AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE, (RECESSED DOOR)
Board of Health Boardroom

Thursday, 7:00 p.m.
2015 June 18

MISSION - MIDDLESEX-LONDON BOARD OF HEALTH

The mission of the Middlesex-London Health Unit is to promote wellness, prevent disease and injury, and protect the public's health through the delivery of public health programs, services and research.

MEMBERS OF THE BOARD OF HEALTH

Mr. Ian Peer (Chair)
Mr. Jesse Helmer (Vice Chair)
Ms. Patricia Fulton
Dr. Trevor Hunter
Mr. Marcel Meyer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Kurtis Smith
Mr. Mark Studenny
Mr. Stephen Turner
Ms. Joanne Vanderheyden

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

BUSINESS ARISING FROM THE MINUTES

DELEGATIONS

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance and Facilities Committee Meeting June 11th (Report 035-15)	Agenda Appendix A Appendix B Appendix C	x	x		To receive information and consider recommendations from the June 11th Finance and Facilities Committee meeting
2	Governance Committee Meeting June 18th (Verbal Report)	Agenda	x	x		To receive information and consider recommendations from the June 18th Governance Committee meeting
Delegations and Recommendation Reports						
3	The Need for Enforcement and Mandatory Safety Standards for E-Cigarette Juice Containing Nicotine (Report 036-15)	Appendix A Appendix B Appendix C		x		To request that the Board of Health endorse a letter to the Prime Minister, Federal Health Minister and local MP's calling on Health Canada to enforce their provisions under the Food and Drug Act
Information Reports						
4	Healthy Babies, Healthy Children Screening Tool (Report 038-15)	Appendix A			x	To provide an update on the changes being implemented in Healthy Babies Healthy Children (HBHC) Program Screening to improve screening rates and compliance with program requirements
5	Application to Local Poverty Reduction Fund – Verbal Update				x	To update the Board of Health an application to the Treasury Board Secretariat's Local Poverty Reduction Fund to enhance Healthy Babies Healthy Children by introducing the Nurse Family Partnership to MLHU and up to five other Ontario health units
6	Update On Ministry's Oral Health Program Changes (Report No. 039-15)	Appendix A Appendix B Appendix C			x	To provide an update on the MOHLTC Oral Health Program Changes
7	Summary Information Report for June 2015 (Report 040-15)	Appendix A Appendix B Appendix C Appendix D Appendix E Appendix F Appendix G			x	To provide a summary of several Health Unit programs for June.
8	Medical Officer of Health Activity Report – June (Report 041-15)				x	To provide an update on the activities of the MOH for June 2015

CONFIDENTIAL

The Board of Health will move in camera to discuss matters concerning an identifiable individual.

OTHER BUSINESS

- Next Finance and Facilities Committee Meeting: Thursday, July 2, 2015 @ 9:00 a.m.
- Next Board of Health Meeting: Thursday, July 16, 2015 at 7:00 p.m.

CORRESPONDENCE

a) Date: 2015 April 29 (received 2015 May 11)
Topic: Bill 45, Making Healthier Choices Act, 2014
From: The Honourable Dipika Damerla, Associate Minister of Health
To: Mr. Ian Peer, Chair, Middlesex-London Board of Health

Background:
Bill 45, the Making Healthier Choices Act, 2014 was passed on May 28, 2015 and mandates the menu labelling of caloric content on items at restaurants with more than 20 locations, a ban of flavoured tobacco sales and restrictions on e-cigarettes by limiting their display, promotion and use in designated areas.

The act provides a regulation-making authority that keeps open the possibility of government requiring additional nutritional content to be posted in the future.

Recommendation:
Receive.

b) Date: 2015 May 5 (via email)
Topic: Bill 45, Making Healthier Choices Act, 2014
From: Ms. Julie Roy, Chair, Board of Health, Northwestern Health Unit
To: Copy of Correspondence to The Honourable Kathleen Wynne, Premier of Ontario and Minister of Agriculture

Background:
See background for correspondence item a).

The Northwestern Health Unit proposes that municipal bylaws should be allowed to address additional nutritional information beyond sodium and calories.

Recommendation:
Endorse.

c) Date: 2015 May 7 (via email)
Topic: Continued support for the implementation of Canada's National Alcohol Strategy
From: Ms. Lesley Parnell, Chair, Board of Health, Peterborough County-City Health Unit
To: Copy of Correspondence to The Right Honourable, Stephen Harper, Prime Minister of Canada, and The Honourable Rona Ambrose, Minister of Health

Background:
Canada's National Alcohol Strategy Advisory Committee (NASAC) was formed in 2008 to: 1) lead the implementation, monitoring and evaluation of the national alcohol strategy; 2) increase awareness of Canadians on matter relating to alcohol abuse; and 3) to reduce the harm associated with alcohol abuse.

The Peterborough County-City Health Unit is creating a local strategy to address alcohol that is complimentary to the work on NASAC.

Recommendation:
Receive.

d) Date: 2015 May 11 (by email)
Topic: Increasing Alcohol Availability in Ontario
From: Dr. Penny Sutcliffe, Medical Officer of Health and CEO, Sudbury and District Health Unit
To: Copy of Correspondence to The Honourable Kathleen Wynne, Premier of Ontario

Background:
An increased alcohol availability is expected as a result of the Liquor Modernization Project in Ontario. The Board of Health received a report from Mary Lou Albanese (Report 032-15) at the May meeting outlined additional regulations that Health Unit could consider to deal with the sale of beer in grocery stores.

Recommendation:
Receive.

e) Date: 2015 May 19 (by email)
Topic: Reducing exposure of second-hand smoke in multi-unit housing
From: Dr. Miriam Klassen, Medical Officer of Health, Perth District Health Unit
To: Copy of Correspondence to The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care

Background:
The Smoke-Free Ontario Act prohibits smoking in common areas and ensures that signage is posted in appropriate locations. However, people who live in multi-unit housing are at risk of being negatively affected by second-hand smoke from adjacent units. Few buildings designate their units to be smoke-free and tenants can have very little choice in their housing arrangements.

Public health units and organizations like the Non-Smokers Rights Association and Smoke-Free Housing Ontario advocate for tenant protection in these multi-unit dwelling through voluntary no-smoking policies and future development of governmental policy to facilitate the provision of smoke-free housing.

Recommendation:
Endorse.

f) Date: 2015 May 21 (by email)
Topic: Invitation to London Health Sciences Centre 2015 Annual Community Meeting
From: London Health Sciences Centre
To: All Members, Middlesex-London Board of Health

Background:
The London Health Sciences Centre 2015 Annual Community Meeting will be held on Monday, June 29, 2015.

Recommendation:
Receive.

g) Date: 2015 May 21 (received 2015 June 2)
Topic: Support of Ontario's Poverty Reduction Strategy
From: Mr. Matt Brown, Mayor, City of London
To: Mr. Ian Peer, Chair, Middlesex-London Board of Health

Background:
Ontario's Poverty Reduction Strategy is a commitment to a sustained, comprehensive, flexible and results-driven approach to breaking the cycle of poverty. It focuses on moving towards employment and income security and a long-term goal of ending homelessness.

Recommendation:
Receive.

h) Date: 2015 May 28 (by email)
Topic: Public Health Support for a Basic Income Guarantee
From: Mr. Barry Ward, Chair, Simcoe Muskoka District Health Unit
To: Copy of correspondence to the following Ministers:
The Honourable Pierre Poilievre, Minister of Employment and Social Development
The Honourable Kellie K. Leitch, Minister of Labour
The Honourable Rona Ambrose, Minister of Health
The Honourable Kevin Daniel Flynn, Ontario Minister of Labour
The Honourable Eric Hoskins, Ontario Minister of Health and Long-Term Care
The Honourable Tracy MacCharles, Ontario Minister of Children and Youth Services
The Honourable Deborah Matthews, Ontario Minister Responsible for the Poverty Reduction Strategy

Background:
A basic income guarantee is a governmental assurance that no one's income will fall below a level that is sufficient to meet their basic necessities and to live with dignity, regardless of employment status. There is a strong association between socioeconomic status and health outcomes. The basic income guarantee has the potential to prevent poverty and to improve health outcomes in our population.

Recommendation:
Endorse.

Copies of all correspondence are available for perusal from the Secretary-Treasurer.

ADJOURNMENT

PUBLIC SESSION – MINUTES

MIDDLESEX-LONDON BOARD OF HEALTH

2015 May 21

MEMBERS PRESENT:
Mr. Jesse Helmer (Vice Chair)
Ms. Trish Fulton
Dr. Trevor Hunter
Mr. Marcel Meyer
Ms. Viola Poletes Montgomery
Ms. Nancy Poole
Mr. Kurtis Smith
Mr. Mark Studenny
Mr. Stephen Turner
Ms. Joanne Vanderheyden

REGRETS:
Mr. Ian Peer (Chair)

OTHERS PRESENT:
Dr. Christopher Mackie, Medical Officer of Health & CEO (Secretary Treasurer of the Board)
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)
Ms. Muriel Abbott, Public Health Nurse
Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention
Ms. Marylou Albanese, Manager, Environmental Health and Chronic Disease Prevention
Ms. Rhonda Brittan, Public Health Nurse
Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy
Ms. Shaya Dhinsa, Manager, Sexual Health
Mr. Dan Flaherty, Manager, Communications
Dr. Gayane Hovhannisyan, Associate Medical Officer of Health
Ms. Kim Leacy, Registered Dietitian
Ms. Heather Lokko, Associate Director, Oral Health, Communicable Disease and Sexual Health Services (OHCDSHS)
Mr. John Millson, Director, Finance and Operations
Mr. Fatih Sekercioglu, Manager, Environmental Health
Ms. Linda Stobo, Manager, Environmental Health and Chronic Disease Prevention
Mr. Alex Tyml, Online Communications Coordinator
Ms. Suzanne Vandervoort, Acting Director, Family Health Services

MEDIA OUTLETS:
None

Board of Health Vice-Chair, Mr. Jesse Helmer, called the meeting to order at 7:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Mr. Helmer inquired if there were any disclosures of conflict of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the **AGENDA** for the May 21, 2015 Board of Health meeting be approved with the addition of a discussion about Nomination to the Association of Local Public Health Agencies Board of Directors.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Studenny, seconded by Mr. Smith *that the **MINUTES** of the April 16, 2015 Board of Health meeting be approved.*

Carried

BUSINESS ARISING FROM THE MINUTES - none

COMMITTEE REPORTS

Item #1 Finance and Facilities Committee Meeting (Report 031-15)

Finance and Facilities Committee member, Ms. Joanne Vanderheyden, reported that the Finance and Facilities Committee received the following reports for information:

- 2014 Vendor Payments & Visa Purchases (**009-15FFC**)
- Sole Source Vendor – Evaluation of the School Travel Planning Program for the Active and Safe Routes to School Committee **(010-15FFC)**
- Q1 Variance Report (**013-15FFC**)

2015 BOH Compensation (**011-15FFC**)

It was moved by Ms. Poletes Montgomery, seconded by Mr. Meyer *that the Board of Health increase the Board of Health member compensation rate for a half day meeting to $147.04 retroactively to January 1, 2015.*

Carried

Great-West Life Benefits - Renewal (**012-15FFC**)

It was moved by Ms. Vanderheyden, seconded by Mr. Turner *that the Board of Health approve the renewal of the group insurance rates administered by Great-West Life as describe in Report No. 012-15FFC re Great-West Life Benefits – Renewal Rates.*

Carried

DELEGATIONS & RECOMMENDATION REPORTS

Generative Conversation: Drug Use in Middlesex-London

Ms. Heather Lokko, Associate Director, OHCDSH, reported on the existing drug use issue in Middlesex-London. Ms. Lokko used a PowerPoint presentation to report on harm reduction programs and the role of a comprehensive community drug strategy. Ms. Lokko also showed a video entitled, **Let's Start a Conversation about Health .**

Discussion ensued about the Social Determinants of Health (SDH) and the role that Health Units have in addressing the SDH. Ms. Lokko mentioned several possible solutions that address specific Social Determinants of Health, including a medical detox centre in London, role of education, guaranteed annual income, for example. The video raised the following comments:

- The video could be interpreted to signify that changes can happen overnight instead of building capacity to make change over time

- The video created an awareness of the need to build from the base such as safe communities, recreation, etc.
- The video did not address individual accountability in his/her own health
- The discrepancy of money was very evident in the video
- The video was tailored for a young/middle age population and did not capture how to assist the geriatric population

Item #2 Regulations on Sale of Beer in Grocery Stores (Report 032-15)

Ms. Marylou Albanese, Manager, Environmental Health, assisted Board members with their understanding of this report and highlighted the additional regulations that the Health Unit recommends dealing with the sale of beer in grocery stores. Discussion ensued, and the following suggestions were made:

- Use extra revenue from taxes from beer sales toward awareness campaigns
- Partner with grocery stores for education to prevent misuse
- Increase punitive consequences of misuse
- Provide better training to staff who are working in the grocery stores and concern about age of sales staff in retail locations

In response to a question about the results of additional alcohol sales outlets in other provinces, Ms. Albanese explained that Centre for Addiction and Mental Health (CAMH) has statistics that show the additional health and social costs of having alcohol available in grocery stores. Availability of alcohol and advertising are two factors that do increase alcohol consumption.

It was moved by Mr. Turner, seconded by Ms. Poole *that the Board of Health consider strategies to advocate to the Ministry of Health and Long Term Care and Ministry of Finance encouraging them to consider additional regulations on the sale of beer in grocery stores as outlined in Report No. 032-15 re Regulations on Sale of Beer in Grocery Stores with the following modification made to the list: Ensure all cashiers and staff who handle alcohol are over the age of 18 and complete the Smart Serve Training.*

Carried

INFORMATION REPORTS

Summary Information Report for May 2015 (**Report 033-15**)

It was moved by Mr. Turner, seconded by Mr. Meyer *that Report No. 033-15 re Summary Information Report for May be received for information.*

Carried

Medical Officer of Health Activity Report – May (**Report 034-15**)

It was moved by Ms. Fulton, seconded by Mr. Smith *that Report No. 034-15 re Medical Officer of Health Activity Report – May be received for information:*

Carried

Representative to the Association of Local Public Health Agencies – Verbal Report

Ms. Poletes Montgomery explained the role of the Board of Health Section Representative to alPHa, and she noted that former Board of Health member, Mr. Al Edmondson, held the role previously.

It was moved by Ms. Poletes Montgomery, seconded by Ms. Poole *that Mr. Marcel Meyer be nominated to serve as the Southwest Representative on the Board of Health Section of the Association of Local Public Health Agencies Board of Directors.*

Carried

CORRESPONDENCE

Representative to the Association of Local Public Health Agencies – Verbal Report

Ms. Poletes Montgomery explained the role of the Board of Health Section Representative to alPHa, and she noted that former Board of Health member, Mr. Al Edmondson, held the role previously.

It was moved by Ms. Poletes Montgomery, seconded by Ms. Poole *that Mr. Marcel Meyer be nominated to serve as the Southwest Representative on the Board of Health Section of the Association of Local Public Health Agencies Board of Directors.*

Carried

OTHER BUSINESS

Upcoming meetings:

a. Finance and Facilities Committee – Thursday, June 11, 2015 @ 9:00 a.m.
b. Governance Committee – Thursday, June 18, 2015 at 6:00 p.m.
c. Board of Health – Thursday, June 18, 2015 @ 7:00 p.m.

CONFIDENTIAL

At 8:25 p.m. it was moved by Ms. Fulton, seconded by Ms. Poole, *that the Board of Health move in camera to discuss matters concerning an identifiable individual and matters concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

At 8:45 p.m., it was moved by Ms. Poletes Montgomery, seconded by Mr. Turner *that the Board of Health rise and return to public session to report that progress was made in matters concerning an identifiable individual and matters concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

ADJOURNMENT

At 8:46 p.m., it was moved by Ms. Fulton, seconded by Ms. Vanderheyden *that the meeting be adjourned.*

Carried

JESSE HELMER **CHRISTOPHER MACKIE**

Chair **Secretary-Treasurer**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 035-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 June 18

FINANCE AND FACILITIES COMMITTEE MEETING JUNE 11TH

The Finance and Facilities Committee met at 9:00 a.m. on June 11, 2015 (Agenda). The draft public minutes are attached as Appendix A. The following items were discussed at the meeting and recommendations made:

Reports	Summary of Discussion	Recommendations for Board of Health's Consideration
2014 Financial Statements (Report 15-15FFC) Appendix B – Financial Statements Appendix C – Auditors' Report	Auditors present to review Auditors' Report	*That the Board of Health approve the audited Financial Statements for the Middlesex-London Health Unit, December 31st, 2014 as appended to Report No. 15-15FFC.*
Sick Leave Reserve Position (Report 16-15FFC)		*That the Board of Health approve a drawdown in 2015 in the amount of $120,000 to partially fund the anticipated shortfall resulting from a retroactive payment to OMERS for past service benefits/adjustments.*
2014 Reserve/Reserve Fund Balances (Report 17-15FFC)		*That the Board of Health:* *1) Approve a $23,438 drawdown from the Accumulated Sick Leave Reserve Fund to fund the 2014 sick leave payments to eligible staff; and further,* *2) Approve a $25,736 drawdown from the Dental Treatment Reserve Fund to fund the 2014 Dental Treatment Clinic operating deficit; and further,* *3) Receive the 2014 -2015 Reserve / Reserve Fund Overview (Appendix A) for information, and* *4) Forward Report No. 17–15FFC, 2014 Reserve / Reserve Fund Balances to the City of London and the County of Middlesex for information.*

The Finance and Facilities Committee moved in camera to discuss matters concerning an identifiable individual and a proposed or pending acquisition of land by the Middlesex-London Board of Health.

The next meeting of the Finance and Facilities Committee has been scheduled for Thursday, July 2, 2015 at 9:00 am..

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

PUBLIC MINUTES
Finance and Facilities Committee
50 King Street, Room 3A
MIDDLESEX-LONDON BOARD OF HEALTH
2015 June 11 9:00 a.m.

COMMITTEE MEMBERS PRESENT:
Ms. Trish Fulton (Committee Chair)
Mr. Jesse Helmer
Mr. Marcel Meyer
Mr. Ian Peer
Ms. Joanne Vanderheyden

OTHERS PRESENT:
Dr. Christopher Mackie, Medical Officer of Health and CEO
Mr. John Millson, Director, Finance and Operations
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)
Ms. Laura Di Cesare, Director, Human Resources and Corporate Strategy
Dr. Trevor Hunter, Board of Health Member
Mr. Ian Jeffreys, Partner, KPMG LLP

At 9:00 a.m., Ms. Trish Fulton, Committee Chair, welcomed everyone to the meeting.

1. DISCLOSURES OF CONFLICT(S) OF INTEREST

Ms. Fulton inquired if there were any disclosures of conflict of interest to be declared. None were declared.

2. APPROVAL OF AGENDA

It was moved by Mr. Meyer, seconded by Mr. Peer *that the **AGENDA** of the June 11, 2015 Finance and Facilities meeting be approved with the addition of a Confidential session being inserted between Items 5.1 and 5.2.*

Carried

3. APPROVAL OF MINUTES

It was moved by Ms. Vanderheyden, seconded by Mr. Peer *that the **MINUTES** from the May 7, 2015 Finance and Facilities Committee Meeting be approved.*

Carried

4. BUSINESS ARISING FROM MINUTES – none

5. NEW BUSINESS

5.1. 2014 Financial Statements (Report 15-15FFC)

Mr. John Millson, Director, Finance and Operations, reviewed the Draft Financial Statements of the Middlesex-London Health Unit using a PowerPoint presentation (filed with the minutes).

Discussion ensued about the budget variance created by income generated by one-time (random) collaborative projects. Mr. Millson reported that any collaborative projects known to Health Unit staff are included in the budget.

Discussion also followed about the differences between miscellaneous revenues and miscellaneous expenditures. Mr. Millson reported that Health Unit Staff members do not enter into collaborative projects without the funding required to complete the project.

In response to a question about amortization in the Financial Statements, Mr. Millson explained that amortization is a non-cash item on the income statement that shows how Health Unit assets have depreciated over the year. Mr. Millson clarified that Health Unit assets are depreciating at a greater rate than reserve funds are growing to replace equipment etc.

It was confirmed that the revised Note 10 that was distributed by Mr. Millson at the beginning of the meeting (page 16 of Appendix A) will be updated in the online report prior to the June 18, 2015, Board of Health Meeting.

Mr. Millson introduced Mr. Ian Jeffreys, Partner, KPMG LLP, who reviewed the Audit Findings Report attached as Appendix B to Report No. 015-15FFC.

It was moved by Mr. Helmer, seconded by Mr. Meyer *that Item 5.1 be tabled until items 5.2 and 5.3 have been discussed.*

Carried

5.2. Sick Leave Reserve Position (Report 16-15FFC)

Mr. John Millson assisted Committee members with their understanding of this report.

It was moved by Mr. Helmer, seconded by Mr. Meyer *that the Finance & Facilities Committee make recommendation to the Board of Health to approve a drawdown in 2015 in the amount of $120,000 to partially fund the anticipated shortfall resulting from a retroactive payment to OMERS for past service benefits/ adjustments.*

Carried

5.3. 2014 Reserve/Reserve Fund Balances (Report 17-15FFC)

It was moved by Mr. Helmer, seconded by Mr. Peer *that the Finance & Facilities Committee recommend that the Board of Health:*

1) *Approve a $23,438 drawdown from the Accumulated Sick Leave Reserve Fund to fund the 2014 sick leave payments to eligible staff; and further,*
2) *Approve a $25,736 drawdown from the Dental Treatment Reserve Fund to fund the 2014 Dental Treatment Clinic operating deficit; and further,*
3) *Receive the 2014 -2015 Reserve / Reserve Fund Overview (Appendix A) for information, and*
4) *Forward Report No. 17–15FFC, 2014 Reserve / Reserve Fund Balances to the City of London and the County of Middlesex for information.*

Carried

6a) CONFIDENTIAL

At 10:00 a.m., it was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee move in camera to discuss matters concerning personal matters about an identifiable individual.*

Carried

At 10:30 a.m., it was moved by Mr. Helmer, seconded by Ms. Vanderheyden *that the Finance and Facilities Committee return to public forum and report that a discussion took place concerning personal matters about an identifiable individual.*

Carried

5.1 2014 Financial Statements (Report 15-15FFC)

It was moved by Mr. Peer, seconded by Mr. Helmer *that the Finance & Facilities Committee review and make recommendation to the Board of Health to approve the audited Financial Statements for the Middlesex-London Health Unit, December 31st, 2014 as appended to Report No. 15-15FFC.*

Carried

6b) CONFIDENTIAL

At 10:35 a.m., it was moved by Mr. Helmer, seconded by Mr. Peer *that the Finance and Facilities Committee move in camera to discuss matters concern a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

At 10:50 a.m., it was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the Finance and Facilities Committee return to public form and report that matters were discussed concerning a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

7. OTHER BUSINESS

The next scheduled meeting of the FFC is Thursday, July 2, 2015 at 9:00 a.m.

