr. Jamie West, MPP, Sudbury
Ms. France Gelinas, MPP, Nickel Belt
Mr. Michael Mantha, MPP, Algoma-Manitoulin
All Ontario Boards of Health
Constituent Municipalities within Public Health Sudbury & Districts
Ms. Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Association of Municipalities of Ontario
Dr. David Diamond, President, Sudbury & District Dental Society
Dr. Tyler McNicholl, vice-president, Sudbury & District Dental Society
Ms. Jacquie Maund, Alliance for Healthier Communities

alPHa
Association of Local PUBLIC HEALTH Agencies

(AMENDED)
CALL FOR BOARD OF HEALTH NOMINATIONS 2019-2020 & 2020-2021 alPHa BOARD OF DIRECTORS

*alPHa is accepting nominations for **four** Board of Health representatives from the following regions for the following term on its Board of Directors:*

1. Central West	***2-year term each*** *(i.e. June 2019 to June 2020 & June 2020 to June 2021)*
2. East	
3. South West	
4. North East	***1-year term only** due to vacancy resulting from expiry of provincial appointee's term*

See the attached appendix for boards of health in each of these regions.

Each position will fill a seat on the Boards of Health Section Executive Committee and a seat on the alPHa Board of Directors.

Qualifications:

- *Active member of an Ontario Board of Health (or regional health committee) that is a member organization of alPHa;*
- *Background in committee and/or volunteer work;*
- *Supportive of public health;*
- *Able to commit time to the work of the alPHa Board of Directors and its committees;*
- *Familiar with the Ontario Public Health Standards.*

An election to determine the representatives will be held at the Boards of Health Section Meeting on June 10 during the 2019 alPHa Annual Conference, Four Points by Sheraton Hotel, 285 King St. E., Kingston, Ontario.

*Nominations close **4:30 PM, Friday, May 31, 2019.***

Why stand for election to the alPHa Board?

- Help make alPHa a stronger leadership organization for public health units in Ontario;
- Represent your colleagues at the provincial level;
- Bring a voice to discussions reflecting common concerns of boards of health and health unit management across the province;
- Expand your contacts and strengthen relationships with public health colleagues;
- Lend your expertise to the development of alPHa position papers and official response to issues affecting all public health units; and
- Learn about opportunities to serve on provincial ad hoc or advisory committees.

Continued

What is the Boards of Health Section Executive Committee of alPHa?

- This is a committee of the alPHa Board of Directors comprising seven (7) *Board of Health representatives*.
- It includes a Chair and Vice-Chair who are chosen by the Section Executive members.
- Members of the Section Executive attend all alPHa Board meetings and participate in teleconferences throughout the year.

How long is the term on the Boards of Health Section Executive/alPHa Board of Directors?

- A full term is two (2) years with no limit to the number of consecutive terms.
- Mid-term appointments will be for less than two years.

How is the alPHa Board structured?

- There are 22 directors on the alPHa Board:
    - 7 from the Boards of Health Section
    - 7 from the Council of Ontario Medical Officers of Health (COMOH)
    - 1 from each of the 7 Affiliate Organizations of alPHa, and
    - 1 from the Ontario Public Health Association Board of Directors.
- There are 3 committees of the alPHa Board: Executive Committee, Boards of Health Section Executive, and COMOH Executive.

What is the time commitment for a Section Executive member/Director of alPHa?

- Full-day alPHa Board meetings are held in person 4 times a year in Toronto; a fifth and final meeting is held at the June Annual Conference.
- Boards of Health Section Executive Committee teleconferences are held 5 times throughout the year.
- The Chair of the Boards of Health Section Executive participates on alPHa Executive Committee teleconferences, which are held 5 times a year.

Are my expenses as a Director of the alPHa Board covered?

- Any travel expenses incurred by an alPHa Director during Association meetings are *not* covered by the Association but are the responsibility of the Director's sponsoring health unit.

How do I stand for consideration for appointment to the alPHa Board of Directors?

- Submit a completed Form of Nomination and Consent along with a biography of your suitability for candidacy and a copy of the motion from your Board of Health supporting your nomination to alPHa by **May 31, 2019.**

Who should I contact if I have questions on any of the above?

- Susan Lee, alPHa, Tel: (416) 595-0006 ext. 25, E-mail: susan@alphaweb.org

Board of Health Vacancies on alPHa Board of Directors

*alPHa is accepting nominations for **three** Board of Health representatives to fill positions on its 2019-2020 and 2020-2021 Board of Directors from the following regions and for the following terms:*

1. Central West ***2. East*** ***3. South West***	***2-year term each*** *(i.e. June 2019 to June 2020 & June 2020 to June 2021)*
4. North East	***1-year term only** due to vacancy resulting from expiry of provincial appointee's term (i.e. June 2019 to June 2020)*

See below for boards of health in these regions.

Each position will fill a seat on the Boards of Health Section Executive Committee and a seat on the alPHa Board of Directors. An election will be held at alPHa's annual conference in June to determine the new representatives (one from each of the regions below). If you are an active member of a Board of Health/Regional Health Committee who is interested in running for a seat, please consider standing for nomination.

Central West Region Boards of health in this region include: Brant Haldimand-Norfolk Halton Hamilton Niagara Waterloo Wellington-Dufferin-Guelph	**South West Region** Boards of health in this region include: Chatham-Kent Grey Bruce Huron Lambton Middlesex-London Perth Southwestern Windsor-Essex
East Region Boards of health in this region include: Eastern Ontario Hastings Prince Edward Kingston Frontenac Lennox & Addington Leeds Grenville & Lanark Ottawa Renfrew	**North East Region** Boards of health in this region include: Algoma North Bay Parry Sound Porcupine Sudbury Timiskaming

alPHa
Association of Local PUBLIC HEALTH Agencies

AMENDED

FORM OF NOMINATION AND CONSENT

alPHa Board of Directors 2019-2020 & 2020-2021

_____ , a Member of the Board of Health of
(Please print nominee's name)

_____, is HEREBY NOMINATED
(Please print health unit name)

as a candidate for election to the alPHa Board of Directors for the following Boards of Health Section Executive seat from (*choose one using the list of Board of Health Vacancies on previous pages)*:

- ❑ **Central East Region (2 year term)**
- ❑ **East Region (2 year term)**
- ❑ **South West Region (2 year term)**
- ❑ **North East Region (1 year term)**

SPONSORED BY:

1) _____
(Signature of a Member of the Board of Health)

2) _____
(Signature of a Member of the Board of Health)

Date: _____

I, _____, HEREBY CONSENT to my nomination
(Signature of nominee)

and agree to serve as a **Director of the alPHa Board** if appointed.

Date: _____

IMPORTANT:

1. Nominations close **4:30 PM, May 31, 2019** and must be submitted to alPHa by this deadline.
2. A **biography** of the nominee outlining their suitability for candidacy, as well as a **motion passed by the sponsoring Board of Health** (i.e. record of a motion from the Clerk/Secretary of the Board of Health) must also be submitted along with this nomination form on separate pages by the deadline.
3. E-mail the completed form, biography and copy of Board motion by **4:30 PM, May 31, 2019** to Susan Lee at susan@alphaweb.org

Algoma PUBLIC HEALTH
Santé publique Algoma
www.algomapublichealth.com

March 8, 2019

To: All Municipal Councilors, District of Algoma Health Unit

RE: Presentation to Councils

Dear Mayor and Council,

As you may be aware, Algoma Public Health has previously provided information sessions to municipalities and we enjoy the opportunity to collaborate with our municipal partners. Funding of public health services throughout Ontario is shared by the province and our municipalities. Since we are at the beginning of a 4 year term and many municipal councils have new members we felt it was timely to provide the opportunity to meet again. New, updated Public Health Standards were introduced in 2018 and the entire health system is expected to undergo a transformation in the near future.

Our usual overview presentation is about 15 minutes in length which encompasses an overview of the programs and services administered through APH, how our budget cycle works and how your municipal contribution is applied. We would be happy to answer questions on a broad range of related topics. If you are aware in advance of any specific questions please let us know in advance so we may obtain the data to address your concerns. Myself, and our new Associate MOH Dr. Jennifer Loo and/or Justin Pino our CFO would attend your Council meeting. The Board of Health member that your council has appointed may also attend.

If you are interested, please provide us with the dates of your Council meetings and we will determine a mutually convenient time.

We are also providing a link to our 2017 Annual Report and to our 2018 Community Health Profile. To arrange a date for a presentation please contact Ms. Tania Caputo, Secretary to the District of Algoma Board of Health: tcaputo@algomapublichealth.com or (705) 759-5421.

Sincerely,

Marlene Spruyt, BSc., MD, CCFP, FCFP, MSc-PH
Medical Officer of Health/CEO

Cc: Lee Mason, Board of Health Chair
for the District of Algoma Health Unit

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

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

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

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

Association of Local PUBLIC HEALTH Agencies

MINDING PUBLIC HEALTH

2019 alPHa Annual Conference

June 9 – 11, Four Points by Sheraton, 285 King St., Kingston ON

DRAFT PROGRAM-AT-A-GLANCE *

**all events held at conference hotel unless otherwise indicated* *updated 2019-03-04*

Sunday, June 9, 2019		
2:00 – 4:00	**Guided Walking Tour of Downtown Kingston** Meeting place: Lobby of Four Points hotel (to be confirmed) Tour Guides: • Dr. Charles Gardner, Medical Officer of Health, Simcoe Muskoka District Health Unit • Susan Cumming, RPP, Adjunct Lecturer, Queen's University and Past President, Ontario Professional Planners Institute	
2:00 – 5:30	**Registration**	
4:00 – 6:00	**alPHa Board of Directors Meeting** Location: KFL&A Public Health, 221 Portsmouth Ave., Kingston	Offsite – see description
	Trolley buses depart hotel 5:30 pm to health unit; depart health unit 7:00 pm to hotel. *Special thanks to trolley sponsors Shoalts and Zaback Architects Ltd., designers of KFL&A Public Health's new office.*	
6:00 – 7:00	**Opening Reception** Greetings by Mark Gerretsen, MP, Kingston and The Islands (to be confirmed) Location: KFL&A Public Health, 221 Portsmouth Ave., Kingston *Special thanks to KFL&A Public Health for sponsoring the reception.*	Offsite – see description
Monday, June 10, 2019		
7:00 – 8:00	**Continental Breakfast & Registration**	
8:00 – 10:00	**Annual General Meeting and Resolutions Session**	

	AGM and Resolutions Chair: Robert Kyle, alPHa President (to be confirmed)	
10:00 – 10:30	**Fitness Break**	
10:30 – 10:35	**Welcoming Remarks** by Bryan Paterson, Mayor of Kingston (to be confirmed)	
10:35 – 11:45	**Opening Plenary Session** • Dr. Theresa Tam, Canada Chief Public Health Officer (confirmed) • Hon. Christine Elliott, Minister of Health & Long-Term Care (to be confirmed)	
11:45 – 1:30	**Distinguished Service Awards Luncheon**	
1:30 – 3:00	**Plenary Session: Panel on Mental Health & Public Health – Part I** (Downstream Focus) Much of public health's work centers on upstream approaches to keep the population healthy. In times of crisis and emergencies, however, public health finds it must employ downstream interventions and strategies to save lives. This session will examine how public health and community partners can best work together to address mental health issues from a downstream perspective using the current opioid epidemic as an example. Moderator: Nadia Zurba, Senior Manager, Ontario Harm Reduction Distribution Program (confirmed) Panelists: • Antje McNeely, Chief of Police, Kingston Police (confirmed) • Monika Turner, Director of Policy, Association of Municipalities of Ontario (confirmed) • TBD	
3:00 to 3:30	**Break**	
3:30 to 5:00	**Plenary Session: Panel on Mental Health & Public Health – Part II (Upstream Focus)** Amidst the growing mental health crisis, there is increasing recognition that getting at the root causes of mental illness and preventing them in the first place will mitigate their negative health impacts at personal and societal levels. This session will focus on the upstream approach that public health and education partners are taking to address the mental health crisis both individually and collectively. Moderator: TBD Panelists:	

