CORRESPONDENCE – September 2019

a) Date: 2019 June 27
Topic: Public Health Modernization
From: Simcoe Muskoka District Health Unit
To: The Honourable Christine Elliott

Background:

On June 4, 2019, the Board of Health for Simcoe Muskoka District Health Unit wrote to Minister Elliott to recommend that provincial-municipal cost sharing of the public health funding formula be phased in over five years commencing in the fiscal year 2021–22. The Simcoe Muskoka District Health Unit expressed concern that municipalities may not be prepared for the financial implications and a gradual financial downloading strategy is required.

Recommendation: Receive.

b) Date: 2019 July 4
Topic: Dental program for low-income seniors
From: Leeds, Grenville and Lanark District Health Unit
To: The Honourable Christine Elliott

Background:

On July 4, 2019, the Board of Health for the Leeds, Grenville and Lanark District Health Unit wrote to Minister Elliott in support of a dental program for low-income seniors and to indicate that the Health Unit is prepared to implement the program effectively and efficiently.

Recommendation: Receive.

c) Date: 2019 July 2
Topic: Health promotion as a core function of public health
From: Windsor–Essex County Health Unit
To: The Honourable Christine Elliott

Background:

On July 2, 2019, the Board of Health for the Windsor–Essex County Health Unit wrote to Minister Elliott in support of KFL&A Public Health's request to the Government of Ontario to maintain the current health promotion mandate of public health and to ask that consultation take place with medical officers of health across Ontario should any changes be considered. Refer to correspondence item r) in the June 20, 2019 Board of Health agenda.

Recommendation: Receive.

d) Date: 2019 May 17 (received July 7)
Topic: Protecting York Region's schoolchildren through immunization

From: York Region
To: Gary McNamara

Background:

On May 17, 2019, the Board of Health for York Region wrote to the Windsor–Essex County Health Unit endorsing the position of the Council of Ontario Medical Officers of Health (COMOH) in support of the immunization registry whereby healthcare providers input immunization information directly at the time of vaccine administration. This strategy aligns with the recommendations outlined in the report "Protecting York Region's School Children through Immunization."

Recommendation: Receive.

e) Date: 2019 July 2 (received July 5)
Topic: Immunization for schoolchildren – seamless immunization registry
From: Windsor–Essex County Health Unit
To: The Honourable Christine Elliott

Background:

On July 2, 2019, the Board of Health for the Windsor–Essex County Health Unit wrote to Minister Elliott in support of York Region's recommendation to endorse COMOH's position in support of a seamless immunization registry whereby healthcare providers input immunization information directly at the time of vaccine administration. Refer to correspondence item d), above.

Recommendation: Receive.

f) 2019 July 2 (received July 5)
Topic: Smoke-Free – Smoke/Vape Free Outdoor Spaces
From: Windsor–Essex County Health Unit
To: The Honourable Christine Elliott

Background:

On July 2, 2019, the Board of Health for the Windsor–Essex County Health Unit wrote to Minister Elliott in support for the resolution regarding Smoke-Free – Smoke/Vape Free Outdoor Spaces in order to reduce exposure of second-hand smoke. The Windsor–Essex County Health Unit encourages municipalities to prohibit smoking or vaping in all municipally owned outdoor sport and recreation properties, parks, beaches, trails, and playgrounds.

Recommendation: Receive.

g) Date: 2019 July 8 (received July 9)
Topic: Concerns about future delivery of health promotion programs and services in Ontario by public health units
From: Southwestern Public Health
To: The Honourable Christine Elliott

Background:

On July 8, 2019, the Board of Health for Southwestern Public Health wrote to Minister Elliott regarding concerns about the Province's position on the future delivery of health promotion-related programs and services. Southwestern Public Health argues that the delivery of health promotion-related activities is needed at the local level in partnership and collaboration with municipalities, community agencies, and residents.

Recommendation: Receive.

h) Date: 2019 June 21 (received July 9)
Topic: Position and mandate for a restructured York Region Public Health
From: York Region Board of Health
To: Trish Fulton, Chair, Middlesex-London Board of Health

Background:

On June 21, 2019, the Board of Health for York Region wrote to Ms. Trish Fulton, MLHU Board of Health chair, advising her that the York Region Board of Health has requested that the geographic area of the restructured public health entity include only the geographic area of York Region. The York Region Board of Health also requested that the current governance and operating model be maintained for York Region Public Health and that the Ministry of Health and Long-Term Care (MOHLTC) authorize financial assistance for planning and transition costs related to restructuring.

Recommendation: Receive.

i) Date: 2019 July 5 (received July 10)
Topic: Public health transformation initiative in Northeastern Ontario
From: North Bay Parry Sound District Health Unit
To: The Honourable Doug Ford, The Honourable Christine Elliott

Background:

On July 5, 2019, the Board of Health for North Bay Parry Sound District Health Unit wrote to Premier Ford and Minister Elliott in support of the resolution related to the public health transformation initiative in Northeastern Ontario. Refer to correspondence item r) in the July 18, 2019 Board of Health agenda.

Recommendation: Receive.

j) Date: 2019 July 17 (received July 19)
Topic: Cancelled funding for Leave the Pack Behind
From: Peterborough Public Health
To: The Honourable Christine Elliott

Background:

On July 17, 2019, the Board of Health for Peterborough Public Health wrote to Minister Elliott expressing concern over the provincial government's decision to cease funding for Leave the Pack Behind program, which is dedicated to tobacco prevention and cessation among young adults. Leave the Pack Behind supported young adults with their quit attempts, which, without such partnerships and collaboration, might not have happened.

Recommendation: Receive.

k) Date: 2019 July 17 (received July 19)
Topic: Support for a national school food program
From: Peterborough Public Health
To: The Right Honourable Justin Trudeau, The Honourable Maxime Bernier, Yves-Francois Blanchet, Elizabeth May, The Honourable Andrew Scheer, Jagmeet Singh

Background:

On July 17, 2019, the Board of Health for Peterborough Public Health wrote to Prime Minister Trudeau and the federal party leaders to request that the federal government move forward with implementation of a cost-shared national school food program. Such a program could improve students' food choices, support academic success, and enable children to develop food and nutrition habits to lead healthy lives.

Recommendation: Receive.

l) Date: 2019 July 22
Topic: Public Health Modernization
From: Warden Kurtis Smith, Middlesex County
To: Trish Fulton, Chair, Middlesex-London Board of Health

Background:

On July 22, 2019, Warden Smith wrote to Chair Fulton regarding financial and operational questions pertaining to the public health modernization initiative. Ms. Fulton responded on July 23, 2019.

Recommendation: Endorsed (July 23, 2019).

m) Date: 2019 July 25
Topic: City of Hamilton board correspondence, April 14, 2019
From: Hamilton City Council
To: All Boards of Health

Background:

On April 14, 2019, Hamilton City Council received correspondence items from the Association of Local Public Health Agencies (alPHa) related to the Winter Symposium and the 2019 provincial budget.

Recommendation: Receive.

n) Date: 2019 July 25
Topic: City of Hamilton board correspondence, May 22, 2019
From: Hamilton City Council
To: All Boards of Health

Background:

At its May 22, 2019 meeting, Hamilton City Council advised that it had received numerous correspondence items as part of the Board of Health report 19-005.

Recommendation: Receive.

o) Date: 2019 July 25
Topic: City of Hamilton board correspondence, July 12, 2019
From: Hamilton City Council
To: All Boards of Health

Background:

At its June 12, 2019 meeting, Hamilton City Council advised that it had received numerous correspondence items as part of the Board of Health report 19-007.

Recommendation: Receive.

p) Date: 2019 July 19
Topic: Proposed provincial restructuring of local public health agencies
From: Regional Council, Niagara Region
To: All Boards of Health

Background:

On July 19, 2019, the Regional Council for Niagara Region wrote to all Boards of Health advising of its support for the Resolution Respecting Proposed Provincial Restructuring of Local Public Health Agencies.

Recommendation: Receive.

q) Date: 2019 July 25
Topic: Update for alPHa membership on public health modernization
From: Loretta Ryan, Executive Director, alPHa
To: All Ontario Health Units, Boards of Health

Background:

The Association for Local Public Health Agencies (alPHa) issued an update to its members on July 25, 2019, in anticipation of the Minister of Health's next steps in seeking input and advice on public

health modernization. Once consultations are underway, alPHa members will be invited to provide input for the submission.

Recommendation: Receive.

r) Date: 2019 July 26
Topic: City of Hamilton board correspondence, March 27, 2019
From: Hamilton City Council
To: All Boards of Health

Background:

At its March 27, 2019 meeting, Hamilton City Council advised that it had received numerous correspondence items as part of the Board of Health report 19-003.

Recommendation: Receive.

s) Date: 2019 July 26
Topic: City of Hamilton board correspondence, April 24, 2019
From: Hamilton City Council
To: All Boards of Health

Background:

At its April 24, 2019 meeting, Hamilton City Council advised that it had received numerous correspondence items as part of the Board of Health report 19-004.

Recommendation: Receive.

t) Date: 2019 July 26
Topic: City of Hamilton board correspondence, May 22, 2019
From: Hamilton City Council
To: All Boards of Health

Background:

At its May 22, 2019 meeting, Hamilton City Council advised that it had endorsed two correspondence items as part of the Board of Health report 19-005.

Recommendation: Receive.

u) Date: 2019 July 26
Topic: City of Hamilton board correspondence, June 26, 2019
From: Hamilton City Council
To: All Boards of Health

Background:

At its May 22, 2019 meeting, Hamilton City Council advised that it had endorsed a correspondence item from KFL&A Public Health, received as part of the Board of Health report 19-006, in regard to health promotion as a core function of public health. Refer to correspondence item c), above.

Recommendation: Receive.

v) Date: 2019 July 26
Topic: City of Hamilton board correspondence, July 12, 2019
From: Hamilton City Council
To: All Boards of Health

Background:

At its July 12, 2019 meeting, Hamilton City Council advised that it had endorsed numerous correspondence items as part of the Board of Health report 19-007.

Recommendation: Receive.

w) Date: 2019 July 26
Topic: Plain and standardized tobacco products packaging
From: James Van Loon, Director General, Tobacco Control Directorate
To: Trish Fulton, Chair, Middlesex-London Board of Health, and Christopher Mackie, Medical Officer of Health and CEO, Middlesex-London Health Unit

Background:

On July 26, 2019, Mr. Van Loon wrote to Ms. Fulton and Dr. Mackie expressing gratitude for the support received in regard to *Tobacco Products Regulations*, published in the Canada Gazette on May 1, 2019.

Recommendation: Receive.

x) Date: 2019 July 24
Topic: Food insecurity
From: The Honourable Jean-Yves Duclos, Minister of Families, Children and Social Development
To: Chair, Middlesex-London Board of Health

Background:

On July 24, 2019, Minister Duclos responded to correspondence from MLHU dated September 20, 2018, regarding food insecurity. The Minister advised that Opportunity for All – Canada's First Poverty Reduction Strategy establishes goals of a 20% reduction in poverty by 2020 and a 50% reduction by 2030. The federal government has committed to new investments of over $12 billion for 2019–20, and, as part of Opportunity for All, has been working with Statistics Canada to improve data on food security. On June 21, 2019, the *Poverty Reduction Act* received Royal Assent.

Recommendation: Receive.

y) Date: 2019 August 21
Topic: 2020 public health cost share announcements
From: Loretta Ryan, Executive Director, alPHa
To: All Ontario Health Units, Boards of Health

Background:

On August 21, 2019, the Association of Local Public Health Agencies (alPHa) announced that, effective January 1, 2020, the 30% cost share of all 100% MOHLTC-funded programs will be included, except for the Ontario Senior Dental, medical officer of health/associate medical officer of health compensation, and the unorganized territories grant. Further details are awaited regarding the promised one-time funding for 2020 to offset the extra costs to municipalities.

Recommendation: Receive.

z) Date: 2019 August 20
Topic: Minister Steve Clark's speech at the Association of Ontario Municipalities 2019 conference
From: Association of Local Public Health Agencies (alPHa)
To: All Ontario Health Units, Boards of Health

Background:

On August 20, 2019, the Association of Local Public Health Agencies (alPHa) released the speech given by Minister Steve Clark at the Association of Ontario Municipalities 2019 conference. In his speech, Minister Clark announced that transitional funding for public health and childcare will be provided for budgeting processes in 2020. The government will also launch renewed consultations with municipalities and partners in public health and emergency services this fall.

Recommendation: Receive.

aa) Date: 2019 August 6
Topic: Restructuring local public health in Ontario
From: KFL&A Public Health
To: The Honourable Christine Elliott

Background:

On August 6, 2019, the Board of Health for KFL&A Public Health wrote to Minister Elliott in support of a set of principles and criteria to guide public health restructuring processes at the provincial level. These principles and criteria were developed by the KFL&A Board of Health, medical officers of health across Eastern Ontario, partners in the Eastern Ontario Wardens Caucus, and CAOs from Eastern Ontario counties.

Recommendation: Receive.

bb) Date: 2019 August 19
Topic: Ontario government's plans to transform public health in Ontario
From: Association of Local Public Health Agencies (alPHa)
To: All Ontario Health Units, Boards of Health

Background:

On August 19, 2019, the Association of Local Public Health Agencies (alPHa) advised that at the Association of Municipalities of Ontario (AMO) annual conference, Premier Ford and Minister Elliott spoke about the government's plans to transform public health in Ontario. These announcements included the following information: 1) the Minister has been working with AMO, the City of Toronto, and alPHA; 2) more time will be allocated to accommodate changes to cost-sharing arrangements; 3) beginning January 1, 2020, all municipalities will transition to a 70-30 cost-sharing funding model; 4) the government will soon launch renewed consultations with municipalities and partners in public health; 5) the next phase of engagement will be supported by an expert advisor, to be announced; and 6) the next phase of engagement will see the release of a discussion paper outlining the proposals for boundaries of the new regional public health entities.

Recommendation: Receive.

cc) Date: 2019 August 20
Topic: Funding update for 2019–20
From: The Honourable Christine Elliott
To: Trish Fulton, Chair, Middlesex-London Board of Health

Background:

On August 20, 2019, Minister Elliott wrote to Chair Fulton advising that MLHU will be provided with up to $23,143,200 in base funding and up to $10,000 in one-time funding for the 2019–20 funding year for provision of public health programs and services. Furthermore, the Ministry of Health and Long-Term Care intends to consult with public health and municipal partners throughout the fall of 2019 to inform development of regional public health entities. To support public health unit planning for 2020 and to provide additional stability as municipalities begin to adapt to the new funding models, the government will provide one-time mitigation funding.

Recommendation: Receive.

dd) Date: 2019 August 23
Topic: Structure of Public Health Literature Review
From: Loretta Ryan, Executive Director, alPHa
To: All Boards of Health

Background:

On August 23, 2019, the Association of Local Public Health Agencies (alPHa) issued the Structure of Public Health Literature Review, which enumerates the components of public health organization or structure that contribute to public health performance.

Recommendation: Receive.

ee) Date: 2019 August 27
Topic: Smoke-free multi-unit dwellings
From: Grey Bruce Health Unit
To: The Right Honourable Justin Trudeau

Background:

On August 27, 2019, the Board of Health for the Grey Bruce Health Unit wrote to Prime Minister Trudeau in support of the motion from the Windsor–Essex County Health Unit to reduce exposure of second-hand smoke in multi-unit housing. Refer to correspondence item p) in the June 20, 2019 Board of Health agenda.

Recommendation: Receive.

simcoe muskoka
DISTRICT HEALTH UNIT

June 27, 2019

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

Dear Minister Elliott:

Re: Public Health Modernization

I am writing on behalf of the Board of Health for the Simcoe Muskoka District Health Unit (SMDHU) to recommend the continued comprehensive mandate of public health as defined in the Ontario Public Health Standards (2018) and for gradual adjustments to the provincial-municipal cost-sharing of public health funding formula be phased in over five (5) years commencing in fiscal year 2021-22.

Since the April 11, 2019 Government of Ontario provincial budget announcements regarding public health modernization, concerns have been raised that there may be shifts in the full mandate of public health to yet to be defined essential services. It is critical that the full mandate of public health continue and that adequate funding be provided to support this through a more gradual financial downloading strategy to ensure municipalities are better prepared for the financial implications.

Extensive work went into modernizing the mandate of public health as reflected in the release of the 2018 Ontario Public Health Standards. These standards reflect a renewed mandate for public health with the goal to improve and protect the health and well-being of the population of Ontario and reduce health inequities. This comprehensive mandate is created on a foundation of quality and accountability ensuring that research, evidence, and best practices inform service delivery.

On May 28, 2019 the following resolution was carried at the alPHa Annual General meeting: Public Health Modernization: Getting it Right! This motion positions that the current mandate of public health not be altered in an effort to achieve budget reduction targets, that the Ontario government delay the implementation of any organizational and financial changes to local public health and engage in meaningful consultation and changes in the cost-shared formula be phased in over five (5) years commencing in fiscal 2021-22 (Appendix A).

The Board of Health commends the decision of Premier Ford reported on May 27, 2019 in a news conference that provincial funding cuts for public health in the provincial budget will not go forward for the 2019 year. This was welcomed news and does allow for additional time for more comprehensive financial planning by health units and municipalities.

The work of public health is inherently cost effective, with an excellent return on investment, and is essential for the province to achieve its goal of ending hallway medicine. Funding for public health is a sound investment in support of the health and wellbeing of the people.

Thank you for considering our recommendations.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

CG:cm

Att. (1)

cc. Mayor and Council of Simcoe and Muskoka
Members of Provincial Parliament for Simcoe and Muskoka
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health

alPHa RESOLUTION A19-12

TITLE: **Public Health Modernization: Getting it Right!**

SPONSOR: **Peterborough Public Health**

WHEREAS the services provided by local boards of public health are critical to supporting and improving the health and quality of life of all residents of the Province; and

WHEREAS public health interventions are an important strategy in the prevention of hallway medicine and have been found to produce significant cost-saving with estimates that every dollar invested will save or avert at least $14 in future costs; and

WHEREAS boards of health are accountable to both the province and their "obligated municipalities" to maximize their financial resources; and

WHEREAS meaningful municipal participation on boards of health ensures that public health agencies understand and respond to local and specific municipal needs; and

WHEREAS revenue opportunities for municipalities are constrained by both the ability to pay and provincial regulation; and

WHEREAS the current proposal for reorganizing the public health sector in Ontario was developed without meaningful consultation with either boards of health or their obligated municipalities;

NOW THEREFORE BE IT RESOLVED that the Ontario public health mandate as currently outlined in the Ontario Public Health Standards not be altered or diminished in an effort to achieve budget reduction targets and that the Province continues to financially support public health units to adequately implement the Standards;

AND FURTHER that the Association of Local Public Health Agencies (alPHa) calls upon the Ontario government to delay the implementation of any organizational and financial changes to local public health until April 1, 2021 with a commitment to engage in meaningful consultation over the next eighteen (18) months;

AND FURTHER that any changes in the cost-shared formula be phased in over five (5) years commencing in fiscal 2021-22;

AND FURTHER that in ongoing consultations with the province, that alPHa propose the establishment of a joint task force made up of both political representatives and professional staff from existing public health agencies, alPHa, the Association of Municipalities of Ontario (AMO) and the City of Toronto to undertake the following activities:

- Establish a set of principles to guide the reorganization of public health in Ontario that include:
    - Assurance that the enhancement of health promotion and disease prevention is the primary priority of any changes undertaken
    - Undertaking the consolidation of health units around a community of interests which include distinguishing between rural and urban challenges, and the meaningful participation of First Nations
    - Taking into account the ability of municipalities to pay, considerations for the broad range of proposed changes in funding arrangements between the province and municipalities
    - Developing a governance structure that provides accountability to local councils required to fund local public health agencies; and
- Conduct public outreach to municipal, public health and other stakeholders to validate both the principles and the resulting plans for future re-organization; and
- Ensure that the municipal and public health perspectives on any proposed changes, including the outcomes of consultation, are incorporated.