8. ADJOURNMENT

At 10:50 a.m., it was moved by Ms. Vanderheyden, seconded by Mr. Helmer *that the meeting be adjourned.*

Carried

_____	_____
TRISH FULTON Committee Chair	CHRISTOPHER MACKIE Secretary-Treasurer

DRAFT

Financial Statements of

MIDDLESEX-LONDON HEALTH UNIT

Year ended December 31, 2014

MIDDLESEX-LONDON HEALTH UNIT

DRAFT - Financial Statements
Year ended December 31, 2014

Financial Statements

MIDDLESEX-LONDON HEALTH UNIT

DRAFT - Financial Statements
Year ended December 31, 2014

Management's Responsibility for the Financial Statements

The accompanying financial statements of the Middlesex-London Health Unit ("Health Unit") are the responsibility of the Health Unit's management and have been prepared in compliance with legislation, and in accordance with Canadian public sector accounting standards for local governments established by the Public Sector Accounting Board of the Chartered Professional Accountants of Canada. A summary of the significant accounting policies are described in Note 1 to the financial statements. The preparation of financial statements necessarily involves the use of estimates based on management's judgment, particularly when transactions affecting the current accounting period cannot be finalized with certainty until future periods.

The Health Unit's management maintains a system of internal controls designed to provide reasonable assurance that assets are safeguarded, transactions are properly authorized and recorded in compliance with legislative and regulatory requirements, and reliable financial information is available on a timely basis for preparation of the financial statements. These systems are monitored and evaluated by management.

The Finance & Facilities Committee meets with management and the external auditors to review the financial statements and discuss any significant financial reporting or internal control matters prior to their approval of the financial statements.

The financial statements have been audited by KPMG LLP, independent external auditors appointed by the City of London. The accompanying Auditor's Report outlines their responsibilities, the scope of their examination and their opinion on the Health Unit's financial statements.

Dr. Christopher Mackie, MD
Medical Officer of Health &
Chief Executive Officer

John Millson, BA, CPA, CGA
Director, Finance & Operations

Ian Peer, Chair
Board of Health

INDEPENDENT AUDITORS' REPORT

To the Chair and Members, Middlesex-London Board of Health

We have audited the accompanying financial statements of Middlesex-London Health Unit, which comprise the statement of financial position as at December 31, 2014, the statements of operations, change in net debt, and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on our judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the entity's preparation and fair presentation of the statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Middlesex-London Health Unit as at December 31, 2014, and its results of operations and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

"DRAFT"

Chartered Professional Accountants, Licensed Public Accountants

June 2015

London, Canada

MIDDLESEX-LONDON HEALTH UNIT

DRAFT - Statement of Financial Position

December 31, 2014, with comparative information for 2013

		2014		2013
Financial Assets				
Cash	$	3,421,643	$	5,373,430
Accounts receivable		370,630		301,798
Grants receivable		344,553		140,234
		4,136,826		5,815,462
Financial Liabilities				
Province of Ontario		447,389		916,210
Government of Canada		98,681		68,197
The Corporation of the City of London		-		883,602
The Corporation of the County of Middlesex		-		168,300
Accounts payable and accrued liabilities		1,206,008		1,531,844
Accrued wages and benefits		905,124		1,136,256
Vested sick leave liability (note 2(a))		156,401		179,975
Post-employment benefits liability (note 2(b))		1,840,000		1,799,200
		4,653,603		6,683,584
Net Debt		(516,777)		(868,122)
Non-Financial Assets				
Tangible capital assets (note 4)		1,961,025		2,460,318
Prepaid expenses		182,991		174,659
		2,144,016		2,634,977
Commitments (note 5)				
Contingencies (note 6)				
Accumulated Surplus (note 7)	$	1,627,239	$	1,766,855

The accompanying notes are an integral part of these financial statements.

MIDDLESEX-LONDON HEALTH UNIT

DRAFT - Statement of Operations

Year ended December 31, 2014, with comparative information for 2013

	2014 Budget	2014	2013
Revenue:			
Grants:			
Ministry of Health and Long-Term Care	$ 20,488,045	$ 20,924,053	$ 20,580,751
Ministry of Children and Youth Services	5,179,323	5,156,343	5,128,113
Government of Canada	271,967	212,833	159,602
The Corporation of the City of London	6,095,059	6,095,059	5,377,922
The Corporation of the County of Middlesex	1,160,961	1,160,961	1,024,366
	33,195,355	33,549,249	32,270,754
Other:			
Property search fees	3,750	2,050	2,297
Family planning	285,000	260,502	284,676
Dental service fees	228,884	199,881	210,380
Investment income	21,200	20,531	21,863
Prenatal class income	8,140	5,210	5,270
Other income (note 8)	317,287	1,147,758	840,594
	864,261	1,635,932	1,365,080
Total Revenue	34,059,616	35,185,181	33,635,834
Expenditures:			
Salaries:			
Medical Officers of Health	481,617	423,345	464,075
Public Health Nurses	9,075,018	9,266,539	8,728,412
Public Health Inspectors	2,567,292	2,460,376	2,414,948
Administrative staff	3,527,524	3,642,632	3,585,882
Dental staff	972,412	977,259	895,108
Other salaries	2,804,612	3,558,592	3,472,081
	19,428,475	20,328,743	19,560,506
Other Operating:			
Benefits	5,287,242	5,413,598	5,186,419
Travel	471,542	401,543	410,229
Materials and supplies	1,041,609	1,288,360	1,311,062
Professional services	3,865,330	3,662,763	3,632,270
Rent and maintenance	1,543,753	1,600,988	1,581,634
Amortization expense	484,563	904,924	961,503
Other expenses (note 9)	1,487,102	1,723,878	1,538,344
	14,181,141	14,996,054	14,621,461
Total Expenditures	33,609,616	35,324,797	34,181,967
Annual surplus / (deficit)	450,000	(139,616)	(546,133)
Accumulated surplus, beginning of year	1,766,855	1,766,855	2,312,988
Accumulated surplus, end of year	$ 2,216,855	$ 1,627,239	$ 1,766,855

The accompanying notes are an integral part of these financial statements.

MIDDLESEX-LONDON HEALTH UNIT

DRAFT - Statement of Changes in Net Debt

Year ended December 31, 2014, with comparative information for 2013

	2014	2013
Annual deficit	$ (139,616)	$ (546,133)
Acquisition of tangible capital assets	(405,631)	(451,231)
Amortization of tangible capital assets	904,924	961,503
	359,677	(35,861)
Acquisition of prepaid expenses	(182,991)	(174,659)
Use of prepaid expenses	174,659	137,355
	(8,332)	(37,304)
Change in net debt	351,345	(73,165)
Net debt, beginning of year	(868,122)	(794,957)
Net debt, end of year	$ (516,777)	$ (868,122)

The accompanying notes are an integral part of these financial statements.

MIDDLESEX-LONDON HEALTH UNIT

DRAFT - Statement of Cash Flows

December 31, 2014, with comparative information for 2013

	2014	2013
Cash provided by (used in):		
Operating activities:		
Annual deficit	$ (139,616)	$ (546,133)
Items not involving cash:		
Amortization	904,924	961,503
Change in employee benefits and other liabilities	17,226	68,089
Change in non-cash assets and liabilities:		
Accounts receivable	(68,832)	142,434
Grants receivable	(204,319)	(28,798)
Prepaid expenses	(8,332)	(37,304)
Due to Province of Ontario	(468,821)	(295,242)
Due to Government of Canada	30,484	49,327
Due to The Corporation of the City of London	(883,602)	717,137
Due to The Corporation of the County of Middlesex	(168,300)	136,595
Accounts payable and accrued liabilities	(325,836)	(436,290)
Accrued wages and benefits	(231,132)	190,640
Net change in cash from operating activities	(1,546,156)	921,958
Capital activities:		
Cash used to acquire tangible capital assets	(405,631)	(451,231)
Net change in cash from capital activities	(405,631)	(451,231)
Net change in cash	(1,951,787)	470,727
Cash and cash equivalents, beginning of year	5,373,430	4,902,703
Cash and cash equivalents, end of year	$ 3,421,643	$ 5,373,430

The accompanying notes are an integral part of these financial statements.

The Middlesex-London Health Unit ("Health Unit") is a joint local board of the municipalities of The Corporation of the City of London and The Corporation of the County of Middlesex that was created on January 1, 1972. The Middlesex-London Health Unit provides programs which promote healthy and active living throughout the participating municipalities.

1. Significant accounting policies:

The financial statements of the Middlesex-London Health Unit are prepared by management in accordance with Canadian public sector accounting standards as recommended by the Public Sector Accounting Board ("PSAB") of the Chartered Professional Accountants of Canada. Significant accounting policies adopted by the Middlesex-London Health Unit are as follows:

(a) Basis of presentation:

The financial statements reflect the assets, liabilities, revenue and expenditures of the reporting entity. The reporting entity is comprised of all programs funded by the Province of Ontario, The Corporation of the City of London, and The Corporation of the County of Middlesex. It also includes other programs that the Board of Health may offer from time to time with special grants and/or donations from other sources.

Inter-departmental transactions and balances have been eliminated.

(b) Basis of accounting:

Sources of financing and expenditures are reported on the accrual basis of accounting with the exception of donations, which are included in the statement of operations as received.

The accrual basis of accounting recognizes revenues as they become available and measurable; expenditures are recognized as they are incurred and measurable as a result of receipt of services and the creation of a legal obligation to pay.

The operations of the Middlesex-London Health Unit are funded by government transfers from the Province of Ontario, The Corporation of the City of London and The Corporation of the County of Middlesex. Government transfers are recognized in the financial statements as revenue in the period in which events giving rise to the transfer occur, providing the transfers are authorized, any eligibility criteria have been met and reasonable estimates of the amounts can be made. Government transfers not received at year end are recorded as grants receivable due from the related funding organization in the statement of financial position.

Funding amounts in excess of actual expenditures incurred during the year are either contributed to reserves or reserve funds, when permitted, or are repayable and are reflected as liabilities due from the related funding organization in the statement of financial position.

1. Significant accounting policies (continued):

(c) Employee future benefits:

(i) The Middlesex-London Health Unit provides certain employee benefits which will require funding in future periods. These benefits include sick leave, life insurance, extended health and dental benefits for early retirees.

The cost of sick leave, life insurance, extended health and dental benefits are actuarially determined using management's best estimate of salary escalation, accumulated sick days at retirement, insurance and health care cost trends, long term inflation rates and discount rates.

(ii) The cost of multi-employer defined benefit pension plan, namely the Ontario Municipal Employees Retirement System (OMERS) pensions, are the employer's contributions due to the plan in the period. As this is a multi-employer plan, no liability is recorded on the Middlesex-London Health Unit's general ledger.

(d) Non-financial assets:

Non-financial assets are not available to discharge existing liabilities and are held for use in the provision of services. They have useful lives that extend beyond the current year and are not intended for sale in the ordinary course of operations.

(i) Tangible capital assets

Tangible capital assets are recorded at cost which includes amounts that are directly attributed to acquisition, construction, development or betterment of the asset. The cost, less residual value, of the tangible capital assets, excluding land, are amortized on a straight line basis over the estimated useful lives as follows:

Asset	Useful Life - Years
Leasehold Improvements	5 - 15
Computer Systems	4
Furniture	7

Assets under construction are not amortized until the asset is available for productive use.

1. Significant accounting policies (continued):

(d) Non-financial assets (continued):

(ii) Contributions of tangible capital assets

Tangible capital assets received as contributions are recorded at their fair market value at the date of receipt and also are recorded as revenue.

(iii) Leased tangible capital assets

Leases which transfer substantially all of the benefits and risks incidental to ownership of property are accounted for as leased tangible capital assets. All other leases are accounted for as operating leases and the related payment are charged to expense as incurred.

(e) Use of estimates:

The preparation of the Middlesex-London Health Unit's financial statements requires management to make estimates and assumptions that affect the reporting amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues and expenses during the period. Significant estimates include assumptions used in estimating provisions for accrued liabilities, and in performing actuarial valuations of employee future benefits.

In addition, the Middlesex-London Health Unit’s implementation of the Public Sector Accounting Handbook PS3150 has required management to make estimates of the useful lives of tangible capital assets.

Actual results could differ from these estimates.

2. Employee future benefits:

The Middlesex-London Health Unit provides certain employee benefits which will require funding in future periods, as follows:

(a) Vested sick leave liability:

Under the sick leave benefit plan, unused sick leave can accumulate and employees may become entitled to a cash payment when they leave the Middlesex-London Health Unit's employment. This plan applies to employees hired prior to January 1, 1982.

The liability for these accumulated days, to the extent that they have vested and could be taken in cash by an employee on termination, amounted to $156,401 (2013 - $179,975) at the end of the year.

A reserve of $283,876 has been established to meet future commitments for this liability.

(b) Post-retirement benefits liability:

The Middlesex-London Health Unit pays certain life insurance benefits on behalf of the retired employees as well as extended health and dental benefits for early retirees to age sixty-five. The Middlesex-London Health Unit recognizes these post-retirement costs in the period in which the employees render services. The most recent actuarial valuation was performed as at December 31, 2014.

	2014	2013
Accrued employee future benefit obligations	$ 2,257,800	$ 1,760,200
Unamortized net actuarial gain/(loss)	(417,800)	39,000
Employee future benefits liability as of December 31	$ 1,840,000	$ 1,799,200

Retirement and other employee future benefit expenses included in the benefits in the statement of operations consist of the following:

	2014	2013
Current year benefit cost	$ 111,100	$ 120,400
Interest on accrued benefit obligation	67,100	79,600
Amortization	300	30,400
Total benefit cost	$ 178,500	$ 230,400

Benefits paid during the year were $ 137,700 (2013 - $167,300).

2. Employee future benefits (continued):

(c) Post-retirement benefits liability (continued):

The main actuarial assumptions employed for the valuation are as follows:

(i) Discount rate:

The obligation as at December 31, 2014, of the present value of future liabilities and the expense for the year ended December 31, 2014, are determined using a discount rate of 3.75% (2013 – 3.75%).

(ii) Medical costs:

Prescription drug costs are assumed to increase at the rate of 8% per year (2013 - 7%) declining to 4% per year over 20 years. Other Medical and Vision coasts are assumed to increase at a rate of 4% per year, and 0% per year respectively.

(iii) Dental costs:

Dental costs are assumed to increase at the rate of 4% per year (2013 - 4%).

3. Pension agreement:

The Middlesex-London Health Unit contributes to the Ontario Municipal Employees Retirement Fund (OMERS) which is a multi-employer plan, on behalf of 339 members. The plan is a defined benefit plan which specifies the amount of the retirement benefit to be received by the employees based on the length of service and rates of pay.

During 2014, the plan required employers to contribute 9.0% of employee earnings up to the year's maximum pensionable earnings and 14.6% thereafter. The Health Unit contributed $1,908,308 (2013 - $1,829,910) to the OMERS pension plan on behalf of its employees during the year ended December 31, 2014.

4. Tangible Capital Assets:

Cost	Balance at December 31, 2013	Additions	Disposals	Balance at December 31, 2014
Leasehold Improvements – 15 years	$ 2,643,847	$ -	$ -	$ 2,643,847
Leasehold Improvements – 5 years	172,879	2,191	-	175,070
Computer Systems	1,542,561	266,971	(289,485)	1,520,047
Furniture & Equipment	2,368,180	136,469	(374,135)	2,130,514
Total	$ 6,727,467	$ 405,631	$ (663,620)	$ 6,469,478

Accumulated amortization	Balance at December 31, 2013	Amortization expense	Disposals	Balance at December 31, 2014
Leasehold Improvements – 15 years	$ 1,690,171	$ 317,892	$ -	$ 2,008,063
Leasehold Improvements – 5 years	143,735	10,080	-	153,815
Computer Systems	969,371	312,922	(289,485)	992,808
Furniture & Equipment	1,463,872	264,030	(374,135)	1,353,767
Total	$ 4,267,149	$ 904,924	$ (663,620)	$ 4,508,453

	Net book value December 31, 2013	Net book value December 31, 2014
Leasehold Improvements – 15 years	$ 953,676	$ 635,784
Leasehold Improvements – 5 years	29,144	21,255
Computer Systems	573,190	527,239
Furniture & Equipment	904,308	776,747
Total	$ 2,460,318	$ 1,961,025

4. Tangible Capital Assets (continued):

Cost	Balance at December 31, 2012	Additions	Disposals	Balance at December 31, 2013
Leasehold Improvements – 15 years	$ 2,642,714	$ 1,133	$ -	$ 2,643,847
Leasehold Improvements – 5 years	172,879	-	-	172,879
Computer Systems	1,615,680	269,383	(342,502)	1,542,561
Furniture & Equipment	2,477,971	180,715	(290,506)	2,368,180
Total	$ 6,909,244	$ 451,231	$ (633,088)	$ 6,727,467

Accumulated amortization	Balance at December 31, 2012	Amortization expense	Disposals	Balance at December 31, 2013
Leasehold Improvements – 15 years	$ 1,372,469	$ 317,702	$ -	$ 1,690,171
Leasehold Improvements – 5 years	114,590	29,145	-	143,735
Computer Systems	996,091	315,782	(342,502)	969,371
Furniture & Equipment	1,455,504	298,874	(290,506)	1,463,872
Total	$ 3,938,654	$ 961,503	$ (633,008)	$ 4,267,149

	Net book value December 31, 2012	Net book value December 31, 2013
Leasehold Improvements – 15 years	$ 1,270,245	$ 953,676
Leasehold Improvements – 5 years	58,289	29,144
Computer Systems	619,589	573,190
Furniture & Equipment	1,022,467	904,308
Total	$ 2,970,590	$ 2,460,318

During the year, the Health Unit deemed to have disposed of fully amortized assets with a cost basis of $663,620 (2013 - $633,008).

5. Commitments:

The Middlesex-London Health Unit is committed under operating leases for office equipment and rental property.

Future minimum payments to expiry are as follows:

2015	$ 911,852
2016	857,311
2017	70,800
2018	70,800
2019	35,400

6. Contingencies:

From time to time, the Health Unit is subject to claims and other lawsuits that arise in the ordinary course of business, some of which may seek damages in substantial amounts. These claims may be covered by the Health Unit's insurance. Liability for these claims and lawsuits are recorded to the extent that the probability of a loss is likely and it is estimable.

7. Accumulated Surplus:

Accumulated surplus consists of individual fund surplus and reserves as follows:

	2014	2013
Surpluses:		
Invested in tangible capital assets	$ 1,961,025	$ 2,460,318
Unfunded:		
Sick leave benefits	(156,401)	(179,975)
Post-employment benefits	(1,840,000)	(1,799,200)
Total Surplus	(35,376)	481,143
Reserves set aside by the Board:		
Accumulated sick leave	283,876	307,314
Funding stabilization	818,258	818,258
Employment Costs	176,077	-
Technology & Infrastructure	250,000	-
Environmental – septic tank	6,044	6,044
Dental Treatment reserve	128,360	154,096
Total reserves	1,662,615	1,285,712
Accumulated surplus	$ 1,627,239	$ 1,766,855

8. Other income:

The following revenues are presented as other income in the statement of operations:

	2014 Budget	2014 Actual	2013 Actual
Collaborative project revenues	$ 2,269	$ 422,868	$ 169,105
Food handler training	42,750	59,015	64,931
Public Fit-testing	15,000	16,849	-
Miscellaneous revenues	191,795	347,500	259,518
Vaccine sales	61,925	293,611	321,065
Workshop fees	3,548	7,915	25,975
	$ 317,287	$ 1,147,758	$ 840,594

9. Other expenses:

The following expenditures are presented as other expenses in the statement of operations:

	2014 Budget	2014 Actual	2013 Actual
Communications	$ 209,188	$ 183,772	$ 190,109
Health promotion/advertising	510,143	526,810	418,658
Miscellaneous expenses	412,150	691,559	596,004
Postage and courier	69,125	61,233	75,232
Printing	131,433	122,327	151,376
Staff development	155,063	138,177	106,965
	$ 1,487,102	$ 1,723,878	$ 1,538,344

10. Budget data:

The budget data presented in these financial statements is based upon the 2014 operating budgets approved by the Board of Health. Amortization was not contemplated on development of the budget and, as such, has not been included. The chart below reconciles the approved budget to the budget figures reported in these financial statements

Revenues:	
Operating budget	$ 34,059,616
Expenses:	
Operating budget	33,125,053
Capital budget	484,563
Total expenses	33,609,616
Annual surplus, as budgeted	$ 450,000

KPMG
cutting through complexity

AUDIT

Middlesex-London Health Unit

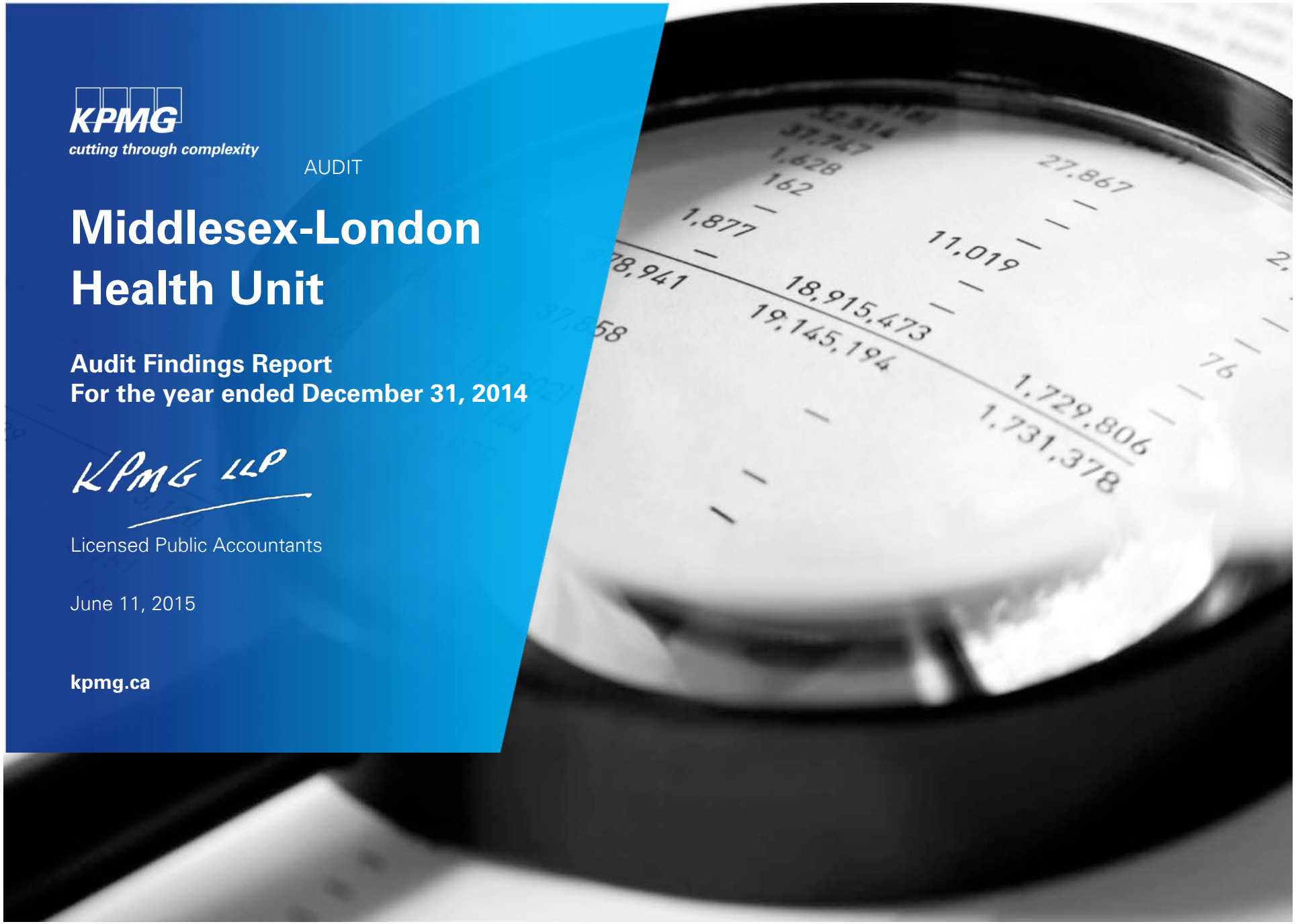
Audit Findings Report
For the year ended December 31, 2014

KPMG LLP

Licensed Public Accountants

June 11, 2015

kpmg.ca



KPMG
cutting through complexity

The contacts at KPMG in connection with this report are:

Ian Jeffreys
Lead Audit Engagement Partner

Tel: 519-660-2137
ijeffreys@kpmg.ca

Melissa Wale
Audit Manager

Tel: 519-660-2124
mwale@kpmg.ca

Table of Contents

At KPMG, we are **passionate** about earning your **trust**. We take deep **personal accountability**, individually and as a team, to deliver **exceptional service and value** in all our dealings with you.