	• Dr. Andrea Feller, Associate Medical Officer of Health, Niagara Region Public Health (confirmed) • TBD • TBD	
5:30 to 7:00	**Reception** (sponsored by Lone Star Texas Grill) *Refreshments provided; cash bar.* Location: Lone Star Texas Grill, 251 Ontario St., Kingston (a 5-minute walk from the Four Points hotel)	Offsite – see description
7:00 onward	Delegates on their own for dinner	
Tuesday, June 11, 2019		
7:30 – 8:30	**Continental Breakfast**	
8:30 – 9:00	**Plenary Session: Lyme Disease Update** Speaker: Dr. Kieran Moore, Medical Officer of Health, KFL&A Public Health (confirmed)	
9:00 – 12:00	**Concurrent Section Meetings** (Boards of Health Section, COMOH)	
12:00	**Conference Ends** Delegates on their own for lunch	
12:30 – 1:30	**Inaugural alPHa Board of Directors Meeting**	

Ontario

2017 ANNUAL REPORT

Of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario

CONNECTED COMMUNITIES healthier together


family
INCLUSION
Participation
SOMEONE TO CONFIDE IN
acceptance
Fellowship
SOCIAL SUPPORT
GOODWILL
COMFORT
INTEGRATION
STABILITY
contribution
Warmth
CARING
Relationships
BELONGING
TRUST
Safety
unity
giving back
COLLABORATION
COMMUNITY
being part of something bigger
Sympathy
Mutual Respect
SOCIAL NETWORKS
PURPOSE
significance
FRIENDSHIP
CONNECTEDNESS
MEANING
FEELING AT HOME
SHARING
togetherness

Ministry of Health and Long-Term Care

Office of Chief Medical Officer of Health, Public Health
393 University Avenue, 21st Floor
Toronto ON M5G 2M2

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

Bureau du médecin hygiéniste en chef, santé public
393 avenue University, 21e étage
Toronto ON M5G 2M2

Téléphone : (416) 212-3831
Télécopieur : (416) 325-8412

February 2019

The Honourable Speaker
Speaker of the Legislative Assembly of Ontario
Room 104, Legislative Building
111 Wellesley St. W
Toronto, Ontario M7A 1A2

Dear Speaker,

I am pleased to provide the 2017 Annual Report of the Chief Medical Officer of Health of Ontario for submission to the Assembly in accordance with the provision of section 81.(4) of the Health Protection and Promotion Act.

Yours truly,

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

EXECUTIVE SUMMARY

Being socially connected to family, friends and our communities – having a sense of belonging – is important to our well-being. People who are connected are happier. They enjoy better health and use fewer health services. They are more resilient in the face of adversity, and they live longer.

Communities where people feel connected have less crime and stronger economic growth. Their children perform better in school. Their citizens are more involved: they are more likely to co-operate to benefit all members of the community and to work together to address the social determinants of health, which leads to greater health equity.

How connected are Ontarians? There are worrying signs that many – particularly younger people – feel less connected than they did in the past. While most Ontarians have friends, they see them much less often. They are also much less likely to volunteer in their communities than they once did and, when they do volunteer, they give less time.

Our sense of community is threatened by large systemic pressures and changes. Changes to family and social structures, increasing work and time pressures, urbanization and sprawl, and growing income inequality all make it harder for people to feel connected. Technologies, including television, computers and smartphones, compete for our attention: a growing number of people have hundreds of friends online but few in-person contacts. Perhaps of greatest concern, a growing number of people have lost trust in governments, institutions and one another, which makes them less likely to actively participate in their communities.

These large systemic pressures require system-wide solutions.

The time to act is now. Loneliness and social isolation are serious public health problems that cost us all. They affect our productivity, health, well-being – even how long we live. It's time to revitalize communities and create a healthier Ontario.

Helping people and communities (re)connect is everyone's business. To (re)build a sense of belonging – create connected communities – individuals, organizations, businesses, communities and governments must work together to foster a society that values social connection.

This report recommends three key ways to create more connected communities:

1. **Invest in Community:** Governments should shine a spotlight on the critical importance of connected communities by investing in collecting data on social connection and sense of community, assessing all government policies for their impact on community, creating built environments that make it easier for people to engage in their communities, and tackling the broader social and economic drivers of social isolation.

2. **Enable Community:** Public health units – uniquely positioned between communities and different levels of government – should play a lead role in enabling community. Public health units can make people aware of the benefit of social connections, use data to develop targeted community-building programs, encourage organizations to partner to address systemic issues that drive social isolation, and champion effective frameworks for community development.

3. **Be Community-Centred and Community-Driven:** We should challenge ourselves and each other to make community health and well-being a priority.

Community begins from the ground up. Individual actions make a big difference. At the local level, individuals and organizations – including businesses – can drive change. They can collaborate, pooling strengths and assets to build community. They can make community health and well-being a priority in all their decisions.

It's time to make social connection and sense of community as important a measure of our health and well-being as blood pressure and economic output.

TABLE OF CONTENTS

HOW DO SOCIAL CONNECTIONS AFFECT HEALTH?

Human beings are hard wired to connect. Our need to be part of a group – a family, a network of friends, or a community – is part of our DNA.

The desire to belong and feel connected doesn't just fulfill a primal urge, it affects our physical and mental health, our sense of well-being – even how long we live.

People who are isolated have a 50 per cent greater risk of dying early than those with strong social connections, about the same negative impact on health as smoking 15 cigarettes a day. Social isolation can be twice as deadly as obesity and as big a killer as diabetes.[1, 2] It also increases the risk of dementia by 64 times.[3]

On the other hand, being socially connected can help people overcome adversity and lead longer, happier lives:

- In a 50-year study of 17,000 children born on the same day in Britain in 1958, those with strong family support were more likely to overcome social disadvantages.[4]
- In a 75-year Harvard study of a highly privileged, educated group of men, the factor that contributed the most to healthy aging was strong, loving relationships. Men who had close family ties and good friendships were healthier and happier in old age than those who did not.[5]

Even those at the top of the socio-economic scale experience dramatic differences in health depending on their connections with other people.

HOW DOES COMMUNITY BELONGING PROTECT OUR HEALTH?

Strong social connections help people recover more quickly from stressful situations. Stress is part of life but when we can manage stress, we are more confident and less anxious. We are better able to calm the "fight or flight" response caused by cortisol, the stress hormone.

Left unchecked, high levels of cortisol threaten our health. They trigger inflammation, headaches, high blood pressure, high blood sugar levels, weight gain, depression, problems remembering or concentrating, and sleep problems.[6] Being isolated often translates into being inactive, which also increases the risk of obesity and diabetes. Not being connected – being isolated – is bad for the body, mind and soul.

On the other hand, people with strong social connections and a sense of community belonging have more emotional support and companionship as well as practical supports, such as financial assistance, in emergencies and other resources that help them succeed in life.

For example, when disaster strikes, people who are socially connected have others around them who will lend them money or provide supports, such as child care or a place to stay – while those who are isolated are less likely to receive help from others.[7, 8] During Chicago's 1995 heat wave, isolated elderly people were the most likely to die and not be found for days.[9] More deaths occurred in a poor, African American community that had less public space and social capital than an equally poor, neighbouring Hispanic community.[10]

Indigenous ways of knowing can help us understand the link between a sense of community and health.

Indigenous peoples recognize that "community is the natural context of human life and activity. We are, one and all, social beings living in relation to one another. Our physical and biological survival is intimately interwoven with the communities that we create and that create us. The community is a complex of physical, social, and psychical relationships that are ever-changing and evolving through time and the generations of people who identify with it."[11]

One of the most powerful expressions of the importance of connectedness comes from the Indigenous concept of health and well-being, which honours and celebrates not only the connections between people – and the importance of nurturing both the young and the old – but also, the connections between human beings and the earth, the natural world and the spiritual world.

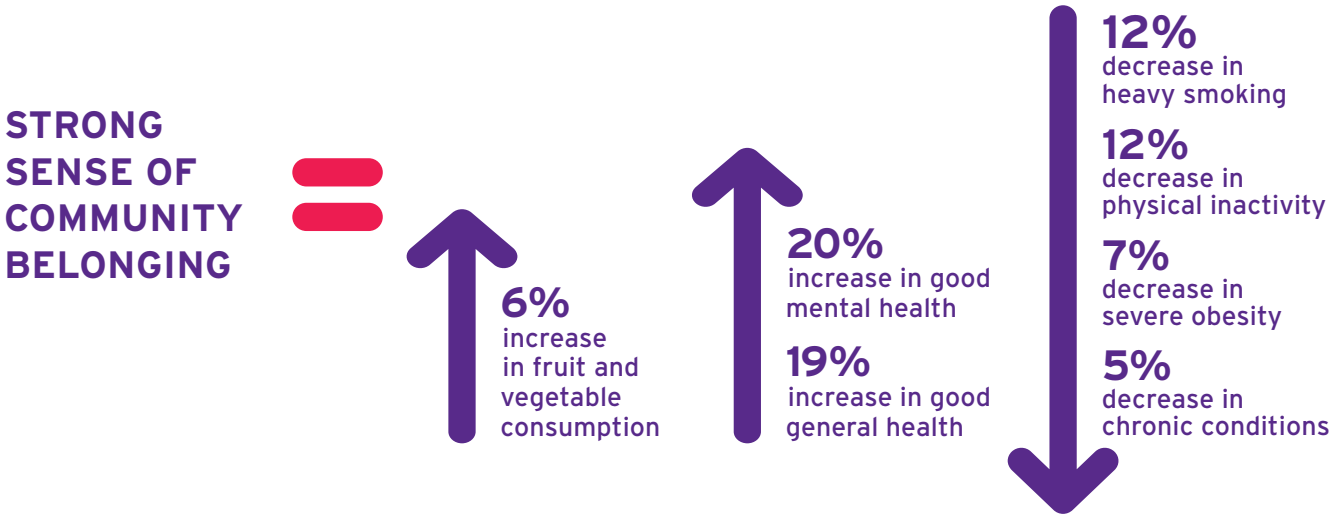
CONNECTED COMMUNITIES ARE RESILIENT

A strong sense of connection makes both individuals and communities more resilient.[10] Communities regularly work together to survive and recover from catastrophes.[12, 13] After the 1995 Kobe earthquake, most people pulled from the rubble of collapsed homes were saved by neighbours, not firefighters or rescue workers.[14, 15, 16]

Compared to those with a weak sense of connection, Canadians with a strong sense of community belonging – regardless of their income – experience significant health benefits. They feel better about themselves and are more likely to make healthy choices like exercising, eating well, drinking moderately and following their health care providers' advice – all of which leads to better health. On the other hand, people who report feeling stressed say that social isolation is a factor in their stress.

Figure I: Association of Community Belonging with Health and Health Behaviours

Adjusted prevalence ratios using the using the 2013/14 Canadian Community Health Survey cohort



People with a weak sense of community belonging are more likely to be in the top five per cent of users of health care services; this five per cent accounts for more than 50 per cent of total health care spending. Of the top one per cent of high resource users, 83.5 per cent use emergency department services and 92.5 per cent require acute hospital care compared to 7.8 per cent and zero per cent for the bottom 50 per cent of resource users. In 2018-19, these high resource users will cost Ontario's health care system a projected $16.5 billion[17] – costs that could be reduced if these individuals were part of connected communities.

What is social capital?

The resources and associated benefits people have access to through their social networks and relationships.[18]

Being socially connected and involved in our communities has benefits beyond individual health and well-being. A strong sense of community gives rise to shared values that benefit society as a whole. In communities where people feel connected (often known as a high level of social capital), people tend to trust one another – even if they do not know each other. These communities have less crime and stronger economic growth. Their children perform better in school and their citizens are more politically involved.[19]

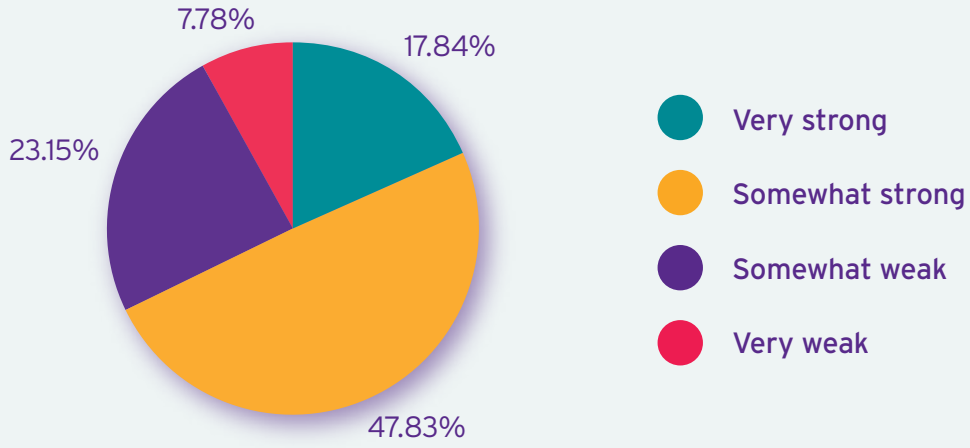
People in communities with high levels of connection and social capital are more likely to co-operate to benefit all members of the community. They are more resilient in the face of disaster, and they are also more likely to work together to address the social determinants of health, which leads to greater equity.