ACTION FROM CONFERENCE: Carried as amended

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

July 2, 2019

The Honorable Christine Elliott
Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

Health Promotion as a Core Function of Public Health

On behalf of the Windsor-Essex County Board of Health we are writing to you in support of Kingston, Frontenac and Lennox & Addington Public Health Unit's request to the Government of Ontario, through a motion passed by their Board on May 22, 2019:

THAT it maintains the current health promotion mandate of public health units, *and*

THAT the KFL&A Board of Health ask the Government of Ontario to consult with Medical Officers of Health across Ontario should they consider any changes to the health promotion mandate and/or functions of local public health units or future public health entities.

The purpose of health promotion is to positively influence the healthy behavior of individuals and communities as well as the living and working conditions that influence their health, thus enhancing quality of life.

The Health promotion process enables individuals to increase control over, and improve, their health, and moves beyond the focus of individual behaviour to positively influence healthy behaviours of individuals as well as communities.

By focusing on prevention, health promotion reduces the costs, both financial and human, that individuals, families, medical facilities, communities, employers, and the province would spend on medical treatment.

The Windsor-Essex County Health Unit thanks you for your consideration.

Sincerely,

Gary McNamara, Chair
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Premier Doug Ford
Loretta Ryan, Association of Local Public Health Units
Hon. Rod Phillips, Minister of Finance
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Ontario Boards of Health
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
WECHU Board of Health

York Region

Regional Clerk's Office
Corporate Services

May 17, 2019

Gary McNamara
Windsor-Essex County Health Unit
1005 Oullette Avenue
Windsor, ON N9A 4J8

Dear Mr. McNamara:

Re: Protecting York Region's School Children through Immunization

On May 16, 2019 Regional Council adopted the following recommendations:

1. Regional Council endorse the position of the Council of Ontario Medical Officers of Health in support of a seamless immunization registry whereby health care providers directly input immunization information at the time of vaccine administration.

2. The Regional Clerk circulate this report to the Minister of Health and Long-Term Care, the Chief Medical Officer of Health, York Region Members of Provincial Parliament, the Association of Municipalities of Ontario, the Association of Local Public Health Agencies, the Council of Ontario Medical Officers of Health, the other 34 Ontario Boards of Health and the local municipalities.

The original staff report is enclosed for your information.

Please contact Marjolyn Pritchard, Director, Infectious Disease Control at 1-877-464-9675 ext. 74120 if you have any questions with respect to this matter.

Sincerely,

Christopher Raynor
Regional Clerk

Attachments

The Regional Municipality of York

Committee of the Whole
Community and Health Services
May 2, 2019

Report of the Commissioner of Community and Health Services and Medical Officer of Health

Protecting York Region's School Children through Immunization

1. Recommendations

It is recommended that:

1. Regional Council endorse the position of the Council of Ontario Medical Officers of Health in support of a seamless immunization registry whereby health care providers directly input immunization information at the time of vaccine administration.

2. The Regional Clerk circulate this report to the Minister of Health and Long-Term Care, the Chief Medical Officer of Health, York Region Members of Provincial Parliament, the Association of Municipalities of Ontario, the Association of Local Public Health Agencies, the Council of Ontario Medical Officers of Health and the other 34 Ontario Boards of Health.

2. Summary

This report outlines York Region Public Health's (Public Health) efforts in enforcing the *Immunization of School Pupils Act* (the Immunization Act) – an Ontario law requiring children under age 18 years attending school to have up-to-date immunization records (or valid exemptions) on file with their public health unit for a designated subset of publicly-funded childhood immunizations.

Key Points:

- Administration and enforcement of the Immunization Act is an important tool for: improving immunization coverage among school-age children; understanding trends and patterns in vaccine coverage; and supporting public health interventions in the event of a vaccine-preventable disease case or outbreak
- Administration of the Immunization Act in York Region would be enhanced if the provincial government were to create a provincial Electronic Medical Record and merge this record with the existing Digital Health Immunization Repository so that any time a health care provider administers a vaccine, it is captured in a central provincial registry

3. Background

Ontario's publicly-funded immunization program prevents diseases that could otherwise cause illness and death

Immunization is one of the most successful and cost-effective public health interventions available. It protects an individual from the negative health impacts of vaccine-preventable diseases like measles or pertussis, and further protects the community at large including those who cannot receive a particular vaccine due to their age or a medical condition.

York Region's immunization program is governed by the *Immunization of School Pupils Act* (the Immunization Act) for school-aged children, and the *Child Care and Early Years Act* for children attending licensed child care centres. Program specific requirements are detailed in the Ontario Public Health Standards, including the requirement to assess, maintain records, and report on the immunization status of children enrolled in schools and licensed child care centres.

Under the Immunization Act, parents or guardians of school-aged children are required to provide Public Health with proof of immunization or a valid exemption (medical or conscience/religious belief). These immunizations include diphtheria, tetanus, polio, measles, mumps, rubella, meningococcal disease, pertussis (whooping cough), and varicella (chickenpox). Most of these vaccine-preventable diseases are highly contagious and can have serious health consequences, including death.

York Regional Council as the Board of Health in York Region supports the activities of Public Health in promoting immunization among school age children

On February 18, 2016 Council endorsed Public Health's role in enforcement of the Immunization Act. The report detailed the administration and enforcement, discussed the benefits of publicly-funded immunization programs and outlined ongoing community efforts to improve immunization uptake and compliance among the Region's students. On April 20, 2017, an update on enforcement of the Immunization Act in York Region was received by Council, including details regarding the approach Public Health would take to improve Immunization Act-related activities in York Region private schools.

Currently, immunization information is not shared between primary health care providers and Public Health

Under the current system, children receive most childhood vaccinations by their primary care provider, who will then typically update the child's personal paper immunization record (the "yellow card"). Immunization information is also recorded in the electronic or paper-based medical record held by their primary care provider. It is then the responsibility of parents or guardians to provide their child's immunization record to Public Health in order for their immunization information to be updated within the provincial Digital Health Immunization Repository.

The Digital Health Immunization Repository is the provincial electronic immunization database that houses all student immunization information. Public Health can input and access student immunization information through this database however, primary health care providers who administer vaccines to children do not have access to the system.

There have been previous attempts to create online portals where patients and health care providers could securely submit immunization information to the Digital Health Immunization Repository. For example, Immunization Connect Ontario developed a platform for both the public as well as primary health care providers to enter information. However, there have been barriers to universal adoption of Immunization Connect Ontario by primary health care providers and public health units across Ontario.

The provincial government recently announced plans to create a provincial Electronic Medical Record and merge it with the Digital Health Immunization Repository

A provincial immunization registry would allow for the seamless reporting of immunization information by primary health care providers at the time of administration.

4. Analysis

Public Health employs a number of strategies to promote immunization among school-aged children

A number of activities occur to support parents and guardians in ensuring their children follow Ontario's publicly-funded immunization schedule (Attachment 1). Public Health sends letters to parents detailing the Immunization Act process and ensures local clinicians are aware of the immunization requirements for school-aged children. Through the school immunization program, Public Health nurses administer three publicly-funded vaccines to grade 7 (twelve year old) students: hepatitis B (two doses), meningitis (one dose, required under the Immunization Act), and human papillomavirus virus (HPV) (two doses). Over the course of the calendar year, community clinics are also held where students can receive publicly funded vaccines.

Public Health responds to vaccine education requests from the community, and proactively raises awareness among the community and local clinicians about the benefits of immunization.

The Immunization Act enforcement process occurs yearly, with Catholic, Public, French and private school boards

The process begins with merging the student demographic information, provided by the schools, with the provincial immunization database and the Digital Health Immunization Repository to identify which students do not have up-to-date records or valid exemptions on file.

Students aged 7 to 17 who are not up-to-date on their immunizations are identified. At least two reminder letters are sent out to parents or guardians and students, which:

- provide information on the benefits of vaccination
- provide the process for submitting updated immunization records to Public Health and how students can receive immunizations they have missed
- notify parents or guardians and students of any pending enforcement activities

Parents or guardians and students have two months after receiving the reminder letters to update their records with Public Health

The Immunization Act provides authority for Public Health to suspend a student for up to a maximum of 20 school days if he/she does not provide up-to-date records or a valid exemption. School principals are responsible for implementing a suspension order. Suspending students is a last resort for Public Health.

Between 2015 and 2018, approximately 82,000 student records were assessed for compliance, resulting in approximately 1,200 suspensions (Table 1). For those students who were suspended, almost all were permitted to return to school within a few days.

Table 1

Results of the Act Enforcement, 2015/16 to 2017/18 School Years, York Region

School Year	Number of student records assessed	Number of students received first letter*	Number of students received second letter	Number of suspension orders sent	Number of students suspended (% of students assessed)
2015/2016[1] First year of Digital Health Immunization Repository	19,415	8,893	5,050	3,098	356 (1.8%)
2016/2017[2]	26,540	17,640	10,696	6,860	273 (1.0%)
2017/2018[3]	36,935	23,866	15,752	12,159	649 (1.8%)

Notes:
1. Only 17 year olds attending York Region Catholic and public high schools were assessed
2. 7 and 17 year olds attending York Region Catholic, public and French schools were assessed
3. 7 and 17 year olds attending York Region Catholic and public schools and 7 to 17-year olds attending York Region private and French schools were assessed
* refers to the total number of students who were non-compliant at the onset of enforcement

In 2012/2013, Public Health set out to build relationships with each of the private schools and their respective boards. This has been a major undertaking because the private schools are not unified by one all-encompassing board like the Catholic, French and Public boards. Public Health recently partnered with York Region's 71 private schools to administer the Immunization Act. This work resulted in 100 per cent compliance with the Act among private

school students age 7 to 17 during the 2017/18 school year within the 70 schools who provided student demographic records that year. Since that time, the additional private school has provided Public Health with their student demographic information. Immunization data for all 71 private schools will be captured in 2018/2019.

Under the Ontario Public Health Standards, Public Health is required to maintain immunization records for children in licensed child care centres

In York Region, licensed child care centre operators collect and retain immunization information from parents, and provide it to Public Health upon request. In the event of a vaccine-preventable disease occurring in a licensed child care centre, Public Health can assess each child's records to decide who to exclude and who can safely remain in the child care centre.

Immunization information for children currently in licensed child care centres is captured in the Immunization Act school enforcement activities when the children turn seven. Moving forward, Public Health will focus on collecting information from younger cohorts since most of the publicly-funded immunizations recommended for children are to be given before school entry (Attachment 1). The earlier Public Health can ensure up-to-date records, the more streamlined the Immunization Act process is once children are enrolled in school.

Parents or guardians are able to obtain a medical or conscience/religious belief exemption if they choose not to immunize their child

Medical exemptions are available to children who are unable to receive a vaccine for medical reasons. Parents may request a medical exemption for a child who has a life-threatening allergy and cannot receive a vaccine that contains the allergy-inducing component, or for a child who is undergoing certain treatments for cancer. A written statement from a physician or a nurse practitioner outlining medical reason(s) why the child should not be immunized must be provided to public health to obtain a medical exemption. For the 2017/18 school year, less than one per cent of 7 year-old students in York Region obtained a medical exemption.

A non-medical exemption may be obtained when a parent or guardian has chosen not to vaccinate their child based on conscience or religious belief. Parents or guardians wishing to file a non-medical exemption must complete a "statement of conscience or religious belief" form, have their exemption form signed and affirmed before a lawyer or notary public, and submit to Public Health. In addition, the Immunization Act requires parents or guardians who are requesting an exemption based on conscience or religious beliefs to attend an education session developed by the Ministry of Health and Long-Term Care (Ministry). Public Health provides these sessions at the immunization clinic located at the Newmarket Health Centre. For the 2017/18 school year, approximately one per cent of 7 year-old students in York Region obtained a religious or conscience (non-medical) exemption. Previous Ontario data suggest that non-medical exemptions are increasing over time, however, the absolute proportion remains low, at less than 2.5 per cent on average for the province.

Public Health uses immunization data from the age seven cohort to estimate immunization coverage

Health units across Ontario report data for the age 7 cohort because most childhood vaccines are administered by this age. Seven year-old students in York Region have higher than average immunization coverage rates compared to the rest of the province. For example, for the 2017/18 school year, the proportion of 7 year-old students (those born in 2010) who are up-to-date for immunizations under the Act in York Region is 86.9 per cent, compared to the provincial average of 79.5 per cent. For specific diseases, York Region students have immunization coverage comparable to the provincial average for the 2016/17 school year (Table 2).

Table 2

Immunization Coverage Estimates[1] (%) for 7 year-olds for Key Childhood Vaccines, 2016/17 school year

	Measles	Mumps	Rubella[2]	Tetanus	Pertussis	Polio
York Region	90.7	90.5	94.1	84.8	84.7	84.9
Ontario	91.2	91.1	96.2	84.7	84.6	85.0

Notes:
1. more robust estimates of vaccine coverage are not available because Ontario does not have a provincial immunization registry
2. the Provincial definition of up-to-date is ≥1 valid dose of rubella compared to ≥2 valid doses for measles and mumps

Public Health is well-positioned to respond in the event of a vaccine-preventable disease case or outbreak in a school, such as measles

Measles has been in the news recently with outbreaks in New York City, Vancouver, and recently, a report of an infected individual being in a public place in York Region. In the event of a measles case in a York Region school, Public Health can quickly determine those students whose records indicate inadequate protection (based on immunization history or exemptions). For students who are under-immunized, the measles vaccine can be administered within 72 hours of exposure to help prevent them from becoming sick, or they can be removed from school to ensure their safety and the safety of others.

Public Health has implemented an eight-year strategic program plan for implementation of the Immunization Act

York Region has the third largest student population in Ontario, with 194,082 students in 408 schools. Immunization information recorded in the Digital Health Immunization Repository covers approximately 83 per cent of students aged 4 to 17, and 95 per cent of students, aged 7 to 17, attending schools in York Region. By June 2023 the annual student record

assessment and the Act enforcement expansion will include all York Region students aged 7 to 17 and moving forward will continue to include every student within this age range, with the exception of the age 12 cohort, which currently receive immunizations directly from Public Health through the grade 7 program.

Once the immunization records of all students, aged 7 to 17 have been collected, Public Health will begin collecting immunization records for school aged children less than seven years of age. Currently, immunization information captured in the Digital Health Immunization Repository covers approximately 33 per cent of students aged four to six. Under Ontario's publicly-funded immunization schedule, two vaccines are administered between the ages of four to six; however immunization records are not captured until age seven when Public Health collects student demographic information from the schools under the Immunization Act.

York Region Public Health and the Council of Ontario Medical Officers of Health strongly support creation of an immunization registry

A major challenge to administration of the Immunization Act is the lack of a provincial immunization registry to seamlessly transfer immunization information from primary health care providers at the time the vaccine is administered, to the Digital Health Immunization Repository. Self-reporting of immunization information without verification is the standard across all Ontario health units. Public Health Units across Ontario do not have a process to verify the "yellow card" with primary health care providers since this would be immensely labour intensive and costly. It is possible some inaccuracies exist in records collected by Public Health because of the reliance on parents to provide immunization information themselves.

In March 2019, the Council of Ontario Medical Officers of Health – a subgroup of the Association of Local Public Health Agencies representing Associate Medical Officers of Health and Medical Officers of Health across the province – wrote to the Minister of Health and Long-Term Care supporting the Ministry's proposed plan to develop a provincial Electronic Medical Record and merge it with the Digital Health Immunization Repository (Attachment 2). This Electronic Medical Record - Digital Health Immunization Repository integration project would allow for the seamless reporting of immunizations from primary health care providers at the time of vaccine administration directly to local public health.

Public Health is very supportive of the recommendation made by the Council of Ontario Medical Officers of Health that the Ministry assume the role of the health information custodian for the Digital Health Immunization Repository. The Ministry has previously assumed this role with the Ontario Laboratory Information System and the Digital Health Repository. The Ministry taking on the role of the health information custodian, instead of 35 Medical Officers of Health doing so would mean a more consistent approach in obtaining consent for the collection of vaccine information not covered under the Immunization Act.

Immunization Act enforcement supports the corporate strategic goal of supporting community health, safety and well-being

The York Region *2019 to 2023 Corporate Strategic Plan: From Vision to Results* articulates the corporate priority of supporting community health, safety and well-being. Enforcing the Immunization Act among designated cohorts of students supports this priority.

5. Financial

In 2018, activities related to enforcement of the Immunization Act were managed within the Public Health Branch council approved budget of $65.7 million. Table 3 provides a summary of the budget for Public Health in 2018. In 2019, program activities related to the enforcement of the Act will continue to be managed within the approved Public Health Branch budget of $68.4 million

Table 3

Public Health Branch 2018 Financial Summary

	2018 Budget ($'000)	2019 Budget ($'000)
Gross expenditures	65,750	68,365
Provincial funding	(48,746)	(49,962)
Net Levy	17,004	18,403

6. Local Impact

There is no direct impact from these recommendations on local municipalities. Enforcement of the Immunization Act relies heavily on partnerships with the local public, Catholic, and French school boards and individual private schools to support suspension orders. Enforcement will continue on a yearly basis to ensure students comply with the legislation and to ensure that students are vaccinated as they move through the publicly-funded immunization schedule, before they reach their 18th birthday when they no longer fall within the requirements of the Immunization Act.

7. Conclusion

York Region Public Health protects the health of the community by preventing vaccine-preventable diseases among our growing population. In light of recent media reports of vaccine-preventable disease outbreaks and issues relating to our current system of

immunization data collection, Public Health will continue to collaborate with parents, local school boards, and individual schools to ensure compliance of the Act, improve immunization rates and protect the health of our communities. Moving toward a seamless immunization registry would increase efficiencies and result in more accurate information about vaccine coverage in the population, supporting public health interventions in the event of a school outbreak or exposure to a vaccine-preventable disease.

For more information on this report, please contact Marjolyn Pritchard, Director, Infectious Disease Control at 1-877-464-9675 ext. 74120. Accessible formats or communication supports are available upon request.