At the end of the day, we measure our success from the **only perspective that matters – yours**.

KPMG
cutting through complexity

Executive summary

Purpose of this report

The purpose of this Audit Findings Report is to assist you, as a member of the Finance and Facilities Committee, in your review of the results of our audit of the financial statements of the Middlesex-London Health Unit as at and for the year ended December 31, 2014.

Audit risks and results

We identified a significant financial reporting risk relating to fraud risk over management override of controls. We are satisfied that our audit work has appropriately dealt with this risk.

No other significant financial reporting risks were identified during the audit; however, we have identified some other areas of audit focus to discuss with you.

See pages 5 – 7.

Audit adjustments and differences

We did not identify differences that remain uncorrected.

As well, we did not identify any adjustments that were communicated to management and subsequently corrected in the financial statements.

Executive summary (continued)

Finalizing the audit

As of May 26, 2015, we have completed the audit of the financial statements, with the exception of certain remaining procedures, which include amongst others:

- completing our discussions with the Finance & Facilities Committee;
- obtaining evidence of the Board's approval of the financial statements;
- receipt of the signed management representation letter

We will update you on significant matters, if any arising from the completion of the audit, including the completion of the above procedures. Our auditors' report will be dated upon the completion of any remaining procedures.

Control and other observations

We identified a control deficiency related to the review of journal entries.

See page 10.

Critical accounting estimates

Overall we are satisfied with the reasonability of critical accounting estimates taken.

- Management identifies all accounting estimates and establishes processes for making accounting estimates.
- There are no indicators of management bias as a result of our audit over estimates.
- Disclosure of estimation uncertainty in the financial statements is included in Note 1(e), Use of estimates. This note provides information on areas in the financial statements that include estimates.
- Management evaluates these estimates on a regular basis to ensure they are appropriate.

Significant accounting policies and practices

There have been no initial selections of, or changes to, significant accounting policies and practices to bring to your attention.

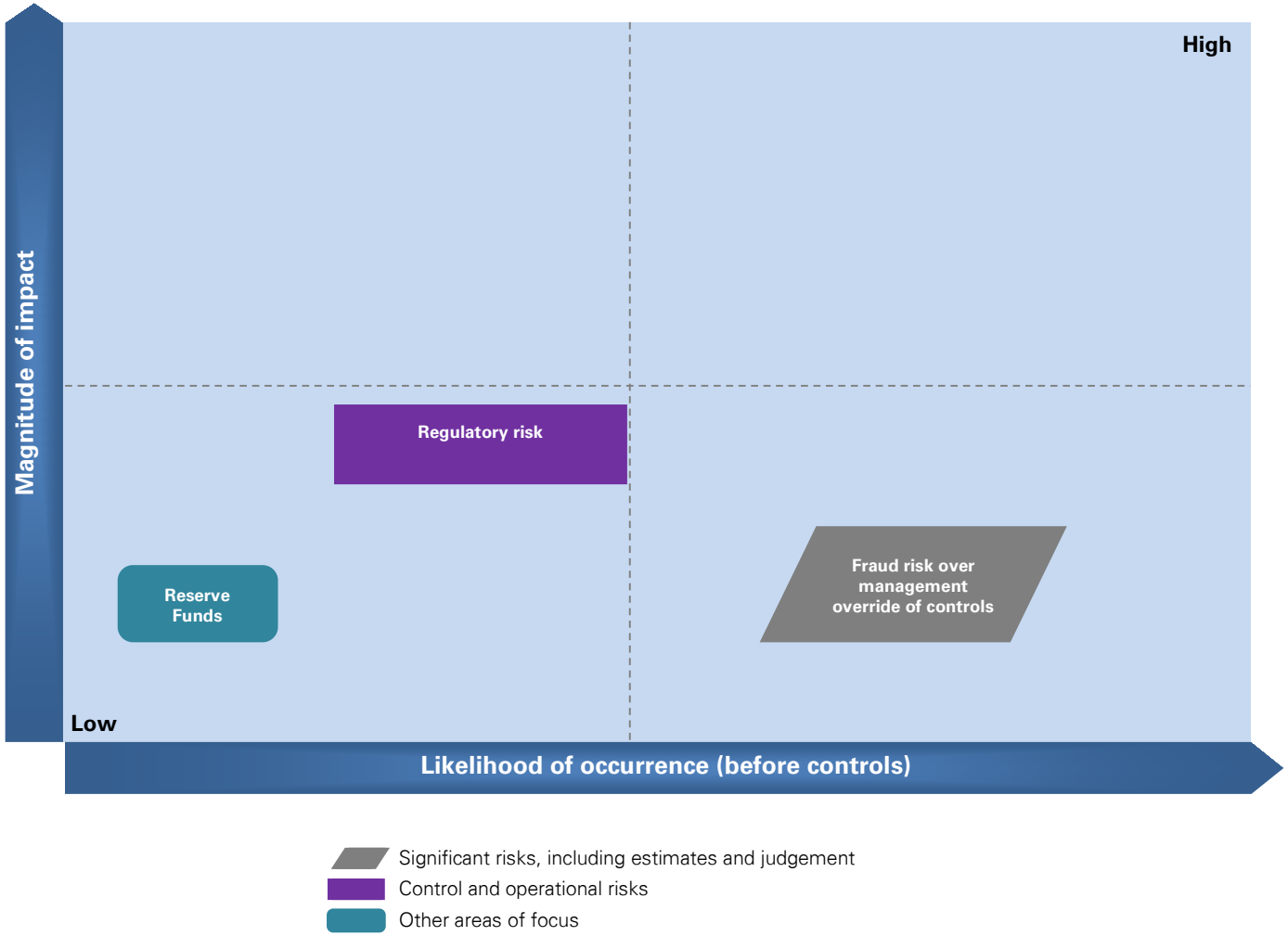
Independence

We are independent with respect to the Company within the meaning of the relevant rules and related interpretations prescribed by the relevant professional bodies in Canada and any applicable legislation or regulation.

KPMG
cutting through complexity

Audit risks and results

This diagram is our top-down view of the key financial reporting risks and their potential misstatement impact, mapped against the likelihood of a misstatement occurring (before controls).



Audit risks and results

Inherent risk of material misstatement is the susceptibility of a balance or assertion to misstatement which could be material, individually or when aggregated with other misstatements, assuming that there are no related controls.

We highlight our significant findings in respect of significant financial reporting risks.

Significant financial reporting risks	Why	Our significant findings from the audit
Fraud risk over management override of controls	This is a presumed fraud risk. We have not identified any specific additional risks of management override relating to this audit.	As the risk is not rebuttable, our audit methodology incorporates the required procedures in professional standards to address this risk. These procedures include testing of journal entries and other adjustments, performing a retrospective review of estimates and evaluating the business rationale of significant unusual transactions. No significant findings were identified as a result of the procedures performed during the audit.

Audit risks and results

Other areas of focus for our audit, include the following:

Other areas of focus	Why	Our significant findings from the audit
Reserve Funds	In fiscal 2014, the Health Unit created two new reserve funds for which up to $450,000 of unused funding can be transferred per year from the City of London and the County of Middlesex.	As at December 31, 2014, $426,077 was held in these reserve accounts instead of showing as payable to the City of London and the County of Middlesex at year end. KPMG agreed the creation of these reserve accounts to the Board of Health Committee minutes and performed substantive procedures over revenue, expenses and payables to other levels of government. KPMG did not identify any issues during testing of this balance.

Financial statement presentation and disclosure

The presentation and disclosure of the financial statements are, in all material respects, in accordance with the Company's relevant financial reporting framework. Misstatements, including omissions, if any, related to disclosure or presentation items are in the management representation letter included in the Appendices.

We also highlight the following:

Form, arrangement, and content of the financial statements	The form, arrangement, and content of the financial statements are appropriate for the Company's purposes.

KPMG
cutting through complexity

Audit adjustments and differences

Adjustments and differences identified during the audit have been categorized as Corrected "adjustments" or Uncorrected "differences." These include disclosure adjustments and differences.

Materiality

In the performance of the audit, KPMG utilized a materiality of $1,056,000 and an audit misstatement posting threshold of $52,800. This was based on total expenses as a benchmark.

Corrected audit adjustments

We did not identify any adjustments that were communicated to management and subsequently corrected in the financial statements

Uncorrected audit differences

We did not identify differences that remain uncorrected.

Control observations

In accordance with professional standards, we are required to communicate to the Audit Committee any control deficiencies that we identified during the audit and have determined to be significant deficiencies in ICFR.

Other control deficiencies may be identified during the audit that do not rise to the level of significant deficiency.

Significant deficiencies

No significant control deficiencies have been identified.

Other control deficiencies

Below is a summary of these other control deficiencies that we identified during the audit:

Process	Potential effect
Journal Entry Review	KPMG notes that there is not consistent review of non-standard journal entries or where there is review, it is not formally documented. This increases the risk of inappropriate journal entries being recorded. It is recommended that all non-standard journal entries be reviewed and signed as evidence that this review has taken place.

Appendices

Appendix 1: Required communications

In accordance with professional standards, there are a number of communications that are required during the course of and upon completion of our audit. These include:

- **Auditors' report** – the conclusion of our audit is set out in our draft auditors' report attached to the draft financial statements
- **Management representation letter** – we will obtain from management at the completion of the annual audit. In accordance with professional standards, copies of the representation letter will be provided to the Finance & Facilities Committee.

Appendix 2: Independence

KPMG maintains a system of quality control designed to reflect our drive and determination to deliver independent, unbiased advice and opinions, and also meet the requirements of Canadian professional standards.

We have prepared the following comments to facilitate our discussion with you regarding independence matters.

The following summarizes the professional services rendered by us to the Company:

Description of professional services
Audit of the financial statements of Middlesex-London Health Unit for the year ended December 31, 2014

Professional standards require that we communicate the related safeguards that have been applied to eliminate identified threats to independence or to reduce them to an acceptable level. Although we have policies and procedures to ensure that we did not provide any prohibited services and to ensure that we have not audited our own work, we have applied the following safeguards related to the threats to independence listed above:

- We instituted policies and procedures to prohibit us from making management decisions or assuming responsibility for such decisions
- We obtained pre-approval of non-audit services, and during this pre-approval process we discussed the nature of the engagement and other independence issues related to the services
- We obtained management's acknowledgement of responsibility for the results of the work performed by us regarding non-audit services, and we have not made any management decisions or assumed responsibility for such decisions

Appendix 3: Management representation letter

KPMG LLP
1400-140 Fullarton Street
London, Ontario N6A 5P2
Canada

June 11, 2015

Ladies and Gentlemen:

We are writing at your request to confirm our understanding that your audit was for the purpose of expressing an opinion on the non-consolidated financial statements (hereinafter referred to as "financial statements") of Middlesex-London Health Unit ("the Entity") as at and for the period ended December 31, 2014.

We confirm that the representations we make in this letter are in accordance with the definitions as set out in **Attachment I** to this letter.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

GENERAL:

1) We have fulfilled our responsibilities, as set out in the terms of the engagement letter dated December 1, 2010, for:

   a) the preparation and fair presentation of the financial statements and believe that these financial statements have been prepared and present fairly in accordance with the relevant financial reporting framework

   b) providing you with all relevant information, such as all financial records and related data and complete minutes of meetings, or summaries of actions of recent meetings for which minutes have not yet been prepared, of shareholders, board of directors and committees of the board of directors that may affect the financial statements, and access to such relevant information

   c) such internal control as management determined is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error

   d) ensuring that all transactions have been recorded in the accounting records and are reflected in the financial statements

INTERNAL CONTROL OVER FINANCIAL REPORTING:

2) We have communicated to you all deficiencies in the design and implementation or maintenance of internal control over financial reporting of which management is aware.

FRAUD & NON-COMPLIANCE WITH LAWS AND REGULATIONS:

3) We have disclosed to you:

   a) the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud

   b) all information in relation to fraud or suspected fraud that we are aware of and that affects the Entity and involves: management, employees who have significant roles in internal control, or others, where the fraud could have a material effect on the financial statements

   c) all information in relation to allegations of fraud, or suspected fraud, affecting the Entity's financial statements, communicated by employees, former employees, regulators, or others

   d) all known instances of non-compliance or suspected non-compliance with laws and regulations, including all aspects of contractual agreements, whose effects should be considered when preparing financial statements

   e) all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements

SUBSEQUENT EVENTS:

4) All events subsequent to the date of the financial statements and for which the relevant financial reporting framework requires adjustment or disclosure in the financial statements have been adjusted or disclosed.

RELATED PARTIES:

5) We have disclosed to you the identity of the Entity's related parties and all the related party relationships and transactions / balances of which we are aware and all related party relationships and transactions / balances have been appropriately accounted for and disclosed in accordance with the relevant financial reporting framework.

ESTIMATES:

6) Measurement methods and significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

NON-SEC REGISTRANTS OR NON-REPORTING ISSUERS:

7) We confirm that the Entity is not a Canadian reporting issuer (as defined under any applicable Canadian securities act) and is not a United States Securities and Exchange Commission ("SEC") Issuer (as defined by the Sarbanes-Oxley Act of 2002). We also confirm that the financial statements of the Entity will not be included in the consolidated financial statements of a Canadian reporting issuer audited by KPMG or an SEC Issuer audited by any member of the KPMG organization.

Yours very truly,

MIDDLESEX-LONDON HEALTH UNIT

By: John Millson, Director, Finance & Operations

By: Dr. Christopher Mackie, MD, Medical Officer of Health and Chief Executive Officer

Attachment I – Definitions

MATERIALITY

Certain representations in this letter are described as being limited to matters that are material. Misstatements, including omissions, are considered to be material if they, individually or in the aggregate, could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements. Judgments about materiality are made in light of surrounding circumstances, and are affected by the size or nature of a misstatement, or a combination of both.

FRAUD & ERROR

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorization.

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

RELATED PARTIES

In accordance with Canadian public sector accounting standards, *related party* is defined as:

- when one party has the ability to exercise, directly or indirectly, control, joint control or significant influence over the other. Two or more parties are related when they are subject to common control, joint control or common significant influence. Two not-for-profit organizations are related parties if one has an economic interest in the other. Related parties also include management and immediate family members.

In accordance with Canadian public sector accounting standards, a *related party transaction* is defined as:

- a transfer of economic resources or obligations between related parties, or the provision of services by one party to a related party, regardless of whether any consideration is exchanged. The parties to the transaction are related prior to the transaction. When the relationship arises as a result of the transaction, the transaction is not one between related parties.

KPMG
cutting through complexity

Appendix 4: Audit Quality and Risk Management

KPMG maintains a system of quality control designed to reflect our drive and determination to deliver independent, unbiased advice and opinions, and also meet the requirements of Canadian professional standards.

Quality control is fundamental to our business and is the responsibility of every partner and employee. The following diagram summarises the six key elements of our quality control systems.

Visit http://www.kpmg.com/Ca/en/services/Audit/Pages/Audit-Quality-Resources.aspx for more information.

- Other controls include:
  - Before the firm issues its audit report, Engagement Quality Control Reviewer reviews the appropriateness of key elements of publicly listed client audits.
  - Technical department and specialist resources provide real-time support to audit teams in the field.
- We conduct regular reviews of engagements and partners. Review teams are independent and the work of every audit partner is reviewed at least once every three years.
- We have policies and guidance to ensure that work performed by engagement personnel meets applicable professional standards, regulatory requirements and the firm's standards of quality.

- All KPMG partners and staff are required to act with integrity and objectivity and comply with applicable laws, regulations and professional standards at all times.
- We do not offer services that would impair our independence.
- The processes we employ to help retain and develop people include:
  - Assignment based on skills and experience;
  - Rotation of partners;
  - Performance evaluation;
  - Development and training; and
  - Appropriate supervision and coaching.
- We have policies and procedures for deciding whether to accept or continue a client relationship or to perform a specific engagement for that client.
- Existing audit relationships are reviewed annually and evaluated to identify instances where we should discontinue our professional association with the client.

Appendix 5: Background and professional standards

Internal control over financial reporting

As your auditors, we are required to obtain an understanding of internal control over financial reporting (ICFR) relevant to the preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances for the purpose of expressing an opinion on the financial statements, but not for the purpose of expressing an opinion on internal control. Accordingly, we do not express an opinion on the effectiveness of internal control.

Our understanding of ICFR was for the limited purpose described above and was not designed to identify all control deficiencies that might be significant deficiencies and therefore, there can be no assurance that all significant deficiencies and other control deficiencies have been identified. Our awareness of control deficiencies varies with each audit and is influenced by the nature, timing, and extent of audit procedures performed, as well as other factors.

The control deficiencies communicated to you are limited to those control deficiencies that we identified during the audit.

Documents containing or referring to the audited financial statements

We are required by our professional standards to read only documents containing or referring to audited financial statements and our related auditors' report that are available through to the date of our auditors' report. The objective of reading these documents through to the date of our auditors' report is to identify material inconsistencies, if any, between the audited financial statements and the other information. We also have certain responsibilities, if on reading the other information for the purpose of identifying material inconsistencies, we become aware of an apparent material misstatement of fact.

We are also required by our professional standards when the financial statements are translated into another language to consider whether each version, available through to the date of our auditors' report, contains the same information and carries the same meaning.

Appendix 6: Current developments

The following is a summary of the current developments that are presented for your information.

Topic	Summary and implications
US Foreign Account Tax Compliance (FATCA) and Not-for-Profit Entities	Not-for-Profit entities must determine their status under FATCA to assess any possible reporting and/or withholding obligations. US Foreign Account Tax Compliance (FATCA) and Not-for-Profit Entities
Cyber security	The threats from cyber adversaries are continuing to grow in scale and sophistication. NPOs worldwide now openly acknowledge that cyber attacks are one of the most prevalent and high impact risks they face. Cyber security for Canada's Not-for-Profit Organizations – Attack is certain – Your loss is not
Employer compliance audits	Recently, Canada Revenue Agency ("CRA") has demonstrated a renewed focus on "Employer Compliance Audits", which include a review of various employer-provided benefits, as well as the nature of the relationship that exists between an employer and its employees and other third party consultants. Employer compliance audits – Are your benefits taxable?
Assets safeguarding	Fraud can derail the good work an NPO performs. Both the financial loss and the reputational damage that result from an incident of fraud can have lasting consequences and tarnish the goodwill created by the NPO's past efforts. Safeguarding Not-for-Profit Organizations from fraud
Income tax issues associated with operating a business	The funding landscape for organizations in the public sector has changed dramatically over the last number of years. Government or public funding agencies no longer have the ability to fully support public purpose organizations that were established legally as either Charities or NPO's for tax purposes. The income tax issues associated with operating a business within a Charity or Not-for-Profit organization

Making the most of your charitable gifts for 2015	How you structure your charitable donations can be as important as the amounts you give, both to the charity and to the donation's after-tax cost to you. Making the most of your charitable gifts for 2015
Why is Risk Management important for NPOs?	Strong governance, supported by effective enterprise risk management, are foundational to a Not-for-Profit organization's ability to anticipate and effectively respond to complex challenges. The importance of Enterprise Risk Management to a Not-for-Profit organization

KPMG
cutting through complexity

kpmg.ca

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 036-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 June 18

THE NEED FOR ENFORCEMENT AND MANDATORY SAFETY STANDARDS FOR E-CIGARETTE JUICE CONTAINING NICOTINE

Recommendations

It is recommended that the Board of Health:

1. ***Endorse Report No. 036-15 re The Need For Enforcement And Mandatory Safety Standards For E-Cigarette Juice Containing Nicotine.***
2. ***Recommend that Health Canada actively enforce legislation against the illegal import, advertising and sale of e-cigarette juice containing nicotine, and conduct mandatory inspections of e-cigarette and e-juice manufacturers regarding safety standards, quality controls and packaging requirements, by sending a letter to the Prime Minister of Canada and the federal Minister of Health, copied to local Members of Parliament, and by asking staff to draft a motion to take to the next Association of Local Public Health Agencies Annual General Meeting for consideration.***

Key Points

- Nicotine is a highly addictive and toxic substance which has the potential to cause acute adverse health effects and which can be lethally poisonous at high doses.
- Electronic cigarettes ("e-cigarettes") containing nicotine and their accompanying nicotine solutions ("e-juice") fall under the federal *Food and Drugs Act*, requiring authorization prior to importation, advertising and sale.
- To date, no nicotine-containing e-cigarette or e-juice has been approved by Health Canada and therefore persons importing, advertising or selling such products are acting in contravention of the *Food and Drugs Act*.
- Despite the current position of Health Canada, e-juice containing nicotine is increasingly visible and available in the retail market, presenting a number of new public health risks, including nicotine poisoning.