HOW CONNECTED ARE ONTARIANS?

Over six in 10 Ontarians say they have a very or somewhat strong sense of community belonging.

Figure II: Sense of Community Belonging

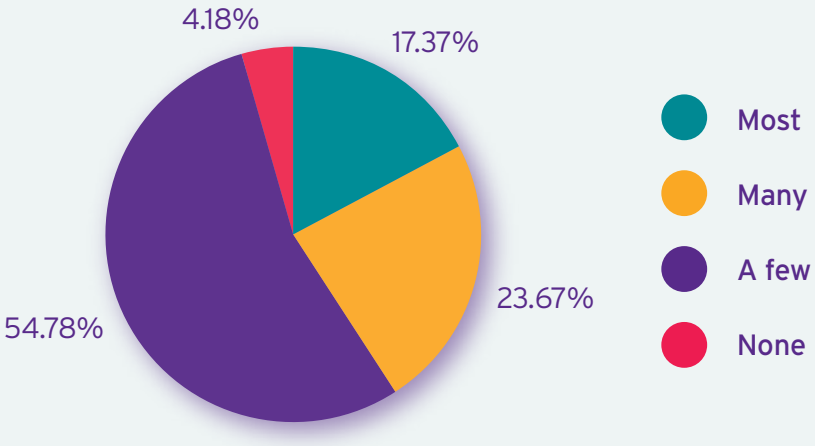
Weighted distribution in Ontario using the 2013/14 Canadian Community Health Survey cohort



However, only four in 10 know many or most of their neighbours.

Figure III: How Many People You Know in Your Neighbourhood

Weighted distribution in Ontario using the 2013 General Social Survey cohort



According to Statistics Canada General Social Survey, Canadians have more friends but they see close friends or family less frequently.[19] There is a growing loneliness gap that we must act now to fill.

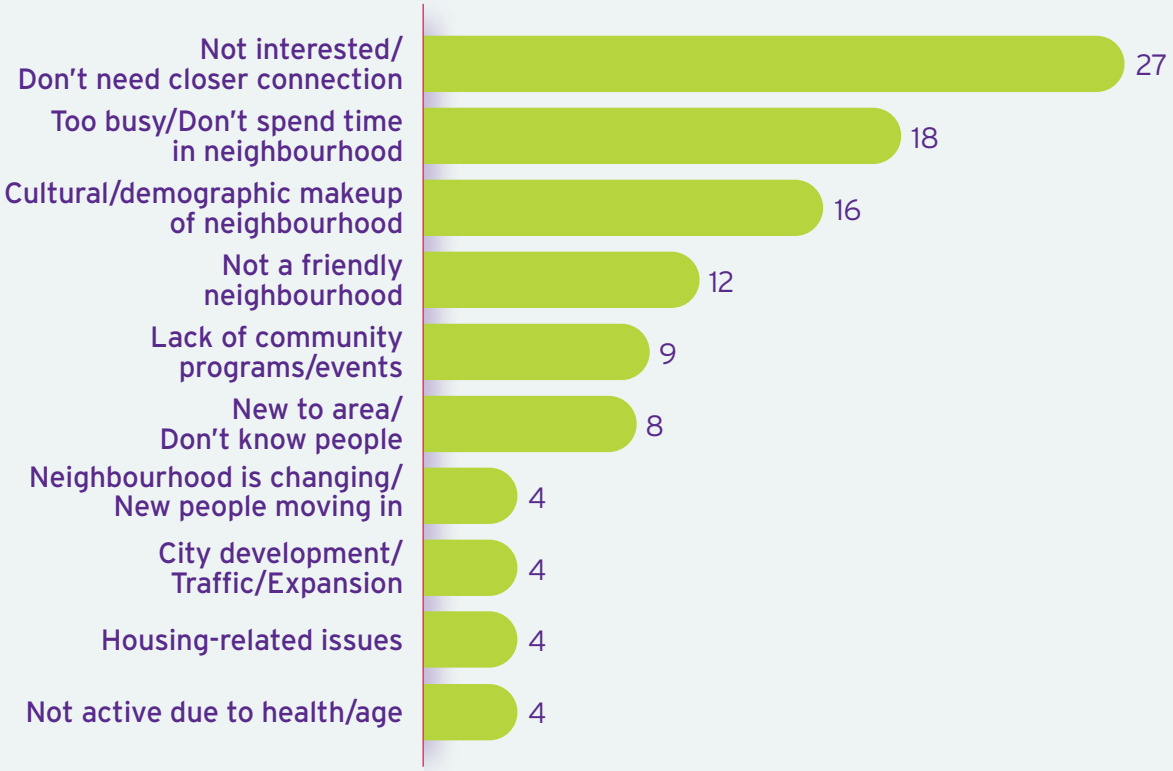
The Toronto Social Capital Study recently asked Torontonians about some key indicators of strong social networks and civic connections.[20] Findings include:

- People are more likely to trust other people if they know their neighbours or are age 55 or older.
- **More than half** of city residents have at least **one close friend** in their neighbourhood and over eight in 10 have one or more other close friends. However, about six per cent (about 100,000 people) reported having no close family and a similar proportion report having no close friends.
- **Two-thirds** of Torontonians participate in at least **one community group** or association, such as cultural/education/hobby groups, union/professional associations, and sports/recreational leagues.
- Just **four in 10** Torontonians reported having done **unpaid volunteer work** in the past 12 months, and those who do volunteer are giving fewer hours.

When asked why they don't have a stronger sense of belonging, Torontonians said: **it wasn't important or they were too busy**. Ontarians may not understand how important social connections are to their health.

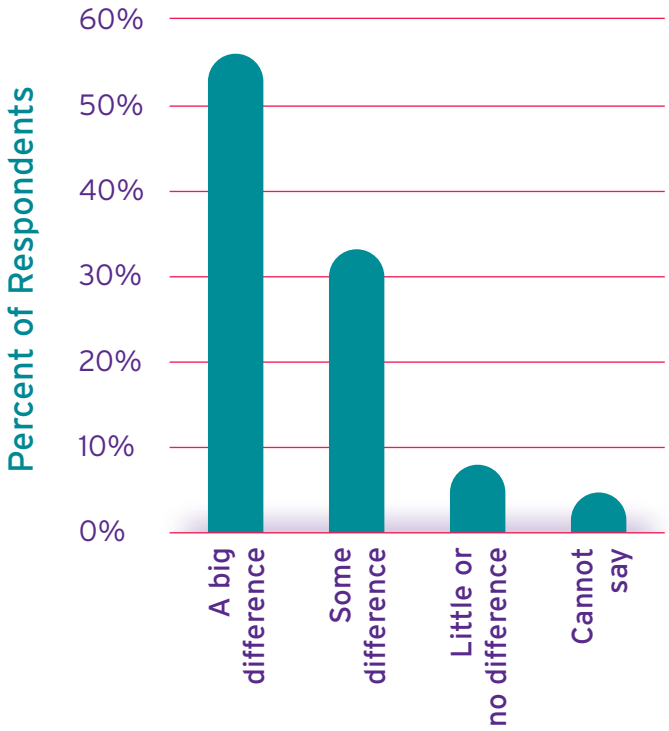
Figure IV: Reasons for not Having Stronger Sense of Community Belonging (%)[20]

Unprompted – Top Reasons (Those who do not feel a very strong sense of belonging)



That being said, most Torontonians agree that people can make a real difference in their communities if they are willing to work together to solve problems.

Figure V: How Much Difference Can People Working together Make in Addressing Problems in Your Community (%)?[20]



HOW DO PEOPLE BUILD A SENSE OF COMMUNITY?

People build community in many different places and ways, such as:

- Close relationships with family members – both biological family and family of choice
- Friendships formed early in life that sustain people over time
- Strong connections with neighbours
- Supportive relationships with colleagues at work
- Connections with others at the same stages of life, such as mothers of young children who meet at the park and provide both social and parenting support and seniors who gather for social activities
- Being part of a supportive cultural, ethnic, religious or spiritual group
- Through a common interest such as the arts or sports or a desire to protect the environment
- Working with others who share common values or political beliefs through service clubs or community groups.

Some connect with others – face-to-face – in their neighbourhoods and communities. Some connect through online networks that bring people together regardless of distance.

WHAT IS FRAGMENTING OUR SENSE OF COMMUNITY?

Our society has changed significantly over the last few decades. Traditional support networks are weaker, and the ways we live and communicate make it harder to connect in meaningful ways.

Family and social structures have changed. Families are smaller and more spread out, so people are not necessarily surrounded by relatives. Fewer people are married. More are divorced. And the number of single person households continues to grow.

According to a recent Vanier Institute report on Canadian families, between 1981 and 2016[21]:

- The proportion of families that included a married couple dropped from 83 per cent to 66 per cent
- The number of lone-parent families increased from 11 per cent to 16 per cent
- Families are getting smaller – from 3.9 to 2.4 persons per household.

Because people are living longer and family structures are changing, **more seniors are isolated**. The National Seniors Council estimates that up to 16 per cent of Canadians age 65 or older (950,000 seniors) experience loneliness and isolation.[22] Isolation affects physical and mental health, which can

lead to a loss of function and cognitive abilities, more emergency department visits and hospitalizations, and higher health and social services costs.

Work and time pressures have increased and work has become more precarious. Over the past 50 years, we have seen dramatic shifts in the workforce: more two-income families, greater concentration of jobs in a small number of urban centres, more contract work, more multiple part-time jobs and less economic certainty or stability. Over this same period, the cost of living – in particular, housing – has increased exponentially, particularly in urban areas. As a result, people feel more anxious and stressed, and are less likely to be involved in all forms of social and community life.[23] Changes that make businesses more efficient and productive are having a negative effect on employees.

It costs more to be socially connected. The general financial anxiety that many people feel is exacerbated by the fact that many social activities, such as adult education classes, fitness programs, music concerts and dancing, are expensive and increasingly out of reach for many people. It is much less expensive to stay home and watch TV than it is to be out in the community taking part in activities that could enhance both connection and health.

With urbanization and sprawl, people spend more time commuting and less time connecting. As jobs migrated to the cities, so did people. However, some communities were not designed with social connection in mind. Many are not walkable: in order to shop, people have to take the bus or drive and these communities often lack the parks and community gathering spots that bring people together.

Faced with rising housing costs in the city core, many people moved to suburban neighbourhoods where they could have larger homes with yards. As commute time increases, willingness to get involved in community activities drops: each additional 10 minutes in daily commuting time cuts involvement in community affairs by 10 per cent.[23] Urban sprawl means that people spend more time alone in the car or on public transport and less time with family, friends and neighbours. It also affects people's sense of community as they are often living, working and shopping in different neighbourhoods and do not feel truly part of any of them.[23]

Television, computers and smart phones increase isolation. In the mid-20th century, Canadians mainly went out into the community for entertainment. With television, low-cost entertainment and leisure came right into our homes, and we began to prefer "spending a quiet evening at home." As the number of television sets per household grew, people spent less time watching TV together and more time watching entirely alone.[23]

> Television is a medium of entertainment which permits millions of people to listen to the same joke at the same time, and yet remain lonesome. – T.S. Eliot

At the turn of the 21st century, television was the single most consistent predictor of people being disconnected from their communities – more significant than education, age, gender, marriage, children, income, financial worries, work obligations and commuting time.[23] Over the past 20 to 30 years, other technologies – computers, smartphones, online networks and streaming services – have competed to take more of our time and attention. A growing number of people have hundreds of friends online, but few in-person contacts. In some cases, these virtual connections are highly supportive. They allow children to "see" and talk to grandparents who live far away and develop a stronger sense of family. They also help people who live in rural and remote areas overcome geographic isolation.

But social media can also make the lonely more isolated. It can connect people who are socially disconnected with those who manipulate them. They may engage only with those who share or amplify their views so they have fewer opportunities to talk to or understand people with different perspectives.