Recommended by:

Katherine Chislett
Commissioner of Community and Health Services

Dr. Karim Kurji
Medical Officer of Health

Approved for Submission:

Bruce Macgregor
Chief Administrative Officer

April 17, 2019
Attachments (2)
#9309454

Publicly Funded Immunization Schedules for Ontario – December 2016

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

Routine Schedule: Children Starting Immunization in Infancy

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

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

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

ATTACHMENT 1

Ontario

coMOH
Council of Ontario
MEDICAL OFFICERS OF HEALTH

The Council of Ontario Medical Officers of Health (COMOH) is a Section of

alPHa
Association of Local PUBLIC HEALTH Agencies

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

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

www.alphaweb.org

ATTACHMENT 2

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

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

March 14, 2019

Dear Minister Elliott,

Re: Support of Immunizations and the Electronic Medical Record (EMR) and Digital Health Immunization Repository (DHIR) Integration Project

On behalf of the Council of Ontario Medical Officers of Health, I am writing to express our thanks for the Minister's support of immunizations and the immunization programs in Ontario. Getting the public support of the Minister in the face of so much misinformation on vaccines is very valuable and appreciated.

We would also like to provide our full support to the Ministry for moving forward with online health records for patients, and in particular, the Electronic Medical Record (EMR) and Digital Health Immunization Repository (DHIR) Integration Project, namely the seamless reporting of immunizations from health care providers directly to local public health. This will reduce the considerable burden on parents to manually report their child's immunizations to local public health units. It will also be more efficient and ensure more accurate vaccine records. If done well, it could also serve as a model for future digital integration between electronic medical record solutions and other provincial health digital assets, supporting the Ontario government's priorities for digitization.

Public health uses vaccination records in the DHIR to prevent and stop outbreaks of infectious diseases such as measles. When EMR integration with the DHIR is established, in order for a vaccination record to be shared between a patient's physician and public health, consent from the patient or their guardian would be required. We would like to encourage the Ministry to consider removing the need for individual informed consent to share vaccine records to improve the efficiency for public health to prevent the spread of infectious diseases.

The Ministry might also consider being the Health Information Custodian for immunization records in the DHIR, administering the DHIR in a manner similar to other Ministry assets like the Ontario Laboratory Information System (OLIS) and the Digital Health Drug Repository. This would further simplify the system by eliminating the need for individual agreements between each of the 35 local public health units and the Ministry and streamline the current process where each local PHU must verify immunization records as they are added to the DHIR.

If the Ministry prefers that local medical officers of health remain the health information custodians for the immunization records of their respective health units, a new consent form would be required. A Ministry-approved, IPC-compliant consent form for the collection of non-ISPA/CCEYA information would be needed for use by all 35 public health units prior to the project being implemented.

Having one database containing the immunization records for all Ontarians would also provide added protection and benefit when outbreaks of infectious diseases occur: quickly identifying those that are susceptible and vulnerable and inform the provision of timely vaccinations to interrupt transmission.

Vaccine wastage or inappropriate administration could also be managed by permitting patients and health care providers across the province to easily access recorded immunization histories.

The proposed project is also consistent with the mention in "Ending Hallway Medicine" to consider technology solutions to improve health outcomes for patients, to integrate care at the local level, and to identify options for integrated health information systems that would facilitate smooth transfers between care settings, in this case from doctor's offices to local public health.

To that end, we thank you again for your announced commitment to this project and look forward to working with your office towards an efficient health care system that meets the needs of Ontarians.

Yours sincerely,

Dr. Chris Mackie
Chair, Council of Ontario Medical Officers of Health

COPY: Dr. David Williams, Chief Medical Officer of Health
Dr. Rueben Devlin, Chair, Premier's Council on Improving Healthcare and Ending Hallway Medicine

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

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Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

July 2, 2019

The Honorable Christine Elliott
Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

Immunization for School Children – Seamless Immunization Registry

On behalf of the Windsor-Essex County Board of Health we are writing to you in support of a letter and accompanying report we received from The Regional Municipality of York where their Regional Council adopted the following recommendation on May 16, 2019:

1. Regional Council endorse the position of the Council of Medical Officers of Health in support of a seamless immunization registry whereby health care providers directly input immunization information at the time of vaccine administration.

Immunization is a crucial part of a heathy lifestyle, preventing disease, reducing health care costs and saving lives. Vaccines are recognized as one of the most successful and cost-effective health investments. Immunization registries electronic systems support the centralized storage and retrieval of immunization events and patient immunization profiles, tracking immunization against vaccine-preventable diseases.

The Electronic Medical Records (EMR) and Digital Health Immunization Repository (DHIR) Integration Project, providing seamless reporting of immunizations from health care providers directly to local public health, will ensure more accurate and efficient vaccine records.

The Windsor-Essex County Health Unit supports the above recommendation, and thanks you for your consideration.

Sincerely,

Gary McNamara, Chair
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Premier Doug Ford
Loretta Ryan, Association of Local Public Health Units
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Council of Medical Officers of Health (COMOH)
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Ontario Boards of Health
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
AMO – Association of Municipalities of Ontario
Corporation of the County of Essex – Clerk's office
Local MP's – Brian Masse, Cheryl Hardcastle, Tracy Ramsey

WINDSOR-ESSEX COUNTY HEALTH UNIT
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July 2, 2019

The Honorable Christine Elliott
Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

On June 20, 2019, the Windsor-Essex County Board of Health passed the following Resolution regarding **Smoke-Free – Smoke/Vape Free Outdoor Spaces** to reduce the exposure of second-hand smoke in outdoor spaces:

Whereas, the legalization of cannabis came into effect October 17, 2018 and the addition of vapour products and cannabis to the *Smoke-Free Ontario Act, 2017*, and

Whereas, outdoor sport and recreation areas, parks, beaches, trails, and playgrounds are intended to promote the health and well-being for all Windsor-Essex County residents, and

Whereas, entrances/exits of municipal buildings, and transit shelters/stops, are other areas of exposure to second-hand smoke, cannabis and vaping, and

Whereas, second-hand smoke has proven to be harmful in particular for vulnerable populations such as youth, and

Whereas, youth are increasingly susceptible to the influence of social normalization, and

Whereas, youth uptake of vaping and exposure to cannabis consumption is increasing.

Now therefore be it resolved that the Windsor-Essex County Board of Health encourages municipalities to prohibit the smoking or vaping of any substance on all municipally owned outdoor sport and recreation properties, as well as parks, beaches, trails, playgrounds, at minimum, 9m from entrances/exits of municipal buildings, transit shelters, and transit stops.

Further, that the Windsor-Essex County Board of Health encourages all Windsor-Essex municipalities to update and adopt smoking by-laws to explicitly prohibit the use of cannabis in public spaces including streets and sidewalks.

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Doug Ford, Premier of Ontario
Hon. Ginette Petitpas Taylor, Minister of Health
Hon. David Lametti, Minister of Justice and Attorney General of Canada
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Centre for Addiction and Mental Health
Association of Local Public Health Agencies – Loretta Ryan
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Cheryl Hardcastle, Tracy Ramsey

St. Thomas Site
Administrative Office
1230 Talbot Street
St. Thomas, ON
N5P 1G9

Woodstock Site
410 Buller Street
Woodstock, ON
N4S 4N2

July 8, 2019

christine.elliott@ontario.ca

The Honourable Christine Elliott
Minister of Health
Ministry of Health
College Park 5th Floor
777 Bay St.
Toronto, ON M7A 2J3

Dear Honourable Christine Elliott,

Re: Concerns about the future delivery of health promotion programs and services in Ontario by public health units

On behalf of the Board of Health for Southwestern Public Health, I am writing to call your attention to Southwestern Public Health's (SWPH) concerns about recent media reports regarding the Province's position on the future delivery of health promotion related programs and services in Ontario. Specifically, the Government of Ontario has noted that the Ministry of Health and Long-Term Care will assume centralized lifestyle messages (e.g. physical activity) and has stated that healthy public policy work (e.g., built environment (bike lanes) is not where public health should invest its resources. Health promotion related activities delivered locally by public health units remains a core function of Public Health and is a critical and tangible driver of ending hallway medicine.

Health Promotion is the methodical and scientific application of a comprehensive approach to address health issues. Health promotion professionals offer expertise and resources to achieve good health by building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, reorienting health care services towards prevention of illness and injury and the promotion of health.

Locally, this includes a wide variety of programs and services which often are offered in partnership and collaboration with municipalities, community agencies and residents of the community. Some examples of partnerships with local municipalities include:

- Supporting municipalities with bylaw or policy development consultation, training, representation at municipal meetings, and public education related to tobacco, and e-cigarettes. SWPH has supported area municipalities when implementing Smoke-Free Bylaws and Smoke Free Social Housing Policies including consultation on policy wording, support to staff, as well as providing smoking cessation services to housing residents.
- Public Health led the securement of $1.94 million dollars in a public and private partnership with area developers and the City of St. Thomas to build a network of off-road trails and improve walkability.

- Partnering with all Elgin St Thomas municipalities to develop, promote and measure the implementation of a comprehensive cycling network across the entire County. This work netted our community a recent Bronze Bicycle Friendly Communities Award. This work is important for individual residents' health but is also recognized as an important economic development driver by the Ministry of Tourism.

- Prior to cannabis legalization, SWPH engaged with municipalities and provided them with key resources to assist in making the decision around opting in or opting out of hosting a cannabis retailer.

The service our Health Promotion staff provide to our local communities is varied and diverse. Health Promotion work cannot be done without the dedicated partners across the Southwestern region. Some additional examples include:

- By building strong relationships with our area school boards, Public Health can be responsive to local needs and work in partnership with the school boards to create evidence-informed education on relevant issues facing youth. A recent example relates to education provided regarding cannabis. Education sessions were created and delivered in collaboration with SWPH and reflected accurate, unbiased information for staff and students. Public Health continues to promote and model comprehensive school health to improve student well-being thereby improving learning.
- Public health has taken a leadership role in gathering a diverse group of community stakeholders and people with lived experience to develop and now implement the Oxford County Community Drug and Alcohol Strategy. A community driven strategy that includes both population-level and targeted approaches to address problematic substance use in Oxford County.

There have been many studies completed on the Return on Investment (ROI) of public health, including the positive impact of health promotion interventions.[3] In the U.S., researchers have estimated that every dollar spent on prevention and health promotion results in a $3.48 financial return in reduced costs to the medical system. [1] In Ontario, between 2006 and 2017, the Ministry of Health & Long-Term Care has provided a total of $465 million in support of the *Smoke-free Ontario Act,* and during this time the smoking rate declined from 22.3% in 2003 to 17.4% in 2014. This decline in smoking between 2004 and 2013 was responsible for approximately $4.1 billion of avoided costs, representing a significant return on investment. [2]

The Smoke-free Ontario strategy is an excellent example of the Government of Ontario and public health units coordinating and working together on developing and implementing healthy public policy province-wide and thereby enhancing the well-being of people. There are additional opportunities to continue this progressive relationship. For example, the Government of Ontario and public health units should work together on developing a comprehensive province-wide strategy to minimize alcohol related harm, and to support safer consumption of alcohol in the province.

Effective health promotion is needed now more than ever as communities deal with the epidemic of chronic diseases. In the Southwestern Public Health region, nine of the ten leading causes of death were due to chronic diseases.[4] With an aging population, increasing rates of obesity, substance use, mental health concerns and injuries the need for health promotion and prevention is growing in order to offset the significant associated financial toll on the provincial health care.

As the pending changes to public health become clearer, it is imperative that the Ministry of Health & Long-Term Care and the new Boards of Health have consideration for the value of Health Promotion in improving the quality of life and health of residents.

Thank you for your consideration.

Sincerely,

Larry Martin
Board Chair, Southwestern Public Health

c. The Hon. Doug Ford, Premier of Ontario
Ernie Hardeman, MPP, Oxford
Jeff Yurek, MPP, Elgin-Middlesex-London
Pegeen Walsh, Executive Director, Ontario Public Health Association
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
County of Elgin
County of Oxford
City of St. Thomas
City of Woodstock
Municipality of Bayham
Municipality of Central Elgin
Municipality of Dutton Dunwich,
Municipality of West Elgin
Town of Aylmer
Town of Ingersoll
Town of Tillsonburg
Township of Blandford-Blenheim
Township of East Zorra-Tavistock
Township of Malahide
Township of Norwich
Township of South-West Oxford
Township of Southwold
Township of Zorra

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York Region

Regional Clerk's Office
Corporate Services

June 21, 2019

Trish Fulton
Middlesex-London Health Unit
50 King Street
London, ON N6A 5L7

Dear Ms. Fulton:

Re: Position and Mandate for a Restructured York Region Public Health

On June 20, 2019 the York Region Board of Health adopted the following recommendations:

1. York Region Board of Health direct the Chair of the Board to send a letter to the Minister of Health, with copy to the Premier of Ontario, to include the following:
    a. Request that the geographic area of the restructured public health entity include only the existing geographic area of York Region.
    b. Request that the governance and operating model of the restructured public health entity maintain the integrated service model which currently exists for York Region Public Health, to continue leveraging of all municipal activities towards addressing the social determinants of health.
    c. Highlight opposition to the cost sharing changes which are estimated to increase the tax levy contributions to public health in the range of $12.7 million.
    d. Highlight that the proposed changes to the operating model and boundaries would create an additional tax levy burden on York Region due to the proposed amalgamation with the Simcoe Muskoka District Health Unit and associated increase in costs.
2. Until the Ministry of Health makes its final decision on the geographic area, and governance and operating models for the new public health entity, York Region Board of Health authorize and direct the Medical Officer of Health to establish a team to engage with the Simcoe Muskoka District Health Unit, guided by the following principles:

a. No significant service loss to York Region residents

b. No reduction in employment for front line positions, given that the population of York Region continues to grow

c. Protect current employees from job loss and maintain years of service as much as possible

d. Ensure that York Region tax levy funding remains in York Region to fund services in the Region

e. Do not exceed, on an annual basis, the total York Region tax levy funding currently contributed to deliver public health services, including both direct and indirect costs

3. York Region Board of Health authorize the Medical Officer of Health to request financial assistance from the Ministry of Health for planning and transition costs related to restructuring York Region Public Health.

4. York Region Board of Health authorize the Medical Officer of Health to retain management consulting resources as required, to advise on the structure and governance of the new public health entity.

5. This report be sent by the Regional Clerk to all nine local municipalities, York Region Members of Provincial Parliament, Canadian Union of Public Employees Local 905 (York Region Unit), Ontario Nurses Association Local 16, the Association of Municipalities of Ontario, the Association of Local Public Health Agencies, the Chief Medical Officer of Health of Ontario, the Ontario Health Agency and the other 34 Boards of Health.

The original staff report is enclosed for your information.

Please contact Dr. Karim Kurji, Medical Officer of Health at 1-877-464-9675 ext. 74012 if you have any questions with respect to this matter.

Sincerely,

Christopher Raynor
Regional Clerk

Attachment

The Regional Municipality of York

Board of Health
June 20, 2019

Report of the Commissioner of Community and Health Services and Medical Officer of Health

Position and Mandate for a Restructured York Region Public Health

1. Recommendations

1. York Region Board of Health direct the Chair of the Board to send a letter to the Minister of Health and Long-Term Care, with copy to the Premier of Ontario, requesting that:

    a. The geographic area of the restructured public health entity include only the existing geographic area of York Region.

    b. The governance and operating model of the restructured public health entity maintain the integrated service model which currently exists for York Region Public Health, to continue leveraging of all municipal activities towards addressing the social determinants of health.

2. Until the Ministry of Health and Long Term Care makes its final decision on the geographic area, and governance and operating models for the new public health entity, York Region Board of Health authorize and direct the Medical Officer of Health to establish a team to engage with the Simcoe Muskoka District Health Unit on the proposed restructuring model proposed by the Ministry, guided by the following principles:

    a. No significant service loss to York Region residents

    b. No reduction in employment for front line positions, given that the population of York Region continues to grow

    c. Protect current employees from job loss and maintain years of service as much as possible

    d. Ensure that York Region tax levy funding remains in York Region to fund services in the Region

    e. Do not exceed, on an annual basis, the total York Region tax levy funding currently contributed to deliver public health services, including both direct and indirect costs

3. York Region Board of Health authorize the Medical Officer of Health to request financial assistance from the Ministry of Health and Long-Term Care for planning and transition costs related to restructuring York Region Public Health.

4. York Region Board of Health authorize the Medical Officer of Health to retain management consulting resources as required, to advise on the structure and governance of the new public health entity.

5. This report be sent by the Regional Clerk to all nine local municipalities, York Region Members of Provincial Parliament, Canadian Union of Public Employees Local 905 (York Region Unit), Ontario Nurses Association Local 16, the Association of Municipalities of Ontario, the Association of Local Public Health Agencies, the Chief Medical Officer of Health of Ontario, the Ontario Health Agency and the other 34 Boards of Health.

2. Summary

This report provides an update to the York Region Board of Health on recent announcements from the Ministry of Health and Long-Term Care (the Ministry) regarding the modernization of Ontario's public health system and the creation of ten new regional public health unit entities by April 1, 2020.

Key Points:

- Changes to Ontario's public health system will require legislative changes, Ministry staff anticipate legislation will be in place this fall, and that there will be consultation with municipalities and independent boards of health

- One of the proposed ten new public health entities would be comprised of York Region Public Health and the Simcoe County portion of the Simcoe Muskoka District Health Unit

- The new public health entity would be a stand-alone, autonomous organization separate from York Region

- The Board of the new public health entity is proposed to be in place by April 1, 2020, York Region Council would no longer serve as the Board of Health and York Region would be required to fund the new entity based on proposed new cost share ratios

- Between April 2020 and April 2021, services are proposed to be transitioned into the new entity

This report recommends the Board of Health advise the Minister of Health on its position regarding the Ministry of Health and Long Term Care's proposal on the size, governance model and administrative model for the new health entity.

- The geographic area of the restructured public health entity should include only the existing geographic area of York Region as the Region's current population is large enough to justify its own health unit, and

- The governance and operating model of the restructured public health entity maintain the models that currently exist for York Region Public Health as the integrated model is effective in addressing the social determinants of health, ensures York Region tax

levy is used to benefit York Region residents, and leverages administrative efficiencies not available in an autonomous model.

Finally, as Ministry staff has requested input on the organizational structure of the new public health entities, this report recommends giving the Medical Officer of Health authorization and a mandate to work with the Simcoe-Muskoka District Health Unit to develop a mutual proposal for consideration by the Province. Given the short timelines, it is important to begin this work in advance of the final decision by the province on the geography, governance model and administrative model for the geographic area of York Region.

3. Background

The 2019 Provincial Budget announced sweeping organizational and governance changes to the public health sector

The province is restructuring the public health system in Ontario from 35 to 10 regional health units. The new entities are proposed to be stand-alone autonomous organizations.

To achieve these proposed changes, Ministry staffs anticipate legislation in fall 2019. As of April 1, 2020, the new public health entity will be in place. As part of the legislative process, the Ministry has indicated there will be consultation with municipalities and independent boards of health. The Ministry also indicated a willingness to receive input on administrative and organizational structures of the new entity.