Background

Electronic nicotine delivery devices, known more commonly as e-cigarettes are battery-powered devices that deliver nicotine, flavourings and other chemicals through the inhalation of a vapour. E-cigarette refill liquids, which may or may not contain nicotine, are referred to as "e-juice". A 2011 survey found that 93% of Canadian e-cigarette users use nicotine e-juice with their devices. Long-term studies on the safety of the devices and their efficacy as a cessation aid are not available. Despite the lack of evidence, e-cigarettes are widely available for sale at pharmacies, grocery stores, convenience stores and gas stations; currently, 70% of Middlesex-London tobacco retailers sell the devices and/or the accompanying e-juice. As global e-cigarette sales are forecasted to reach $3 billion by the end of 2015, London has seen an increase in the number of e-cigarette specialty stores ("vape stores") opening for business over the past two years. Such stores exclusively sell electronic smoking equipment and accessories, including e-juice. Worldwide, there are now over 450 brands being marketed in over 7000 flavours.

E-juice is manufactured predominantly in China and bottles are not subject to any legal safety standards for labelling or packaging such as those imposed on the pharmaceutical industry in the production of medication. In 2009, Health Canada issued a Public Notice Advisory to Canadians, attached as Appendix A,

and a notice to stakeholders, attached as Appendix B, instructing persons importing, advertising or selling e-cigarette products in Canada to stop doing so immediately as such activity contravened the *Food and Drugs Act*. The Notice outlined the legal requirement for product market authorization and advised Canadians not to purchase or use the products. Middlesex-London Health Unit Tobacco Enforcement Officers (TEO) distributed this Notice to all tobacco retailers in 2011 due to an increase in calls from tobacco retailers and members of the public. The sale of nicotine e-juice in retail shops in Middlesex-London, primarily flea markets, kiosks in shopping centres and specialty vape stores, were referred by TEOs to Health Canada's Health Products and Food Branch Inspectorate for investigation. A template acknowledgement letter was received by the Health Unit. Every premise reported to Health Canada continues to illegally sell nicotine juice.

Ontario's *Electronic Cigarette Act, 2015* regulates the use of e-cigarettes in places where smoking is prohibited, and imposes sales and advertising restrictions, as described in Report No. 040-15; however, enforcement of the sale of nicotine e-juice lies solely with Health Canada. Failure of Health Canada to actively enforce contraventions of the *Food and Drugs Act* is contributing to the increased availability, marketing and sale of illegal nicotine products.

Public Health Concerns

With an estimated median lethal dose between 1 and 13 mg per kg of body weight, 1 teaspoon (5 ml) of a 1.8% nicotine solution could be lethal to a 90-kg person. A 20ml bottle of e-juice contains on average 360 mg of nicotine, several times the lethal dose. Incidents of nicotine poisoning have risen substantially, especially in the United States. In Canada, the risks associated with unregulated nicotine e-juice compositions include variable concentrations of chemicals and nicotine, dangerous nicotine dose levels or undisclosed ingredients. According to laboratory testing commissioned by Health Canada, approximately one-half of all products labelled as nicotine-free contained nicotine. In addition, unsealed, leaky or non-child proof bottles containing a potent poison is a concern. The rising prevalence of e-cigarette use is also a concern; use is highest among young people with one in five youth (aged 15-19) and young adults (aged 20-24) having ever tried an e-cigarette. Prevalence varies across provinces; among youth aged 15-19, ever use ranged from 15% in Ontario to twice that (31%) in Quebec. The use of flavourings and lifestyle marketing tactics mimic tobacco industry advertising and promotional practices. All main transnational tobacco companies are now selling e-cigarettes, and are investing hundreds of millions of dollars into product development and manufacturing.

Local Concerns

During recent inspections in London, TEOs found that all nine retail shops which mainly sell drug paraphernalia also sell e-cigarettes and nicotine e-juice. The seven known specialty vape stores in London also sell nicotine e-juice. In addition, TEOs are finding that e-cigarette displays have become more visible and elaborate in tobacco retailer premises. Nicotine e-juice is now prominently displayed on point of sale shelving and countertops of many tobacco retailers in Middlesex-London. Although some still appear to be from "independent" distributors, many are Vapur brand. The Vapur brand e-juice bottles on display are labelled to contain nicotine and participating storeowners have been given a document titled "About Vaporizers and E-Juice", attached as Appendix C. The information sheet is issued by Casa Cubana, the umbrella company of Vapur, who is also an importer and distributor of cigars and tobacco accessories. The document's wording encourages retailers to sell their nicotine juice to customers. The TEOs expressed concern that tobacco retailers may have difficulty understanding the high-literacy language used in the communication, especially for those whom English is a second language. The Casa Cubana document advises retailers that e-cigarettes containing nicotine are "a political and regulatory grey area in Canada" with an "arguable legal status," and retailers are advised to not comply with Health Canada's Advisory Notice.

Next Steps

The inaction of Health Canada in enforcing legislation banning marketing and sale of nicotine juice in stores is contributing to a disregard of the federal law by suppliers, distributors and retailers. The subsequent increased availability of these new commercially-branded, marketed and visibly-displayed nicotine e-juice bottles is misleading retailers and their customers regarding the legal status and safety of the products. There is a need for active enforcement against the illegal import, advertising and sale of e-cigarette juice containing nicotine, and manufacturers need to be subjected to mandatory inspections regarding safety standards, quality controls and packaging requirements to protect children, youth and adult consumers.

This report was prepared by Ms. Leila Davis, Tobacco Enforcement Officer and Ms. Linda Stobo, Chronic Disease Prevention and Tobacco Control Manager.

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

This report addresses the following requirement(s) of the Ontario Public Health Standards: Foundations: Principles 1, 2; Comprehensive Tobacco Control: 1, 6, 9, 11 and 13

Health Canada Santé Canada

Canada

Health Canada
www.hc-sc.gc.ca

Health Canada Advises Canadians Not to Use Electronic Cigarettes

Advisory
2009-53
March 27, 2009
For immediate release

OTTAWA - Health Canada is advising Canadians not to purchase or use electronic smoking products, as these products may pose health risks and have not been fully evaluated for safety, quality and efficacy by Health Canada.

These products come as electronic cigarettes, cigars, cigarillos and pipes, as well as cartridges of nicotine solutions and related products. These products fall within the scope of the *Food and Drugs Act*, and under the *Act*, require market authorization before they can be imported, advertised or sold. The sale of these health products is currently not compliant with the *Food and Drugs Act* since no electronic smoking products have been granted a market authorization in Canada.

In recent months, a number of electronic cigarettes, cigars and pipes as well as cartridges of nicotine solutions and related products have been marketed in Canada, and through the Internet. Most of these products are shaped and look like their conventional counterparts. They produce a vapour that resembles smoke and a glow that resembles the tip of a cigarette. They consist of a battery-powered delivery system that vapourizes and delivers a liquid chemical mixture that may be composed of various amounts of nicotine, propylene glycol, and other chemicals.

Nicotine is a highly addictive and toxic substance, and the inhalation of propylene glycol is a known irritant. Although these electronic smoking products may be marketed as a safer alternative to conventional tobacco products and, in some cases, as an aid to quitting smoking, electronic smoking products may pose risks such as nicotine poisoning and addiction. Please visit the Health Canada website for further information about nicotine and addiction. …..***cont'd on reverse)***

While no electronic smoking product has yet been authorized for sale in Canada, Health Canada has authorized the sale of a number of smoking cessation aids, including nicotine gum, nicotine patches, nicotine inhaler, and nicotine lozenges.

Electronic smoking products, including their nicotine cartridges, must be kept out of the reach of children at all times, given the risk of choking or nicotine poisoning. Nicotine is hazardous to the health and safety of certain segments of the population such as children, youth, pregnant women, nursing mothers, people with heart conditions, and the elderly.

Persons importing, advertising or selling electronic cigarette products in Canada must stop doing so immediately. Health Canada is providing information to interested stakeholders on how to apply for the appropriate market authorizations and establishment licences.

Canadians who have used e-cigarette products and are concerned about their health should consult with a health care practitioner.

Complaints involving electronic smoking products can be reported to the Health Products and Food Branch Inspectorate by calling the toll-free hotline at 1-800-267-9675, or by writing to:

Health Products and Food Branch Inspectorate
Health Canada
Address Locator: 2003C
Ottawa, Ontario K1A 0K9

You can also contact a Health Products and Food Branch Inspectorate Regional Operational Centre:

ONTARIO OPERATIONAL CENTRE
Health Products and Food Branch Inspectorate
2301 Midland Avenue
Scarborough, Ontario
M1P 4R7
Tel: (416) 973-1600
Fax: (416) 973-1954
E-mail: insp_onoc-coon@hc-sc.gc.ca

Please see the attached Health Canada Notice to Stakeholders regarding E-Cigarettes.

Health Canada Santé Canada

March 27, 2009

NOTICE

Our file number: 09-108446-55

To All Persons Interested in Importing, Advertising or Selling Electronic Smoking Products in Canada

Electronic smoking products (i.e., electronic products for the vaporization and administration of inhaled doses of nicotine including electronic cigarettes, cigars, cigarillos and pipes, as well as cartridges of nicotine solutions and related products) fall within the scope of the *Food and Drugs Act*. All of these products require market authorization prior to being imported, advertised or sold in Canada. Market authorization is granted by Health Canada following successful review of scientific evidence demonstrating safety, quality and efficacy with respect to the intended purpose of the health product. This evidence is provided by the sponsor seeking market authorization. To date, no electronic smoking product has been authorized for sale by Health Canada.

In the absence of evidence provided by the sponsor establishing otherwise, an electronic smoking product delivering nicotine is regulated as a New Drug under Division 8, Part C of the *Food and Drug Regulations*. In addition, the delivery system within an electronic smoking kit that contains nicotine must meet the requirements of the *Medical Devices Regulations*. Appropriate establishment licences issued by Health Canada are also needed prior to importing, and manufacturing electronic cigarettes.

Health Canada is aware that some electronic smoking products have been advertised and sold in Canada without market authorization from Health Canada. Persons who may be importing, advertising or selling electronic smoking products without the appropriate authorizations are asked to stop doing so immediately. Products that are found to pose a risk to health and/or are in violation of the *Food and Drugs Act* and related *Regulations* may be subject to compliance and enforcement actions in accordance with the Health Products and Food Branch Inspectorate's Compliance and Enforcement Policy (POL-0001).

If you wish to submit a complaint about the advertising or sale of a health product without market authorization, please contact the Health Products and Food Branch Inspectorate.

…/2

The following Web links are provided for your information:

"How to Submit a Trade Complaint":
http://www.hc-sc.gc.ca/dhp-mps/compli-conform/prob-report-rapport/gui_38_trade-industrie_cp-pc-eng.php

For information pertaining to applications and submissions for drugs and health products:
http://www.hc-sc.gc.ca/dhp-mps/prodpharma/applic-demande/index-eng.php

Information about establishment licensing requirements may be found at:
http://www.hc-sc.gc.ca/dhp-mps/compli-conform/licences/index-eng.php

Sponsors interested in seeking market authorisation for electronic smoking products may contact Health Canada's Therapeutic Products Directorate for information about the drug submission process at: SIPDMail@hc-sc.gc.ca.

April 2015

ABOUT VAPORIZERS & E-JUICE

What is the current situation?

The vaping market in Canada has evolved over the last several years – from standard disposable E-cigarettes, to now include vape tanks and liquids (with/without nicotine).

In Canada, most e-cigarettes users are smokers aiming to cut back on cigarettes (or quit them altogether) and searching for alternative nicotine free and nicotine delivery products. Consequently, thousands of vape shops have opened up across the country in the last several years – all offering e-cigarette/liquids consumers a nicotine alternative.

Through its established VAPUR® brand, Casa Cubana has decided to introduce a range of nicotine delivering liquids specifically designed for the Convenience & Gas Channel.

Are liquids with nicotine legal in Canada?

Health Canada has long stated that all products containing nicotine are regulated under Canada's Food and Drugs Act (FDA) – effectively requiring subsequent approval or certification before being sold in Canada. But everyone knows that tobacco products, as one example, although containing much larger amounts of nicotine than typical E-juices found in our marketplace – are not regulated under the FDA.

Despite some general public positioning and subsequent Cease and Desist letters since issued to shop owners across the country, Health Canada has yet to seize any product or stop any retail outlet from selling any branded E-Juices (with nicotine) in Canada over the last 3 years.

Because the nicotine ingredient in VAPUR® liquids is dispensed in/at such low levels – it is the longstanding position of the E-Juice industry in Canada that this type of product is effectively exempted from regulation (as a drug) under Canada's Food and Drugs Act.

Because the VAPUR® liquids (with or without nicotine) are not marketed as health products (i.e. for medicinal use) or sold as healthier alternatives to smoking or as smoking cessation devices – the product is also not regulated as a Natural Health Product under the Federal Government's Natural Products Regulations.

Consequently, it remains the industry's position that no specific government approval or certification (at this time) is required for selling these (low-level nicotine) products in Canada.

CASA CUBANA 275, rue Stinson, Montréal (Québec) H4N 2E1
T 514-737-0066 1-877-606-1806 **F** 514-737-5211 1-877-228-2262

Are Casa Cubana clients doing anything illegal by distributing VAPUR® liquids with nicotine?

Casa Cubana takes its commitments and responsibilities to its commercial partners quite seriously. We are confident that if ever challenged in any way, our activities and products would be well argued and defended.

That being said, Governments and government inspectors have the authority to interpret legislation (or review their interpretations) whenever and however they see fit – and on any consumer product.

Know that Casa Cubana stands 100% behind the quality and legality of all of our products.

Are electronic cigarettes containing nicotine still illegal in Canada?

Electronic cigarettes containing nicotine remain a political and regulatory grey area in Canada. While the devices do not make any health claims and deliver (exempted) low-levels of nicotine to consumers – existing Canadian laws should arguably not impact these products.

Despite the arguable legal status of these products, Health Canada remains steadfast in its position that they do require market authorization before being imported and sold in Canada. Their enforcement activities to date have led to the continued refusal of imported product into Canada (refusal at Customs). Because no E-cigarette product is actually manufactured in Canada, these products are consequently seldom found in the marketplace.

Does Casa Cubana guarantee its products?

We stand behind everything that we sell. Period.

Should any issue ever arise as to the quality or legality of any of our VAPUR® products or for more information regarding the content of this document, please do not hesitate in contacting us.

CASA CUBANA 275, rue Stinson, Montréal (Québec) H4N 2E1
T 514-737-0066 1-877-606-1806 **F** 514-737-5211 1-877-228-2262

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 038-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 June 18

HEALTHY BABIES HEALTHY CHILDREN POSTPARTUM SCREENING

Recommendation

It is recommended that Report No. 038-15 re Healthy Babies Healthy Children Postpartum Screening be received for information.

Key Points

- Changes are being implemented in Healthy Babies Healthy Children (HBHC) Program Screening to improve screening rates and compliance with program requirements.
- At London Health Sciences Centre, the Screening Liaison Public Health Nurse began completing postpartum screening in partnership with hospital nursing staff effective March 30th.
- An HBHC Partnership Agreement with LHSC is under development.

HBHC Program Screening

HBHC Screening in Ontario is completed prenatally, postpartum and with families with children under the age of 6 as a process to identify and offer program services to vulnerable families that would benefit from home visiting support for effective parenting and healthy child development. HBHC Postpartum Screening has been identified by the Ministry of Children and Youth Services (MCYS) as a priority for improvement as part of the Continuous Quality Improvement activities required for Health Units in 2015. The HBHC Screen is attached as Appendix A to this report.

Postpartum Screening in Hospital

HBHC Postpartum Screening, although required by MCYS to be universal, has been occurring at well below the provincial target of 100% at London Health Sciences Centre (LHSC). In 2014, the screening rate was 65%. While LHSC recognizes the importance of the HBHC program and is committed to supporting universal screening with families, postpartum screen completion has continued to be a challenge using the approach of screens being completed by hospital nursing staff.

In Ontario, most health units now have Public Health Nurses (PHNs) in hospital providing postpartum screening at the bedside in partnership with hospital staff. Provincial evaluation research indicates that the Postpartum Screen completion and accuracy are most effective when completed by a PHN. In 2012, MCYS implemented funding a fulltime PHN at each Health Unit dedicated to Hospital Liaison Screening. Somee health units have achieved screening rates over 95%, demonstrating the effectiveness of this model. Based on this information, the model for HBHC Postpartum Screening at LHSC changed effective March 30, 2015 as a strategy to improve both the screening rate and the quality of screen completion. A draft partnership agreement supporting this model has been developed and is in the process of being reviewed for approval by both organizations.

The MLHU Screening Liaison PHN's expanded role at LHSC for completing HBHC screening in partnership with hospital nursing staff is as follows:

- Weekdays: Screening Liaison PHN completing postpartum HBHC screening
- Weekends and Statutory Holidays: Hospital nursing staff completing HBHC postpartum screening
- Other Screening Liaison PHN activities: In addition to screen completion include continuing to provide training of hospital nursing staff; supporting quality assurance for completion of the screens; and coordinating communication of the screens to the Health Unit.

At the Strathroy Middlesex General Hospital, postpartum HBHC Screening continues to be completed by hospital nursing staff with support activities being provided by our Screening Liaison PHN.

Conclusion

In 2015 multiple Continuous Quality Improvement initiatives are being implemented to improve compliance with HBHC program requirements which will result in improvements in program services provided and outcomes for families in our community. This change in the screening process at LHSC is an important strategy in our efforts for improving postpartum screening rates at LHSC; and HBHC program and service delivery to families.

This report was prepared by Ms. Nancy Greaves, Ms. Kathy Dowsett and Ms. Mary Huffman, Managers of the Best Beginnings Team, Family Health Services.

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

Healthy Babies Healthy Children Screen

MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com
FAX: 519-663-8243

Ontario

Name: _____

Address: _____

_____ Postal Code:_____

Telephone No.: ( ) _____ - _____

Client's D.O.B.: _____

HBHC SCREEN:

☐ Prenatal ☐ Postnatal ☐ Early Childhood (>6wk<6yr) ☐ LHSC ☐ Middlesex Hospital Alliance ☐ Other

Phone: _____ - _____ - _____ *(if not on addressograph)*

TO BE SIGNED BY PARENT:

Health Units offer a program called Healthy Babies, Healthy Children. It is a voluntary program to support all expectant mothers and families with children from birth to 6 years old. I *(Health/Service Provider)* will ask you a series of questions about your pregnancy and birth; parenting and your family history. This information will be sent to the Health Unit and a Public Health Nurse may call you.

I consent to share personal information/health information and to participate in the Healthy Babies, Healthy Children Program.

☐ Yes, please
☐ No, thank you

Client Signature _____ Date: _____

Client Signature _____ Date: _____

LET'S GROW NEWSLETTER:

Providing your email address will register you to receive the free online Let's Grow Newsletter and to receive health information about caring for your baby. Your email address will be kept confidential and will not be disclosed to a third party.