Some social media platforms have taken steps to limit inaccurate and misleading information and reduce cyber bullying. Some platforms have simple nudges designed to help people reduce screen time – such as programs that tell people how much time they spend each day looking at their screens. However, more must be done to reduce the negative impact of technology on social connections.

Social media technologies also allow people to share information, which may or may not be accurate. Real harm can be done – both to individuals and society – when people spread inflammatory, unverified or false information.

THE IMPACT OF SCREEN TIME ON YOUTH

Excessive screen time is particularly harmful for today's teens. The Monitoring the Future survey, funded by the U.S. National Institute on Drug Abuse, asks teens how happy they are and how much of their leisure time they spend on various activities, including non-screen activities (e.g., in-person social interaction, exercise) and screen activities (e.g., using social media, texting, browsing the web). The results are clear: teens who spend more time than average on screen activities are more likely to be unhappy, and those who spend more time than average on non-screen activities are more likely to be happy.[24]

Technology may actually increase health inequities among youth: lower income teens clock significantly more screen time (eight hours and seven minutes a day) than their higher income peers (five hours and 42 minutes). They are less likely to benefit from direct social interactions and more likely to experience the social isolation and other negative impacts of excessive screen time.[25]

The more time teens spend looking at screens, the more likely they are to report symptoms of depression. This may be due to the fact that social media exacerbate age-old teen concerns about being left out. The proportion of teens who feel left out has reached all-time highs across age groups as has the number of teens – particularly girls – who report being bullied online. Cyberbullying is feeding an increase in both depression and suicides.[26]

If you were going to give advice for a happy adolescence based on this survey, it would be straightforward: Put down the phone, turn off the laptop, and do something – anything – that does not involve a screen.[27]

People have lost trust in governments and institutions. According to the Edelman Trust Barometer, a survey of 28 countries, the world is facing a crisis of trust in its institutions. In 20 of the 28 countries, average trust in government, business, non-governmental organizations and media was below 50 per cent.

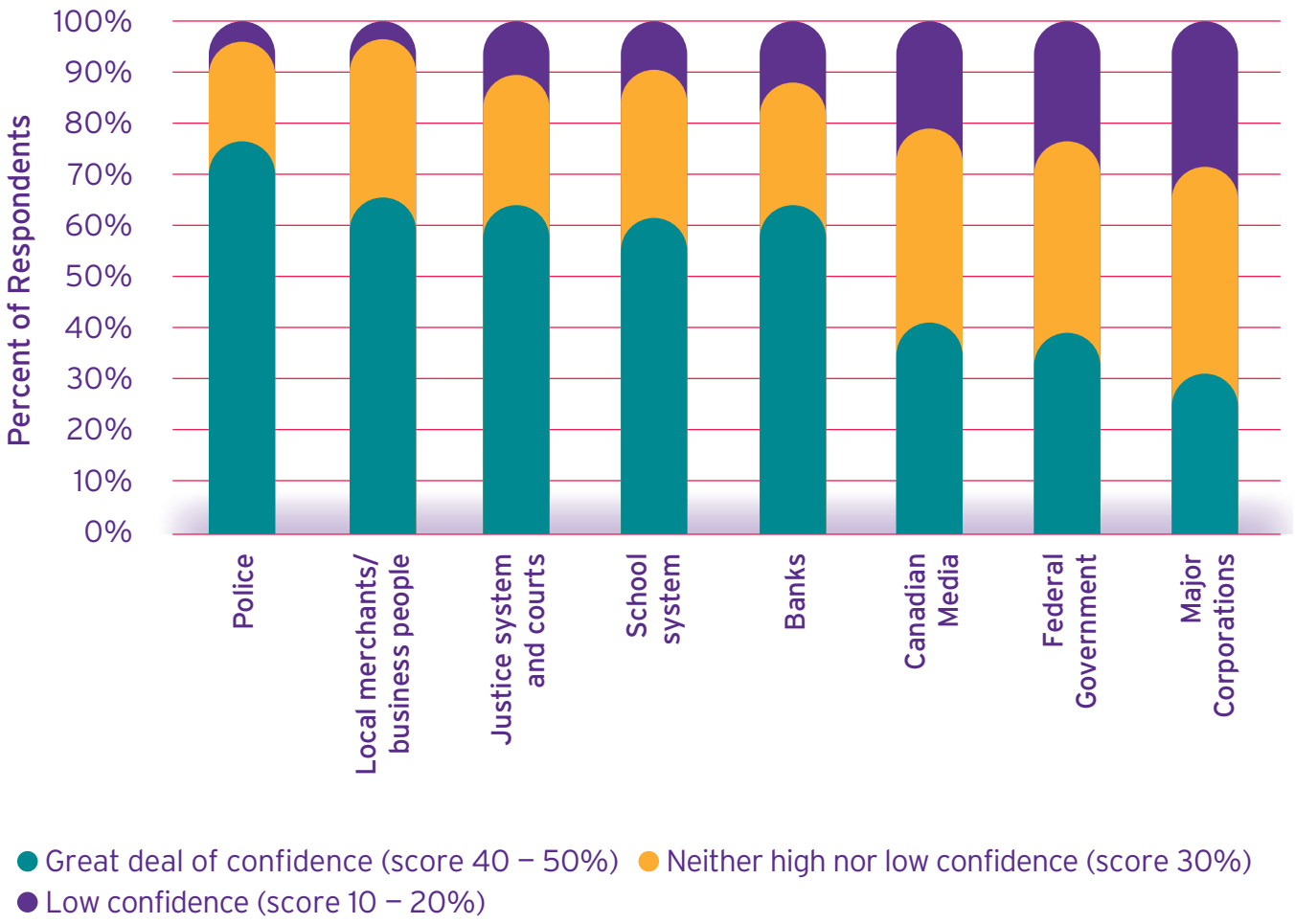
Trust is the "belief that someone or something is reliable, good, honest, effective." High levels of trust promote healthy interactions, whereas low levels of trust undermine constructive relationships.[28]

Compared to many other countries, Canada actually scored relatively well on the 2018 Edelman Trust Barometer. Between 2017 and 2018, Canadians' trust in government and media increased (from 58 to 61 per cent and from 52 to 59 per cent respectively), while their confidence in non-governmental organizations dropped (from 74 to 65 per cent) and their trust in business remained relatively steady (63 per cent). In general, Canadians said they wanted to see all their institutions play a more active role in creating a stronger, fairer society.[29]

In Ontario, over three in four people have a great deal of confidence in police and about six in 10 have confidence in local businesses and the justice and school systems. On the other hand, fewer Ontarians have confidence in the media, the federal government and major corporations.

Figure VI: Confidence in Institutions

Weighted distribution in Ontario using the 2013 General Social Survey cohort



People have less trust in political systems when they are having money problems or are unemployed.[30] On the other hand, people living in jurisdictions with stronger property rights and extensive labour market regulations have more trust in their institutions and governments.[31]

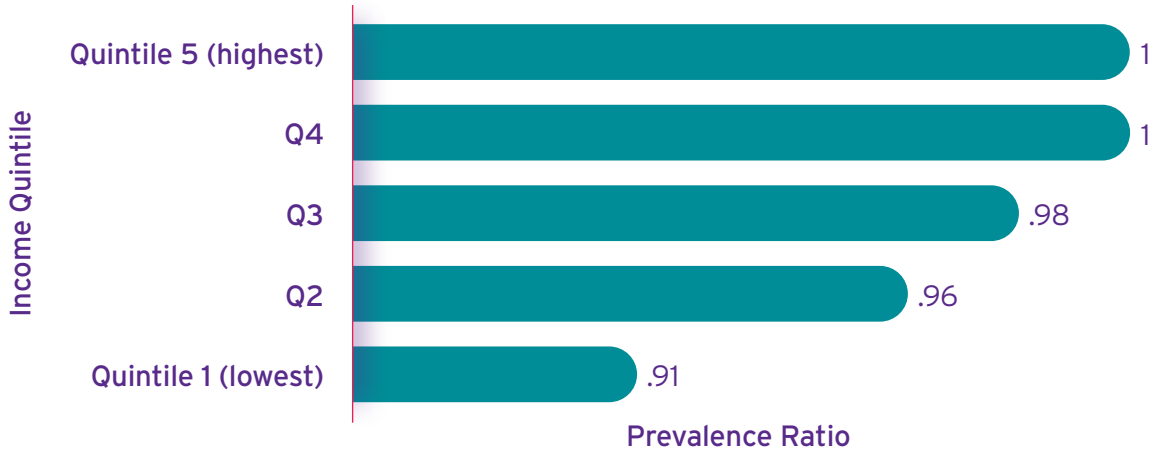
When those with more resources or power have a disproportionate influence over economic opportunities, income gaps widen, more people become marginalized, inequities increase, and community connection and trust are broken.[32]

INCOME INEQUALITY THREATENS COMMUNITY

When we look more closely at sense of belonging, we see that it is influenced by income. Ontarians in the highest income quintiles report a much stronger sense of belonging while those with the lowest incomes feel more isolated.

Figure VII: Sense of Belonging by Income Quintile

Adjusted prevalence ratio using the 2013/14 Canadian Community Health Survey cohort



Disconnection and lack of trust leads to more disconnection. Lack of connection to our communities and lack of trust in government can lead to public disorder. People who live in neighbourhoods with visible signs of disorder – such as people dealing drugs, vandalism, graffiti or property damage – feel more vulnerable and fearful of crime.[33] They are more likely to report being afraid when walking alone after dark, using or taking public transportation or home alone in the evenings. They also report less life satisfaction.[34]

People who trust law enforcement are more likely to participate in activities designed to improve community safety. However, people who live in neighbourhoods with high crime rates – particularly members of racialized communities – report being more likely to be stopped and questioned, and more distrustful of police. These disparities create the sense of an unequal society where some feel comforted by the law and others feel suspicious and distrustful.[28]

WHAT CAN WE DO TO HELP ONTARIANS (RE)BUILD COMMUNITY?

The growing sense of social isolation Ontarians are experiencing can be slowed or stopped. Many factors driving isolation and loneliness are systemic so they require a system-wide approach. Individuals, organizations, businesses, communities and governments must work together to foster a society that values and invests in social connection and community.

Sound public policies can nurture well-being.

There are many relatively simple steps we all can take to (re)build community. Many people are already involved in innovative efforts to connect people and create supportive, connected communities

Connecting People

Building community and social connections often happens informally. Sometimes it's as simple as talking to your neighbours or inviting someone to join you at an event. Sometimes it's part of more formal efforts by organizations to either bring people together or create spaces where people can gather.

Connecting Newcomers to Neighbours

Beginning in 2015, groups of Canadians came together to privately sponsor Syrian refugee families. A recent evaluation of the country's refugee resettlement programs found that privately sponsored refugees had a significantly better chance of getting help settling in Canada, finding a job and having better health outcomes than government-assisted refugees. They were more likely to have received help learning key skills, such as speaking English or French, shopping for food and finding a doctor. Within nine months of arriving in Canada, over 50 per cent of privately sponsored refugees were working compared to 10 per cent of government-assisted refugees.[35]

Unlike government institutions, private sponsors provide emotional support. They introduce refugees to their social networks, give them a tour of the best places in town to shop and help them set up new businesses. The experience is also a positive one for the sponsors themselves. They gain a greater sense of connection from being involved and contributing to the welfare of others.[36]

Connecting People to Culture

Most Indigenous peoples with life-limiting illnesses die in urban hospitals or long-term care homes. They do not have access to palliative care at home or in their First Nations or Aboriginal community, surrounded by family, friends, culture and spirituality.

To connect people to culturally safe end-of-life care, the South West Local Health Integration Network collaborated with the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) and other partners – including Chippewas of the Thames First Nation, Munsee-Delaware Nation, Oneida Nation of the Thames and Cancer Care Ontario – to implement an Indigenous-led palliative model of care, including an Indigenous Palliative Care Team (IN-PaCT). The team includes physician support, a nurse practitioner, a registered nurse, a mental health counselor and a traditional Indigenous healer who supports the spiritual needs of patients and families.

For families, one of the most meaningful aspects of the IN-PaCT model is the care provided after the person dies. The team visits families and supports them in their grief and healing process. Within Indigenous culture, family and follow-up care fosters a sense of social connection for continued healing.