The proposed geographic area of the public health entity will add an area close to three times the size of York Region

As of April 1, 2020, the new public health entity is proposed to consist of York Region Public Health and the Simcoe County portion of the Simcoe-Muskoka District Health Unit. The merger of Simcoe County with York Region would create the third largest new public health entity in terms of population (after Toronto and the entity that includes Peel/Halton Regions). Planning for York Region's large, diverse and growing population is already a significant undertaking and the size of our geography at present does present operational considerations in how we provide service.

According to the 2016 Census, Simcoe County's population was 520,123 and covers a geographic area of 4,859 square kilometres, nearly three times the size of York Region. On May 15, 2019, the Board of Health for Simcoe Muskoka District Health Unit wrote a letter to the Minister of Health and Long-Term Care advocating that the full territory of their health unit be merged with York Region. This would result in a geographic area of approximately 8,800 square kilometres and a population of 584,562 (2016 Census) (Attachment 1 – Map). This position has been endorsed by three additional health units (Sudbury and District; Timiskaming; and North Bay Parry Sound). The province intends to consult on the geographical boundaries, and they may change.

York Region Public Health, while understanding of the challenges faced by Simcoe Muskoka District Health unit, does not support the merger.

Public Health has a history of integration with York Region human services, maximizing the influence on the social determinants of health and healthy public policy

Public health has been a municipal program since 1833 when the Legislature of Upper Canada allowed local municipalities to establish boards of health. As a municipal service, it helps ensure healthy communities by working with and influencing municipal functions including urban planning, transportation planning, water and waste water, housing, child care, income supports and employment. Many of these supports have direct connections to the social determinants of health (i.e. all of those factors outside of health care services that influence how healthy a community is), demonstrating the many advantages to maintaining a direct municipal connection to public health.

Public health became a Regional function in 1978 and has been fully integrated into Regional strategic planning and operations ever since. Some successes from having public health integrated within Regional service delivery include the passing of the No-Smoking Bylaw, which was greatly facilitated by having a Board of Health that includes political leaders from the local municipalities, and quick access to Regional staff and assets to support public health during the emergencies of SARS in 2003 and H1N1 in 2009. The Region also benefits from the current integrated model. Public health has made significant contributions to healthy public policy including an opioid action plan, built environments that support health, and climate change action plans.

From a departmental level, in 2007 Public Health joined the Region's Community and Health Services Department (CHS), integrating the full range of human services under one leadership group. This has maximized Public Health's ability to address the social determinants through a much broader range of initiatives than it could do on its own through provincially mandated programs under the Ontario Public Health Standards. For example, the Region's Community Investment Fund has been leveraged by Public Health to address health service gaps in the Region such as food insecurity. Public Health and the Social Services Branch partnered to deliver a breast pump discretionary benefit program for people who rely upon Ontario Works income supports. In addition, York Region Public Health operations are more efficient because of the ability to access shared administrative supports within CHS, and access a wide range of specialized expertise from other Regional departments.

York Region Public Health has been recognized as a provincial leader in excellence, innovation and wellness

In June 2019, York Region Public Health applied to become the first public health unit in Ontario to be accredited at the Gold Level against Excellence Canada's stringent Excellence, Innovation and Wellness Standard. This nationally recognized standard scrutinizes the work, culture, deliverables and staff perspectives of working within the Branch. It addresses key

requirements in five specific drivers of: leadership, planning, customers, people and processes.

Prior to applying to be considered for this important distinction, all four public health divisions were successful at receiving Silver Level against the same Excellence, Innovation and Wellness standard.

Some of the past evidence applauded by the assessors from Excellence Canada built on numerous benefits that result from the integration of public health within the Region's structure, including:

- Positive and productive relationships across a range of departments and the local municipalities
- Innovative and effective service delivery
- Several regional guidelines and standards are in place to support compliance with relevant provincial regulations and standards, including human rights, privacy, health and safety, disability, accessibility, employment standards, etc.

Other public health units and organizations are reaching out to York Region Public Health to learn about our accreditation journey.

4. Analysis

Transition into a new public health entity may negatively impact public health services for York Region residents

Public health's integration into the municipal structure has provided more effective opportunities and influence on other municipal activities to improve the lives of York Region residents. The economies of scale and specialized expertise available to the Public Health Branch as part of a large, diverse and multi-service municipal government would be lost with a move to an autonomous board and expanded geographic area. These changes may cause programming to be less effective in addressing the social determinants of health and population health.

Further, York Region has historically provided additional funding beyond the minimum required for cost-sharing. This has enabled public health to address health service gaps to benefit its citizens and meet our local needs with proactive and responsive programs. It is uncertain that the same level of quality services would be affordable under the new model.

Finally, many administrative services are provided to public health through Regional programs including Integrated Business Services Branch (e.g., finance, IT support) and Corporate Services (e.g., human resources). When York Region Public Health is no longer a Regional function, the funding for these services will need to come from the approved public health entity budget. Based on current financial commitments for these costs, there will be service delivery implications if public health needs to use funding that has historically been used to deliver mandated public health programs and services.

There are differences in the populations of York Region and Simcoe County

Despite its close proximity to York Region, there are differences in social determinant of health status indicators between Simcoe County and York Region residents resulting in each health unit providing services in response to the local need of residents. Given the differences in local needs, delivery of services and programs will not be uniform across the proposed new geographic area that would include York Region. This in turn will affect the efficiency of service delivery. For example, there are regional differences in the number of public beaches and casinos that could impact public health service delivery. More specifically, casinos have a number of social and economic issues associated with them including increased alcohol consumption and smoking as well as considerations around gambling addictions and mental health concerns.

5. Financial

Investments in public health save money and improve health

The public health sector receives approximately two per cent of the overall provincial health care budget, yet it provides a high return on investment. Under the proposed modernization plans, this already small portion of the provincial health care budget will be reduced further over the next three years, with the province anticipating $200 million in savings.

Examples of this return on investment include:

- Every $1 invested into adding fluoride to drinking water, saves $38 in dental care
- Every $1 invested into tobacco prevention programs, saves $20 in future health care costs
- Every $1 spent on vaccinating children with the measles-mumps-rubella vaccine, saves $16 in health care costs
- Every $1 spent on early childhood health and development, saves up to $9 in future spending on health, social and justice services
- Every $1 spent on mental health and addictions, saves up to $7 in health care costs and $30 dollars in lost productivity and social costs

Changes to the number of public health units and their funding model are expected to produce future savings

The 2019 Provincial Budget indicated that modernizing public health units in Ontario would lead to future annual savings of approximately $200 million by transitioning from 35 public health units to 10. On the May 9, 2019 teleconference, the Ministry outlined budgetary considerations that will impact the new public health entities moving forward.

First, the Province advised the cost share model is changing starting in 2019. Historically, public health has been funded 75 per cent by the Ministry and 25 per cent from Regional tax levy. Starting April 1, 2019, this will be changed to a 70/30 cost-share agreement. There was

no immediate impact to public health's 2019 budget based on this announcement as the Region has historically funded public health by greater than its 25 per cent minimum requirement and over 30% in 2018. This new cost share arrangement will continue until April 2021 when it changes to a 60/40 arrangement. Subsequently, the Premier announced that retroactive changes in funding would not be implemented in 2019. No further information has been provided by the Province

Second, public health units have been tasked with identifying a 10 per cent reduction in overall spending starting April 2020. The savings are being labelled as "administrative efficiencies" resulting from the reduction of health units and the change in the cost-sharing formula. Neither the 10 per cent estimated reduction nor how the savings are to be identified has been finalized. Any budget reductions to public health funding will have an impact on front-line service delivery that York Region residents rely on.

York Region will be required to continue funding public health programs under the new entity

When the new public health entities are established, public health will no longer be a Regional function. The Region will be required to continue to fund the new entity using tax levy funds allocated under the Regional Mandatory Tax Levy Cost Share. Currently York Region would not be able to deliver on the Ontario Public Health Standards if not for the additional funding the Region provides over and above the Mandatory Tax Levy Cost Share. The impact may be that services decline, or that the costs levied on the Region by the new entity will include funding that is discretionary today.

In addition, the separation of public health from the Region would have implementation costs. It is unclear who would be responsible for these costs. Ministry staff have advised York Region Public Health that additional financial support will be available to support eligible transition costs, such as voluntary attrition packages, severances, new entity transition start-up costs, IT migration and human resources. However, this funding is not guaranteed and specific details have not been announced by the Ministry as of the writing of this report.

York Region will need to engage in transition planning

The Ministry anticipates the actual merger of public health units into the new entities would occur starting April 2020 and extend into 2021/22. It is important that the Medical Officer of Health begin to engage in official discussions with other public health units regarding transition considerations. The Medical Officer of Health will also need to maintain open dialog with Ministry staff to obtain information on transition considerations. This report recommends that the Medical Officer of Health be authorized to request financial assistance from the Ministry of Health and Long-Term Care for planning and transition costs related to restructuring York Region Public Health. Staff will report back to Board of Health in the fall, 2019 as these transition details materialize.

In addition, the Medical Officer of Health has requested authorization to work collaboratively with Simcoe-Muskoka District Health Unit to develop a proposal to the Ministry. Staff would also request Ministry funding for these costs.

6. Local Impact

Separation of York Region Public Health from the Region may temporarily or permanently interrupt progress being made on addressing the Social Determinants of Health

Initial potential impacts include the following:

- Public Health would operate externally from the Region. Currently, York Region Public Health is integrated within the Regional corporate structure and operation. This has facilitated collaborative opportunities, such as the Seniors Strategy, Mental Health Initiative, Built Environments that support health, Outreach Van program, Community Hubs Initiative, the Food Systems Workgroup, the Social Determinants of Health Department Workgroup and the Human Services Planning Board. These collaborations benefit multiple clients and partners, and support a strategic and holistic approach to service planning and delivery. Public Health operating as a separate entity may impede collaborative opportunities going forward.

- Separation of Public Health would impact the Region's ability to align with the provincial direction for integrated human services, and its ability to implement a social determinants service delivery model in York Region. Research suggests that 50% of population health is determined by our social and economic environment (Canadian Medical Association 2013). Many of the social determinants of health are strongly influenced by the actions and decisions of Regional and local municipal governments (for example, water and sanitation, and housing).

7. Conclusion

The changes outlined in the 2019 Provincial Budget are the biggest public health has faced since its inception into the municipal context. Historically public health provides an effective connection between the community and health care system to prevent conditions and factors that increase demands on the acute care system. Public health prevents disease, protects and promotes health and helps ensure fewer people require the more expensive acute care. Public health works when you cannot see it, and it has been working in tandem with municipalities since for nearly 200 years.

Feedback and recommendations to the Ministry encouraging the maintenance of York Region Public Heath's current geographic boundaries and governance structure are required. The letter to the Minister of Health and Long-Term Care advocates for this to protect public health programs and services in York Region that residents have come to rely on.

Administrative, geographic and governance-related changes will not have the same impact using an efficiency finding lens as they will in other public health jurisdictions in Ontario. York Region Public Health is operationally lean and well-positioned to continue to meet the mandate while ensuring excellent, evidence-informed programs and services to residents

when, where and how they need them. Transitioning York Region Public Health into a new entity would result in decreased service delivery that is less responsive to the needs of a growing diverse population.

For more information on this report, please contact Dr. Karim Kurji, Medical Officer of Health, at 1-877-464-9675 ext. 74012. Accessible formats or communication supports are available upon request.

Recommended by:

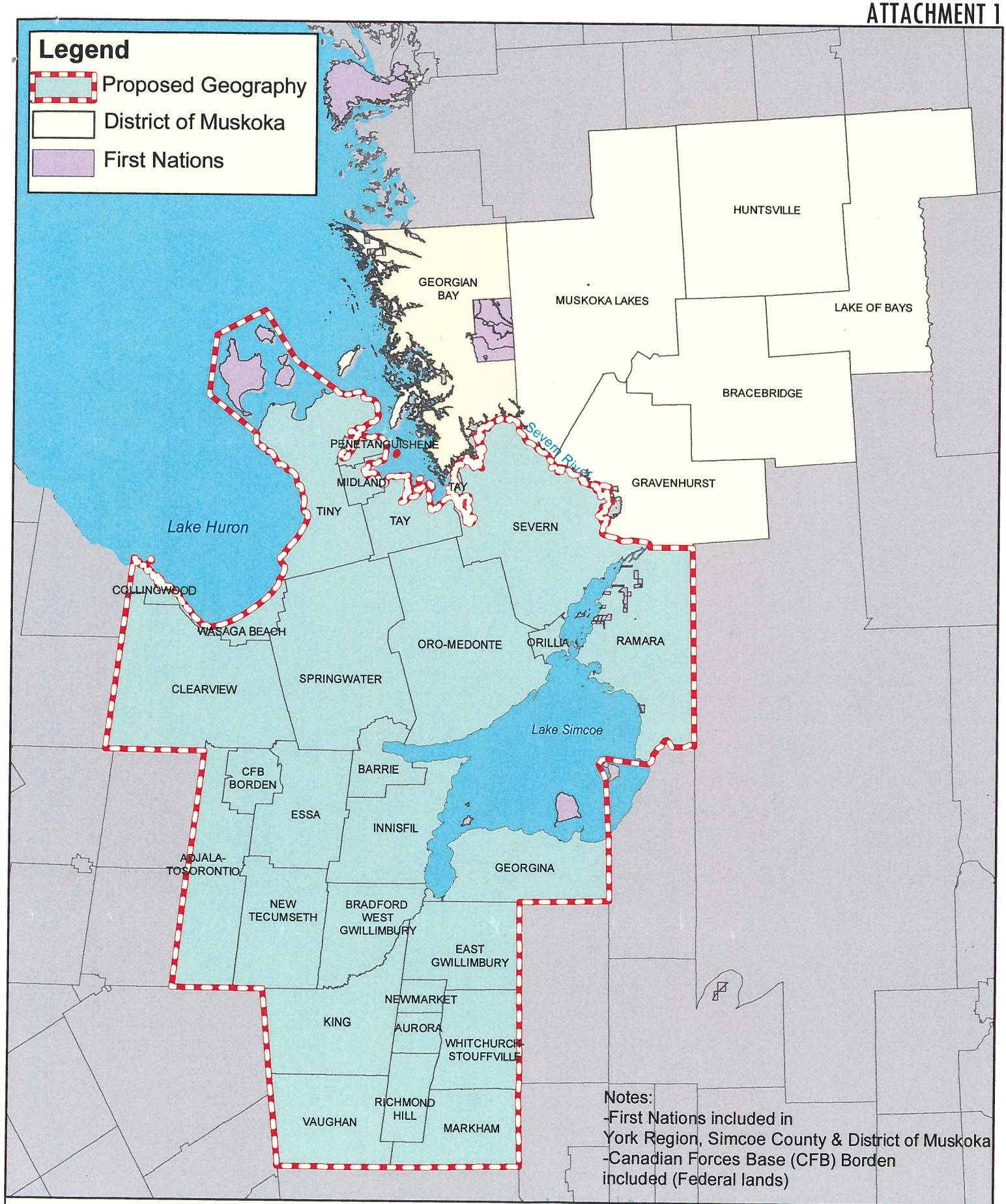
Dr. Karim Kurji
Medical Officer of Health

Katherine Chislett
Commissioner of Community and Health Services

Approved for Submission:

Bruce Macgregor
Chief Administrative Officer

June 12, 2019
Attachment
9629825



Proposed Geography for the New Public Health Entity & District of Muskoka

June 11, 2019

0 5 10 km

York Region

Produced by:
The Regional Municipality of York
Integrated Business Services Branch
Community and Health Services
June 2019

Peterborough Public Health
1889-2019 LOCAL & STRONG

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

July 17, 2019

The Honourable Christine Elliott
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4
Sent via e-mail: christine.elliott@pc.ola.org

Dear Minister Elliot,

Re: Funding Cancelled for Leave the Pack Behind

At its meeting on June 12, 2019, the Board of Health for Peterborough Public Health had the opportunity to review communication from Leave the Pack Behind, a longstanding provincial partner in tobacco prevention and cessation among young adults. On behalf of the Board of Health, I am writing to express our concern over the provincial governments' decision to cease funding for Leave the Pack Behind.

Young adults aged 20 - 24 have the highest prevalence of e-cigarette use and other tobacco products like cigars and water pipes, and one of the highest rates of cigarette use in the province.[1] Additionally, the transition to daily, regular smoking in Ontario is likely established between the ages of 18 and 21 making cessation and prevention programs for young adults more imperative than ever.[2]

In Peterborough, both Fleming College and Trent University have smoke-free campus policies that protect students, staff, and visitors from the involuntary exposure to second-hand smoke and vapour. However, the success of these policies depends on a comprehensive approach to commercial tobacco control that includes cessation support for those that want to make a quit attempt.

Working with Leave the Pack Behind staff at both post-secondary institutions has allowed us to engage hundreds of young adults and inspire dozens of quit attempts that otherwise would not have happened without partnerships and collaboration.

It has been widely reported that the Provincial government has pledged to end 'hallway medicine' and is committed to balancing the budget. Reinstating the funding of this vital program will help the government meet both of those goals as for every dollar spent on tobacco control, $20 are saved in future health care costs.[3,4] Furthermore "there is now a substantial body of evidence showing that the majority of health care expenditures are spent on conditions that are largely preventable."[5]

Leave the Pack Behind was part of a 'no wrong door approach' that supported young adults with their quit attempts. As "tobacco dependence treatment can have a significant impact on health and be very cost-effective when compared with other health system activities"[6] we are urging the Ministry to reconsider the cancelation of this comprehensive and impactful program.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

cc: Hon. Michael Tibollo, Associate Minister of Mental Health and Addictions
Local MPPs
Kelli-an Lawrance, PhD, Director & Principal Investigator of Leave the Pack Behind, Brock University
Heather Travis, Manager, Leave the Pack Behind, Brock University
Ontario Boards of Health
Association of Local Public Health Agencies

[1] https://uwaterloo.ca/tobacco-use-canada/sites/ca.tobacco-use-canada/files/uploads/files/tobacco_use_in_canada_2019.pdf
[2] https://tobaccocontrol.bmj.com/content/14/3/181
[3] https://jech.bmj.com/content/jech/71/8/827.full.pdf
[4] https://www.youtube.com/watch?v=TVZxtuZhN_M
[5] https://www.cpha.ca/making-economic-case-investing-public-health-and-sdh
[6] https://www.ccohealth.ca/sites/CCOHealth/files/assets/CCOChronicDiseaseReport.pdf

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1889-2019 LOCAL & STRONG

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July 19, 2019

The Right Honourable Justin Trudeau
Prime Minister of Canada
justin.trudeau@parl.gc.ca

The Hon. Maxime Bernier, MP, Beauce
Leader, People's Party of Canada
maxime.bernier@parl.gc.ca

Yves-François Blanchet
Leader, Bloc Québécois
3750, boul. Crémazie Est
bureau 402
Montréal, QC H2A 1B6

Elizabeth May, MP, Saanich - Gulf Islands
Leader, Green Party of Canada
elizabeth.may@parl.gc.ca

The Hon. Andrew Scheer, MP, Regina - Qu'Appelle
Leader, Conservative Party of Canada
andrew.scheer@parl.gc.ca

Jagmeet Singh, MP, Burnaby South
Leader, New Democratic Party of Canada
jagmeet.singh@parl.gc.ca

Dear Prime Minister Trudeau and Federal Party Leaders:

Re: Support for a National School Food Program

The Board of Health for Peterborough Public Health requests that you honour and move forward with implementing a cost-shared, national school food program, as outlined in the Federal healthy eating policy with a commitment of resources.