☐ Yes, please send me my copy of Let's Grow to: Email:_____
☐ No, thank you

INFANT:

DOB: _____ Name: _____

Gestation: wks _____ **Birth** Wt: _____gms **Discharge Wt**: _____gms **Apgars:** _____+_____ **Sex:** M☐ F☐

Was baby discharged with mother? Yes☐ No ☐ Baby's Discharge Date: _____

MOTHER:

Marital Status: S ☐ M ☐ Common-law ☐ GTPAL: _____

Mother's Maiden Name: _____ *Partner's name:* _____

Family Physician: _____ Language: English ☐ Other: _____

Delivery: Vaginal ☐ C-Section ☐ EDB:_____ Mother's Discharge Date: _____

AT DISCHARGE:

ONLY Breastmilk ☐ ONLY Formula ☐ Both ☐

Birth Attended by: Physician ☐ Midwife ☐ Other _____

Cont'd on Page 2

Healthy Babies Healthy Children Screen

MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com
FAX: 519-663-8243

Ontario

Name: _____

Address: _____

_____ Postal Code:_____

Telephone No.: ( ) _____ - _____

Client's D.O.B.: _____

Section A: *Pregnancy & Birth*

	Yes/No	Reason for no response
1) Multiple birth?	Y☐ N☐	A☐ B☐ C☐
*2) Premature? *(born at less than 37 weeks gestation)*	Y☐ N☐	A☐ B☐ C☐
*3) Was the birth weight less than 1500g?	Y☐ N☐	A☐ B☐ C☐
*4) Was the birth weight more than 4000g?	Y☐ N☐	A☐ B☐ C☐
*5) Apgar score of less than 5 at five minutes?	Y☐ N☐	A☐ B☐ C☐
6) Health conditions/medical complications during pregnancy that impact infant? *eg. diabetes*	Y☐ N☐ *Please List :*	A☐ B☐ C☐
*7) Complications during labour and delivery? *(e.g. scheduled caesarean, emergency caesarean, infant trauma or illness such as respiratory distress syndrome, difficult vaginal birth including forceps or vacuum*	Y☐ N☐ *Please List :*	A☐ B☐ C☐
8) Maternal smoking of cigarettes during pregnancy?	Y☐ N☐	A☐ B☐ C☐
9) Maternal smoking of more than 100 cigarettes (5 packs) in her lifetime prior to pregnancy?	Y☐ N☐	A☐ B☐ C☐
10) Maternal alcohol use during pregnancy?	Y☐ N☐	A☐ B☐ C☐
11) Maternal drug use during pregnancy? *(Include information on illegal drug use and prescription drugs that impact on activities of daily living or are teratogenic)*	Y☐ N☐ *Please List :*	A☐ B☐ C☐
12) No prenatal care before sixth month?	Y☐ N☐	A☐ B☐ C☐

Section B: *Family*

Mother		
13) Is less than 18 years old?	Y☐ N☐	A☐ B☐ C☐
14) Was less than 18 years old when first child was born?	Y☐ N☐	A☐ B☐ C☐
15) Experienced a previous loss? (pregnancy or baby)	Y☐ N☐	A☐ B☐ C☐
16) Is a single parent?	Y☐ N☐	A☐ B☐ C☐
17) Mother and child do **NOT** have a designated primary care provider?	Y☐ N☐	A☐ B☐ C☐
18) Does **NOT** have an OHIP number?	Y☐ N☐	A☐ B☐ C☐
19) Did **NOT** complete high school?	Y☐ N☐	A☐ B☐ C☐
Infant/Child		
20) Congenital or Acquired Health Challenge?	Y☐ N☐	A☐ B☐ C☐
Please *List:*		
*21) Maternal separation from infant greater than 5 days?	Y☐ N☐	A☐ B☐ C☐
Please specify reason:		
Partner/Father/Support Person		
22) Father/partner/support person is **NOT** involved with care of baby?	Y☐ N☐	A☐ B☐ C☐

Reason for no response:

A requires further assessment, **B** client declined to answer, **C** unable to assess

Section C: *Parenting*

	Yes/No	Reason for no response
23) Client cannot identify support person to assist with parenting of the baby/child?	Y☐ N☐	A☐ B☐ C☐
24) Client cannot identify support person to assist with care of the baby/child?	Y☐ N☐	A☐ B☐ C☐
25) Client or family in need of newcomer support?	Y☐ N☐	A☐ B☐ C☐
26) Client has concerns about money to pay for housing/rent and family's food, clothing, utilities and other basic necessities?	Y☐ N☐	A☐ B☐ C☐
27) Client or parenting partner has a history of depression, anxiety, or other mental illness?	Y☐ N☐	A☐ B☐ C☐
28) Client or parenting partner has a disability that may impact parenting?	Y☐ N☐	A☐ B☐ C☐
29) Client expresses concern about their ability to parent child/baby?	Y☐ N☐	A☐ B☐ C☐
30) Client expresses concern about their ability to care for baby/child?	Y☐ N☐	A☐ B☐ C☐
31) Client's relationship with parenting partner is strained? (evidence of relationship stress observed)	Y☐ N☐	A☐ B☐ C☐
32) Client or parenting partner has been involved with Child Protection Services as a parent?	Y☐ N☐	A☐ B☐ C☐
*33) Client expresses that his/her child is difficult to manage?	Y☐ N☐	A☐ B☐ C☐
*34) Client's response patterns are inconsistent or inappropriate to the baby's child's cues? *(evidence of inappropriate responses observed)*	Y☐ N☐	A☐ B☐ C☐

Section D: *Infant/Child Development*

*35) Parent(s) identified a risk factor? *(e.g., hearing, speech and language, communication skills, social development, emotional development behaviour, motor skills, vision, cognitive development, self help skills)*	Y☐ N☐	A☐ B☐ C☐

Section E: *Health Care Professional Observations*

36) Health care professional has concerns about the wellbeing of client and/or baby?	Y☐ N☐	A☐ B☐ C☐

Additional Comments:

***Signature(s)* of health care professional(s) completing Screen with client:**

_____ Date: _____

Please print name: _____

Professional Title: ☐RN ☐RPN ☐NP ☐Midwife ☐MD Other_____

_____ Date: _____

_____ Date: _____

Please print name: _____

Professional Title: ☐RN ☐RPN ☐NP ☐Midwife ☐MD Other_____

The Personal Information on this Healthy Babies, Healthy Children Screen is being collected under the authority of the *Health Protection and Promotion Act* and the Ontario Public Health Standards, 2008 (Reproductive Health). This information will be used to identify families and children with risks to healthy child development and to determine eligibility for participation in the HBHC Program.
Any questions about the collection of this information should be directed to the HBHC Manager, 519-663-5317 ext. 2280.

HEALTHY BABIES HEALTHY CHILDREN SCREENING TOOL

Instructions, Definitions, Additional Information for Care Providers

MIDDLESEX-LONDON HEALTH UNIT www.healthunit.com

Ontario

Regular Screening of Families

Health care providers are in a unique position to have an impact on positive childhood development outcomes by virtue of their ongoing contact with patients and families over time. Completed screens need to be sent to your local public health department's Healthy Babies Healthy Children Program so that families can receive the supports and services needed. This screen is intended to identify with risk families who may benefit from the Healthy Babies Healthy Children home-visiting program during the prenatal, postnatal or early childhood periods.

Instructions for Completion

Please provide ONE response for each question: If a yes/no response cannot be provided, please indicate the reason for no response in the right-hand column. Reason for no response: ***A.*** individual completing the screen may have concerns or suspect a risk but needs more information in order to confidently identify this item as a risk. ***B.*** indicates that the client declined to answer the question. ***C.*** unable to assess or unable to ask the client (for example, client was in distress, there was no opportunity for a private discussion about the risk, etc.).

For all questions, a "Yes" indicates a risk. Some items have been reversed, questions 17, 18, 19 and 22, so that a "yes" indicates a risk. For example, "Mother does NOT have an OHIP number". The more "yes" responses, the more likely a family is at risk.

This HBHC Screen should be used for prenatal, postnatal and early childhood clients:

Screening of prenatal clients:

- Conception to birth of infant.
- Answer all questions except for questions 2, 3, 4, 5, 7, 21, 33, 34, 35 (marked with an asterisk). These questions DO NOT apply when screening prenatal clients and should be left BLANK.

Screening of postnatal clients:

- Birth up to 6 weeks of age. In the case of multiple births, one screen is completed for each infant.
- Answer all questions.

Screening of early childhood clients

- From 6 weeks of age. One screen is completed for each infant/child.
- Answer all questions.

Suggested Introduction to Screening for Health Care Professionals

"As part of the Healthy Babies Healthy Children program, all families in Ontario are offered the chance to speak to someone about how they are doing (during their pregnancy, after the birth of a baby, or when their children are in early childhood).

I would like to spend some time talking to you about your family, the supports you have, and any challenges that you may face. We gather the same kind of information from all families at this stage (pregnancy, after birth, early childhood of children) and use the information to support families in getting services that they may find helpful.

If you find there are some things you don't feel comfortable talking to me about, just let me know and we will move to another topic. If you have an
y questions or concerns throughout our discussion today, please let me know. If you and your family might need some extra support. A Public Health Nurse will contact you to talk about services that may be available to you."

Additional Information for Selected Questions

All questions are grounded in evidence and are reflective of the identification of potential risk. References are available upon request.

The following provides additional tips for completing specific questions.

Section A: Pregnancy and Birth (Questions 1-12)

5) Please complete even if scores are provided.

6) Health conditions/medical complications during pregnancy that ***impact*** infant.
Include: diabetes, eclampsia, congenital herpes, rubella, HIV, Hepatitis B, abruption placenta.

7) Complications during labour and delivery.
Include: labour that required mid forceps, including breech delivery or emergency caesarean due to complications. Infant trauma or distress including respiratory distress syndrome and convulsions.

9) Evidence demonstrates that 100 cigarettes is the threshold for establishing Nicotine addiction.

10) Ask every mother about her alcohol use throughout her pregnancy. Discussing alcohol use and fetal development with all women normalizes discussion of this issue and introduces a harm reduction approach to prevention.

11) Maternal drug use during pregnancy
Include: illegal drug use during pregnancy and prescription drugs that impact on activities of daily living or are teratogenic. Exclude: non-teratogenic prescription drugs and small amounts of over-the-counter drugs.

Section B: Family (Questions 13-22)

15) Include previous loss at any stage of pregnancy and at any age, includes loss of a twin, stillbirth, miscarriage, and abortion due to complications.

16) Include if mother identifies herself as sole primary caregiver for child (include unmarried, separated, widowed, divorced and common-law relationship less than one year).

20) Include confirmed congenital or acquired health challenge with probability of permanent disability (e.g. vision or hearing impairment, Down's Syndrome, birth asphyxia, etc.). If a suspected health challenge exists then "A" should be checked off.

21) Include mothers sent home from hospital while baby is still hospitalized (applies to postnatal period).

22) Question refers to the person that the mother identifies as the secondary caregiver to her current child and can include biological father, boyfriend, her mother, friend.

Section C: Parenting (questions 23-34)

23 & 24) Parenting refers to meeting the baby/child's emotional and social needs (e.g. providing comfort, responding to needs with warmth and sensitivity, being emotionally and physically available, and appropriate communication). Care refers to meeting the baby/child's basic physical needs (e.g. feeding, diapering, and washing).

25) A mother who is new to Canada, less than 5 years living in Canada, who lacks social supports, or is experiencing social isolation (newcomer is defined as someone new to Canada).

27) Include present or past depression, anxiety or emotional problems. Include if either mother OR father/parenting partner indicates a history of mental illness.

28) Include mental or physical challenge for mother OR father/parenting partner.

29 & 30) Parenting refers to meeting the baby/child's emotional and social needs (e.g. providing comfort, responding to needs with warmth and sensitivity, being emotionally and physically available, and appropriate communication). Care refers to meeting the baby/child's basic physical needs (e.g. feeding, diapering, and washing).

31) Include distress or conflict between parenting partners (e.g. separation, frequent arguments, presence of physical, verbal, emotional or sexual abuse in the home). This could be broadly defined as either by direct observation or expressed by the client.

Note: Screening questions related to partner violence should not be asked with partner present with client.

32) Include family's past or present involvement with Child Protection Services. Exclude involvement of client or parenting partner with Child Protection Services when they were a child.

33) Consider client's perception of difficulty managing the baby/child's behavior *(eg. Temper tantrums, excessive crying, biting, etc.)*

34) Include inappropriate or lack of response when baby/child is in need of comfort, lack of eye contact or physical contact. This could be broadly defined as either by direct observation or expressed by the client.

Section D: Infant/Child Development (Question 35)

35) This question should be answered in direct response to a developmental concern specifically raised by the parent and should not include parent concerns or questions about the normal care of a newborn or child. Areas of development include vision, hearing and communication, gross and fine motor, cognitive, social/emotional, and self-help. Parental concerns may be identified through the Nipissing Developmental District Screening TM (NDDS) tool that assists parents and caregivers to monitor child development. More information on the NDDS can be found at www.ndds.ca

Section E: Health Care Professional Observations (Question 36)

36) Health care professional's concern(s) includes professional observations of the client and family.

Consent:

The check box for consent refers to verification by the health care provider that the necessary consent has been obtained (as described in PHIPA). Client consent refers to both consent to disclose personal information and personal health information, and consent to participate in the HBHC Program. If client declines further participation in the HBHC Program, cross out participation only.

Signature:

The screen should be signed by the individual who obtains consent from the mother and completes the Screen. If additional information is completed by another practitioner, this individual should provide their initial and signature with designation on the Screen, and initial the responses collected.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 039-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 June 18

UPDATE ON MINISTRY'S ORAL HEALTH PROGRAM CHANGES

Recommendation

It is recommended that Report No. 039-15 re Update on Ministry's Oral Health Program Changes be received for information.

Key Points

- The integration of all provincial publicly-funded oral health programs for children and youth into one Healthy Smiles Ontario program has been delayed until January 2016; children eligible to receive services under current programs will be eligible in the new program.
- The integrated dental program will include preventive dental services, and emergency and essential treatment for families in need.
- Little is known about the future program's governance, funding mechanisms, and implementation plan.
- The implementation delay to January 2016 is not expected to negatively impact service delivery but is likely to impact 2015 financial projections by approximately $140,000.

Background

On December 16, 2013, the Ministry of Health and Long-Term Care (MOHLTC) announced several changes to Oral Health Programs effective August 2015 (Appendix A). A summary of the proposed changes and their implications were outlined in Report No. 007-14 re Changes to Oral Health Programs.

Recent Communications from the Ministry

On May 29, 2015, the MOHLTC released a Health Bulletin (Appendix B) which announced that the integrated dental program for children and youth will be expanded to include:

- preventive dental services currently delivered by public health units, which are critical to preventing oral health issues from escalating and reducing emergency room visits
- emergency and essential treatment for families in need based on clinical assessment and demonstrated financial hardship

In addition, it was stated that the full implementation date of these changes has been extended to January 2016. Included therein is a commitment from the MOHLTC to ensure that children currently eligible for free dental services will continue to be eligible in the future integrated program.

The delay, extended eligibility, and maintenance of services commitments arose from the advice of public health and other sectors who raised concerns that the proposed changes would reduce access to care and that the timelines were too aggressive. In addition, a working group is developing recommendations for the Ministry regarding new and related requirements to be included in the Ontario Public Health Standards (Appendix C).

Implications for the Middlesex-London Health Unit

As previously shared in Report No. 007-14, it is likely that MLHU will no longer be involved in claims management.

While recent communications have confirmed the intention to maintain preventive dental services, and clarified that "public health units will be asked to assess eligibility for preventive services which will be available to clinically eligible children whose families attest to financial hardship", it is unclear who will be providing those services.

Similarly, while the Ministry has stated they "will also provide further direction to Public Health Units on a common approach to be employed to assess financial hardship for preventive and urgent treatment", public health's role in delivering emergency and essential treatment is unclear.

Other implications of the changes to the Oral Health Programs and the clients served by them remain unclear given that the MOHLTC has not finalized details about the new integrated program's governance, structure, funding mechanisms, and implementation plan.

Once available, additional information from the MOHLTC related to the following items will assist Health Unit staff to determine implications for Programs and impacts on the oral health of children and youth in our community:

- Process by which public health units and social service agencies will transition clients from their original program to the new program.
- Messaging to advise providers about implementation dates and transition process.
- The role of public health units with respect to preventive service delivery and disease surveillance currently mandated in the Ontario Public Health Standards.
- Overall funding model for future state and funding scheme during transition period.
- A communication plan for the public and families who are currently enrolled in the six different dental programs.
- Sustainable funding arrangements for publicly funded dental clinics

Budget Considerations

Had the program changes announced by the Ministry moved ahead as originally planned on August 1st, MLHU would have experienced a positive variance within the 2015 budget. With the recent announcement of the implementation delay to January 2016, no negative impact on service delivery is expected. There is likely to be, however, an impact on expected gapping by approximately $140,000.

Next Steps

The MOHLTC continues to work closely with health units as the future state of the integrated program is planned and implemented. Two Health Unit staff members are actively engaged in this process at the provincial level, to ensure that the oral health needs of children and youth will continue to be met. Anticipatory planning for a number of scenarios is underway to ensure MLHU is as prepared as possible for various options that may unfold as the Ministry continues in its planning and implementation processes.

This report was prepared by Dr. Maria VanHarten, Dental Consultant, and Ms. Heather Lokko, Associate Director, OHCDSH.

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

Ministry of Health and Long-Term Care

Chief Medical Officer of Health

Public Health Division
11th Floor, Hepburn Block
Queen's Park
Toronto ON M7A 1R3

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

Ministère de la Santé et des Soins de longue durée

Médecin hygiéniste en chef

Division de la santé publique
Édifice Hepburn, 11e étage
Queen's Park
Toronto ON M7A 1R3

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

Ontario

DEC 16 2013

MEMORANDUM

To: **Medical Officers of Health, Board Chairs and CEOs**

Re: **Ontario to Expand Eligibility and Improve Access to Dental Programs for Low-Income Children and Youth**

Dear Colleagues,

As part of Ontario's Action Plan for Health Care to provide the right care, at the right time, in the right place and in support of Ontario's Poverty Reduction Strategy, I'm pleased to inform you of today's government announcement to expand eligibility and improve access to dental programs, making it easier for more children and youth to receive timely dental care.

The province will integrate six publicly-funded dental programs currently provided through Healthy Smiles Ontario, the Children In Need Of Treatment program, Ontario Works, the Ontario Disability Support Program, Assistance for Children with Severe Disabilities and preventive services within the *Ontario Public Health Standards, 2008*, into one seamless program for children and youth aged 17 and under from low-income families, beginning August 2015.

The new program will provide eligible children with:

- a simplified enrolment and renewal process;
- access to the full range of dental services, from preventive care such as cleanings and fluoride treatments to basic care such as fillings, extractions and X-rays;
- dental coverage for a full year.

The new program will also streamline administration and delivery of services, reducing confusion for families looking to access care. Children of social assistance recipients will be automatically enrolled into the new dental program, while all other low-income families will be able to apply through a simplified and more streamlined application process.

The province will also increase access to oral health services such as cleanings, diagnostic services and basic treatment by expanding eligibility for the Healthy Smiles Ontario program, starting in April 2014. The current financial eligibility threshold will be increased, and will vary according to the number of children in the family.

For municipal social assistance delivery agents and boards of health, the new program will result in a reduced administrative burden, allowing more time to be spent with clients on direct service delivery. We plan to actively engage with you to better understand the impact of the new program

on your day-to-day business and to ensure that this program is designed in a way that best meets the needs of clients and their families.

To assist the Ministry with this work, we'll be engaging you more extensively in the coming months to help shape the program's implementation and ongoing operation. We will also be establishing an ongoing program advisory group comprised of delivery partners to help ensure that this engagement is continuous and that your input is included every step of the way. I will also provide additional details on this initiative at the CMOH/MOH teleconference on December 19, 2013.

The new integrated program demonstrates the commitment of the Ontario government to reduce poverty, reduce inequities and increase access to oral health care in Ontario. We all recognize and agree that good oral health is important to overall health including playing a role in preventing chronic disease. I truly believe this program will go a long way to improve the oral health and overall health of Ontario's most vulnerable children and youth.

Thank you for your continuous partnership and collaboration to improve the oral health of Ontario's children.

Sincerely,

Dr. Arlene King
Chief Medical Officer of Health

cc. Kate Manson-Smith, Assistant Deputy Minister, Health Promotion Division, Ministry of Health and Long-Term Care
Roselle Martino, Executive Director, Public Health Division, Ministry of Health and Long-Term Care
Elizabeth Walker, Director, Public Health Planning and Liaison Branch, Public Health Division, Ministry of Health and Long-Term Care

Health Bulletins

Improving Access to Free Dental Care for Children and Youth

New Integrated Dental Program to Begin January 2016

May 29, 2015

Ontario is integrating six publicly funded dental programs into one, which will provide seamless enrolment and make it easier for eligible children and youth to get free dental care.

After thorough consultation, the plan for implementing this initiative has been adjusted to ensure that more children and youth from low-income families have access to free dental care. All children who are currently eligible for free dental services will continue to be eligible in the new integrated program.

To improve access to free dental care for children and youth, the integrated program will be expanded to include:

- Preventive dental services currently delivered by public health units, which are critical to preventing oral health issues from escalating and reducing emergency room visits.
- Emergency and essential treatment for families in need based on clinical assessment and demonstrated financial hardship.

To successfully implement the new program, the full implementation date has been extended to January 2016. The new date will not impact those currently enrolled in existing dental programs. Ontario is working in partnership with local providers of the province's current public dental programs to ensure that the transition to the new integrated program is seamless for current clients and that no services are disrupted.

In April 2014, the government expanded the Healthy Smiles Ontario

program so that more kids from low-income families without dental coverage could access free dental care. More than 70,000 additional children are now eligible for services under the Healthy Smiles Ontario program as a result of this expansion, for a total of over 460,000 children.

Providing more children and youth with access to free dental care *<https://www.ontario.ca/health-and-wellness/get-dental-care>* is part of Patients First: Action Plan for Health Care *<http://www.health.gov.on.ca/en/ms/ecfa/healthy_change>* and Ontario's Poverty Reduction Strategy *<http://www.ontario.ca/home-and-community/realizing-our-potential-ontarios-poverty-reduction-strategy-2014-2019>* .

For More Information

If you are a reporter with a question for a story, or with comments about how this News Room section could serve you better, send us an e-mail at: media@moh.gov.on.ca *<mailto:media@moh.gov.on.ca>*

Media Line
Toll-free: 1-888-414-4774
In Toronto: 416-314-6197

Public Inquiries
Call ServiceOntario, Infoline
at 1-866-532-3161
TTY 1-800-387-5559.
In Toronto, TTY 416-327-4282
Hours of operation : 8:30am - 5:00pm

Ministry of Health and Long-Term Care

Executive Director's Office
Public Health Division
21st Floor, 393 University Avenue
Toronto ON M5G 2M2
Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

Bureau du directeur général Division de la santé publique
393 avenue University, 21e étage
Toronto ON M5G 2M2
Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

Office of the Assistant Deputy Minister
Health Promotion Division
777 Bay Street, 19th Floor
Toronto ON M7A 1S5
Tel.: 416-326-4790
Email: Martha.Greenberg@ontario.ca

Bureau du sous-ministre adjoint
Division de la promotion de la santé
777, rue Bay, 19e étage
Toronto ON M7A 1S5
Tél.: 416-326-4790
Courriel: Martha.Greenberg@ontario.ca

Date June 2, 2015

Re: Status update on low income dental integration

Dear colleagues,

We are writing in follow up to a bulletin that was posted on the Ministry of Health and Long-Term Care's website regarding Low Income Dental Integration (LIDI). As you know the Government of Ontario announced its intent to integrate a number of oral health programs into a single 100% provincially-funded program in December 2013.

This commitment is about supporting Ontario's most vulnerable children and families. The Ontario government is seeking to make improvements to current programs and/or benefits to make them easier to understand and navigate, to expand access, to implement administrative improvements to encourage provider participation, and to achieve and demonstrate improvements in the oral health status of the children and youth served.

The Ministry of Health and Long-Term Care has been working to implement the LIDI commitment in collaboration with delivery partners, including public health units. The advice of the public health and other sectors has been invaluable as this work proceeds. A number of concerns related to this commitment were raised with respect to eligibility once the programs were integrated and the aggressiveness of the implementation time lines.

We are writing today to reassure you that your concerns have been heard. Minister Hoskins has made it clear that the Ontario government is committed to ensuring that currently eligible children will continue to be eligible in the future state integrated program.

As you likely know, the future state program has an income eligibility threshold which is higher than the current Healthy Smiles Ontario program but more restrictive than current eligibility for preventive

services under the Ontario Public Health Standards (OPHS). As well, in the current Children in Need of Treatment Program (CINOT) families are asked to attest to financial hardship and children have access to a robust schedule of services.

Based on your feedback and the understanding of eligibility requirements for the current programs, the new program has been adjusted to ensure that currently eligible children continue to be eligible. With respect to preventive services, public health units will be asked to assess eligibility for preventive services which will be available to clinically eligible children whose families attest to financial hardship. The services that will be included in this component of the program are being considered by the Dental Services Schedule Review Expert Panel (DSSREP) based on the 3 services currently in the Preventive Services Protocol of the OPHS. This approach will, in fact, make more children eligible than in the current state under the Protocol which currently defines financial eligibility as one of the following: enrollment in the CINOT program; the child is a dependent of a recipient of the Ontario Child Benefit, or the family's income is below the financial eligibility cut-off (the cut-off is set at 20 percent above Statistic Canada's low income cut-offs).