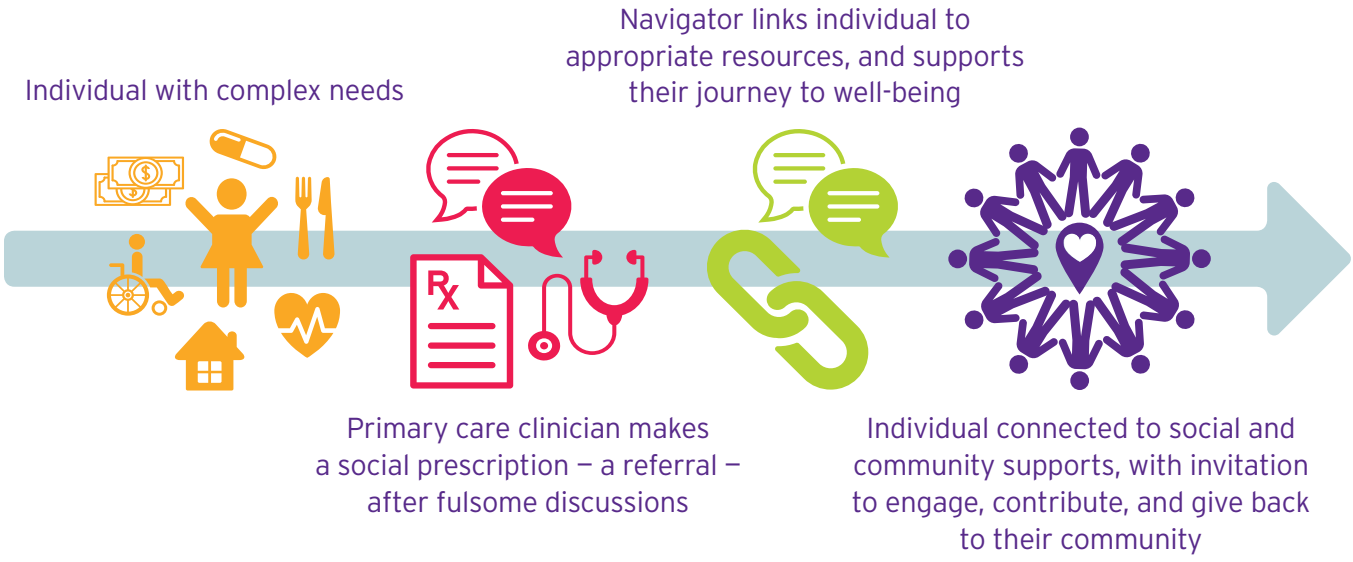
Connecting Health Professionals

Certain parts of the province are designated to provide French language services. The *Public Health en français* Community of Practice started as a collaboration among health units to connect professionals delivering French language services so they could share resources and expertise.

With more than 100 members, the Community of Practice keeps professionals from feeling isolated in their work which, in turn, helps support and strengthen the Francophone community and improve access to equitable high quality public health services. Members are now more aware of resources and tools, and more likely to collaborate with one another to deliver consistent services.

PRESCRIBING FOR LONELINESS

When people are struggling with loneliness, they don't need prescriptions for treatment as much as they need help connecting with people and groups in their community. The Alliance for Healthier Communities – the association of community health centres, Aboriginal health access centres, community family health teams and nurse practitioner-led clinics – is piloting a social prescribing project. Eleven diverse community health centres are prescribing activities that help people connect to social activities in their communities, such as support groups for newcomer women, an intergenerational knitting in motion group and a support group for LGBTQ youth. They will monitor the impact that social prescribing has on health. Social prescribing looks a little different depending on each local community's needs and capacity, but the approach generally looks like the process below:



Adapted with permission from the Alliance for Healthier Communities

Creating Supportive, Connected Communities

Reaching and Connecting Isolated Seniors

To help break the cycle of social isolation for seniors, seven organizations in Hamilton came together to develop the Hamilton Seniors Isolation Impact Plan (HSIIP). The goal is to have more seniors feel connected to family and friends, access support and participate in physical and social activities, and feel valued.

HSIIP has established three connector programs:

- The Hospital Connector Program connects seniors being discharged from hospital to services and activities in the community.
- The Community Connector Program connects isolated seniors in the community to services and activities.
- The Peer Connector Program trains peers to provide friendly visiting services.

HSIIP strives to:

- Find and work with seniors at risk for social isolation
- Help reduce barriers to seniors' engagement in activities and networks
- Create opportunities for seniors to become involved in meaningful social activities and their communities
- Build more sustainable and inclusive communities that value the contribution of all members, regardless of age.

The HSIIP and the ENRICHes Collaborative are funded in part by the Government of Canada's New Horizons for Seniors Program. The Program provides grants and contributes funding for projects that make a difference in the lives of seniors and in their communities.

Between May 2016 and March 2018, the collaborative helped 1,014 seniors. Every senior was connected to some form of visiting and information-sharing, and most were anchored into other services and activities. The program was able to close gaps in services and relieve pressure on an overburdened health care system.

Connecting Family Caregivers to Supports and Resources

When seniors with complex health problems age at home, they often rely on a family or informal caregiver – who is also aging – to look after them. Family caregivers often struggle to provide this care. They can experience high levels of stress, financial hardship and isolation. Five organizations in Toronto – Alzheimer Society Toronto, Canadian Mental Health Association Ontario, North York Community House, WoodGreen Community Services and the Reitman Centre at Sinai Health System (the lead for the collective) – are part of the ENRICHES Collaborative. Together, they are trying to reduce social isolation in caregivers age 55 and older.

Using the collective impact model (see page 25), the ENRICHES Collaborative organizations identify caregivers in need of support, engage them in activities, connect them to programs and services, and build health system capacity to respond to caregiver needs.

ENRICHES has engaged over 12,000 caregivers and connected them to services, such as workshops and education sessions, social and recreational opportunities, as well as digital literacy and financial empowerment programs offered through the various ENRICHES partners. These services help caregivers build resilience and expand their social networks. They also empower them to navigate the health system and manage their own health and well-being.

Connecting and Integrating Newcomers

Rural communities often face demographic challenges such as youth out-migration and labour shortages. Many need newcomers to maintain their vibrancy and economic health. When newcomers are able to build social capital, they feel a sense of belonging in their new communities and are more likely to stay.

Newcomer: A person who has moved into the community in the last five years. This includes those that have moved from abroad, from elsewhere in Canada or moved back after a significant time away.[18]

When residents in the host community use their influence to help newcomers, all benefit. When newcomers develop their networks, resources and assets, they build up the community.[18] It's crucial for communities to provide opportunities for newcomers to become connected and develop social capital.

The Rural Ontario Institute has gathered and distilled information on effective ways to help newcomers integrate:

- **Strong intentional community leadership.** Municipalities make a conscious effort to create welcoming communities.
- **A commitment to reduce system barriers.** Successful communities work to address issues such as public transportation, social supports, affordable housing, language and settlement services. They also actively communicate positive messages about the importance and value of newcomers to the community.
- **Opportunities to build relationships.** Communities create opportunities for newcomers to connect in meaningful ways with people in the community, which can have a profound effect on social capital. Newcomers and members of the community get to know each other and develop lasting bonds that benefit everyone.
- **Robust support systems.** Rural communities that develop strong, accessible support systems for newcomers are more likely to retain their newfound residents.

Creating Built Environments that Encourage Connection

The physical spaces where people live, play, work and study — the built environment — affects their health.

In all types of communities — urban, suburban or rural — supportive built environments can promote mental and physical well-being, improve quality of life and foster social connections. The way that communities, neighbourhoods and housing complexes are physically laid out can affect social capital and sense of community.[11]

> It is unreasonable to expect large proportions of the population to make individual behaviour changes that are discouraged by the existing environment and social norms.[37]

It's important to keep social connection and health goals in mind when designing streets and neighbourhoods by, for example:

- providing wider, barrier-free streets that encourage social interaction and support different ways of moving, such as walking, cycling, roller blading and driving
- building mixed use neighbourhoods that include homes, retail stores, services and cafes so people can walk to get the things they need
- creating good quality public and green spaces with landscaping, lighting, facilities and pathways that invite people to gather.

When residents have more control over the areas around their homes, including lobbies, streets and grounds, they feel more connected to these community spaces and to their neighbours. These neighbourhoods have lower rates of crime and higher levels of social capital.[11]

When residents have access to places to meet (often called "third places" because they are not private residences or work spaces), such as coffee shops, bookstores, bars, hair salons, public squares and libraries, there are opportunities for social interactions that build connected communities.[37]

Making Health Part of City Planning

Ontario's Places to Grow Act, 2005 recognizes that, to provide a high quality of life, communities must be planned strategically.[39]

Public health units in the Greater Golden Horseshoe have been working with municipal planners and community partners to encourage healthy community policies that:

- encourage walking, cycling and other forms of active transportation
- promote complete community design
- advocate to preserve land and water to ensure a sustainable food system
- improve the built environment to enhance social cohesion and well-being.

The Simcoe Muskoka District Health Unit (SMDHU) supported a series of active transportation workshops that led many municipalities to develop active transportation and trail plans. Some are now creating trails connecting to schools, way-find projects, cycling lanes, road diets, transit initiatives and more. Some have been designated age-friendly, youth-friendly, walk-friendly and bike-friendly communities. All this activity is the result of community engagement.

These communities are also leading the way in innovative community design:

- Essa included waterways in its trails system
- Wasaga Beach was the first municipality in Ontario to install portable roll-out mats on the beach so all residents and visitors — including those in wheelchairs and strollers — could enjoy the beach and feel more connected to the community
- Collingwood, Essa and Wasaga Beach have established healthy community committees that focus on healthy community design, social cohesion and well-being.

Healthy Barrie — an innovative partnership among the Dalla Lana School of Public Health (University of Toronto), the City of Barrie, the Barrie and Community Family Health Team and SMDHU — is using population health indicators to measure health and social well-being in local neighbourhoods and assess the impact of neighbourhood design and access to city and health care services. Findings will inform service changes and the official city plan. Ideally this assessment will be repeated so Barrie can measure the impact of changes on community health.

Capitalizing on Infrastructure Projects to Build Community

Poverty and economics are strong drivers of social disconnection. Community benefits agreements are formal agreements between a private or public development and a coalition that reflects and represents people who are affected by a large development project. They help ensure that communities benefit – both economically and socially – from investments in infrastructure and purchases of goods and services.

Community benefits agreements are clauses added to contracts that require companies to, for example, improve public spaces, hire local workers and/or provide appropriate training. These agreements often require significant time and commitment to be successful, but can be a strategic tool for community wealth.

Community benefits agreements are usually negotiated collaboratively by government, businesses, labour, advocacy coalitions and local residents.

The Toronto Community Benefits Network is using this approach to influence the development process and deliver social benefits that help build connected communities. Here are a few successes from community benefits agreements:

- Local people received jobs as part of the Regent Park redevelopment.
- The contract for the Eglinton Crosstown LRT included a commitment to provide training and employment for local people and to procure supplies from local businesses.
- As part of the Pan Am games, local suppliers and social enterprises were encouraged to bid on contracts.

FRAMEWORKS FOR MEASURING CONNECTEDNESS AND BUILDING COMMUNITY

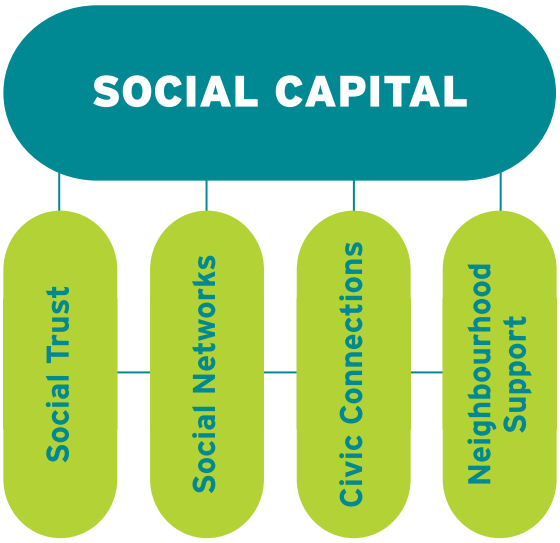
To reduce social isolation and build social capital, we need ways to measure connectedness and belonging as well as effective frameworks that help build community.

Measuring Connectedness and Community

A number of jurisdictions are trying to measure connectedness (social capital) and social isolation, and use the findings to build community and improve health.

Toronto Social Capital Study

The Toronto Social Capital Study is measuring the extent to which social capital contributes to outcomes, such as health, happiness and life satisfaction.[20] The study team identified four measures of social capital:



Asking about social networks helps assess how large people's social networks are, how often they connect, how invested they are in these friendships and the extent to which they rely on their social networks for help and support.