Universal access to healthy food every day at school could improve students' food choices and support their academic success (including academic performance, reduced tardiness and improved student behaviour). An important step towards health equity, universal healthy school meals contribute to students' physical and mental health. Its' success requires all levels of government to be engaged and supportive. Canada is the only G7 country that does not provide federal funding or resources to support school food and nutrition programs.

Our Board of Health supports initiating consultations to develop an adequately funded national cost-shared school food program. As public health experts with extensive experience working with Ontario student nutrition programs, we urge that a universal program include appropriate nutrition education and food safety training of staff and volunteers, provide an optional and culturally appropriate daily nutrition meal, use best practices in service and delivery, function in inspected and adequately equipped spaces, and provide students with the opportunity to implement Canada's Food Guide key messages; specifically, students are given the opportunity to eat more vegetables and fruit, whole grains and protein foods in a socially inclusive environment where they enjoy, prepare and eat healthy food with others.

A well designed national school food program has the potential to enable children to develop food and nutrition habits they need to lead healthy lives and succeed at school.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

cc: Local MPs
Association of Local Public Health Agencies
Ontario Boards of Health

Office of the Warden

County of Middlesex, 399 Ridout Street North, London Ontario N6A 2P1
klsmith@middlesex.ca

July 22, 2019

Ms. Trish Fulton, Chair
Middlesex-London Board of Health
50 King Street
London, Ontario N6A 5L7

Dear Chairperson Fulton:

On behalf of the Council of the County of Middlesex, I am writing today to follow up on some important financial and operational questions that we have raised in the past and to present some supplementary questions that emerged following a recent presentation by Dr. Mackie to County Council.

I understand that this is a complicated and challenging time to answer questions related to the future of public health services. With this being said, there have been a number of definitive statements made by the MLHU in recent weeks and I would appreciate your timely response to Council's questions.

1. Recently, Dr. Mackie referred to the Public Health Modernization initiative as an amalgamation of Health Units. It is clear to Council that this initiative is intended to be a restructuring that will result in a non-municipal employer being responsible for public health services. Is it your understanding that the province's intent is to establish a new employer responsible for public health services?

2. The Modernization initiative will create a new regional health services employer and as a result, employees currently employed by the MLHU will be entitled to severance costs. Dr. Mackie stated that all reserves and reserve funds will be depleted by April 1, 2020. Have you calculated the anticipated severance costs for the MLHU? Have you calculated the additional employee close-out costs such as ongoing WSIB claims for MLHU employees? In light of these costs, is it a wise course of action for the MLHU Board of Directors to spend all of the reserves and reserve funds on facility costs?

…../2

3. On several occasions over the past two years, County Council stated that it was not appropriate and inefficient to create a service delivery model for Middlesex-London in advance of the provincial restructuring of public health. The pending restructuring of public health was very apparent well before capital decisions by the MLHU Board were made and the pursuit of alternative service delivery models by the province was also a clear direction. In response to these concerns, the MLHU has stated that the new entity providing public health services will undoubtedly need a facility in London and the new MLHU facility will be the best facility to deliver public health services from in the future. Our obvious concern is that a new governance body for public health is under no obligation to utilize an existing facility over the course of the twenty-year life of the lease signed by the MLHU. As a result, it is very possible that our taxpayers will be responsible for the significant cost of a facility with no apparent use for Middlesex residents. To make matters worse, the MLHU has communicated that the 100% municipally funded reserves and reserve funds will be utilized by April 1 for the development of this facility with no guarantee or even assurance that this facility will have a use beyond the restructuring. This is a significant financial risk that the MLHU Board has taken on behalf of our residents. Has the MLHU received any assurances from the Province of Ontario that the facility you are investing our resident's money in for the next twenty years will be utilized by the new public health services entity?

Thank you for your attention to our request for information

Sincerely,

Kurtis Smith, Warden
Middlesex County

From: Kolar, Loren <Loren.Kolar@hamilton.ca>
Sent: Thursday, July 25, 2019 9:52 AM
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health receipt of correspondence - April 14, 2019

Good morning,

At the April 14, 2019 meeting of Hamilton City Council, the following correspondence items were received as part of Board of Health Report 19-004.

(ii) Correspondence from the Association of Local Public Health Agencies respecting the Winter Symposium held on February 21, 2019 (Item 5.3)

That Correspondence from the Association of Local Public Health Agencies respecting the Winter Symposium held on February 21, 2019, be received.

(iii) Correspondence from the Association of Local Public Health Agencies respecting the 2019 Provincial Budget (Added Item 5.4)

That Correspondence from the Association of Local Public Health Agencies respecting the 2019 Provincial Budget, be received.

Please email me directly if you require a copy of the original correspondence.

Loren Kolar
Legislative Coordinator
City Clerk's Office
City Hall, 71 Main St. W., 1st Floor
Hamilton, ON L8P 4Y5
T | (905) 546-2424 ext. 2604
E | loren.kolar@hamilton.ca

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The Legislative Division aims to strengthen and promote local government by facilitating the proceedings of City Council and its Committees, fulfilling the requirements of various Provincial statutes and educating the public to make it understandable and accessible.

From: Kolar, Loren <Loren.Kolar@hamilton.ca>
Sent: Thursday, July 25, 2019 9:55 AM
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health receipt of correspondence - May 22, 2019

Good morning,

At the May 22, 2019 meeting of Hamilton City Council, the following correspondence items were received as part of Board of Health Report 19-005.

(i) Correspondence from Peterborough Public Health respecting Funding for the Healthy Babies, Healthy Children Program (Item 5.1)

(ii) Correspondence from Board of Health for Southwestern Public Health respecting a Vision Screening Funding Request (Item 5.2)

(iii) Correspondence from the Association of Local Public Health Agencies respecting a Post 2018 Municipal Election Flyer (Item 5.3)

(iv) Correspondence from the Association of Local Public Health Agencies respecting the 2019 Ontario Budget (Item 5.4)

(v) Correspondence from the Association of Local Public Health Agencies respecting the 2019 Ontario Budget Highlight's from the Association of Municipalities Ontario (Item 5.5)

(vi) Correspondence from the Association of Local Public Health Agencies respecting the 2019 Ontario Budget and Reducing Investments in Public Health (Item 5.6)

(vii) Correspondence from Kingston, Frontenac and Lennox & Addington Public Health respecting Ontario's Public Health Restructuring (Item 5.7)

(viii) Correspondence from the Thunder Bay District Health Unit respecting their Resolution regarding the Restructuring of Public Health in Ontario (Item 5.8)

(ix) Correspondence from the Perth District Health Unit respecting the 2019 Ontario Budget and the Impact on Public Health (Item 5.9)

(x) Correspondence from the Leeds, Grenville & Lanark District Health Unit respecting the 2019 Ontario Budget (Item 5.10)

(xi) Correspondence from Kingston, Frontenac and Lennox & Addington Public Health respecting their Endorsement of the Children Count Task Force Recommendations (Item 5.11)

(xii) Correspondence from Kingston, Frontenac and Lennox & Addington Public Health, respecting the Announced Expansion of the Sale of Alcohol in Ontario (Item 5.12)

(xiii) Correspondence from Hasting Prince Edward Board of Health, and Hasting Prince Edward Public Health respecting the 2019 Ontario Budget (Item 5.13)

Please email me directly if you require a copy of the original correspondence.

Loren Kolar
Legislative Coordinator
City Clerk's Office
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From: Kolar, Loren <Loren.Kolar@hamilton.ca>
Sent: Thursday, July 25, 2019 9:58 AM
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health receipt of correspondence - July 12, 2019

Good morning,

At the June 12, 2019, 2019 meeting of Hamilton City Council, the following correspondence items were received as part of Board of Health Report 19-007.

(ii) Correspondence from Peterborough Public Health respecting Changes to Provincial Autism Supports (Item 5.2)

(iii) Correspondence from the Association of Local Public Health Agencies respecting Corrections to Resolution A19-9, Public Health Support for Accessible, Affordable, Quality Licensed Child Care (Item 5.3)

(iv) Correspondence from Peterborough Public Health respecting the Association of Local Public Health Agencies response to their Financial Changes to Local Public Health resolution (Item 5.4)

Loren Kolar
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E | loren.kolar@hamilton.ca

Vision:
The Legislative Division is Dedicated to Excellence in the Provision of Service to the Community, Corporation & Council with Integrity, Accuracy and Transparency.

Mission:
The Legislative Division aims to strengthen and promote local government by facilitating the proceedings of City Council and its Committees, fulfilling the requirements of various Provincial statutes and educating the public to make it understandable and accessible.

Administration
Office of the Regional Clerk
1815 Sir Isaac Brock Way, PO Box 1042, Thorold, ON L2V 4T7
Telephone: 905-685-4225 Toll-free: 1-800-263-7215 Fax: 905-687-4977
www.niagararegion.ca

July 19, 2019

Council Session, July 18, 2019
Public Health and Social Services Committee Session, July 9, 2019
PHD-C 06-2019, July 9, 2019

ALL BOARDS OF HEALTH

SENT ELECTRONICALLY

Resolution Respecting Proposed Provincial Restructuring of Local Public Health Agencies
PHD-C 06-2019

Regional Council, at its meeting held on July 18, 2019, passed the following resolution:

WHEREAS the Provincial Government has announced restructuring local public health agencies from 35 public health units to 10 new Regional Public Health Entities, governed by autonomous boards of health;

WHEREAS the Province expects to reduce provincial spending on local public health by $200 million by 2021-22 from a current provincial budget for local public health of approximately $750 million;

WHEREAS the Province is adjusting the cost-sharing formula with municipalities for local public health;

WHEREAS municipalities such as Niagara, Hamilton, and most others have been contributing more than their 25% share under Provincial policy for many years in order to ensure community needs are met based on the Ontario Public Health Standards, as set out by the provincial government;

WHEREAS the announcements do not contain sufficient detail to be able to fully understand the costs and implications of the proposed restructuring;

WHEREAS the scale of the proposed changes to the governance, organization and funding of local public health is unprecedented in Ontario;

WHEREAS the role of municipal councils is not clear in the proposed restructuring;

WHEREAS local public health agencies that are part of local government such as Niagara already achieve significant administrative efficiencies through the economies of scale from being part of much larger organizations than the future Public Health Entities;

WHEREAS local public health benefits from significant collaboration with social service, planning, recreation, and transportation services all of which address the social determinants of health and determine half of health outcomes;

WHEREAS separating public health agencies that are part of local government may have unintended negative consequences such as reducing municipal leadership on public health issues, reducing transparency and public scrutiny, as well as reducing effectiveness in collaboration on the social determinants of health;

WHEREAS the announcements appear to have a significant likelihood to impact on the delivery of local public health services;

WHEREAS Niagara Regional Council confirms its support of its public health staff in all the work that they do;

WHEREAS lessons from the past show that when the public health system is weakened, serious consequences occur;

WHEREAS expert reports, such as those following Walkerton's drinking water contamination and the outbreak of Severe Acute Respiratory Syndrome (SARS) have highlighted the need for a strong and independent public health sector to protect the health and safety of the public;

WHEREAS local public health has a unique mandate that focuses on upstream approaches to prevent injuries and illness before they occur, as well as health protection measures that contribute to the safety of our food, water, and environment, and protect us from infectious diseases;

WHEREAS the evidence shows that the success of prevention is largely invisible, but the social and economic returns on these investments are immense with every dollar invested in public health programming saving on average eight dollars in avoided health and social care costs;

WHEREAS to achieve health and reduce "hallway medicine" both a strong health care and a strong public health system are needed;

WHEREAS the independence of the Board of Health and the Medical Officer of Health as the doctor for the community are essential parts of a strong and transparent public health system;

WHEREAS local perspectives add value to provincial priority-setting and decision making;

WHEREAS significant advances in public health have been led through local action, such as the development of tobacco control bylaws; and

WHEREAS the Province has indicated a willingness to consult with boards of health and municipalities on the phased implementation of the proposed changes.

NOW THEREFORE BE IT RESOLVED:

1. That Regional Council **THANKS** the Premier and the Minister of Health for responding to feedback by municipalities to delay funding changes to public health and other municipally operated health and social services;
2. That the Regional Chair **BE DIRECTED** to write a letter to the Minister of Health and the Minister of Municipal Affairs and Housing to request that any restructuring or modernization of local Public Health ensure adherence to the following principles:
    i. That its unique mandate to keep people and our communities healthy, prevent disease and reduce health inequities be maintained;
    ii. That its focus on the core functions of public health, including population health assessment and surveillance, promotion of health and wellness, disease prevention, health protection, and emergency management and response be continued;
    iii. That sufficient funding and human resources to fulfill its unique mandate are ensured;
    iv. That the focus for public health services be maintained at the community level to best serve residents and lead strategic community partnerships with municipalities, school boards, health care organizations, community agencies and residents;
    v. That there be senior and medical leadership at the local public health level to provide advice on public health issues to municipal councils and to participate in strategic community partnerships;
    vi. That local public health services be responsive and tailored to the health needs and priorities of each local community, including those of vulnerable groups or those with specific needs such as the indigenous community;
    vii. That representation of municipalities on any board of health be proportionate to both their population and to the size of the financial contribution of that municipality to the regional Public Health Entity; and
    viii. That any transition be carried out with attention to good change management, and while ensuring ongoing service delivery;
3. That the Regional Chair **BE DIRECTED** to work with MARCO/LUMCO and AMO to describe the benefits of Public Health remaining fully integrated with other Niagara Region functions;
4. That the Medical Officer of Health **BE DIRECTED** to continue to report to the Board of Health in a timely manner as any new developments occur;

5. That at a minimum, the Chair of the Board of Health or co-Chair (Public Health) of the Public Health & Social Services Committee **PARTICIPATE** in Ministry consultations with boards of health on public health restructuring, and through the Association of Local Public Health Agencies (alPHa); and
6. That this resolution **BE CIRCULATED** to the Minister of Health, the Minister of Municipal Affairs and Housing, all municipalities, all Boards of Health, AMO, MARCO/LUMCO, and the Association of Local Public Health Agencies.

A copy of PHD-C 06-2019 is enclosed for your reference.

Yours truly,

Ann-Marie Norio
Regional Clerk
:KL

CLK-C 183-2019

In accordance with the notice and submission deadline requirements of Sections 18.1 (b) and 11.3, respectively, of Niagara Region's Procedural By-law, the Regional Clerk received from Councillor Ip a motion to be brought forward for consideration at the June 20, 2019 Council meeting respecting Response to Proposed Provincial Restructuring of Local Public Health Agencies.

Response to the Proposed Provincial Restructuring of Local Public Health Agencies

WHEREAS the Provincial Government has announced restructuring local public health agencies from 35 public health units to 10 new Regional Public Health Entities, governed by autonomous boards of health;

WHEREAS the Province expects to reduce provincial spending on local public health by $200 million by 2021-22 from a current provincial budget for local public health of approximately $750 million;

WHEREAS the Province is adjusting the cost-sharing formula with municipalities for local public health;

WHEREAS municipalities such as Niagara, Hamilton, and most others have been contributing more than their 25% share under Provincial policy for many years in order to ensure community needs are met based on the Ontario Public Health Standards, as set out by the provincial government;

WHEREAS the announcements do not contain sufficient detail to be able to fully understand the costs and implications of the proposed restructuring;

WHEREAS the scale of the proposed changes to the governance, organization and funding of local public health is unprecedented in Ontario;

WHEREAS the role of municipal councils is not clear in the proposed restructuring;

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WHEREAS Niagara Regional Council confirms its support of its public health staff in all the work that they do;

WHEREAS lessons from the past show that when the public health system is weakened, serious consequences occur;

WHEREAS expert reports, such as those following Walkerton's drinking water contamination and the outbreak of Severe Acute Respiratory Syndrome (SARS) have highlighted the need for a strong and independent public health sector to protect the health and safety of the public;

WHEREAS local public health has a unique mandate that focuses on upstream approaches to prevent injuries and illness before they occur, as well as health protection measures that contribute to the safety of our food, water, and environment, and protect us from infectious diseases;

WHEREAS the evidence shows that the success of prevention is largely invisible, but the social and economic returns on these investments are immense with every dollar invested in public health programming saving on average eight dollars in avoided health and social care costs;

WHEREAS to achieve health and reduce "hallway medicine" both a strong health care and a strong public health system are needed;

WHEREAS the independence of the Board of Health and the Medical Officer of Health as the doctor for the community are essential parts of a strong and transparent public health system;

WHEREAS local perspectives add value to provincial priority-setting and decision making;

WHEREAS significant advances in public health have been led through local action, such as the development of tobacco control bylaws; and

WHEREAS the Province has indicated a willingness to consult with boards of health and municipalities on the phased implementation of the proposed changes.

NOW THEREFORE BE IT RESOLVED:

1. That Regional Council **THANKS** the Premier and the Minister of Health & Long Term Care for responding to feedback by municipalities to delay funding changes to public health and other municipally operated health and social services;

2. That the Regional Chair **BE DIRECTED** to write a letter to the Minister of Health & Long Term Care and the Minister of Municipal Affairs and Housing to request that any restructuring or modernization of local Public Health ensure adherence to the following principles:

    i. That its unique mandate to keep people and our communities healthy, prevent disease and reduce health inequities be maintained;

    ii. That its focus on the core functions of public health, including population health assessment and surveillance, promotion of health and wellness, disease prevention, health protection, and emergency management and response be continued;

    iii. That sufficient funding and human resources to fulfill its unique mandate are ensured;

    iv. That the focus for public health services be maintained at the community level to best serve residents and lead strategic community partnerships with municipalities, school boards, health care organizations, community agencies and residents;

    v. That there be senior and medical leadership at the local public health level to provide advice on public health issues to municipal councils and to participate in strategic community partnerships;

    vi. That local public health services be responsive and tailored to the health needs and priorities of each local community, including those of vulnerable groups or those with specific needs such as the indigenous community;

vii. That representation of municipalities on any board of health be proportionate to both their population and to the size of the financial contribution of that municipality to the regional Public Health Entity; and

viii. That any transition be carried out with attention to good change management, and while ensuring ongoing service delivery;

3. That the Regional Chair **BE DIRECTED** to work with MARCO/LUMCO and AMO to describe the benefits of Public Health remaining fully integrated with other Niagara Region functions;

4. That the Medical Officer of Health **BE DIRECTED** to continue to report to the Board of Health in a timely manner as any new developments occur;

5. That at a minimum, the Chair of the Board of Health or co-Chair (Public Health) of the Public Health & Social Services Committee **PARTICIPATE** in Ministry consultations with boards of health on public health restructuring, and through the Association of Local Public Health Agencies (alPHa); and

6. That this resolution **BE CIRCULATED** to the Minister of Health & Long Term Care, the Minister of Municipal Affairs and Housing, all municipalities, all Boards of Health, AMO, MARCO/LUMCO, and the Association of Local Public Health Agencies.