In terms of urgent treatment, access to this stream of the program will continue to be based on clinical need and attestation of financial hardship. The DSSREP has been asked to provide advice regarding a definition of urgent need as well as a related basket of services. The Panel will be providing its advice to government in the coming weeks however, this aspect of the program will ensure that children in urgent need are provided with access to an appropriate course of treatment to fully address the urgent need. Providers will also have the discretion to be able to provide additional treatment to children where other clinical needs would soon become urgent if not addressed. Further operational details related to this component of the program will continue to be developed once advice from the DSSREP is received. The Ministry will also provide further direction to Public Health Units on a common approach to be employed to assess financial hardship for preventive and urgent treatment.

A working group is also being established to review the current protocols under the OPHS related to all aspects of oral health within the context of the newly integrated program. This group will be providing advice to the Ministry in the coming months regarding new and related requirements to be included in the OPHS.

Lastly, we have heard your concerns regarding the aggressive timelines for this project. While we feel it is important for children and families to benefit from this initiative as soon as possible, we share your commitment to getting it right, and the Ontario government has extended the full implementation date out to January 2016. We understand that a shift in date at this point may have implications for public health unit budgets for the 2015 fiscal year, and we will be following up with your shortly regarding these impacts. The ministry will work closely with each health unit to mitigate these potential impacts and ensure all health units are able to continue to meet the needs of the current programs until the launch of the integrated program, taking place in January 2016.

In response to some of your questions regarding planning for this program beyond 2016, the ministry continues to explore ways to improve accountability and transparency of provincial public health funding that aligns with other ministry funding processes and principles, with a view to achieving a more equitable approach to public health funding more broadly.

In closing, we would like to reiterate how invaluable your input has been as we have worked to implement the LIDI commitment. I know that your concerns demonstrate the level of your commitment to Ontario's children. We look forward to your continued advice and collaboration as this work continues. If you have any questions related to implementation of the LIDI commitment please contact

Liz Walker, Director, Public Health Planning and Liaison Branch at 416-212-6359 or by email at Elizabeth.Walker@ontario.ca.

Sincerely,

Roselle Martino
Executive Director
Public Health Division

Martha Greenberg
Interim Assistant Deputy Minister
Health Promotion Division

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 040-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 June 18

SUMMARY INFORMATION REPORT FOR JUNE 2015

Recommendation

It is recommended that Report No. 040-15 re Information Summary Report for June 2015 and the attached appendices be received for information.

Key Points

- *Be Brighter with Breakfast* (BBWB) is a comprehensive school health approach aimed at improving breakfast eating patterns among secondary school youth through education, youth engagement activities and creating more supportive environments.
- The Middlesex London Health Unit, the Strathroy-Caradoc Police Service and the Ontario Provincial Police (OPP) are collaborating on a Fentanyl Patch Return Program aimed at reducing the incidence of overdoses due to misuse of fentanyl patches.
- Ministry of Health and Long-Term Care's Healthy Community Fund – Partnership Stream funding has been discontinued.
- Between signing the MOA in May 2014 as a FoodNet Canada Ontario Sentinel Site, and the fiscal year end on March 31, 2015, a number of key operational milestones were achieved in this area.
- Tuberculosis (TB), a reportable disease, continues to rise in our community; the increasing costs associated with TB programs and service is putting pressure on the Infectious Disease Control budget.
- Bill 45, the *Making Healthier Choices Act, 2015*, which aims to restrict the promotion and sale of e-cigarettes, ban the sale of flavoured tobacco products, and require restaurants with 20 or more locations to post caloric information on their menus and menu boards, received royal assent on May 28th, 2015.
- In recognition of World No Tobacco Day, the Campaign for Justice on Tobacco Fraud issued a media release to increase public awareness and to urge Government leaders to aggressively pursue the lawsuits that have been filed against the Canadian tobacco companies and their international parent companies for alleged tobacco industry conspiracy and fraud.
- The Mobilizing Newcomers and Immigrants to Cancer Screening Programs was a multi-agency, peer-to-peer cancer awareness and screening initiative that intended to develop, deliver and evaluate an evidence-based cancer prevention and screening service delivery model for under/never screened newcomer and immigrant populations in London (funded by the Public Health Agency of Canada).

Background

This report provides a summary of information from a number of Health Unit programs. Appendices and links will provide further details, and additional information is available on request.

Be Brighter With Breakfast

Studies show that breakfast is beneficial; however, as children get older often breakfast consumption declines. This was highlighted in the *Feeding our Future* report.

The *BBWB* initiative is a four year comprehensive school health initiative aimed at improving breakfast eating patterns in secondary school youth through education, youth engagement activities and creating a more supportive environment. In 2013-14, thirteen secondary schools participated in the BBWB initiative. The 2013-14 informal breakfast poll results found a 3.5% increase in breakfast eaters amongst those polled in participating schools. For 2014-15, attention will focus specifically on vegetable and fruit consumption and breakfast *"Eat in Colour … Add Fruit and Vegetables to your Breakfast"*. To complement the BBWB school initiative, parents are learning about the importance of breakfast through a social media campaign called *Boost your Brain with Breakfast*. The campaign used Facebook to drive parents in Middlesex London to watch a short video scripted and produced by a local secondary school.

Fentanyl Patch Return Program

The Middlesex London Health Unit, the Strathroy-Caradoc Police Service and the Ontario Provincial Police are working together on a new initiative called the Fentanyl Patch Return Program in Middlesex County (see Backgrounder attached as Appendix A). This type of program, endorsed by the Ontario Association of Chiefs of Police, is being run in various areas of the province to reduce the amount of diverted prescription fentanyl patches for recreational drug use. Fentanyl is a potent, 100 times stronger than morphine and 10-20 times stronger than heroin, pain reducing opioid that is typically prescribed for moderate to severe chronic pain. When used for non-medical purposes, fentanyl has been resulting in significant overdose deaths. The Ontario Office of the Chief Coroner reports that from 2009-2013, 549 deaths have been associated with fentanyl in Ontario and that 36 of those deaths have been in Middlesex-London. This Fentanyl Patch Return Program aims to have physicians, pharmacists and patients working together to promote the safe, effective and responsible use of fentanyl patches. The program is up and running in Strathroy-Caradoc and will be implemented in the remaining County Municipalities in May 2015. The next step is to bring the program to the City of London. Program documents for physicians, pharmacists and patients can be found on the Health Unit Website.

Middlesex London Healthy Community Partnership

In 2010/11, the Ministry of Health and Long-Term Care (MOHLTC) initiated the Healthy Community Fund – Partnership Stream, a grant to public health units to shift local policy forward to enhance the health of residents. The original vision statement for the Partnership stream was "Healthy Communities working together and Ontarians leading healthy and active lives". Originally the Ministry identified six areas of priority for a community to select. However, over time the Ministry reduced the priorities of focus to physical activity and healthy eating. Through an in depth community consultation, physical activity was selected as the area of focus and the Middlesex London Healthy Community Partnership was formed. Since 2011, with the administrative support of the Health Unit, the partnership has been active in supporting and advocating for enhanced policies that would enable residents to increase their level of physical activity. Some examples of projects have been the endorsement of the Toronto Charter for Physical Activity, submissions to municipal official plan processes, and increasing awareness about the relationship between individual health and healthy community design. In May 2015, MOHLTC notified Medical Officers of Health that the Partnership Stream would no longer be continuing. The Healthy Communities and Injury Prevention Team will continue to support local policy initiatives that meet the Ontario Public Health Standards requirements supporting physical activity and healthy community design.

FoodNet Canada Ontario Sentinel Site: Highlights from 2014-2015

Since May 2014, MLHU has been the Ontario sentinel site for the Public Health Agency of Canada (PHAC) FoodNet Canada (FNC) program. As of March 31, 2015, MLHU completed the first fiscal year of the three-year agreement with PHAC. A number of key operational milestones were achieved in 2014-2015, and MLHU is now fully operational as the Ontario sentinel site. The first fiscal year of participation in FNC is felt to have been a successful one, with benefits realized both locally and provincially. PHAC is pleased with the quality of effort delivered by MLHU, and the progress made to date as a sentinel site. Appendix B provides additional information about highlights and early successes.

Increasing Tuberculosis Activity and Workload in Middlesex-London

Tuberculosis (TB) prevention and control is a public health responsibility of utmost importance. There are approximately 1,640 cases of new, active TB reported annually in Canada, including 624 from Ontario, and, on average, nine from Middlesex-London. In 2014, MLHU followed 17 new active cases and, in 2015 to date, seven new active cases have been identified, including two multi-drug resistant cases. The Infectious Disease Control Team (IDCT) performs case investigation and contact tracing for all potentially infectious active and suspected active TB cases as well as targeted screening for refugee populations. With each new active case reported, measures are established immediately to curtail spread and all close contacts are tested for TB infection. The TB workload has grown significantly since 2009 and the IDCT has responded by undergoing a team-wide, data-driven workload redistribution process resulting in more team resources being dedicated to TB management and follow-up. However, as client rosters continue to increase, particularly for physician and Public Health Nurse-led TB clinics, increasing logistical costs and nursing time put pressure on the IDC budget. Despite further assistance from within the team, there remains an inability to dedicate resources to TB health promotion activities, as listed in the Ministry of Health and Long Term Care's TB Prevention and Control Protocol and recommended in the latest Canadian TB Standards. Additional information regarding the increase of TB activity in the City of London and in Middlesex County is available in Appendix C. Financial impact will be presented to the Finance and Facilities Committee in July.

Bill 45 – The Making Healthier Choices Act – 2015 Update

On May 28th, 2015, Bill 45, the *Making Healthier Choices Act, 2015*, received royal assent. The *Act* enables the enactment of the *Healthy Menu Choices Act, 2015* (Schedule 1) and the *Electronic Cigarettes Act, 2015* (Schedule 3) and enables the amendment of the *Smoke-Free Ontario Act* (Schedule 2). A brief summary of each schedule is outlined on Appendix D.

Campaign for Justice on Tobacco Fraud

The provinces and territories are suing or have initiated lawsuits against the Canadian tobacco companies and their parent companies for tobacco-related health care costs incurred by the governments. Trans-national tobacco companies have been proven in courts of law to have committed conspiracy, fraud and negligence; they have lied about tobacco risks, nicotine addiction, nicotine manipulation, targeting and promoting their products to youth, the risks of 'light' and 'mild' cigarettes and second-hand smoke.

Campaign for Justice on Tobacco Fraud is a national non-profit organization that aims to reduce the disease and death caused by tobacco industry products by supporting litigation against the trans-national tobacco companies for their corporate misbehavior. Attached as Appendix E, is a news release that was issued to the media which profiled:

a) That a letter from the Campaign, attached as Appendix F, with over 60 signatures by health and legal experts was sent to the Attorney Generals and Health Ministers of the provinces urging for aggressive pursuit of the litigation; and,

b) Results of a National Poll, attached as Appendix G, that reveal that less than one percent of Canadians are aware of the provincial lawsuits, highlighting the need for greater public awareness about the role that the tobacco industry has played in the tobacco epidemic that public health is attempting to remedy.

More information is available on the Campaign's website.

Mobilizing Newcomers & Immigrants to Cancer Screening Programs

In June 2011 the Mobilizing Newcomer and Immigrants to Cancer Screening Partnership MNICSP was formed to develop, deliver and evaluate an evidence-based cancer prevention and screening model for breast, cervical and colorectal cancers targeted to newcomer and immigrant under/never screened populations in London, Ontario. Funded by the Public Health Agency of Canada, the project ran from June 2011 to November 2014. The partnership, led by the South West Regional Cancer Program included the Canadian Cancer Society Elgin-Middlesex, London InterCommunity Health Centre, and the Middlesex-London Health Unit. Two established immigrant groups, the Arabic and Spanish-speaking populations, and two emerging newcomer groups, the Iraqi and Nepalese were identified as target populations. A team of Peer Educators were employed from the target communities to conduct community-based focus groups to identify barriers to cancer screening and to test the content of the education modules and materials under development. The Peer Educators delivered a series of culturally appropriate education modules in their preferred spoken language. Local family physicians, nurse practitioners, cancer screening and treatment staff and specialists were invited to participate in three knowledge exchange events to enhance cultural their competency. To sustain the project, the Canadian Cancer Society Elgin-Middlesex has incorporated the model into their volunteer program and the resources developed and tested are available for adaptation and use in other communities. The Project Tool Kit is available online and has been shared with like-minded organizations across Canada

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

Fentanyl Patch Return Program

What is Fentanyl?

Fentanyl is a potent synthetic opioid produced by licensed pharmaceutical laboratories. The drug is prescribed to reduce chronic pain in people suffering from serious health issues, like cancer or end of life care. Fentanyl was originally developed as an anesthetic used during surgery. In the early 2000s, transdermal patches were introduced to manage chronic pain in patients who require continuous opioid pain control. Medication is slowly released through the skin into the bloodstream over a 48 to 72 hour period. Fentanyl is up to 100 times stronger than morphine and 10-20 times stronger than heroin. It is one of the strongest pain relievers available and has a high risk for abuse.

Fentanyl Diversion and Abuse

Typically, transdermal fentanyl patches are discarded after three days (72 hours) of use and replaced by a new patch. Disposal procedures vary with some being thrown in the garbage, flushed down the toilet, deposited into sharps containers, or returned to a pharmacy. Even after three days of use, fentanyl patches contain a large percentage of the medication (60-80%) which makes them a wanted commodity for sale on the street. The street value of a fentanyl patch varies between $150-$500.

Fentanyl can be diverted via pharmacy thefts, fraudulent prescriptions, home invasions, and illicit distribution by patients and registrants (physicians and pharmacists). Theft has also been identified at nursing homes and other long-term care facilities.

The fentanyl patches are often cut up and sold on the street. The gel contents from the patches are smoked, ingested or injected or the pieces chewed. These methods deliver a much higher dose of fentanyl than the original prescription intended. Since the distribution of the medication is unknown when cut, a single patch can be lethal.

When used for non-medical purposes, fentanyl has been resulting in significant overdose deaths. The Ontario Office of the Chief Coroner reports that from 2009-2013, 549 deaths have been associated with fentanyl in Ontario and that 36 of those deaths have been in Middlesex-London.

What is the Fentanyl Patch Return Program?

A Fentanyl Patch Return Program is a collaborative partnership between physicians, pharmacists and patients to promote the safe, effective and responsible use of fentanyl patches. The program applies a “one in, one out" model, where the patient returns any patches received back to the pharmacy before they are able to receive more. The goal is to ensure proper disposal of used fentanyl patches to avoid harm to others (e.g., children and pets) and to eliminate illicit street diversion.

The program is designed to reduce diversion with increasing fentanyl patch tracking by:

1. Physicians prescribing and pharmacies dispensing no more than a one-month supply of fentanyl patches at a time to patients with fentanyl prescriptions.
2. Ensuring that patients are provided education on the program and an information fact sheet that is also used as a patch return sheet.
3. Prescriptions are written to direct the pharmacist to collect used or unused patches before dispensing the next set of patches.
4. Documenting the date and the number of patches returned.
5. Dispensing one new patch for every used patch returned.
6. Increasing communication between pharmacies and physicians (and police if necessary) if there is a concern about diversion or other inappropriate fentanyl patch use.

More Information

Program documents for physicians, pharmacists and patients can be found on the Health Unit Website.

FoodNet Canada Ontario Sentinel Site: Highlights from 2014-2015

Background

In February 2014, the Board of Health reviewed Report No. 017-14 "Health Unit Participation in FoodNet Canada" and endorsed becoming the Ontario sentinel site of Public Health Agency of Canada's (PHAC) FoodNet Canada (FNC) program. The FNC Memorandum of Agreement (MOA) was signed in May 2014, based on the recommendation of the Finance and Facilities Committee (see Report Nos. 016-14FFC and 025-14), formally entering the Middlesex-London Health Unit (MLHU) into a three-year agreement with PHAC. Under the terms of the agreement, MLHU is responsible for carrying out two of the four components of the FNC program: enhanced follow-up of human cases of food- and water-borne illnesses, and purchasing retail food items of interest to be sent to a laboratory so they can be tested for infectious agents that can cause illnesses. This report provides an update from the first fiscal year (to March 31, 2015) of the three-year agreement.

Progress in 2014-2015

Between signing the MOA in May 2014 and the fiscal year end on March 31, 2015, a number of key operational milestones were achieved, including:

- Hiring a Site Coordinator, who began in June 2014;
- Commencing the retail sampling component of the program as of July 2014;
- Enhancing and developing collaborative partnerships with local and provincial laboratories;
- Enhancing and developing paper and electronic data collection tools to support enhanced follow-up of human cases of food- and water-borne illness, and providing staff education about using these tools, to ensure collection of high quality data;
- Establishing secure methods to receive additional laboratory testing results for human cases of food- and water-borne illness, and to transmit anonymized case information to PHAC;
- Organizing the official program launch in October 2014, attended by key local, provincial and federal stakeholders;
- Establishing a sentinel site steering committee with representation from MLHU, PHAC, Public Health Ontario (PHO), the Public Health Ontario Laboratory (PHOL), and the Ministry of Agriculture, Food and Rural Affairs (OMAFRA);
- Participating in and contributing to a number of PHAC-led meetings involving the FNC British Columbia and Alberta sentinel sites, as well as other collaborators such as the Canadian Food Inspection Agency (CFIA) and the US Centers for Disease Control and Prevention (CDC) FoodNet program.

Since becoming the FNC Ontario sentinel site, program staff at MLHU have realized a number of benefits through participation in the program, including:

- Collaborating with an expanded network of local, provincial and federal public health partners, and food and water safety experts;
- Enhancing information sharing with key partners through the FNC Ontario sentinel site steering committee;
- Participating in new learning and knowledge sharing activities, such as collaborative meetings with PHAC partners; and
- Enhancing knowledge and practice through access to evidence-based research and knowledge exchange activities.

An early success of participation in the enhanced and integrated surveillance program of FNC was realized in the summer and autumn of 2014. At the time, there was an increase across the province (including cases from Middlesex-London) in the number of people confirmed to have a specific type of *Salmonella* infection. As part of the FNC program, MLHU was purchasing food items of interest so that they could be tested for infectious agents known to cause illnesses. Testing these food items revealed that frozen chicken nuggets and strips were testing positive for the same type of *Salmonella* associated with the increase in human cases. Further, one particular manufacturer accounted for higher percentage of the results for that type of *Salmonella* than other manufacturers. Not only did the integration of enhanced case information and the testing of retail food items significantly contribute to a provincial outbreak investigation, it led to collaboration and action with the manufacturer by provincial and federal partners to address the problem.

Overall, the first fiscal year of participation in FNC is felt to have been a great success. Not only were benefits realized locally and provincially, PHAC was pleased with the progress and quality of effort delivered by MLHU as the FNC Ontario sentinel site.

Next steps in 2015-2016

MLHU is currently reviewing a draft of the *2014 FoodNet Canada Short Report*, which is expected to be published in summer 2015. It will contain findings from the 2014 calendar year from all FNC sentinel sites and will be the first FNC report containing data from the Middlesex-London region as the Ontario sentinel site.

Now fully operational as the FNC Ontario sentinel site, the second fiscal year of participation will focus on continuing to collect high quality data, and continuing to make important contributions to activities aimed at reducing the burden of food- and water-borne illnesses at the local, provincial and federal levels.

INCREASING TUBERCULOSIS ACTIVITY AND WORKLOAD IN MIDDLESEX-LONDON

Background Information:

Tuberculosis (TB) prevention and control is a public health responsibility of utmost importance. The Infectious Disease Control Team (IDCT) is responsible for the prevention and control of TB in Middlesex-London. The TB program is divided into three principle components:

- The management of people with active TB and their contacts;
- Immigration Medical Surveillance for new immigrants / refugees who are identified by Citizenship and Immigration of Canada (CIC) as high-risk for developing active TB disease during a mandatory medical evaluation prior to arrival to Canada and reported to the Health Unit and;
- The follow-up of individuals with latent TB who are reported to the Health Unit or who are identified through the Targeted Screening Program as having a high risk of progression to active TB. This follow-up involves clinical components for assessment and ongoing treatment by the IDCT TB PHNs and includes both monthly physician and nurse led TB clinics.

Management of Active Tuberculosis (TB) in Middlesex-London

Two main presentations of TB are inactive (latent) TB infection and active TB disease. Latent TB develops when TB bacteria are inhaled, however, in the majority of the cases the bacteria does not grow within the body. Active TB develops when TB bacteria overcome the immune barrier of the body and start growing in the body. Active pulmonary TB, which involves lungs or throat, can be spread to others through the sharing of common airspace. From a public health perspective, this type of TB is the most concerning as there is a risk of the infection spreading to others.; in these situations, the IDCT's timely response is imperative to prevent and limit any spread of TB infection.

There are approximately 1,640 cases of new, active TB reported annually in Canada (2013 incidence rate of 4.7 per 100,000 population), including 624 from Ontario, and, on average, nine from Middlesex-London (2013 incidence rate of 2.4 per 100,000). While the incidence rate in Middlesex-London is lower than the Ontario rate, the 2013 local rate was 82% higher than the local 2012 rate. In 2014, MLHU followed 17 new active cases and, in 2015 to date, 7 new active cases have been identified including two multi-drug resistant cases. Figure 1 illustrates the number of new suspect and confirmed active cases reported to MLHU per year since 2009.

The IDCT performs case investigation and contact tracing for all active and suspected active TB cases. Measures to curtail spread of TB infection are established immediately and all active pulmonary TB cases receive'direct observation therapy' (DOTs) from IDCT staff to ensure medications regimens are followed properly. DOT regimens, administered daily during the first 8-12 weeks of treatment, last six to nine months but can take up to twelve months to complete. DOTs present significant and ongoing logistical challenges, particularly when required by multiple clients concurrently. Contact tracing involves establishing the infectiousness period of the index cases and estimation of the risk of transmission to others. Each active case's household contacts and others that have been at risk are followed-up and tested for TB infection.

Recent TB activity

In January, 2015, MLHU was notified of two multi-drug resistant (MDR-TB) cases. These were the first MDR-TB cases reported to MLHU since a lone case in 2010. While the principles of the case management do not change for MDR cases, contact management of MDR-TB cases is more resource intensive. In total, 64 contacts were screened during on-site TB skin testing clinics., resulting in 27 follow-up TB clinic appointments to date. Contacts of the MDR cases will continue to be followed for the next two years by regular chest-x rays and clinical examinations for early identification of an active TB disease.

Due to the lack of community physicians able to attend to the health care needs of refugee populations, the Middlesex-London Health Unit continues to provide clinics run by the IDCT TB team in partnership with a local Pediatric Infectious Disease Specialist and a Respirologist. The following graphs illustrate the increase in numbers of both physician-led and nurse-led TB clinics organized (Figure 2) and of clients seen (Figure 3).