Asking about civic connections helps assess how engaged people are in their community and the extent to which they volunteer or take part in activities that benefit their communities. For example, are they meeters, joiners and co-operators – all measures of connectedness – or are they less involved and more isolated?

To develop the Toronto Social Capital Study survey, researchers pulled questions from established surveys in Canada, such as the Canadian General Social Survey, the Equality, Security and Community Survey, and the Neighbourhood Effects on Health and Well-being Study.

Asking about neighbourhood support helps assess how people see their neighbourhood and how welcoming and resilient that neighbourhood is. Are there safe places for children to play? Are people willing to help their neighbours?

These measures of social capital – which were recently applied in the City of Toronto – help health and city planners understand how connected their communities are and the role that social capital plays in that sense of community belonging. The information can also be used to identify neighbourhoods that would benefit from community building.

What is Well-being?

The presence of the highest possible quality of life in its full breadth of expression focused on but not necessarily exclusive to: good living standards, robust health, a sustainable environment, vital communities, an educated populace, balanced time use, high levels of democratic participation, and access to and participation in leisure and culture.[40]

Canadian Index of Wellbeing

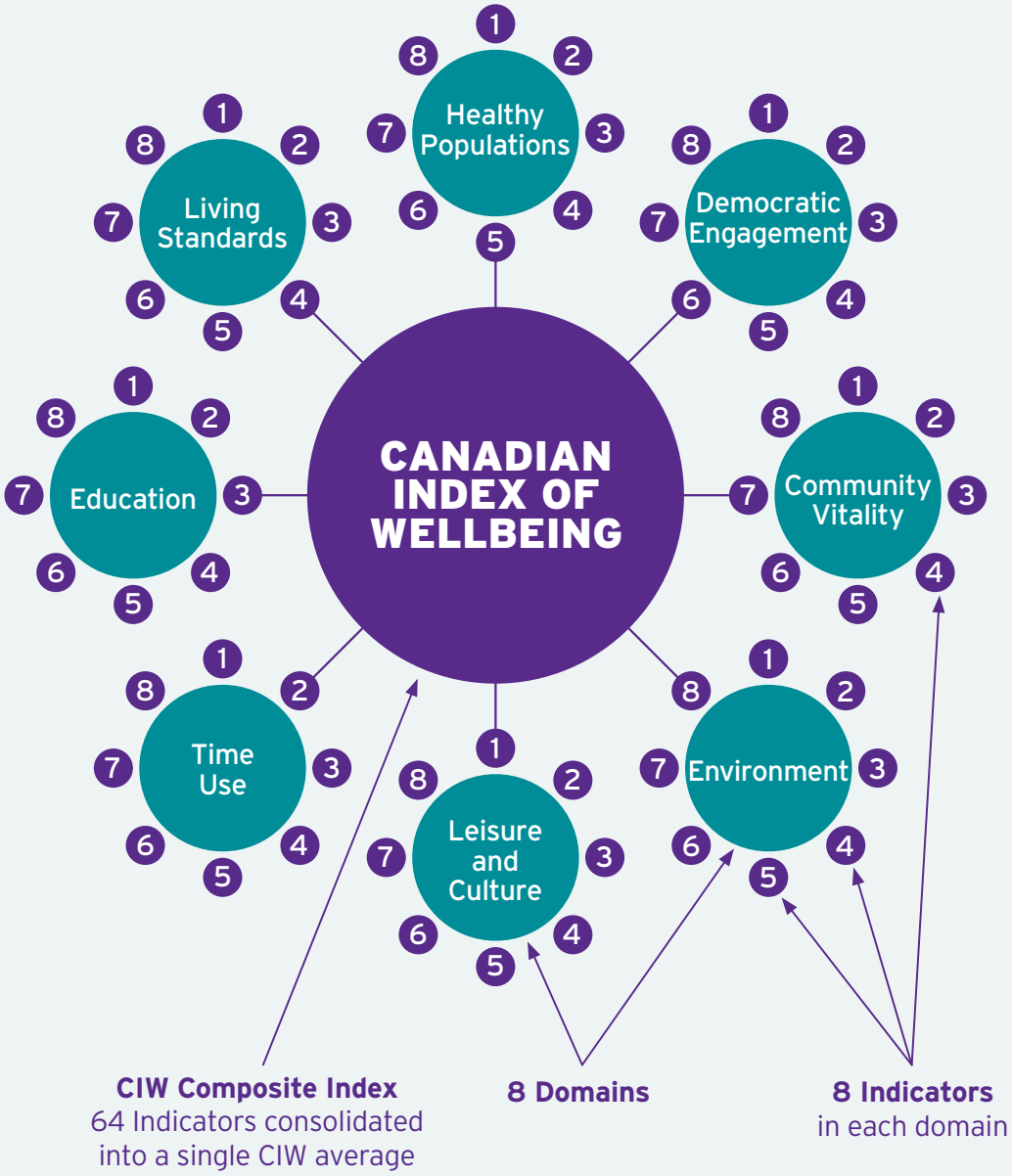
The Canadian Index of Wellbeing at the University of Waterloo, developed by researchers from across Canada, is based on talking to Canadians about what is most important to their quality of life. From those consultations the researchers developed eight domains:

- **Community vitality** looks at social relationships. Do people have a sense of belonging? Do they volunteer? Do they have close friends they can turn to and do they provide unpaid help for others? Do they trust others and feel safe in their community?
- **Democratic engagement** looks at the extent to which people participate in the democratic process. Do they vote? Do they participate in political groups? Are they satisfied with the way democracy works in Canada?
- **Education** looks at access to education across the lifespan. How many registered child care spaces does a community have? How much does it spend on educating students? How many young people complete high school? How many adults have university degrees? How many adults participate in ongoing education?
- **Environment** looks at the availability and use of natural resources, and the impact of human activity on the environment. How clean is our air? How much energy do we use? What about our fresh water resources? What actions do we take to help protect the environment?
- **Healthy populations** looks at health status, lifestyle and behaviour as well as health care system factors. How many Canadians rate their physical and mental health as good? What is our life expectancy? How many people have diabetes? How many smoke? How many have a doctor?
- **Leisure and culture** assess the amount of time and money Canadians spend in social, physical or cultural activities. How many hours do they volunteer for recreation and cultural organizations? How much time do they spend on holidays? How often do they visit national parks and historic sites?
- **Living standards** measures average income and wealth, as well as income gaps. How many Canadians have incomes below the low income cut-off? How many households are food insecure? What percentage of the labour force is employed? How many people are in high quality jobs? What about housing affordability?
- **Time use** looks at how Canadians spend their time and how our time use affects our well-being. How many Canadians work more than 50 hours a week at a main job? How many minutes each day do we spend with friends? How long do we spend commuting? How many people have flexible work hours? How many report time pressure? How many people get seven to nine hours sleep a night?

Taken together, these domains paint a picture of Canadians' well-being. Planners can use the results to understand trends and advocate for policies, programs and other changes that improve wellbeing. Findings can start a dialogue about what truly matters to Canadians and how communities, governments, organizations and businesses can enhance health and strengthen communities.

Jurisdictions can use the Canadian Index of Wellbeing to: create a community well-being profile; identify strengths and weakness, as well as inequities; and, using the insights gained, develop community plans.

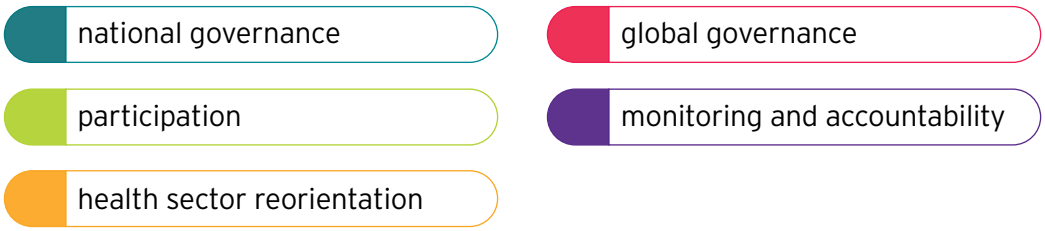
In 2016, Oxford County used the Canadian Index of Wellbeing. The findings? Rural residents reported higher levels of life satisfaction than urban residents – including a greater sense of community belonging and they were more likely to help others. Adults with children were more likely to experience problems with work-life balance. Newcomers had longer commutes and less job security. People living alone had lower levels of well-being. People with low incomes (<$40,000 a year) had poorer quality of life. The county was able to see how all the factors that distinguish community were at play in the region. Oxford County is using the survey results to monitor progress in achieving the goals in its Community Sustainability Plan with an aim to reduce inequities.



Rio Declaration on Social Determinants of Health

In 2011, member states of the World Health Organization (WHO) pledged to reduce health inequities – a key factor in the fragmentation of communities. A group established by the WHO, the Public Health Agency of Canada and the Canadian Institutes of Health Research (CIHR) Institute of Population and Public Health identified 36 indicators across five domains that jurisdictions could use to monitor their progress in reducing health inequities.[41]

The domains include:



The focus on participation highlights the importance of involving civil society in creating equitable health policies. Governments can use these indicators to assess how well they are doing in addressing underlying systemic issues and social determinants of health that drive social isolation.

Building Community

The Chief Medical Officer of Health's 2016 report – *Improving the Odds: Championing Health Equity in Ontario* – highlighted the important role communities can play in reducing health inequities[42]:

"Community development interventions can bring community members together to take collective action and solve common problems. They can also help build social cohesion which, in turn, improves health... Different players and levels of government have different levers... Working together as a system, they can reduce or eliminate health disparities."

That report challenged government and organizations to champion community development and pursue partnerships within and beyond the health sector to improve health equity.

Here are three effective approaches to building community. All share a commitment to engaging people in solving complex problems that fragment community.

Collective Impact Model

Collective impact is based on the idea that organizations must work collectively – not in isolation – to create social change and solve complex dynamic problems like social isolation. Successful collective impact initiatives build on all partners strengths and share five criteria:

- **Common agenda:** All participating organizations share a vision for social change: a common understanding of the problem and a joint approach to solving it.
- **Shared measurement system:** Agreement on how success will be measured and reported, with key indicators.
- **Mutually reinforcing activities:** A diverse set of stakeholders, typically in multiple sectors, coordinating activities through a plan of action.
- **Continuous communication:** Frequent communications among key players within and between organizations to build trust and encourage ongoing learning and adaptation.
- **Backbone organization:** Ongoing support provided by an independent staff that helps move the work forward.

The collective impact framework, developed in the U.S., has been adapted by the Tamarack Institute in Canada to shift it from a managerial to a movement-building paradigm (Collective Impact 3.0) that "opens up peoples' hearts and minds to new possibilities" and "emboldens policymakers" and system leaders. Building a movement requires strong relationships based on a common vision, values and stories that can rally like-minded organizations.[43]

Connected Community Approach

The Connected Community Approach is a way of understanding how to work in a community using a community development lens. Its focus is on changing and strengthening local systems: the way people interact, access programs and services, and spend their time, energy and money. It includes the ways organizations conduct outreach, institutions engage community members and businesses hire.

The Connected Community Approach aims to change the community itself, which is quite different from services that offer support and knowledge. It draws inspiration from the collective impact model[44] and uses its language to describe the work of supporting organizations, which is where the concept of a community backbone organization comes from. By focusing on strengthening social networks between and among people and organizations, a community backbone organization can be a catalyst that stimulates community-based social and economic improvement and mobilizes local assets, skills, aspirations, talents and resources.

The East Scarborough Storefront is an example of the Connected Community Approach. Originally a one-stop shop where agencies serving the community could provide a range of education, legal, employment and settlement services, the Storefront has evolved into an organization that supports resident agency and strategic engagement of other community players. Its goal is to: facilitate collaboration and help people learn and create together, live healthy lives, find meaningful work, play and thrive.