From: Loretta Ryan <loretta@alphaweb.org>
Sent: Thursday, July 25, 2019 4:06 PM
To: All Health Units
Subject: Update for the alPHa Membership on Public Health Modernization

Update for the alPHa Membership on Public Health Modernization

It is anticipated the Minister of Health will soon be seeking input and advice on the province's next steps regarding public health modernization and looking for feedback on matters such as roles and responsibilities for the province and the new regional entities; governance structure including performance, accountability, and strategies to address community needs; leadership models and other change management and implementation considerations. Consultations were expected to start in July but have not yet taken place. alPHa continues to urge the government to consult with our members as soon as possible. Once consultations are underway, members will be invited to provide input for consideration for inclusion in the alPHa submission.

alPHa supports a strong local public health system in Ontario that maintains a focus on the wellbeing of Ontario's residents, increases efficiencies in service delivery, advances alignment with the health care system, enhances staff recruitment and retention, and improves public health promotion and protection. In keeping with this and, in addition to numerous post-budget activities, alPHa has recently undertaken the following:

- Letter to the Minister of Health regarding Resolution A19-12 on June 21st.
- Letter to the Minister of Health on Digital Public Health on June 28th.
- Meetings with the staff from the Office of the Chief Medical Officer of Health (June through July).
- Meeting with the Deputy Premier and Minister of Health, Hon. Christine Elliott, on July 9th.
- Letter to the Chief Medical Officer of Health on Indigenous Engagement on July 11th.
- The Minister and Chief Medical Officer of Health have been invited to speak with alPHa members about Public Health Modernization on November 6th at the upcoming alPHa Fall Symposium. (Further details on the symposium are coming soon.)

Updates, submissions, and other information can be found at: alPHa's Public Health Modernization page and alPHa Correspondence. Members are encouraged to frequently check these pages.

Loretta Ryan, CAE, RPP
Executive Director
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto, ON M5B 1J3
Tel: 416-595-0006 ext. 22
Cell: 647-325-9594
loretta@alphaweb.org
www.alphaweb.org

From: Kolar, Loren <Loren.Kolar@hamilton.ca>
Sent: Friday, July 26, 2019 10:46 AM
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health endorsements - March 27, 2019 (Items 5.1, 5.2 and 5.13)
Attachments: EDRMS-#636528-v1-05_1 _Communications_Durham_Motion_re_Cannabis_Use_in_Public_Places.pdf; EDRMS-#636529-v1-05_2 _Communications_Windsor_Essex_County_Health_Unit_Smoke_Free_Ontario_Act_2017 _and_Cannabis_Legislation.pdf; EDRMS-#636540-v1-5_13 _Communications_Renfrew_County_and_District_Health_Unit_SFOA_2017 _Promotion_of_Vaping.pdf

At the March 27, 2019 City Council meeting, the following correspondence items were endorsed, as part of the Board of Health Report 19-003:

(i) Correspondence from the Regional Municipality of Durham respecting their Cannabis Use in Public Places Resolution (Item 5.1)

(ii) Correspondence from the Windsor Essex County Health Unit respecting the Smoke Free Ontario Act, 2017 and Cannabis Legislation (Item 5.2)

(iii) Correspondence from the Renfrew County and District Health Unit respecting Strengthening the Smoke-Free Ontario Act, 2017 to Address the Promotion of Vaping (Item 5.13)

The original correspondence items have been attached for your information.

Loren Kolar
Legislative Coordinator
City Clerk's Office
City Hall, 71 Main St. W., 1st Floor
Hamilton, ON L8P 4Y5
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DURHAM REGION

The Regional Municipality of Durham

Corporate Services Department
Legislative Services

605 Rossland Rd. E.
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905-668-7711
1-800-372-1102
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Don Beaton, BCom, M.P.A.
Commissioner of Corporate Services

January 31, 2019

The Honourable Doug Ford
Premier of Ontario
Minister of Intergovernmental Affairs
Room 281
Legislative Building, Queen's Park
Premier's Office
Toronto ON M7A 1A1

Dear Minister Ford:

RE: Motion re: Cannabis Use in Public Places
Our File: P00

Council of the Region of Durham, at a meeting held on January 30, 2019, adopted the following recommendations of the Committee of the Whole:

"A) Whereas the use of cannabis became legalized in Canada on October 17, 2018; and

B) Whereas every time cannabis is used it can adversely affect learning and remembering, mental health, and mood and feelings; and

C) Whereas regular cannabis use over a prolonged period of time can injure the lungs, adversely affect mental health, and lead to physical dependence or addiction; and

D) Whereas cannabis use in public places combined with its known health effects can adversely affect community safety, such as through impaired driving, etc.; and

E) Whereas Section 11 of Schedule 1 (*Cannabis Act, 2017*) of *The Cannabis, Smoke-Free Ontario and Road Safety Statute Law Amendment Act, 2017*, S.O. 2017, c. 26 – Bill 174 prohibited the use of cannabis in public places; and

F) Whereas Section 11 of Schedule 1 (Amendments to the Cannabis Act, 2017 and Other Acts) repealed Section 11 (Restrictions on places of consumption) of the *Cannabis Act, 2017*; and

G) Whereas Section 12 of the *Smoke-Free Ontario Act, 2017* prohibits the smoking or holding of lighted cannabis in only enclosed public places and workplaces; and

H) Whereas it is desirable to mitigate the human health effects of cannabis use and to de-normalize the use of cannabis in all public places, particularly with respect to children and youth; and

I) Whereas it is also desirable to mitigate the community safety impacts of cannabis use in all public places;

J) Now therefore be it resolved that the Council of the Regional Municipality of Durham urges the Government of Ontario to amend the *Smoke-Free Ontario Act, 2017* such that the smoking or holding of lighted cannabis is prohibited in all public places; and

K) Now be it further resolved that the Councils of Durham's lower-tier municipalities are requested to endorse this resolution; and

L) Now be it further resolved that the Premier of Ontario, Deputy Premier & Minister of Health and Long-Term Care, Attorney General of Ontario, Minister of Finance, Durham's MPPs, Chief Medical Officer of Health, AMO, alPHa and all Ontario Boards of Health be so advised."

Ralph Walton,
Regional Clerk/Director of Legislative Services

RW/np

c: Honourable Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care
The Honourable Caroline Mulroney, Attorney General
The Honourable Victor Fedeli, Minister of Finance
Dr. David Williams, Chief Medical Officer of Health
Pat Vanini, Executive Director, Association of Municipalities of Ontario (AMO)

Loretta Ryan, Executive Director, Association of Public Health Agencies (alPHa)
Rod Phillips, MPP (Ajax/Pickering)
Lorne Coe, MPP (Whitby/Oshawa)
Lindsey Park, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Peter Bethlenfalvy, MPP (Pickering/Uxbridge)
David Piccini, MPP (Northumberland-Peterborough South)
Ontario Boards of Health
Dr. R.J. Kyle, Commissioner and Medical Officer of Health

If you require this information in an accessible format, please contact 1-800-372-1102 ext. 2097.

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

February 11, 2019

The Honorable Caroline Mulroney
Ministry of the Attorney General
McMurtry-Scott Building, 720 Bay Street
Toronto, ON M7A 2S9
Caroline.mulroney@pc.ola.org

Dear Minister Mulroney:

Smoke-Free Ontario Act, 2017 and Cannabis legislation

On behalf of our board of health, I am writing you in support of Peterborough Public Health's (PPH) call to action and shared concern regarding funding associated with the cannabis legislation and the introduction of the *Smoke-Free Ontario Act 2017*.

The Windsor-Essex County Health Unit (WECHU) applauds the ministry on the modernization of smoking regulations in Ontario and welcomes the additional restrictions outlined in the new legislation due to their alignment with local and regional goals related to reducing places of use for harmful products. The consequences however, of the inclusion of electronic cigarette-use and the smoking of cannabis as prohibited products in prescribed places involve the added responsibility of public health tobacco enforcement officers in enforcing these regulations. In addition, the transfer of responsibility from the province to local public health units related to the oversight of tobacconist and specialty vape store authorizations represents an additional burden on administrative and enforcement resources.

Although boards of health were permitted to submit for reimbursement of costs incurred due to the legalization of cannabis, through a one-time grant application process in which the Windsor-Essex County Health Unit requested $197, 392 , there are concerns about the ability to ensure effective enforcement and oversight over the long-term without sustained resources dedicated to enforcement, administration, and public education. To date, no such resources have been received by the Windsor-Essex County Health Unit and there is no guarantee that resources allocated to municipalities to assist with the costs associated with cannabis legalization will be redistributed to public health agencies.

With the introduction of a sustained and dedicated funding model to account for the additional responsibilities introduced through the Smoke-free Ontario Act 2017, as well as those associated with cannabis legalization, public health units across Ontario will be able to efficiently and effectively enforce and provide oversight over these new requirements. Without these supplementary resources, WECHU has significant and legitimate concerns related to its ability to maintain existing programming when these new requirements are taken into account.

The Windsor-Essex County Health Unit thanks you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette, RN, MSc
Chief Executive Officer, Chief Nursing Officer

https://www.wechu.org/board-meetings/january-2019-board-meeting

Encl. Peterborough Public Health – Letter to Hon. Caroline Mulroney – Nov 2018

c: The Hon. Doug Ford, Premier of Ontario
The Hon. Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
Association of Local Public Health Agencies (alPHa)
Association of Municipalities of Ontario (AMO)
Ontario Boards of Health
Local Municipal Councils
Windsor-Essex MPPs
Windsor-Essex Board of Health

Renfrew County and District Health Unit

"Optimal Health for All in Renfrew County and District"

March 04, 2019

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

Dear Minister Elliott,

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

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

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

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

Carried

Sincerely,

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

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

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

7 International Drive, Pembroke, Ontario K8A 6W5 • www.rcdhu.com
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• Immunization 613-735-8653 • Environmental Health 613-735-8654 • Reception 613-732-3629 • Fax 613-735-3067
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Peterborough Public Health

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

November 5, 2018

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

Dear Minister Elliott,

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

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

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

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

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

Sincerely,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

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

---

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

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

From: Kolar, Loren <Loren.Kolar@hamilton.ca>
Sent: Friday, July 26, 2019 11:00 AM
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health Correspondence- April 24, 2019 (Items 5.1 and 5.2))
Attachments: EDRMS-#638658-v1-05_1 _Windsor_Essex_County_Health_Unit_-_Increase_Action_in_Response_to_the_Current_Opioid_Crisis.pdf; EDRMS-#638660-v1-05_2 _City_of_Toronto_-_Expanding_Opioid_Substitution_Treatment_with_Managed_Opioid_Programs.pdf

At the April 24, 2019 City Council meeting, the following correspondence items were endorsed, as part of the Board of Health Report 19-004:

Correspondence from the Windsor Essex County Health Unit in support of Peterborough Health Unit's Support for Increased Actions to the Opioid Crisis (Item 5.1)

The following correspondence item was received:

Correspondence from the Toronto Board of Health, Urging the Ministry of Health and Long-Term Care to Support Managed Opioid Programs (Item 5.2)

The original correspondence has been attached to this email for your information.

Loren Kolar
Legislative Coordinator
City Clerk's Office
City Hall, 71 Main St. W., 1st Floor
Hamilton, ON L8P 4Y5
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Fernandes, Krislyn

From: Elspeth Troy <etroy@wechu.org>
Sent: March-21-19 10:51 AM
To: Premier Doug Ford
Cc: The Right Hon. Justin Trudeau ; The Hon. Ginette Petitpas Taylor, Minister of Health; Christine Elliott (christine.elliottco@pc.ola.org); Dr. Theresa Tam, Chief Public Health Officer of Canada; Dr. David Williams; Loretta Ryan (loretta@alphaweb.org); alPHA ; MPP Lisa Gretzky; MPP Percy Hatfield ; MPP Taras Natyshak ; Sleiman, Ed; Joe Bachetti; Tracy Bailey (tbailey@lakeshore.ca); Gary McNamara, Mayor of Tecumseh, Warden Windsor-Essex County; Snively, Larry; Ken Blanchette - St. Clair Colege (drkenblanchette@gmail.com); Debbie Kane; Judy Lund (jlund@fswe.ca); Carlin Miller ; John Scott; 'Michelle Watters'; Councillor Rino Bortolin; Councillor Fabio Constante; Councillor Chris Holt; Theresa Marentette; Nicole Dupuis; Wajid Ahmed; Kristy McBeth; Dan Sibley; Lorie Gregg
Subject: Support for Increased Actions in Response to the Opioid Crisis
Attachments: Letter of Support-Opioid Crisis-Feb 2019.pdf

Dear Premier Ford,

Please see the attached correspondence from Windsor Essex County Health Unit in support of Peterborough Health Unit's letter Re: Support for Increased Actions in Response to the Opioid Crisis.

Thank you,

ELSPETH TROY | **Executive Assistant | Administration**
Windsor-Essex County Health Unit
1005 Ouellette Avenue, Windsor, N9A 4J8
Ph. 519-258-2146 ext. 1220
Fx. 519-258-6003

Our vision is a healthy community.

Employees of WECHU represented by the Ontario Nurses' Association (ONA) are on strike effective Friday, March 8. To find out which public health services will be impacted, please visit https://www.wechu.org/ona-strike.

WINDSOR-ESSEX COUNTY HEALTH UNIT
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

March 5th, 2019

The Honorable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
Doug.fordco@pc.ola.org

Dear Premier Ford,

Re: Increase actions in response to the current opioid crisis

On behalf of our board of health, I am writing you in support of Peterborough Public Health's request of the federal and provincial government to increase their actions in response to the current opioid crisis.

Throughout Canada the misuse of opioids, particularly fentanyl, is a growing public health crisis resulting in epidemic-like numbers of overdose deaths. In Windsor-Essex we have focused on multi-sector collaboration aimed at addressing the four pillars of harm reduction, prevention, treatment and enforcement. A comprehensive approach such as this requires significant investment and ongoing support and sustainability.

We support our colleagues in urging all levels of government to continue their efforts and support to address the crisis in our province and county with a coordinated pan-Canadian action plan spanning all four pillars of the national drug strategy.

The Windsor-Essex County Health Unit thanks you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

https://www.wechu.org/boh-docs

https://www.peterboroughpublichealth.ca/wp-content/uploads/2019/01/BOH-Agenda-Jan-12-2019-original.pdf

cc: The Right Hon. Justin Trudeau, Prime Minister of Canda
The Hon. Ginette Petitpas Taylor, Minister of Health
The Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. Theresa Tam, Chief Public Health Officer of Canada
Dr. David Williams, Ontario Chief Medical Officer of Health
Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
Windsor-Essex MPP's

Windsor-Essex Board of Health

Peterborough Public Health
1889-2019 LOCAL & STRONG

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

January 7, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
doug.ford@pc.ola.org

Dear Premier Ford,

On behalf of the Board of Health for Peterborough Public Health, I am writing a letter of support for Southwestern Public Health's request of both the provincial and federal governments to increase their actions in response to the current opioid crisis.

Throughout Canada the misuse of opioids, particularly fentanyl, is a growing public health crisis resulting in epidemic-like numbers of overdose deaths. The overall economic cost (healthcare costs, lost productivity costs, criminal justice costs and other direct costs) of substance use in Canada in 2014 was estimated to be $38.4 billion. This estimate represents a cost of approximately $1,100 for every Canadian regardless of age. Opioids contributed $3.5 billion or 9.1% of these total costs.

Our current approaches to managing this situation- focused on changing prescribing practices and interrupting the flow of drugs- have failed to reduce the death toll. An enhanced comprehensive public health approach based on the evidence-informed four pillars of harm reduction, prevention, treatment and enforcement is necessary. This approach should include the meaningful involvement of people with lived expertise as well as stakeholders including Indigenous peoples' governance organizations to establish prevention, harm reduction and health promotion programs that meet the needs of their communities.

The time to act is now. In the Chief Public Health's Officer's Report on the State of Public Health in Canada 2018: Prevention Problematic Substance Use in Youth, Dr. Theresa Tam states that "The national life expectancy of Canadians may actually be decreasing for the first time in decades, because of the opioid overdose crisis".

We are urging all levels of government to continue their efforts to address this crisis in our country with a coordinated pan-Canadian action plan spanning all four pillars of the national drug strategy.

Sincerely,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

/ag
Encl.

cc: The Right Hon. Justin Trudeau, Prime Minister of Canada
The Hon. Ginette Petitpas Taylor, Minister of Health
The Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. Theresa Tam, Chief Public Health Officer of Canada
Dr. David Williams, Ontario Chief Medical Officer of Health
Local MPs
Local MPPs
Association of Local Public Health Agencies
Ontario Boards of Health

SOUTHWESTERN Public Health
Oxford • Elgin • St.Thomas

St. Thomas Site
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Woodstock Site
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Woodstock, ON
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October 24, 2018

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

Dear Honourable Doug Ford,

On behalf of the Southwestern Public Health Board, I am writing to both our provincial and federal government leaders to reinforce the urgency of the opioid poisoning emergency in our country and urge both the provincial and federal governments to increase actions in response to this emergency based on the evidenced-informed four pillar approach of harm reduction, prevention, treatment and enforcement.

There is an expanding opioid crisis in Canada that is resulting in epidemic-like numbers of overdose deaths. These deaths are the result of an interaction between prescribed, diverted and illegal opioids (such as fentanyl) and the recent entry into the illegal drug market of newer, more powerful synthetic opioids. The current approaches to managing this situation – focused on changing prescribing practices and interrupting the flow of drugs – have failed to reduce the death toll and should be supplemented with an enhanced and comprehensive public health approach. Such an approach would include the meaningful involvement of people with lived experience. [1]

We call on both levels of government to support initiatives that address the causes and determinants of problematic substance use, to make all tools and resources available to support efforts to address the opioid crisis at a community level, to expand and strengthen the integration of surveillance information between provincial and federal partners, to expedite approvals for newer therapeutic modalities for medication assisted and opioid substitution treatment, to provide funding to municipalities and regional health services to establish safe consumption facilities, and to support harm reduction and health promotion services needed to mitigate the opioid crisis at a regional level.

Injection drug use is associated with many serious drug-related harms, such as the transmission of blood borne infections (HIV, Hepatitis C, Hepatitis B), and with fatal and non-fatal overdoses and injection site bacterial infections. In some parts of the world, these harms are widespread among people who inject drugs. Access to interventions such as needle and syringe exchange, opioid substitution therapies, naloxone distribution, sharps management strategies, overdose prevention sites, and supervised consumption sites are essential to reducing these harms and improving the health of the people who use drugs.[2]

We are urging both our federal and provincial Ministers of Health to continue their efforts to address this crisis in our country with a coordinated pan-Canadian action plan spanning all four pillars of the national drug strategy.