The TB clinic has increased its client base to include all Government Assisted Refugees (GARs) as of September, 2013. he IDCT continues to see high-risk individuals; the majority of clients seen in the TB clinic are GARs who have been targeted for TB screening due to high burden of TB in this population and their increased risk of progression from latent to active disease (see Figure 4). Although Citizenship and Immigration Canada requires all individuals coming to Canada be screened for TB, the objective is to detect active TB (not to screen for latent TB). Individuals found to have active TB are not permitted to enter the country until treated and those with suspicious chest-rays that may require further follow-up are referred to the receiving health units. Due to the limitations of this screening, the Canadian TB Standards recommend post-landing screening of refugees. Since 2010, the TB clinic has been instrumental in the early diagnosis of 8 active cases of TB in newly arrived GARs. Without MLHU's TB clinics, diagnosis of these active cases would have been significantly delayed with resulting implications for increased risk of disease transmission to the public.

Over the past three years, the IDCT has gained efficiencies from the following investments: enhancements to its TB-dedicated Microsoft Access Database, the contributions of individuals participating in the New Nurse Graduate Program and, most recently, from the addition of a 0.2 full time equivalent Clinical Team Assistant. However, the TB component of the IDC budget continues to grow as logistical costs associated with swelling service delivery needs (e.g. additional staffing hours, interpretation services, transportation, medications) outpace funding.

Conclusion

As of the time of this report, the IDC TB Team continues to follow 7 active cases, 7 suspect active cases, 153 contacts of active cases, 228 latent cases, and 61 individuals monthly in the TB clinic. Further, another 72 government assisted refugees are booked for TB screening in June, 2015.

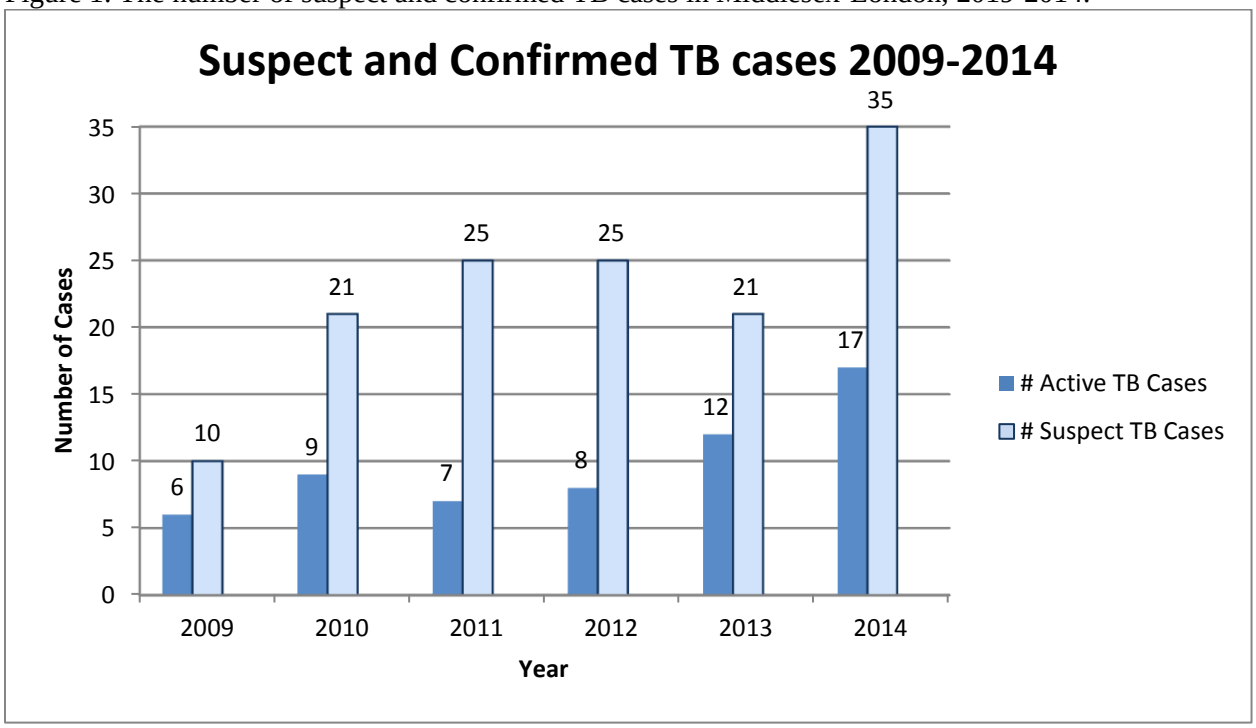
The workload specific to TB has grown significantly over the past several years and the IDCT has responded by undergoing a team-wide, data-driven, workload redistribution process to dedicate more team resources to TB management and follow-up. However, as clientele rosters continue to increase, particularly for physician- and PHN-lead clinics, increasing logistical costs and nursing time are placing the IDC budget in a structural deficit position. Despite further assistance from within the team, there remains an inability to dedicate resources to TB health promotion activities, as stated in the MOHLTC's TB Prevention and Control Protocol and recommended in the latest Canadian TB Standards.

This report was prepared by Jody Paget, Public Health Nurse, Infectious Disease Control Team, and Tristan Squire-Smith, Program Manager, Infectious Disease Control Team.

This report addresses the following requirement(s) Ontario Public Health Standards:

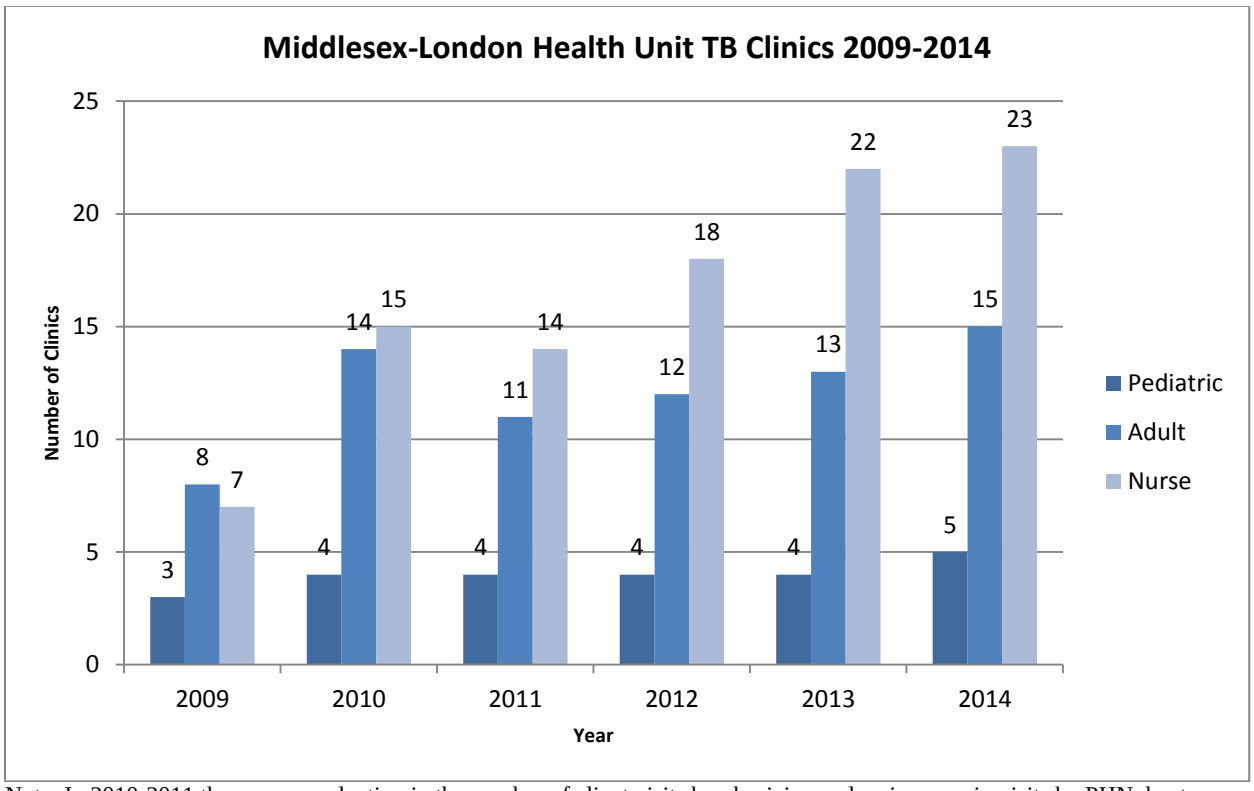
Tuberculosis Prevention and Control: To prevent or reduce the burden of tuberculosis

Figure 1: The number of suspect and confirmed TB cases in Middlesex-London, 2019-2014.



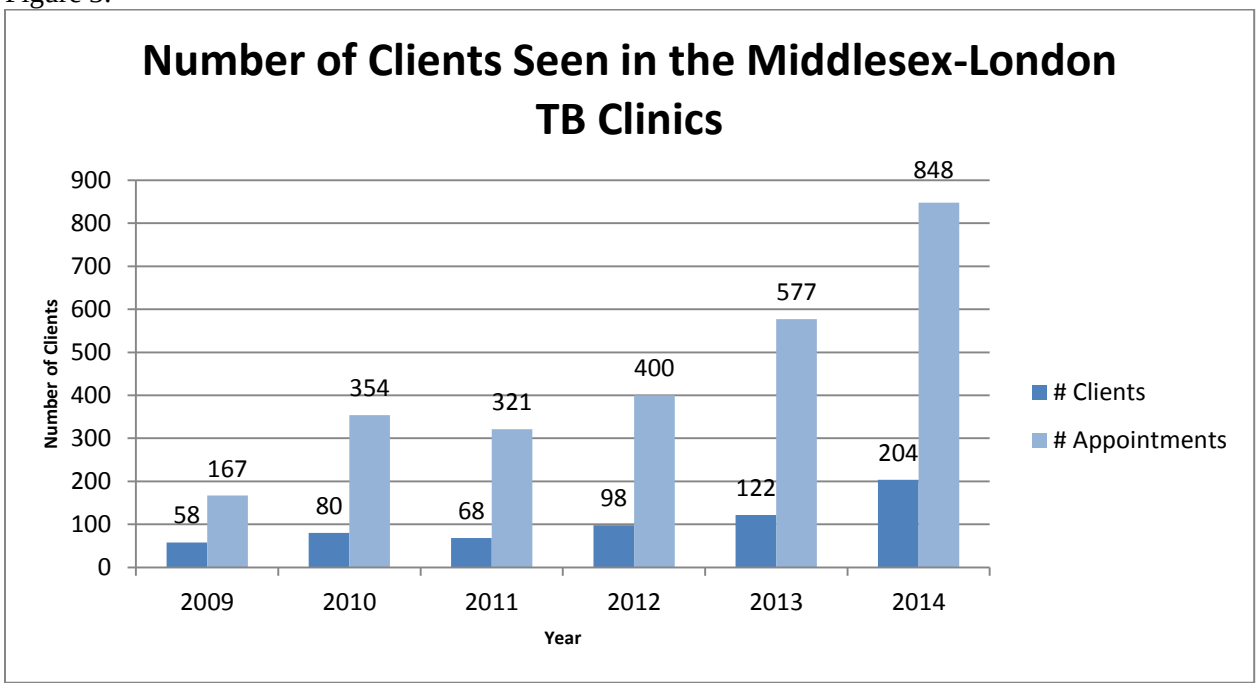
Note: In September, 2013, the TB Team began screening all GARs in partnership with the LCCLC. Previous to this, MLHU screened only the Karen and Bhutanese Regugees as recommended by the Minishtry of Health and Long Term Care.

Figure 2:The number of pediatric, adult, and nurse-led TB clinics held at Middlesex-London Health Unit, 2009-2014.



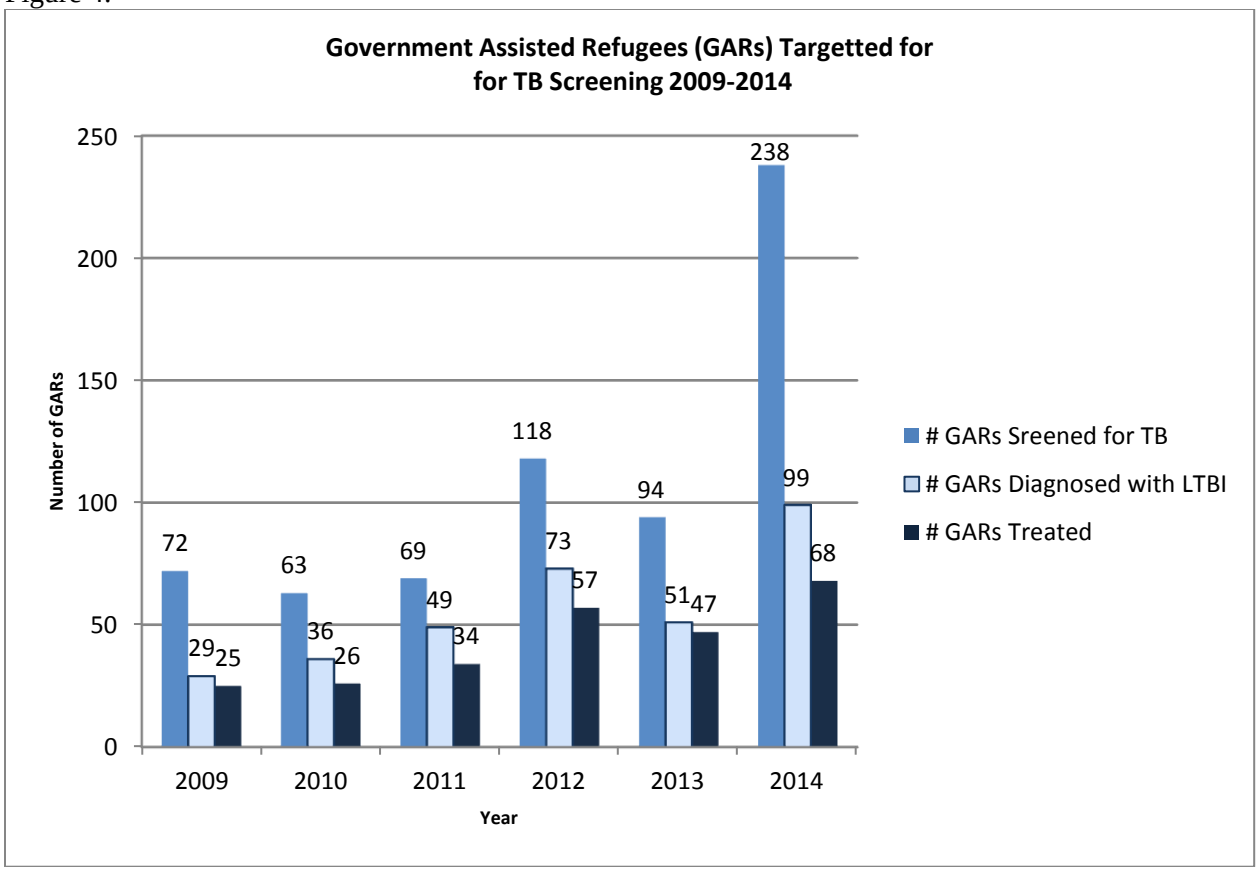
Note: In 2010-2011 there was a reduction in the number of client visits by physician and an increase in visits by PHN due to changes in the Canadian TB Standards' recommendations that individuals on LTBI medication be seen monthly.

Figure 3:



Note: Clients who start on TB medication are seen monthly by either the Physician or PHN. In the adult clinics, clients who start TB medication are seen once by the Physician and the PHN monthly for the balance of nine months. In the pediatric clinics, clients who start TB medication are seen by the physician four times and the PHN for the balance.

Figure 4:



Note: In September 2013, the TB Team began screening all GARs in partnership with the London Cross Cultural Learners Centre. Previous to this, only the Karen and Bhutanese refugees were screened.

Appendix D to Report No. 040-15

A Brief Summary of Bill 45, the *Making Healthier Choices Act, 2015*

Schedule 1 - *Healthy Menu Choices Act, 2015*

The *Act* intends to create more supportive food environments to support families in making healthier food choices when dining out as one strategy to improve health outcomes of Ontario children. This legislation requires calories for food and beverages, including alcohol, to be posted on menus and menu boards in restaurants, convenience stores, grocery stores and other food service premises with 20 or more locations in Ontario, making it easier for families to make informed and healthy food choices. Despite support from many public health agencies, including MLHU, the requirement to post milligrams of sodium in standard menu items was not included in the legislation at this time.

The *Act* comes into effect January 1, 2017.

Schedule 2 - Amendments to the *Smoke-free Ontario Act*

The *Act* will ban the sale of all flavoured tobacco products, provides Health Units with the authority to seize samples of shisha for the purposes of testing for the presence of tobacco, increases the individual and corporation penalties for multiple convictions under the *Act*, and increases the Health Units' tobacco seizure authority.

The *Act* comes into effect on a day to be named by proclamation of the Lieutenant Governor.

Schedule 3 - *Electronic Cigarettes Act, 2015*

The *Act* bans the sale of e-cigarettes and their component parts to anyone under the age of 19 years, restricts the promotion and advertising of e-cigarettes and bans the use of e-cigarettes in all places where smoking tobacco products is already prohibited under the *Smoke-Free Ontario Act*.

The *Act* comes into effect on a day to be named by proclamation of the Lieutenant Governor.

NEWS RELEASE

Embargoed until Monday, May 25, 2015

Sixty health and legal experts release poll for World No Tobacco Day and express alarm over near zero awareness of landmark provincial lawsuits against Big Tobacco.

Toronto – Exposure of the unsavoury practices of the tobacco industry is one of the key objectives of the World Health Organization's World No Tobacco Day held on May 31 each year. The WHO understands that knowledge of the industry's behaviour is a key ingredient in any effort to eradicate the tobacco epidemic.

This has relevance for public health in Canada say 60 health and legal experts in a letter to the provinces released today. Provincial governments are suing tobacco manufacturers to recover health care costs incurred from alleged industry conspiracy and fraud and the public knows virtually nothing about the behaviour behind the lawsuits.

"Canadians should take note then, as World No Tobacco Day approaches," says Garfield Mahood, president of the Campaign for Justice on Tobacco Fraud, "that if the provincial allegations are proven in court, the fraud involved would be the largest and most destructive in the history of Canadian business or public health."

The provinces allege that for five decades the manufacturers lied about cigarette risks, addiction, second-hand smoke and marketing to kids. Yet, according to a national poll made public for the first time today, "less than 10 percent of Canadians know that the provinces are suing tobacco companies over their behaviour" said Donna Dasko, the pollster who conducted the research. This surprised Dr. Dasko, a former lead researcher for Health Canada in the development of tobacco control policies. "Of even greater concern, less than one percent of Canadians are aware that the provinces are claiming that the manufacturers conspired to commit fraud by lying and hiding information about the risks of their products."

Suite 500, 720 Spadina Avenue, Toronto, Ontario M5S 2T9 Tel: 416-972-0707
www.justiceontobaccofraud.ca info@justiceontobaccofraud.ca

Once made aware of the litigation, a majority of Canadians, 60 percent, believe the provinces are justified in suing the tobacco companies to recover health care costs. "This poll reveals a real potential for the provinces to raise public support for the litigation to higher levels," said Dr. Dasko. "A large majority, 77 percent, say their support for the litigation would increase if some of the money recovered through court awards or settlements were used to change tobacco company behaviour in the interests of public health."

Today, the Campaign is making public both the poll and the letter from more than 60 health and legal experts pressing provincial attorneys general and health ministers to inform Canadians about the litigation and the alleged illegal behaviour behind the suits. The letter reveals strong support for public health gains to be outcomes of the tobacco litigation.

"The almost total lack of awareness of the predatory behaviour behind the lawsuits revealed by the poll is not good news for public health," said Dr. Fernand Turcotte, professor emeritus of public health at Laval University. "For example, research tells us that knowledge of the industry's behaviour, such as awareness that an industry preyed on smokers when they were in their teens, increases the odds that a smoker will try to quit and increases the resolve of former smokers to stay smoke-free."

"Lack of knowledge about this litigation may lead to other undesired outcomes from a public health perspective", said Robert Solomon, distinguished professor in the faculty of law and public health at Western University. "In the absence of public awareness of these lawsuits and the destructiveness of the illegal behaviour, provinces may be less inclined to take the manufacturers to trial. Inadequate settlements before trial threaten both the potential for public health gains from the litigation and justice for the one to two million smokers whose deaths may have been contributed to or caused by the wrongful behaviour."

"Failure to take the manufacturers to trial combined with an ill-informed public could produce sweetheart out-of-court settlements similar to the smuggling fraud settlements of 2008 and 2010," said Mahood (see http://www.nsra-adnf.ca/cms/file/files/What_Were_They_Smoking-FINAL_Aug_26_2013.pdf). "Those settlements failed to put tobacco documents into the public domain, recovered a mere pennies-on-the-dollars claimed and stayed pending criminal charges against tobacco executives. The smuggling settlements seemed designed to protect tobacco tax revenue streams rather than to produce health measures to repair the damage caused by industry dishonesty."

Major public health gains were realized in the United States when four state attorneys general took the industry to trial and spoke publicly about the industry's behaviour. The trial process gave public health 40 million pages of documents that are still aiding litigation and prompting industry regulation and law reform. These trials and documents led to a US $246 billion settlement involving another 46 states, as well as to the creation of a multi-million dollar public health trust to reduce the use of the industry's products.

The letter released today represents the second time that professors of law, public health, and medicine as well as the CEOs of major health organizations have urged provincial attorneys general and health ministers to take the industry to trial. Last June, they pressed provinces to demand health-related litigation outcomes: the full disclosure of industry documents, the establishment of an arms-length tobacco control trust, and court-ordered performance guarantees to change the industry's behaviour. And they called for efforts by the provinces to educate the public about the claims before the courts.

There are no legal reasons why the provinces cannot take steps to ensure that Canadians are aware of these lawsuits and understand the illegal behaviour that attorneys general allege is behind them. The CJTF challenges the provinces to throw a spotlight on this critical litigation. They can do so, for example, at various stages in the litigation with news releases and public statements that draw attention to the alleged wrongful behaviour, not just to the amount of the claims. The signatories of the letter also challenge the attorneys general and health ministers to use recovered health care costs from the litigation to reduce the tobacco-caused disease and death predicted for addicted smokers now alive. "Justice for the alleged tobacco conspiracy and fraud requires nothing less," said Mahood.

The litigation awareness survey was based on a national random sample of 1,000 adult Canadians, 18 years of age and older, conducted by telephone from September 17 to 23, 2012. A sample of this size drawn randomly from the population would be expected to produce results accurate to within plus or minus 3.1 percentage points in 95 out of 100 samples.