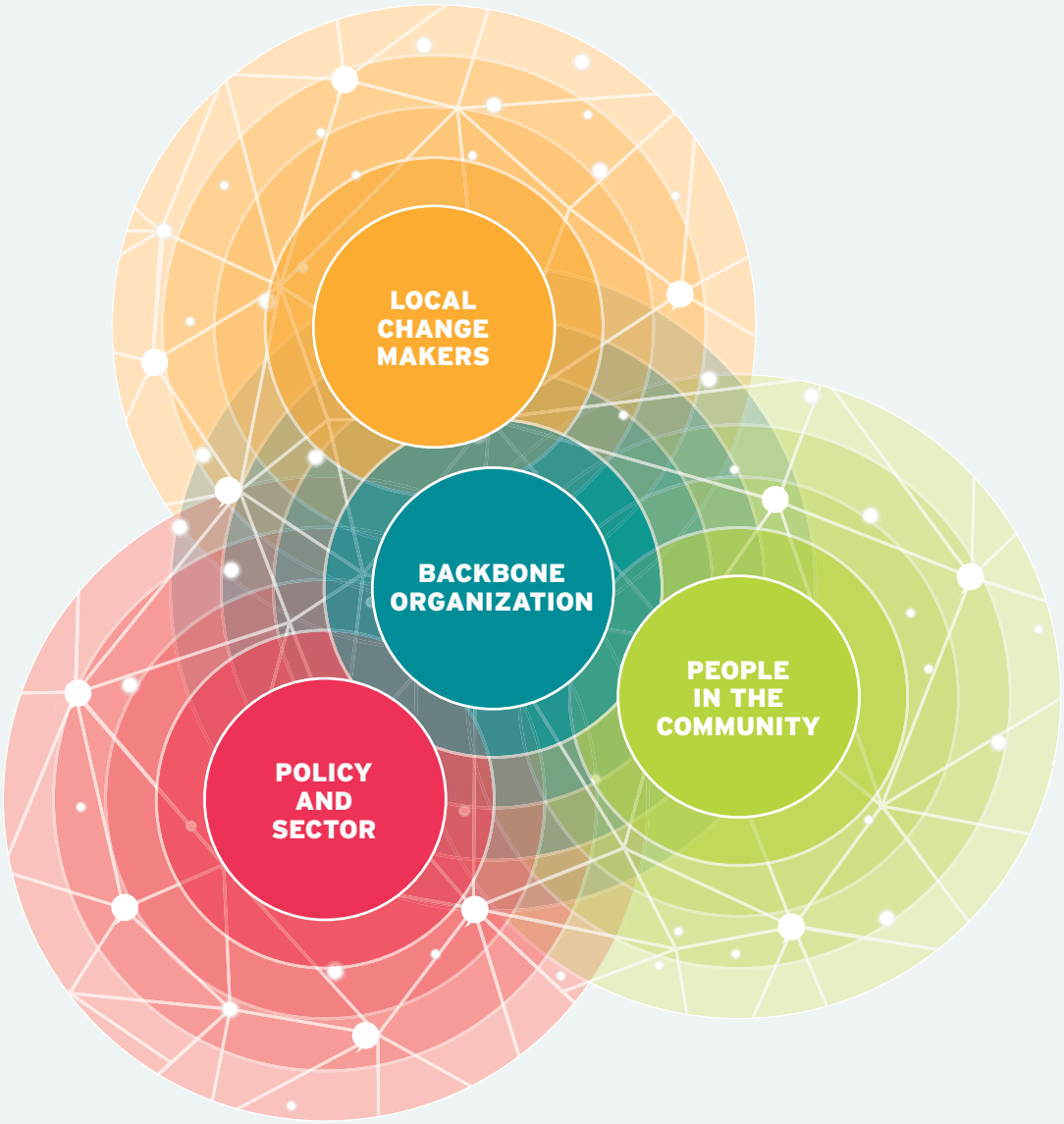
The community now works together to identify and solve problems. Solutions have included:

- petitioning for better bus service
- a community youth art project and community event to reclaim a bridge that was unpopular because of traffic speed, narrow sidewalks and a history of suicides
- a skills-building project that involved youth in renovating a former police station to become the Storefront's home
- Residents Rising – volunteers working in the community to engage residents in neighbourhood issues
- a business network that cross-promotes local businesses and helps them learn from one another, and helps new entrepreneurs with business planning.

The impact of empowering connected communities is impressive: more at-risk youth attending college, a stronger local economy and an increase in literacy and leadership.

Neighbourhoods are the places where people interact and where there is real opportunity to create meaningful change

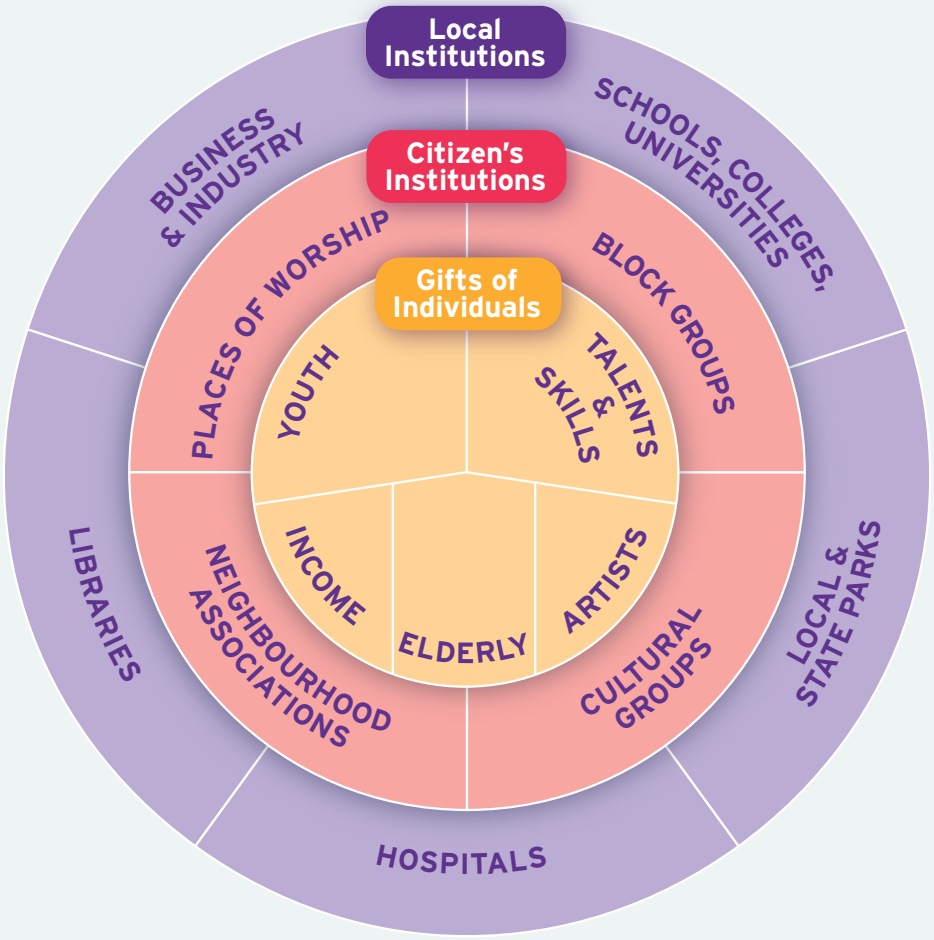
... When information, ideas, relationships, supports and resources are shared, talents and assets can be mobilized and combined in multiple ways. When people and organizations work together in different ways over time, they begin to foster a sense of shared identity and belonging. Multiple players from multiple sectors can all play a role in continuous neighbourhood improvement. That is what the Connected Community Approach does.[45]



Design by Randal Boutilier, RGD of Openly

Asset-Based Community Development

Asset-Based Community Development (ABCD) is a strengths-based approach to community development.[46] It recognizes that communities are diverse and potent webs of gifts and assets – rather than complex masses of needs and problems. Each community has a unique set of skills and capacities that can be channeled for community development.



ABCD organizes resources and assets into six groups:

1. **Individuals:** Every resident of the community has assets and gifts that need to be recognized. In community development, you cannot do anything with people's needs, only their assets.
2. **Associations:** Small informal volunteer groups of people working with a common interest, such as clubs, are critical to community mobilization. They don't control anything; they just come together by individual choice around a common interest.
3. **Institutions:** Paid groups of people – generally professionals – organized within a structure. They include government agencies, private business and schools. The assets of these institutions help the community capture valuable resources and establish a sense of civic responsibility.
4. **Built and Natural Environment:** Physical assets include land, buildings, space and funds.
5. **Local Economy or Exchange:** In the non-monetary world, there are three forms of exchange: 1) intangibles, 2) tangibles, and 3) alternative currencies. In the commercial world, there is a fourth form of exchange: money. There must be an exchange between people sharing assets by, for example, bartering. People who make these connections – normally through building relationships individual by individual – are connectors.

6. **Stories:** Local culture or "the community way" often finds expression in the ways people have learned through time to survive and thrive within their home places. When we cooperate with our neighbours to create and exchange stories of a compelling future that respects our traditions, we ensure our culture or "way" prevails. Stories help us pass on important life lessons and are powerful connection points between generations.

PRINCIPLES AND PRACTICES OF ABCD

Everyone has Gifts: each person in a community has something to contribute.

Relationships Build a Community: people must be connected in order for sustainable community development to take place.

Citizens at the Centre: citizens should be viewed as actors – not recipients – in development.

Leaders Involve Others: community development is strongest when it involves a broad base of community action.

People Care: challenge notions of "apathy" by listening to people's interests.

Listen: decisions should come from conversations where people are heard.

Ask: asking for ideas is more sustainable than giving solutions.

RESOURCES

For more information on tools, frameworks and initiatives, please go to:

- Asset Based Community Development Canada
  http://www.deepeningcommunity.org/abcd-canada-home
- Connected Community Approach
  https://thestorefront.org/how/the-connected-community-approach
- Canadian Index of Wellbeing
  https://uwaterloo.ca/canadian-index-wellbeing
- Collective Impact Approach
  http://nccdh.ca/images/uploads/comments/Collective_impact_and_public_health_An_old_new_approach_Two_Canadian_initiatives_EN_FV.pdf
- Community of Practice – Public Health en Français
  www.publichealthfrancais.ca
- Rio Political Declaration on Social Determinants of Health
  https://www.who.int/sdhconference/declaration/en
- Alliance for Healthier Communities
  https://www.allianceon.org/Alliance-Resources
- Environics Institute: Toronto Social Capital Project
  https://www.environicsinstitute.org/projects/project-details/toronto-social-capital-project

CONCLUSION

Loneliness and social isolation are serious public health problems that cost us all. They affect our productivity, health and well-being – even how long we live.

Community begins from ground-up individual actions.

Because the impact of social isolation is so pervasive, helping people and communities (re)connect is everyone's business. Individuals, organizations and businesses, communities and all levels of government must act – together – to build a sense of community.

It's time to revitalize communities and create a healthier Ontario.

Key Messages

Being connected to other people and part of a community are essential to our physical and mental health and well-being. Being socially connected can help people overcome adversity and lead longer, happier lives. People who have a sense of community belonging recover more quickly from stressful situations. They feel better about themselves and make healthy choices. They trust one another and co-operate to benefit all community members. Connected communities have less crime and stronger economic growth. Their children perform better in school and their citizens are more politically involved.

Complex systemic issues fragment community and threaten our sense of belonging. Over the past 50+ years, rapid changes in family structure, the workforce and technology have disrupted our sense of community belonging. Families are smaller. More people live alone. Work has become more precarious and life less certain. People now spend more time commuting and less time connecting. Technologies, such as televisions, computers and smart phones, compete for our attention. Attention is focused on economic goals at the expense of social and environmental goals. As income and opportunity gaps widen and more people feel socially and economically "left behind", they lose trust in institutions, including government. People are less willing to be involved in their communities and become more isolated.

Strong resilient communities are an effective way to tackle social isolation. Efforts to (re)build community and (re)connect people reinforce the critical importance of engaging people in their communities and investing in activities that nurture and balance social, environmental and economic health. Social capital enhances people's capacity to manage life stresses and leads to innovative policies that value families, friends, neighbours and other relationships that build connected communities. Organizations across Ontario are working to build community. There are highly successful approaches to measuring well-being as well as developing community that Ontario must leverage to improve health.

Recommendations

To stop the growing public health "epidemic" of social isolation, stress and loss of community, governments must be community-friendly, public health units must be community enablers and all organizations and individuals must be community-centred and community-driven.

1. Invest in Community

The provincial and municipal governments should actively invest in community:

- Make measuring social connection and sense of community as important as measuring other indicators of well-being, such as blood pressure and economic output
- Collect data on social well-being and social capital over time to establish a baseline and then measure/evaluate the impact of community-building initiatives
- Assess all policies and initiatives for their impact on community
- Tackle the broader social and economic drivers that fragment communities
- Create built environments/infrastructure that make it easier for people to connect and be engaged in their communities.