Sincerely,

Bernie Wiehle
Chair, Board of Health
Southwestern Public Health

copy:

Honourable Justin Trudeau, Prime Minister of Canada
Honourable Ginette Petitpas Taylor, Federal Minister of Health
Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
Honourable Jeff Yurek, Member of Provincial Parliament, Elgin – Middlesex – London
Honourable Ernie Hardeman, Member of Provincial Parliament, Oxford
Association of Local Public Health Agencies
Ontario Boards of Health

1 https://www.cpha.ca/opioid-crisis-canada
2 Harm reduction international www.hri.global/public-health-approaches-to-drug-related-harms

Fernandes, Krislyn

From: Eileen de Villa <Eileen.deVilla@toronto.ca>
Sent: March-12-19 11:37 AM
To: comoh@lists.alphaweb.org
Subject: Expanding Opioid Substitution Treatment with Managed Opioid Programs
Attachments: HL3.02 - Managed Opioid Programs.pdf

ATTN: ONTARIO BOARDS OF HEALTH

Please see the attached report from the Toronto Board of Health urging MOHLTC to support Managed Opioid Programs.

http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2019.HL3.2

Thank you,

Elena Zeppieri
Administrative Assistant to Dr. de Villa
Office of the Medical Officer of Health
Toronto Public Health
Office: 416-338-7820

TORONTO

REPORT FOR ACTION

Expanding Opioid Substitution Treatment with Managed Opioid Programs

Date: February 12, 2019
To: Board of Health
From: Medical Officer of Health
Wards: All

SUMMARY

The opioid poisoning crisis continues unabated in Toronto in large part due to the illicit drug supply, which has become increasingly toxic with fentanyls and other potent drugs. There is a critical need to expand treatment options to include managed opioid programs. This strategy is part of the response to the overdose crisis in British Columbia and Alberta, and is urgently needed in Toronto and elsewhere in Ontario.

Methadone and Suboxone™ are the most commonly offered opioid substitution treatments. These need to be expanded to include managed opioid programs which provide patients with oral or injectable hydromorphone or diacetylmorphine (pharmaceutical heroin) under medical supervision. Managed opioid programs are evidence-based programs that have been shown to increase retention in treatment, reduce the use of street drugs, and decrease crime.

The Province of Ontario recently announced a $102 million funding agreement with the federal government for drug treatment. In the context of the current opioid poisoning crisis, the Ministry of Health and Long-Term Care should target some of this funding to rapidly scale up implementation of managed opioid programs in Toronto and elsewhere in Ontario to help save lives, and improve health outcomes for people who use drugs.

RECOMMENDATIONS

The Medical Officer of Health recommends that:

1. The Board of Health urge the Ministry of Health and Long-Term Care to:

    a. Immediately target operational and capital funding to support rapid scaled up implementation of managed opioid programs (including low barrier models) in Toronto and elsewhere in Ontario given the urgency of the opioid poisoning crisis.

    b. Take immediate action to ensure the required concentrations of managed opioid medications (i.e. 50 milligrams/milliliters and 100 milligrams/milliliters

hydromorphone) are accessible to treat people with opioid use disorder in Ontario. And further, to take the necessary steps to add these medications at the appropriate concentrations to the Ontario Drug Benefit Formulary for the treatment of opioid use disorder.

c. Seek authority from Health Canada to import diacetylmorphine (pharmaceutical heroin) for use as a managed opioid program medication in Ontario.

d. Work with Health Canada and other necessary federal bodies to address barriers to procuring, storing and transporting diacetylmorphine (pharmaceutical heroin) and/or mitigate their effects to facilitate use of this managed opioid program medication, and

e. Ensure that managed opioid medications are universally accessible to all Ontarians who could benefit from these kinds of programs, and that cost is not a barrier.

FINANCIAL IMPACT

There are no financial impacts associated with this report.

DECISION HISTORY

In June 2018, as part of a status report on implementation of the *Toronto Overdose Action Plan*, the Board of Health approved a recommendation supporting urgent implementation of managed opioid programs, including low barrier options.
http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2018.HL27.1

In March 2017, the Board of Health endorsed the *Toronto Overdose Action Plan*, which included recommendations for the provincial and federal governments to expand access to diacetylmorphine (pharmaceutical heroin) and/or hydromorphone as an opioid substitution treatment option.
http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2017.HL18.3

COMMENTS

Opioid deaths in Toronto

The opioid poisoning crisis continues unabated in Toronto as it is elsewhere in the country. In 2017, there were 308 opioid toxicity deaths in Toronto, which is a 66 percent increase from 2016, and a 125 percent increase from 2015[1]. Most of these deaths were accidental, and 71 percent were due to fentanyl as a contributing cause[2]. More detailed information from the Office of the Chief Coroner for Ontario about deaths caused by opioids (for the period of July 1, 2017 to June 30, 2018) found that fentanyl or its analogues were a contributing cause in over 77 percent of these deaths in Toronto, higher than in the rest of Ontario (69 percent)[1].

Preliminary data from the Office of the Chief Coroner for Ontario for the first six months of 2018 shows there were 111 opioid toxicity deaths in Toronto[1]. This number is expected to rise as the cause of death is confirmed for more cases.

Toxic illicit drug supply

The illicit drug supply in Toronto and elsewhere in the province has become increasingly toxic. In 2017, Health Canada's Drug Analysis Service[3] found fentanyl or its analogues 2469 times in drugs seized by Ontario police services, which is a 178% increase from 2016. In the first three months of 2018 (most recent data available), 59% of all heroin samples analyzed in Ontario also contained fentanyl or analogue(s).

Toronto Public Health (TPH) works with community partners to compile and share information about toxic substances, including issuing alerts when there are widespread reports of probable adulterated or particularly harmful drugs. Most recently, in January 2019, TPH issued an alert following many reports of concerning symptoms after use of a particular opioid in the illicit market. Toronto Overdose Prevention Society members worked with the laboratory at the Centre for Addiction and Mental Health to have post-use residue tested from this substance. The results found a toxic mix of different drugs, with a particularly toxic synthetic cannabinoid, AMB-FUBINACA, present along with opioids, cocaine, ketamine, methamphetamine, and other drugs.

Managed opioid programs

Comprehensive substance use treatment in Toronto needs to include a range of options to meet the diverse needs of people with substance use issues. Methadone and Suboxone™ are the most commonly offered opioid substitution treatments. Slow-release oral morphine has also emerged as a more recent opioid substitution medication[4]. These treatment options should be expanded to include managed opioid programs (MOP), which provide patients with oral or injectable hydromorphone (HDM) or diacetylmorphine (DAM or pharmaceutical heroin), along with methadone or slow release oral morphine for overnight relief.

Managed opioid programs have been shown in research and practice to be effective[4] and cost-saving[5]. In reviews of scientific evidence, MOP have demonstrated that they increase people's retention in treatment, reduce use of street drugs, and decrease crime[6]. Cost-effectiveness studies have shown that providing MOP to people for whom current treatment for opioid use disorder (such as methadone) has not worked is good value for the resources invested. Managed opioid programs that provide DAM to people with opioid use disorder who have not responded to other forms of treatment have been in place in several cities in Europe for decades[8]. Diacetylmorphine is available in The Netherlands and Switzerland, where it accounts for about 9 percent of all opioid substitution treatment, and is also available in Germany, England, and Denmark[9]. Managed opioid programs can be delivered in a variety of different models[10] including regulated low-barrier distribution programs[11].

Due to the unpredictability of the current illicit drug supply, there is an urgent need to expand treatment options, and implement managed opioid programs. This strategy is a

key aspect of the response to the overdose crisis in British Columbia and Alberta, and is urgently needed in Ontario.

The Ministry of Health and Long-Term Care (MOHLTC) has just negotiated a new treatment funding agreement ($102 million) with the federal government. Details of how this new funding will be allocated have not been announced, but ensuring some of the funds are targeted to MOP is critical. It is therefore recommended that the MOHLTC immediately target operational and capital funding to support a rapid scale up of MOP in Ontario (including low barrier models) given the urgency of the current opioid poisoning crisis.

Canadian managed opioid programs

In Canada, MOP began in 2005 as a research trial in Vancouver and Montreal[12], and have included the provision of both DAM, and/or HDM. These research trials demonstrated the effectiveness of this treatment option in decreasing both crime and improving retention in drug treatment[12, 13]. Programs based on this research have expanded and are now being delivered by several health care providers in Vancouver to respond to the overdose crisis[14]. New clinics in Surrey, British Columbia and Calgary, Alberta have recently opened, and more are planned. In Ottawa, there is one shelter-based MOP run by Ottawa Inner City Health, which has been successfully stabilizing a small group of people on HDM since late 2017[15]. New innovative programs that distribute HDM pills are being planned in British Columbia.[11]. In addition, clinical and other guidelines have been produced to guide practitioners in the effective delivery of these programs based on best practices[10, 16]. The foundations are therefore in place to scale up the implementation of these kind of programs in Ontario.

The stories from people participating in MOP in Vancouver demonstrate the kind of recovery that is possible with this form of treatment[17]:

"My life is starting to become more manageable… and I'm only two and a half months into it… I'm putting on weight, that's one thing. I'm eating better… It's stabilized my life…I don't wake up in the morning having to figure out what crime I'm going to do to pay for my drugs…and I'm actually looking for other things in my life, like even going swimming, leisure and stuff like that. …And this is only at the start."

"I don't get sick. I sleep all night. I don't do crimes. That's really good."

Barriers to implementation

Despite the evidence on the effectiveness of MOP, and the precedents of programs in other parts of Canada, there are a number of barriers to implementing MOP in Ontario, many of which could be addressed by the MOHLTC.

The current medications used in opioid substitution treatment (methadone and Suboxone™) are listed on the Ontario Drug Benefit Formulary. The costs for these medications are covered for people who are eligible for the Ontario Drug Benefit program (i.e. people aged 65 or older, and people enrolled in the Trillium Drug Program, Ontario Works, or the Ontario Disability Support Program). However, the concentrations of injectable HDM (50mg/ml and 100mg/ml) required as treatment for opioid use

disorder are not listed on the Ontario Drug Benefit Formulary. It is therefore recommended that the MOHLTC take immediate action to ensure the required concentrations of MOP medications (i.e. 50mg/ml and 100mg/ml hydromorphone) are accessible to treat people with opioid use disorder in Ontario. For example, the MOHLTC could provide funding to health care providers or other related organizations to cover the costs of these medications. Because many people who are treated for opioid use disorder are eligible for the Ontario Drug Benefit program, it is also important for the MOHLTC to take the necessary steps to add these medications at the appropriate concentrations to the Ontario Drug Benefit Formulary for the treatment of opioid use disorder.

Diacetylmorphine (pharmaceutical heroin) is currently not available in Ontario. Health Canada must authorize use and importation of this medication, and provinces must request special access. It is therefore recommended that the MOHLTC seek authority from Health Canada to import diacetylmorphine for use as a MOP medication in Ontario.

There are also considerable barriers to procuring, storing and transporting DAM, which make it inaccessible for most potential MOP providers. These regulations are federal as well as provincial, and there is a lack of information from the MOHLTC about who would pay for this medication even if the regulatory barriers to procuring, storing and transporting it were reduced or managed. It is therefore recommended that the MOHLTC work with Health Canada and other necessary federal bodies to address barriers to procuring, storing and transporting diacetylmorphine (pharmaceutical heroin) and/or mitigate their effects to facilitate use of this MOP medication. It is further recommended that the MOHLTC ensure that MOP medications are universally accessible to all Ontarians who could benefit from these kinds of programs, and that cost is not a barrier.

Treatment programs that offer opioid substitution therapies need to offer more than just medication. Supports for people in these programs should include case management, and other psychosocial supports. Health facilities may need to be renovated or expanded to accommodate the supervision of injectable medications. The MOHLTC often provides the funds to support these kind of services in community-based settings.

Conclusion

Managed opioid programs are an important part of a comprehensive response to the opioid crisis, which is associated with considerable preventable and premature deaths. Better treatment options and other services are urgently needed in Toronto to meet the needs of people who use substances and are at high risk of overdose. These treatment options help move people out of the illicit drug market, which is currently contaminated with very potent opioids (such as fentanyl and other analogs), and onto a safe supply of pharmaceutical opioids under medical supervision.

Urgent action and investment is needed from the MOHLTC to rapidly scale up the implementation of MOP in Toronto and elsewhere in Ontario to help save lives and improve health outcomes for people who use drugs.

CONTACT

Jann Houston, Director, Strategic Support, 416-338-2074, jann.houston@toronto.ca

SIGNATURE

Dr. Eileen de Villa
Medical Officer of Health

REFERENCES

1. Toronto Public Health. Toronto Overdose Information System 2019 [Available from: https://www.toronto.ca/community-people/health-wellness-care/health-inspections-monitoring/toronto-overdose-information-system/.
2. Ontario Agency for Health Protection and Promotion (Public Health Ontario). Interactive Opioid Tool 2018 [Available from: https://www.publichealthontario.ca/en/dataandanalytics/pages/opioid.aspx.
3. Health Canada. Drug Analysis Service: Summary report of samples analysed 2017 - Canada.ca 2018 [Available from: https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/drug-analysis-service/2017-drug-analysis-service-summary-report-samples-analysed.html.
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17. Boyd S, Murray D, SNAP, MacPherson D. Telling our stories: heroin-assisted treatment and SNAP activism in the Downtown Eastside of Vancouver. Harm Reduct J. 2017;14(1):27.

From: Kolar, Loren <Loren.Kolar@hamilton.ca>
Sent: Friday, July 26, 2019 11:16 AM
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health endorsements - May 22, 2019 (Items 5.14 and 5.15)
Attachments: EDRMS-#640044-v1-5_14 _To_be_endorsed_Sudbury_and_Districts_Public_Health_Support_for_Bill_S-228 _Child_Health_Protection_Act.pdf; EDRMS-#640045-v1-5_15 _To_be_endorsed_Simcoe_Muskoka_District_Health_Unit_Urgent_Provincial_Action_to_Address_Harms_from_Alcohol_Retail_Sales.pdf

At City Council on May 22, 2019, the following correspondence items were endorsed, as part of Board of Health report 19-005:

Correspondence from Sudbury & Districts Public Health, respecting Support for Bill S-228, the Child Health Protection Act (Item 5.14)

Correspondence from the Simcoe Muskoka District Health Unit, respecting Urgent Provincial Action to Address the Potential Health and Social Harms from the Ongoing Modernization of Alcohol Retail Sales in Ontario (Item 5.15)

Copies of the original correspondence has been attached to this email for your information.

Loren Kolar
Legislative Coordinator
City Clerk's Office
City Hall, 71 Main St. W., 1st Floor
Hamilton, ON L8P 4Y5
T | (905) 546-2424 ext. 2604
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Vision:
The Legislative Division is Dedicated to Excellence in the Provision of Service to the Community, Corporation & Council with Integrity, Accuracy and Transparency.

Mission:
The Legislative Division aims to strengthen and promote local government by facilitating the proceedings of City Council and its Committees, fulfilling the requirements of various Provincial statutes and educating the public to make it understandable and accessible.

Public Health
Santé publique
SUDBURY & DISTRICTS

April 10, 2019

All Ontario Senators
The Senate of Canada
Ottawa, ON K1A 0A4

Dear Honourable Ontario Senators:

Re: Support for Bill S-228, Child Health Protection Act

On behalf of the Board of Health for Public Health Sudbury & Districts, please accept this correspondence reaffirming our full support for Bill S-228, Child Health Protection Act, which, when passed, would ban food and beverage marketing to children under 13 years of age.

Food and beverage advertisements directed at children can negatively influence lifelong eating attitudes and behaviours (including food preferences, purchase requests, and consumption patterns). Regulation of food and beverage marketing to children is considered an effective and cost saving population-based intervention to improve health and prevent disease.

In 2016, the Board of Health supported a motion in support of Bill S-228 and urged the federal government to implement a legislative framework to protect child health by ensuring protection from aggressive marketing of unhealthy food and beverages. Additionally, the Association of Local Public Health Agencies and the Ontario Dietitians in Public Health have submitted letters expressing their full support for Bill S-228.

The Board of Health for Public Health Sudbury & Districts commends you for your leadership in the development of this landmark piece of legislation. Bill S-228 has passed its third reading in the House of Commons and is awaiting royal assent. As a critical step to improving the health of Canadians, we respectfully request that you pass Bill S-228 without further delay.

Sincerely,

René Lapierre, Chair
Board of Health, Public Health Sudbury & Districts

cc: Association of Local Public Health Agencies
Ontario Boards of Health

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Toll-free / Sans frais
1.866.522.9200

phsd.ca

April 17, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister Elliott:

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

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I am writing to urge the Government of Ontario to develop a comprehensive provincial alcohol strategy to mitigate harms and monitor the health impacts of increasing access and availability of alcohol in Ontario.

Alcohol costs to the individual and society are significant. In 2014, Ontario spent $5.34 billion on alcohol-related harms, including $1.5 billion for healthcare and $1.3 billion for criminal justice.[1] Since 2015, alcohol use has contributed to more than 43,000 emergency room visits and 66 hospitalizations per day, a significant and avoidable burden on Ontario's healthcare system.[2]

It is well established that increased alcohol availability leads to increased consumption and alcohol-related harms. A comprehensive, provincially led alcohol strategy can help mitigate the potential harms of alcohol use as the government liberalizes access. Such a strategy should include:

- Strong policies to minimize the potential health and social harms of alcohol consumption;
- An improved monitoring system to track alcohol-related harms;
- Rigorous enforcement of alcohol marketing regulations, and;
- Public education and awareness campaigns aimed at changing attitudes and social norms around consumption.

The Ontario Government has committed to ensure the health and safety of our communities as it increases the availability of alcohol; however, recent changes in the way alcohol is sold and the 2019 Ontario Budget 'Protecting What Matters Most' [3] released on April 11, 2019 suggest that economic interests are superseding the health and well-being of Ontarians and further diminishes the likelihood of meeting the goal of ending hallway medicine. Recent changes that raise the potential for increased alcohol-related harms include reducing the minimum retail price of beer to $1.00, halting the annual inflation-indexed increase in the beer tax, and extending the hours of sale for alcohol retail outlets. This is in conjunction with the anticipated changes of legislation permitting municipalities to designate public areas for consumption of alcohol, advertising happy hour and creating a tailgating permit for eligible sporting events including post-secondary events.

The SMDHU Board of Health has on numerous occasions sent advocacy letters to the provincial government to support healthy alcohol policy, most recently in 2017, calling on the government to

prioritize the health and well-being of Ontarians by enacting a comprehensive, evidence-based alcohol strategy.