This poll was commissioned in 2012 for CJTF strategic planning purposes. It is being made public today because of its importance to public health. Dr. Dasko and other experts hold that they are unaware of any developments in the last two years that would alter the findings of this survey.

-30-

(The news release letter to attorneys general and health ministers and the poll will be available to the public at http://www.justiceontobaccofraud.ca/ *at 0800. Click on NEWS.)*

The Campaign for Justice on Tobacco Fraud is a health advocacy group incorporated under the *Canada Not-for-profit Incorporations Act*.

Contacts

Garfield Mahood 416-972-0707, cell 416-451-4285, res. 416-964-6279
gmahood@justiceontobaccofraud.ca

Fernand Turcotte, 514-389-1240, (May 16 to June 1 418-364-7395)
Fernand.Turcotte@msp.ulaval.ca

Dr. Donna Dasko, 647-282-5727, 416-966-5170
Donna.dasko@gmail.com

CAMPAIGN FOR JUSTICE ON TOBACCO FRAUD
CAMPAGNE POUR OBTENIR JUSTICE FACE À LA FRAUDE DU TABAC

May , 2015

Address

This is the template of the letters sent to attorneys general and ministers of health in the provinces.

Dear Attorney General / Dear Minister:

Re: Absence of public knowledge about provincial lawsuits in response to allegations of tobacco industry conspiracy and fraud

As only a few Canadians are aware, the provinces and territories are suing or have taken steps toward suing Canadian tobacco companies and their international parents for tobacco-related health care costs incurred by these governments as a result of alleged tobacco industry conspiracy and fraud. As outlined in provincial statements of claim, these companies lied about tobacco risks including addiction, 'light' and 'mild' cigarettes, nicotine manipulation, second-hand smoke and marketing to kids. Provincial claims now exceed $110 billion and are expected to reach $150 billion.

If these allegations are proven in court, the predatory corporate misconduct involved would become the largest fraud in the history of Canadian business. Because health authorities believe this wrongful behaviour has caused or contributed to one to two million tobacco deaths in the decades at the centre of the lawsuits, proven allegations would constitute the most destructive fraud in the history of public health. As you may recall, in a letter to the provinces and territories in June 2014, 137 health and legal experts wrote and asked the provinces and territories to demand that public health outcomes be included in any court awards or settlements from this litigation http://www.justiceontobaccofraud.ca/#news-link . We the signatories of this letter still hold that deterrence, public health benefits and justice must remain objectives of these lawsuits.

Unfortunately, Canadians have extremely limited knowledge that this litigation is even before the courts. In a national poll to be released publicly for the first time in the next few days, a poll completed by one of Canada's most experienced pollsters, we learn that less than 10 percent of Canadians are aware that the provinces are suing the manufacturers of the country's largest cause of preventable illness and death. More disturbing, the poll found that less than one percent of Canadians are aware that this industry is being sued for conspiracy and fraud. This is tantamount to a total lack of awareness of the corporate behaviour behind a totally preventable epidemic.

This litigation should be pursued aggressively for several reasons beyond the important recovery of monies out of which the provinces have been defrauded. Deterrence of other corporate misbehaviour is one. But if no one is aware of the litigation the objective of deterrence is lost.

Box 83513, 87 Avenue Road, Toronto, Ontario M5R 3T6 Tel: 416-972-0707
www.justiceontobaccofraud.ca info@justiceontobaccofraud.ca

Remedying a past wrong is another. Research now shows that when smokers become aware of the industry's ugly behaviour, smoking cessation attempts increase. And when this occurs, illness is prevented and lives are saved. But if Canadians are totally unaware of the predatory practices behind the litigation, this public health benefit is also lost.

Of course justice for the millions of industry victims should be a critical objective of the lawsuits. However, since it is unlikely that any of the people behind the wrongful behaviour will be charged criminally, the civil litigation underway may be the only opportunity for victims to feel that a measure of justice has been realized. Yet, here too, if few know about the lawsuits, this element of the justice objective will also be lost.

When similar fraud litigation was underway in the United States, there was extensive media coverage of the lawsuits, related trials and potential settlements. And substantial public awareness of the industry's unconscionable behaviour followed. In Canada, there appears to be little reference to potential health outcomes in any litigation communication strategy. And, if a health outcome communication strategy exists, it has failed to communicate effectively any litigation objective other than a financial one, one that the industry describes as "a cash grab".

We ask you to correct this with aggressive individual and joint provincial communication strategies. The allegations behind the lawsuits can be disseminated via news releases, news conferences, litigation updates and through the very legitimate, independent-of-the-litigation public health strategy known to health departments as Tobacco Industry Denormalization. *

We are pleased to enclose a copy of the Dasko national poll. This poll was conducted in 2012 but, for strategic reasons, will not be released until May 25. Dr. Donna Dasko, a former lead public opinion supplier to Health Canada and other experts hold that they are unaware of any developments in the last two years that would alter the findings of this survey.

Virtually zero awareness of this litigation is not in your best interests as legislators and it is not in the best interests of justice or public health. Therefore, we leave you with this important question. What steps will you and your government take to create greater awareness of this litigation and of the alleged predatory industry behaviour that led to the cost recovery lawsuits?

* The Tobacco Industry Denormalization strategy transfers the responsibility for the tobacco epidemic from individual behaviour to corporate misbehaviour. It is a public health response to the predatory industry behaviour in a similar fact scenario that led a United States federal court to rule that the tobacco industry engaged in racketeering (*United States of America et al*. v *Philip Morris USA Inc. et al*. Final Opinion: August 17, 2006).

Sincerely,

Garfield Mahood, OC
President
Campaign for Justice
on Tobacco Fraud

Robert Solomon, LLB, LLM
Distinguished University Professor,
Faculty of Law and Interfaculty Program on Public Health
Western University

Fernand Turcotte, MD, MPH, FRCPC
Professor Emeritus
Faculty of Medicine,
Université Laval

Garfield Mahood, Robert Solomon and Fernand Turcotte have signed on behalf of the following signatories. Approvals are on file in the office of the Campaign for Justice on Tobacco Fraud.

Leigh Allard, President and Chief Executive Officer, The Lung Association, Alberta and Northwest Territories

Mark Asbridge, MA, PhD, Associate Professor, Department of Community Health and Epidemiology, Department of Emergency Medicine, Dalhousie University

Mary Jane Ashley, MD, Professor Emerita, Dalla Lana School of Public Health, University of Toronto, and Chair, Expert Panel on the Renewal of the Ontario Tobacco Strategy (1999)

John Blatherwick, CM, OBC, CD, MD, FRCPC, Chief Medical Health Officer (1984-2007), City of Vancouver and Vancouver Coastal Health

Geneviève Bois, MD, Porte-parole, Coalition québécoise pour le contrôle du tabac

Jack Boomer, Director, Clean Air Coalition of B.C.

Marcel Boulanger, MD, FRCPC, Medical Director (retired), Montreal Heart Institute

Debbie Brown, BN, MEd, Chief Executive Officer, Manitoba, Heart and Stroke Foundation

MaryAnn Butt, Chief Executive Officer, Newfoundland and Labrador, Heart and Stroke Foundation

Paul Byrne, MB, ChB, FRCPC, Interim Director, John Dossetor Health Ethics Centre, University of Alberta

Jim Chirico, H. BSc, MD, FRCP, (C), MPH, Medical Officer of Health / Executive Officer North Bay Parry Sound District Health Unit, Ontario

Kevin Coady, Executive Director, Newfoundland and Labrador Alliance for the Control of Tobacco

C. Ian Cohen, MD, CCFP, Dip. Sports Medicine, Sport and Exercise Physician,
Faculty of Kinesiology and Physical Education, University of Toronto

Charlotte Comrie, Chief Executive Officer, Nova Scotia and Prince Edward Island,
Heart and Stroke Foundation

Ian Culbert, Executive Director, Canadian Public Health Association

Charl Els, MD, Associate Clinical Professor, John Dossetor Health Ethics Centre,
University of Alberta

Robert Evans, OC, PhD, FRCS, FAHS, University Killam Professor,
Centre for Health Services and Policy Research, Professor, Department of Economics,
University of British Columbia

Pamela C. Fralick, MA, MPA, ICD.D, President and Chief Executive Officer,
Canadian Cancer Society

Lorraine Fry, Executive Director, Non-Smokers' Rights Association

John M. Garcia, PhD, Professor of Practice, School of Public Health and Health Systems,
Associate Director, Professional Graduate Programs, Applied Health Sciences,
University of Waterloo

Murray Gibson, Executive Director, Manitoba Tobacco Reduction Alliance

Doris Grinspun, RN, MSN, PhD, LLD (hon), O.ONT., Chief Executive Officer,
Registered Nurses' Association of Ontario

George Habib, President and Chief Executive Officer, Ontario Lung Association

Les Hagen, Executive Director, Action on Smoking and Health, Alberta

Donna Hastings, Chief Executive Officer, Alberta, North West Territories and Nunavut,
Heart and Stroke Foundation

David Hill, CM, QC, Founding Partner, Perley-Robertson, Hill & McDougall LLP, Ottawa

Roger Hodkinson, MA, MB, BChir (Cantab), FRCPC, Chairman, Bio-ID Diagnostic Inc.
(a Canadian Biotechnology Company), Saskatoon

Dan Holinda, MSW, Executive Director, Canadian Cancer Society, Alberta/NWT Division

C. Stuart Houston, OC, SOM, DLitt, DCnL, MD, FRCPC, Professor Emeritus,
Medical Imaging and Radiology, University of Saskatchewan

Howard Hu, MD, MPH, ScD, Dean, Professor of Environmental Health, Epidemiology and Global Health, Dalla Lana School of Public Health, and Professor of Medicine, University of Toronto

Alex Hukowich, MD, CCFP, Medical Officer of Health, Kawartha, Pine Ridge District Health Unit and Coroner, County of Northumberland (retired)

Allan C. Hutchinson, LLB (Hons), LLM, LLD, FRSC, Distinguished Research Professor and former Associate Dean, Osgoode Hall Law School, York University

Brian Iler, LLB, founding partner, Iler Campbell LLP, Toronto

Milan Khara, MBChB, CCFP, ABAM, Clinical Assistant Professor, Faculty of Medicine, University of British Columbia

Miriam Klassen, MD, MPH, Medical Officer of Health, Perth District Health Unit, Ontario

Donald B. Langille, MD, MHSc, Professor, Community Health & Epidemiology, Faculty of Medicine, Dalhousie University

Eric LeGresley, Hons BSc, MSc, LLB, LLM, former advisor to the World Health Organization, tobacco document specialist, Ottawa

Trudo Lemmens, LicJur, LLM Bioethics, DCL, Professor and Scholl Chair in Health Law Policy, Faculty of Law, Faculty of Medicine, and Joint Centre for Bioethics, University of Toronto

Joel Lexchin, MD, MSc, Professor, School of Health Policy and Management, Faculty of Health, York University

Barbara MacKinnon, President and Chief Executive Officer, New Brunswick Lung Association

Tom McAllister, Chief Executive Officer, Ontario, Heart and Stroke Foundation

Scott McDonald, President and Chief Executive Officer, BC Lung Association

Krista McMullin, President, Smoke-Free Nova Scotia

Anne McTiernan-Gamble, Chief Executive Officer, Canadian Cancer Society, New Brunswick

Jack Micay, MD, President, MediCinema Ltd., Toronto

Donald Neal, MD, CCFP, Adjunct Professor, Department of Family Medicine, Western University and Ontario Coroner, Goderich, Ontario

Rosana Pellizzari, MD, CCFP, MSC, FRCPC, Medical Officer of Health, Peterborough County City Health Unit, Ontario

Michael Perley, Director, Ontario Campaign for Action on Tobacco

Michael Rachlis, MD, MSc, FRCPC, LLD (Hon), Adjunct Professor, Institute of Health Policy, Management and Evaluation, University of Toronto

Barbara Riley, PhD, Executive Director, Propel Centre for Population Health Impact, Faculty of Applied Health Sciences, University of Waterloo

Jean Rochon, LL.L, MD, DrPH, Associate Expert, Institut national de santé publique du Québec, Minister of Health and Social Services, Province of Quebec (1994-1998), and Director Health Protection and Promotion Division, World Health Organization (1990-1994)

Richard Schabas, MD, MHSc, FRCPC, Medical Officer of Health, Hastings and Prince Edward Counties Health Unit, and Chief Medical Officer of Health, Province of Ontario (1987-1997)

Robert Schwartz, PhD, Executive Director, Ontario Tobacco Research Unit, Senior Scientist, Centre for Addiction and Mental Health, Associate Professor, Dalla Lana School of Public Health, University of Toronto

David Sculthorpe, Chief Executive Officer, Heart and Stroke Foundation

Richard S. Stanwick, MD, MSc, FRCP, FAAP, Chief Medical Officer of Health, Vancouver Island Health Authority

Larry Stinson, BSc, MPA(M), President, Ontario Public Health Association

Alix Stevenson, BA (Hons), LLB

Linda Stewart, BA, MBA, Executive Director, Association of Local Public Health Agencies, Ontario

David Sweanor, JD, Adjunct Professor of Law, University of Ottawa

James L. Winslow, MA, MSc, PhD, Neuroscience Programme, Faculty of Medicine, University of Toronto

Awareness and Support for Health Care Cost Recovery Litigation: Results of a National Survey

Summary Report for the Campaign for Justice on Tobacco Fraud

Donna Dasko, Ph.D.

April 2015

Dr. Donna Dasko is one of Canada's best known and respected survey research experts. During her 30-year career, as Senior Vice-President of Environics Research Group Ltd., she led hundreds of survey and focus group projects for government, non-government, and media clients. Her areas of expertise are tobacco control, heath promotion, and population health. From 1996 to 2008 Dr. Dasko became the lead researcher to Health Canada in its development of tobacco control policies, and, in particular, in its development and implementation of new warning labels on tobacco products. During this period she led over 90 studies for Health Canada in tobacco control, leading to transformational changes in tobacco control policy of world-wide significance. She has led tobacco control research for non-governmental organizations, including the World Health Organization and the Canadian Cancer Society, and served as an expert witness in tobacco control legal proceedings. She has a Ph.D. in Sociology from the University of Toronto, and holds a CMRP (Certified Market Research Professional) designation from the Market Research Industry Association. She can be reached at donna.dasko@gmail.com.

Introduction

The Campaign for Justice on Tobacco Fraud (CJTF) is a non-profit organization incorporated under the *Canada Not-for-profit Corporations Act*. The CJTF's mission is to reduce the morbidity and mortality caused by tobacco industry products.

By September 2012, all provinces had passed legislation to facilitate litigation that would enable them to recover the health care costs to smokers that the governments allege resulted from tobacco industry conspiracy, fraud and negligence over several decades. Nine provinces had filed claims. It is expected that when all claims are filed, they will approach $150 billion.

The CJTF has undertaken a national public opinion survey to examine Canadian's awareness of and support for the litigation efforts of these governments. In addition to examining public awareness and support for these lawsuits, the survey examined what information and initiatives might enhance public support for the litigation.

The survey finds that public awareness of the litigation effort is extremely low, and awareness of the alleged illegal behavior of tobacco companies underlying the lawsuits is even lower. However, when informed about the litigation, a significant majority of Canadians support it. In addition, support for the litigation increases significantly if some of the recovered money would be spent on tobacco-related public health initiatives.

The survey was based on a national random sample of 1,000 adult Canadians, 18 years of age and older, conducted by telephone from September 17 to 23, 2012. A sample of this size drawn randomly from the population would be expected to produce results accurate to within plus or minus 3.1 percentage points in 95 out of 100 samples.

The survey was led by independent consultant Donna Dasko, Ph.D., former Senior Vice-President of the Environics Research Group. Dr. Dasko is a leader in tobacco control research (see Appendices).

This report presents the key findings of the survey. All results in the tables below are expressed as a percentage of the total sample.

Awareness of the litigation

- Few Canadians – less than 10 percent – are aware that the provinces are suing the tobacco companies to recover health care costs and less than one percent of Canadians are aware of the alleged illegal behavior underlying the lawsuits.

When asked a series of open-ended questions to gauge awareness of the litigation efforts of the provinces against the tobacco companies, it is clear that few have knowledge of these lawsuits. When asked, first, as to whether they are aware of any governments, organizations, or individuals that are suing tobacco companies in Canada, 34 percent of Canadians say yes. Of this group who say yes, 29 percent mention that the provinces are suing the tobacco companies. And of this group who mention that the provinces are suing the tobacco companies, 87 percent are aware that the provinces are suing to recover health care costs. Only 7 percent are aware that they are suing because the companies are alleged to have committed fraud, lied or hid information about the harm caused by smoking.

In summary, then, only 9.9 percent of Canadians know that the provinces are suing the tobacco companies; and 8.7 percent of Canadians are aware that the lawsuits seek to recover health care costs. Less than one percent of Canadians are aware of the alleged illegal behavior underlying the lawsuits.

Awareness of litigation

9.9% Aware	90.1% Not aware that provinces are suing tobacco companies

*	99.3% Not aware that provinces are suing tobacco companies because they allegedly committed fraud, lied or hid information about the harm caused by smoking.

***** Aware=less than 1%/ not to scale.

Support for the litigation

- Six in ten Canadians believe the provinces are justified in suing the tobacco companies.

When informed that the provinces are suing the major tobacco companies to recover health care costs and presented with two points of view – a reason to support the litigation initiative and a reason to oppose it – a significant majority of Canadians say they support it. A total of 60 percent of the public agrees that "the provinces are justified in suing the tobacco companies because the provinces have spent billions of dollars over many decades treating diseases caused by tobacco-industry products." Significantly fewer, 36 percent, agree that "the provincial governments have made enough money from tobacco companies and smokers through taxes and are not justified in suing to get more."

Support for litigation

Provinces are justified because they have spent billions treating tobacco-related diseases	60
Provinces are not justified because they have made enough money from tobacco companies and smokers through taxes	36
DK/NA	3

Support for the litigation is higher than average in Quebec and among Canadians with higher levels of education.

Arguments in support of the litigation

- A large majority of Canadians, 77 percent, say their support for the litigation would increase if some of the monies recovered would be used to change tobacco company behaviour in the interests of public health.

Three arguments were tested for their salience to enhance support for the litigation efforts.

When informed that the provinces claim that the tobacco companies lied or hid information about the harm caused by tobacco, its addictiveness, and their marketing to youth, and asked whether these activities justify the litigation, a significant majority of 65 percent say yes and 32 percent say no. This argument has salience for enhancing support for the litigation.

When informed that the wrongful behaviour of the industry claimed by the provinces, if proven in court, would constitute the largest fraud in Canadian history, and asked whether this fact would increase their support for the litigation, more than half, 56 percent, say yes and 40 percent say no.

Finally, when it is suggested that some part of the monies recovered by governments from the tobacco lawsuits might be used “to change the tobacco industry’s behavior in the interests of public health, to prevent children from starting to smoke and to help smokers to quit smoking” and asked whether this would increase their support for the litigation, a large majority of 77 percent say yes and only 22 percent say no.

Moreover, it is very significant that over half (55 percent) of those who initially opposed the litigation say they would change their opinion and support the litigation if some of the recovered money was used for tobacco-related public health purposes. Clearly a commitment to using some of the proceeds from litigation for this purpose has the most salience for the public in enhancing support for the litigation.

Arguments in support of litigation

	Justified/increase support	Not justified/not increase support	DK /NA
Provincial governments claim that tobacco companies lied or hid info over several decades	65	32	3
If damages claimed would be the largest fraud in Canadian history	56	40	4
If some part of the money recovered would be used to change tobacco company behaviour in the interests of public health	77	22	1

Support for all three arguments is higher than average in Quebec.

APPENDICES

Survey Questions

Donna Dasko Biography

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 041-15

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2015 June 18

MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – JUNE

Recommendation

It is recommended that Report No. 041-15 re Medical Officer of Health Activity Report – June be received for information.

The following report highlights activities of the Medical Officer of Health (MOH) from the May Medical Officer of Health Activity Report to June 5, 2015.

The MOH joined many staff to participate in the 2015 alPHa Fitness Challenge on May 7th. alPHa encourages staff from all health units to engage in at least 30 minutes of physical activity. This year the Workplace Wellness and Fun Committee arranged for noon hour walks, a carnival themed exercise circuit as well as other fun activities. MLHU had a respectable 74% participation but top honours this year went to the Porcupine Health Unit who were able to get 100% participation.

On May 14th an all staff meeting was held to primarily discuss, share and further develop the strategic planning process. Staff were also given updates on office location/lease and on potential organizational restructuring.

The MOH held several meetings and teleconferences to prepare a grant application to the Local Poverty Reduction Fund to enhance existing MLHU Healthy Babies Healthy Children programming by offering a more intensive, targeted version of home visiting for the most vulnerable clients.

As part of Nursing week activities, the MOH, Acting Chief Nursing Officer Brenda Marchuk and Board Chair Ian Peer joined MPPs Peggy Sattler (NDP – London West) and Theresa Armstrong (NDP – London Fanshawe) for a tour of the 50 King St. office and a visit to a Well Baby/Child and Breastfeeding Clinic that was held at the White Oaks Family Centre.

The MOH attended the Canadian Public Health Association 2015 Conference held in Vancouver B.C. on May 25-27 where he participated on an expert panel about public health values, and a presentation about the PBMA process.

The Medical Officer of Health and CEO also attended the following teleconferences and events:

May 8	Met with Mr. Glen Pearson of the Food Bank regarding collaboration to address poverty
May 11	Attended United Way Community Impact Experience at the Canadian Mental Health Association (CMHA) Coffee House
May 12	Attended a Healthy Human Development Table meeting in Toronto
May 13	Met with Councillor Virginia Ridley Attended the CEO/CAO Dinner at John Paul II Catholic Secondary School

May 14	Hosted a Code Red Initiative Steering Committee meeting Met with staff from London Intercommunity Health Centre (LIHC) to discuss a Community Dental Health Initiative Attended the launch of London Community News' new brand "Our London" which was held at the Western Fair Agriplex
May 28	Attended a YOU Board Meeting
May 29	Met with City of London staff to discuss Living Accommodations Attended a meeting in Toronto of the Cessation Strategy Advisory Group
June 3	Attended a meeting of the United Way Cabinet Chaired a meeting in regards to the Local Poverty Reduction Fund – Expression of Interest submission Attended a YMCA event as an expert consultant on fitness
June 4	Attended a Code Red Champion meeting

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

This report addresses Ontario Public Health Organizational Standard 2.9 Reporting relationship of the medical officer of health to the board of health