2. Enable Community

Public health units should play a critical role in enabling community. They are uniquely positioned to assess, evaluate and address this serious public health issue:

- Make communities aware of the benefits of social connections and social capital
- Connect communities and governments to influence change
- Leverage the new, less prescriptive Ontario Public Health Standards to develop targeted community-building programs
- Develop partnerships with municipalities and other organizations to (re)build community and address system barriers, policies and practices that drive social isolation
- Use data on community well-being and social capital to work with communities to develop concrete action plans
- Adopt effective evidence-based frameworks for community development that engage people in addressing social determinants of health, building healthy communities and increasing health equity.

Public health has a long history of community development and should play a key role in building connected communities. Public health units can take the lead on measuring community connectedness and wellness, identifying strengths and resources, hosting connecting events, and using data to realign programs and services to focus on social connections. They can draw attention to the underlying social and economic drivers of social isolation and loss of community and the failure of institutions — governments, businesses and community organizations — to invest in people and services that reinforce a sense of belonging. They can draw attention to investments that promote community connections and social engagement, such as affordable daycare programs, programs for seniors and their caregivers, walkable communities and infrastructure projects that include community benefits agreements.

3. Be Community-Centred and Community-Driven

Community begins from the ground up. Individual actions make a big difference. At the local level, individuals and organizations — including businesses — can drive change by being community-centred and community-driven. They can collaborate, pooling strengths and assets to build community. They can make community health and well-being a priority in all their decisions:

- Be aware of how their decisions affect people's sense of belonging
- Enhance their own social capital, connections and partnerships
- Invest in community.

Strong, resilient communities are an effective way to tackle these large social, economic and environmental issues. There are already many examples of community building underway in Ontario, including efforts to connect people, connect communities and create built environments that reduce social isolation. There are also frameworks for measuring connectedness and building community — described in this report — that we can use to create more connected and healthier communities.

ACKNOWLEDGEMENTS

Advisory Committee:
Dianne Alexander, Charles Gardner, Thelma Gee, Heather Mair, Heather Manson, Patricia O'Campo, Joanne Plaxton, Blake Poland, Suzanne Stewart

Lead Staff:
Elizabeth Choi, Daniel Warshafsky

Staff:
Catherine Fraser, Fiona Kouyoumdjian, Gillian MacDonald, Laura Seeds

Writer:
Jean Bacon

Publishing:
Leora Conway

Data and Analytics:
The data in figures I, II, III, VI and VII were provided by Dr. Laura Rosella, Meghan O'Neill and Kathy Kornas of the Population Health Analytics Lab, University of Toronto. Dr. Rosella is supported by a Canadian Institutes of Health Research Foundation Scheme Grant [FDN-148456] and by a Canada Research Chair in Population Health Analytics.

Contributors:
Alliance for Healthier Communities, Canadian Index of Wellbeing, Centre for Connected Communities, Engagement to Reduce Social Isolation in Caregivers at Home and Enhance Seniors Collaborative, Hamilton Social Isolation Impact Project, Indigenous Primary Health Care Council, Rural Ontario Institute, Southwest Ontario Aboriginal Health Access Centre, Simcoe Muskoka District Health Unit, Toronto Social Capital Project

Other:
Ministry of Health and Long-Term Care , Ministry of Municipal Affairs

Special thanks to Clayton Shirt, Suzanne Stewart and the Waakebiness-Bryce Institute for Indigenous Health

Catalogue No. 026857 ISSN 1912-3590 (Print) 250 February, 2019

REFERENCES

[1] Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med*, 7(7), e1000316.

[2] Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-analytic Review. *Perspect Psychol Sci*, 10(2), 227-237.

[3] Holwerda, T. J., Deeg, D. J., Beekman, A. T., van Tilburg, T. G., Stek, M. L., Jonker, C., & Schoevers, R. A. (2014). Feelings of Loneliness, but not Social Isolation, Predict Dementia Onset: Results From the Amsterdam Study of the Elderly (AMSTEL). *J Neurol Neurosurg Psychiatry*, 85, 135-142.

[4] Elliott, J., & Vaitilingam, R. (2008). *Now we are 50: Key Findings from the National Child Development Study*. London, UK: The Centre for Longitudinal Studies.

[5] Waldinger, R. J., & Schulz, M. S. (2010). What's Love Got To Do With It?: Social Functioning, Perceived Health, and Daily Happiness in Married Octogenarians. *Psychol Aging*, 25(2), 422-431.

[6] Grant, N., Hamer, M., & Steptoe, A. (2009). Social Isolation and Stress-related Cardiovascular, Lipid, and Cortisol Responses. *Ann Behav Med*, 37, 29-37.

[7] Dynes, R. (2005). *Community Social Capital as the Primary Basis for Resilience*. Newark, NJ: University of Delaware, Disaster Resource Center.

[8] Dynes, R. (2006). Social Capital: Dealing with Community Emergencies. *Homeland Security*, 2(2), 1-26.

[9] Klinenberg, E. (2002). *Heat Wave: A Social Autopsy of Disaster in Chicago*. Chicago, IL: The University of Chicago Press.

[10] Aldrich, D. P., & Meyer, M. A. (2015). Social Capital and Community Resilience. *Am Behav Sci*, 59(2), 354-269.

[11] Cajete, G. (1994). *Look To The Mountain: An Ecology of Indigenous Education*. Durango, CO: Kivakí Press.

[12] Fischer, H. W. (2008). *Response to Disaster: Fact versus Fiction and its Perpetuation* (3rd ed.). Lanham, MD: University Press of America.

[13] Quarantelli, E. L., & Dynes, R. R. (1977). Response to Social Crisis and Disaster. *Ann Rev Sociol*, 3, 23-49.

[14] Aldrich, D. P. (2011). The Power of People: Social Capital's Role in Recovery From the 1995 Kobe Earthquake. *Nat Hazards*, 595-611.

[15] Horwich, G. (2000). Economic Lessons of the Kobe Earthquake. *Econ Dev Cult Change*, 48, 521-542.

[16] Shaw, R., & Goda, K. (2004). From Disaster to Sustainable Civil Society, the Kobe Experience. *Disasters*, 28, 16-40.

[17] Rosella, L. C., Fitzpatrick, T., Wodchis, W. P., Calzavara, A., Manson, H., & Goel, V. (2014). High-cost Health Care Users in Ontario, Canada: Demographic, Socio-economic, and Health Status Characteristics. *BMC Health Serv Res*, 14, 532.

[18] Rural Ontario Institute. (2017). *Newcomer Engagement and Social Capital in Rural Communities*. Guelph, ON: Rural Ontario Institute.

[19] Turcotte, M. (2015). *Trends in Social Capital in Canada*. Ottawa, ON: Statistics Canada.

[20] Environics Institute for Survey Research. (2018). *Toronto Social Capital Study*. Toronto, ON: Toronto Foundation.

[21] Battams, N. (2018). *A Snapshot of Family Diversity in Canada*. The Vanier Institute of the Family. Retrieved from https://vanierinstitute.ca/snapshot-family-diversity-canada-february-2018

[22] National Seniors Council. (2016). *Who's At Risk and What Can be Done About it?: A Review of the Literature on the Social Isolation of Different Groups of Seniors*. Gatineau, QC: Employment and Social Development Canada.

[23] Putnam, R. D. (2001). *Bowling Alone: The Collapse and Revival of American Community*. New York, NY: Simon & Schuster.

[24] Twenge, J. M. (2017). *iGen: Why Today's Super-Connected Kids Are Growing Up Less Rebellious, More Tolerant, Less Happy – and Completely Unprepared for Adulthood – and What That Means for the Rest of Us*. New York, NY: Atria Books.

[25] Common Sense Media. (2015). *The Common Sense Census: Media Use by Tweens and Teens*. Common Sense Media Inc.

[26] Twenge, J. M., Joiner, T. E., Rogers, M. L., & Martin, G. N. (2018). Increases in Depressive Symptoms, Suicide-Related Outcomes, and Suicide Rates Among U.S. Adolescents After 2010 and Links to Increased New Media Screen Time. *Clin Psychol Sci*, 6(1), 3-17.

[27] Twenge, J. M. (2017, September). Have Smartphones Destroyed a Generation? *The Atlantic*.

[28] Edelman, Inc. (2018). 2018 *Edelman Trust Barometer*.

[29] Friedman, M. (2014, September 9). What Happens When We Don't Trust Law Enforcement? The Importance of Law Enforcement's Role in Our Society's Well-Being. *Psychology Today*.

[30] Guiso, L., Herrera, H., Morelli, M., & Sonno, T. (2018). Populism: Demand and Supply. *CEPR Discussion Paper*, No. DP11871.

[31] Robbins, B. G. (2016). What is Trust? A Multidisciplinary Review, Critique, and Synthesis. *Sociology Compass*, 10(10), 972-986.

[32] Wakefield, S. E., & Poland, B. (2005). Family, Friend or Foe? Critical Reflections on the Relevance and Role of Social Capital in Health Promotion and Community Development. *Soc Sci Med*, 60(12), 2819-2832.

[33] Cotter, A. (2016). *Canadians' Perceptions of Neighbourhood Disorder*. Statistics Canada.

[34] Pain, R. (2000). Place, Social Relations and the Fear of Crime: A Review. *Prog Hum Geog*, 24(3), 365-387.

[35] Immigration, Refugees and Citizenship Canada. (2016). *Rapid Impact Evaluation of the Syrian Refugee Initiative*. Ottawa, ON: Immigration, Refugees and Citizenship Canada.

[36] El-Chidiac, S. (2018, July 20). The Success of the Privately Sponsored Refugee System. *Policy Options*.

[37] Schmid, T. L., Pratt, M., & Howze, E. (1995). Policy as Intervention: Environmental and Policy Approaches to the Prevention of Cardiovascular Disease. *Am J Public Health*, 85(9), 1207-1211.

[38] Oldenburg, R. (1999). *The Great Good Place: Cafes, Coffee Shops, Bookstores, Bars, Hair Salons, and Other Hangouts at the Heart of a Community* (3rd ed.). Washington, DC: Marlowe.

[39] Places to Grow Act, 2005, https://www.ontario.ca/laws/statute/05p13

[40] Canadian Index of Wellbeing. (2016). *How are Canadians Really Doing?* Waterloo, ON: Canadian Index of Wellbeing and University of Waterloo.

[41] Working Group for Monitoring Action on the Social Determinants of Health. (2018). Towards a global monitoring system for implementing the Rio Political Declaration on Social Determinants of Health: developing a core set of indicators for government action on the social determinants of health to improve health equity. *Int J Equity Health*, 17, 136.

[42] Office of the Chief Medical Officer of Health. (2017). *2016 Annual Report of the Chief Medical Officer of Health of Ontario to the Legislative Assembly of Ontario, Improving the Odds: Championing Health Equity in Ontario*. Toronto, ON.

[43] National Collaborating Centre for Determinants of Health. (2017). *Collective Impact and Public Health: An Old/New Approach – Stories of Two Canadian Initiatives*. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.

[44] Kania, J., & Kramer, M. (2011). Collective Impact. *Stanford Social Innovation Review*, 9(1), 36-41.

[45] Gloger, A. (2016). *Connected Community Approach: What it is and Why it Matters*. Toronto, ON: Centre for Connected Communities

[46] McKnight, J. L., & Russell, C. (2018). *The Four Essential Elements of an Asset-Based Community Development Process*. Asset-Based Community Development Institute at DePaul University.

APPENDIX

Ontario Health Units with Vacant Medical Officer of Health (MOH) Positions* Filled By Acting MOHs as of January 24, 2019

- Huron County Health Unit
- Niagara Region Health Unit
- Renfrew County & District Health Unit

Total = 3 Health Units with MOH Vacancies

**Under 62. (1)(a) of the Health Protection and Promotion Act, every board of health shall appoint a full-time medical officer of health*

Ontario Public Health Units with Vacant Associate Medical Officer of Health (AMOH) Positions* as of January 24, 2019

- Durham Region Health Department
- Grey Bruce Health Unit
- Halton Region Health Unit**
- Kingston, Frontenac and Lennox & Addington Health Unit
- Niagara Region Health Unit**

Total = 5 Health Units with AMOH Vacancies

**Under 62. (1)(b) of the Health Protection and Promotion Act, every board of health may appoint one or more associate medical officers of health.*

***Vacancies may include less than or more than one FTE position per health unit and include positions filled by qualified physicians awaiting appointment by boards of health and ministerial approval.*