We believe it is possible to create a healthy alcohol culture in Ontario that balances interests in public health, government revenue, economic development, and consumer preferences without sacrificing the health of Ontarians. We support both the Council of Ontario Medical Officers of Health and Association of Local Public Health Agencies' request to ensure such a balance, and we thereby encourage the government to develop a provincial alcohol strategy that incorporates health goals.[4, 5] This would include a monitoring and evaluation plan to measure intended and unintended impacts of policy change. Now is the time for Ontario to take leadership and address the harms of alcohol use in our province.

Thank you for your consideration.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

cc. Hon. Vic Fedeli, Minister of Finance
Ken Hughes, Special Advisor for the Beverage Alcohol Review
Doug Downey, MPP Barrie-Springwater-Oro-Medonte
Jill Dunlop, MPP Simcoe North
Andrea Khanjin, MPP Barrie-Innisfil
Norman Miller, MPP Parry Sound-Muskoka
Hon. Caroline Mulroney, MPP York-Simcoe
Jim Wilson, MPP Simcoe-Grey
Dr. David Williams, Chief Medical Officer of Health for Ontario
Loretta Ryan, alPHa Executive Director
Ontario Boards of Health

References

1. The Canadian Centre on Substance Use and Addiction. (2018) Canadian Substance Use Costs and Harms in the Provinces and Territories (2007–2014)
2. Ontario Public Health Association. (2018) The Facts: Alcohol Harms and Costs in Ontario.
3. Ministry of Finance of the Ontario Government, 2019 Ontario Budget Protecting What Matters Most, April 11, 2019 , Honourable Victor Fedeli
4. Council of Ontario Medical Officers of Health, Re: Alcohol Choice & Convenience Roundtable Discussions [Letter written March 14, 2019 to Honorable Vic Fedeli].
5. Association of Local Public Health Agencies, Re: Alcohol Choice & Convenience Roundtable Discussions [Letter written March 8, 2019 to Honorable Vic Fedeli].

From: Kolar, Loren <Loren.Kolar@hamilton.ca>
Sent: Friday, July 26, 2019 11:19 AM
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health endorsements - June 26, 2019 (Item 5.1)
Attachments: EDRMS-#642108-v1-05_1 _Endorse_-_(2019-05-23)_Kingston_Frontenac_Lennox_Addington_Public_Health_-_Health_Promotion_as_Core_Function.pdf

At City Council on June 26, 2019, the following correspondence item was endorsed, as part of Board of Health Report 19-006:

Correspondence from Kingston, Frontenac and Lennox & Addington Public Health respecting Health Promotion as a Core Function of Public Health (Item 5.1)

The original correspondence has been attached to this email for your information.

Loren Kolar
Legislative Coordinator
City Clerk's Office
City Hall, 71 Main St. W., 1st Floor
Hamilton, ON L8P 4Y5
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Vision:
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KFL&A Public Health

May 23, 2019

Received May 23 2019
MOH Office

VIA: Electronic Mail (christine.elliott@pc.ola.org)

Honourable Christine Elliott
Minister of Health and Long-Term Care and Deputy Premier of Ontario
Hepburn Block
10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

RE: Health Promotion as a Core Function of Public Health

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its May 22, 2019 meeting:

THAT the KFL&A Board of Health strongly urge the Government of Ontario to maintain the current health promotion mandate of local public health units; and

THAT the KFL&A Board of Health ask the Government of Ontario to consult with Medical Officers of Health across Ontario should they consider any changes to the health promotion mandate and/or functions of local public health units or future public health entities.

There has been a recent flurry of media attention on public health in Ontario in response to announced changes to the public health system including decreased funding, a change in how public health units are funded, and the transition of 35 public health units to ten regional public health entities. In this media maelstrom, there has been recognition of the importance of public health and the programs and services it provides; however, the current media rhetoric regarding the benefits of public health is almost exclusively focused on the health protection and disease prevention mandates of public health agencies (e.g., preventing and mitigating infectious diseases such as measles and SARS). While these are critical aspects of the work public health provides to our communities, the Provincial Government has been silent on the importance of health promotion as a core function of public health. Furthermore, when health promotion work is mentioned, the Government of Ontario has noted that the Ministry of Health and Long-Term Care will assume centralized lifestyle messages or has noted that the work (e.g., a study of energy drinks or bike lanes) is not where public health should invest its resources. This is worrisome.

. . . / 2

Health promotion is more than just crafting messages and making posters. It is the methodical and scientific application of a comprehensive approach to address health issues. Components of health promotion include strengthening community action, developing personal skills, creating supportive environments, building healthy public policy, and re-orienting the health care system. Health promotion, when used with fidelity, has demonstrated great success. Tobacco is a great example of a health promotion success story. While most people would agree that the policy and taxation levers used by the federal and provincial governments are responsible for the dramatic and sustained drop in smoking rates, it is the work of health promotion that enabled those tools to be created and enacted. It was through successful knowledge translation activities informing the general public of the evidence that smoking causes lung cancer, the evaluation of prevention and cessation programs, and community action and advocacy from non-smokers—all the result of health promotion—that put tobacco on the public's agenda. Once tobacco was on the public's agenda, and recognized as a health hazard, policies were implemented, and continue to be implemented to this day, to protect the public from the harms of tobacco use. Clearly, health promotion is an effective tool to improve the health of the population.

Furthermore, effective health promotion is needed now more than ever as communities across Ontario grapple with the epidemic of chronic diseases. In Ontario, chronic diseases are the leading cause of disability and death and account for nearly 80% of all deaths. With a rapidly aging population, the prevalence of chronic diseases is expected to rise along with a significant associated financial toll on the provincial health care budget. Health care costs in Ontario are projected to account for 70 percent of the provincial budget by 2022 and 80 percent by 2030, making the prevention of chronic diseases a health and financial priority.

Medical Officers of Health -- highly trained and trusted professionals with the expertise to address health threats in their communities -- are well-positioned to determine effective strategies to address common risk factors for chronic disease (i.e., tobacco use, alcohol use, unhealthy eating and physical inactivity) and other factors that impact health such as early childhood development, mental health and the social determinants of health. Medical Officers of Health must be afforded the full slate of public health tools to protect and promote the health of their communities.

. . . / 3

Health protection, disease prevention and health promotion are equally important and core functions of public health. Having a well-resourced public health system with the tools required to address both acute and chronic health threats is the best chance that Ontario has to make our health care system sustainable, to end hallway medicine, and to protect what matters most – health.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Doug Ford, Premier
Ian Arthur, MPP Kingston and the Islands
Randy Hillier, MPP Lanark-Frontenac-Kingston
Daryl Kramp, MPP Hastings-Lennox and Addington
Loretta Ryan, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Canada
Dr. Chris Mackie, Chair, Council of Medical Officers of Health
Susan Stewart, Chair, Ontario Chronic Disease Prevention Managers in Public Health
Monika Turner, Director of Policy, Association of Municipalities of Ontario
Ontario Boards of Health

From: Kolar, Loren <Loren.Kolar@hamilton.ca>
Sent: Friday, July 26, 2019 11:48 AM
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health endorsements - July 12 2019 (Item 5.5 - 5.7))
Attachments: EDRMS-#644570-v1-05_5 _Endorse_-_(2019-06-07)_Sudbury_and_Districts_Public_Health_-_Public_Mental_Health_Parity_of_Esteem_Position_Statement.pdf; EDRMS-#644571-v1-05_6 _Endorse_-_(2019-06-25)_Peterborough_Public_Health_-_Children_Count_Task_Force.pdf; EDRMS-#644572-v1-05_7 _Endorse_-_(2019-05-22)_Windsor_Essex_County_Health_Unit_-_Smoke_Free_Multi_Unit_Dwellings.pdf

At City Council on July 12, 2019, the following correspondence items were endorsed, as part of Board of Health Report 19-007:

(a) Correspondence from Sudbury & Districts Public Health respecting Parity of Esteem Position Statement (Item 5.5)

(b) Correspondence from Peterborough Public Health respecting Support for Children Count Task Force Recommendations (Item 5.6)

(c) Correspondence from the Windsor-Essex County Board of Health respecting Smoke-Free Multi-Unit Dwellings (Item 5.7)

Recommendation: Be endorsed, and referred to staff to prepare a letter addressed to the Prime Minister, copied to the Minister of Health, Hamilton MPPs, the Association of Local Public Health Units, and Ontario Boards of Health in support of the Windsor-Essex County Boards resolution on Smoke-Free Multi-Unit Dwellings.

Copies of the original correspondence has been attached to this email

Loren Kolar
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Peterborough Public Health

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peterboroughpublichealth.ca

5.6

June 25, 2019

The Honourable Todd Smith
Minister of Children, Community and Social Services
Sent via e-mail: ***todd.smith@pc.ola.org***

The Honourable Stephen Leece
Minister of Education
Sent via e-mail: ***minister.edu@ontario.ca***

The Honourable Christine Elliott
Minister of Health and Long-Term Care
Sent via e-mail: ***christine.elliott@pc.ola.org***

Dear Ministers,

Re: Support for Children Count Task Force Recommendations

On behalf of the Board of Health for Peterborough Public Health (PPH), I am writing in support of the recommendations of the Children Count Task Force. These recommendations support the health and wellbeing of Ontario's children and youth by streamlining and improving the systems that monitor and assess their health.

Peterborough Public Health is required as outlined in the Ontario Public Health Standards, 2018 (OPHS) to: "collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to the health of school-aged children and youth and report and disseminate the data and information in accordance with the Population Health Assessment and Surveillance Protocol, 2018".[1]

Unfortunately, measuring the status of child health is not a straight-forward task. Although the assessment and surveillance requirements outlined in the OPHS specify which aspects must be measured and reported, a comprehensive system for monitoring the status of child health in the province has yet to be developed, and there are gaps in indicator development and data collection.[2,3] The existing data only partially measure the health of children in the province, and in some cases even less information is available at the local public health agency level. The collection of relevant provincial and regional data on the full spectrum of child health indicators, with such data being made freely accessible to public health agencies, should be a future goal for Ontario.[4]

As such, we strongly support the Children Count Task Force's overarching recommendation to create a secretariat responsible for overseeing the implementation of the systems, tools, and resources required to improve the surveillance of child and youth health and well-being in Ontario.[5] Additionally, to further support this secretariat, we support the following five recommendations made by the task force:

- ***Recommendation 1:*** Create an interactive web-based registry of database profiles resulting from child and youth health and well-being data collection in Ontario schools.
- ***Recommendation 2:*** Mandate the use of a standardized School Climate Survey template in Ontario schools and a coordinated survey implementation process across Ontario.
- ***Recommendation 3:*** Develop and formalize knowledge exchange practice through the use of centrally coordinated data sharing agreements.
- ***Recommendation 4:*** Develop and implement a centralized research ethics review process to support research activities in Ontario school boards.
- ***Recommendation 5:*** Work with the Information and Privacy Commissioner (IPC) of Ontario to develop a guideline for the interpretation of privacy legislation related to student health and wellbeing data collection in schools.[6]

A strength of the Children Count Task Force and its recommendations is the broad range of perspectives, knowledge and expertise shared by leaders in federal and provincial government agencies and ministries, academics, local public health agencies, boards of education, and non-government organizations. We believe that implementing the recommendations will provide the information that all stakeholders need to properly assess the health status of our children and youth and the return on investment of related programs and services. Furthermore, implementation will result in a more efficient and improved data collection system.

We respectfully request that the Honourable Ministers seriously consider implementing these recommendations and welcome any opportunities to consult or engage in future actions that would support this work.

Thank you for your consideration.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

cc: Hon. Doug Ford, Premier of Ontario
Local MPPs
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Children Count Task Force (c/o Nicole Dupuis, Windsor Essex County Health Unit)
Ontario Boards of Health

References:
1. Ministry of Health and Long-Term Care (2018) Protection and Promoting the Health of Ontarians, Ontario Public Health Standards: Requirements of Programs, Services and Accountability.
2. Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2013) Measuring the Health of Infants, Children and Youth for Public Health in Ontario: Indicators, Gaps and Recommendations for Moving Forward. Queen's Printer for Ontario, Toronto, ON.
3. Association of Public Health Epidemiologists in Ontario (2012).Gaps in Public Health Indicators and Data in Ontario. Public Health Ontario, Toronto.
4. Peterborough Public Health (2018). Early Growth and Development: supporting Local Evidence-informed Decision Making. Peterborough, ON. Gail Chislett, Andrew Kurc and Asma Razzaq.
5. Children Count Task Force. (2019). Children Count: Task Force Recommendations. Windsor, ON. Windsor-Essex County Health Unit.
6. Ibid

WINDSOR-ESSEX COUNTY HEALTH unit
Bureau de santé de Windsor-comté d'Essex

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Leamington 33 Princess Street, Leamington, ON N8H 5C5

May 21, 2019

The Right Honorable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6
Justin.trudeau@parl.gc.ca

Dear Prime Minister Trudeau:

On May 16, 2019, the Windsor-Essex County Board of Health passed the following Resolution regarding **Smoke-Free Multi-Unit Dwellings** to reduce the exposure of second-hand smoke in multi-unit housing:

Whereas, the federal government has passed the Cannabis Act, 2017 to legalize non-medical cannabis, coming into effect on October 17th, 2018, and

Whereas, cannabis smoke contains many of the same carcinogens, toxins, and irritants found in tobacco smoke with the added psychoactive properties of cannabinoids like THC, and

Whereas, Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported, and

Whereas, indoor air studies show that, depending on the age and construction of a building, up to 65% of the air in a private residence can come from elsewhere in the building and no one should be unwillingly exposed or forced to move due to unwanted second-hand smoke exposure,

Now therefore be it resolved that the Windsor-Essex County Board of Health endorse the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

1. Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties and explicitly include cannabis smoke and vaping of any substance in the definition of smoking;

2. All future private sector rental properties and buildings developed in Ontario should be vape and smoke-free from the onset;

3. Encourage public/social housing providers to voluntarily adopt no-smoking and/or vaping policies in their units and/or properties;

4. All future public/social housing developments in Ontario should be smoke and vape-free from the onset.

5. Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.

AND FURTHER that this resolution be shared with the Honorable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Doug Ford, Premier of Ontario
Hon. Christine Elliott, Minister of Health & Long-Term Care
Hon. Ginette Petitpas Taylor, Minister of Health
Hon. David Lametti, Minister of Justice and Attorney General of Canada
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Centre for Addiction and Mental Health
Association of Local Public Health Agencies – Loretta Ryan
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Cheryl Hardcastle, Tracy Ramsey

Public Health
Santé publique
SUDBURY & DISTRICTS

June 7, 2019

VIA EMAIL

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

Dear Minister Elliott:

Re: Public Mental Health – Parity of Esteem Position Statement

I am very pleased to highlight for you the recent decision of the Board of Health for Public Health Sudbury & Districts to formally adopt the Parity of Esteem Position Statement. The Position Statement asserts that public health equally values mental and physical health.

The Parity of Esteem Position Statement is in direct alignment with Bill 116 in its recognition that mental health is an essential element of health. We are very enthusiastic about the provisions within Bill 116 to establish a Mental Health and Addictions Centre of Excellence and to implement a mental health and addictions strategy with sustained commitment from all sectors and levels of government. Please be assured that the Board of Health for Public Health Sudbury & Districts is a committed local partner in this important work.

At its meeting on May 16, 2019, the Board of Health carried the following resolution #15-19:

> *WHEREAS* the Board of Health for Public Health Sudbury & Districts recognizes that there is no health without mental health; and
>
> *WHEREAS* Public Health Sudbury & Districts intentionally adopts the term, public mental health, to redress the widespread misunderstanding that public health means public physical health;

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phsd.ca

> *THEREFORE BE IT RESOLVED THAT* the Board of Health for Public Health Sudbury & Districts endorse the Public Mental Health - Parity of Esteem Position Statement, May 16, 2019; and
>
> *FURTHER THAT* copies of this motion and position statement be forwarded to local and provincial partners including all Ontario boards of health, Chief Medical Officer of Health, local MPPs, Ontario Public Health Association (OPHA), Association of Local Public Health Agencies (alPHa), local municipalities and Federation of Northern Ontario Municipalities (FONOM).

Officially adopting parity of esteem reinforces new, current and ongoing work which has been identified in our Public Mental Health Action Framework. The Framework is action-oriented and provides the roadmap for interventions, articulating our commitment to concepts and investments to improve mental health opportunities for all throughout the Public Health Sudbury & Districts service area.

Our local public health work in mental health will be more sustainable and effective if it is supported by organizational and provincial policies and structures that acknowledge mental health as an explicit goal along with physical health.

Yours sincerely,

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

Enclosure (1)

cc: All Ontario Boards of Health
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
Mr. Jamie West, MPP, Sudbury
Ms. France Gelinas, MPP, Nickel Belt
Mr. Michael Mantha, MPP, Algoma-Manitoulin
Ms. Pageen Walsh, Executive Director, Ontario Public Health Association
Ms. Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Constituent Municipalities within Public Health Sudbury & Districts
Ms. Alison Stanley, Executive Director, Federation of Northern Ontario Municipalities

Position Statement
Parity of Esteem

Position Statement

The Board of Health for Public Health Sudbury & Districts actively supports the concept of parity of esteem, which is defined as equally valuing mental and physical health, for the wellbeing of all in our community. We will intentionally utilise the term public mental health to acknowledge mental health as an explicit goal in addition to the goal for physical health and well-being.
To advance mental health opportunities for all throughout the Public Health Sudbury & Districts service area, the Board further commits to:

- Ensuring that public mental health practice be relevant for everyone, regardless of mental illness diagnoses, with appropriate adaptations,
- Understanding mental health from a social determinants of health perspective and to working to improve equity in mental health,
- Understanding and shining a light on systemic and often hidden prejudice in support of opportunities for mental health for all,
- Privileging the voices of those with lived experiences and their families and carers, and
- Informing our public mental health practice with the aspiration to build hope, empowerment, and resilience in individuals and communities.

Background

Like physical health, mental health and well-being are influenced by the social, economic, and physical environments in which people work, live, and play. We also know that populations with socio-economic disadvantages are disproportionately affected by mental health problems and challenges.

People who experience mental illness and addictions are more likely to die prematurely than the general population. Mental illness can cut 10 to 20 years from a person's life expectancy. The disease burden of mental illness and addiction in Ontario is 1.5 times higher than all cancers put together and more than seven times that of all infectious diseases. This includes years lived with less than full function and years lost to early death. ,

The 2018 Ontario Public Health Standards (OPHS) identifies mental health in its mandate. Local public health must address mental health, focusing on mental health promotion, prevention, and early identification and referral. Within OPHS, the role of public health "is to support and protect the physical and mental health and well-being, resiliency and social connectedness of the health unit population . . . reaching all . . . with a special focus on those with greater risk of poor health outcomes".

Public Health Sudbury & Districts supports the concept of parity of esteem, or equally valuing mental and physical health. We support the assertion that our work in mental health will be more sustainable and effective if it is supported by organizational policies that acknowledge mental health as an explicit goal, while recognizing that it is also fundamental to physical health and well-being . There is no health without mental health.

The Public Mental Health Action Framework is Public Health Sudbury & Districts' roadmap that will assist us in putting into practice parity of esteem. The goals and outcomes for public mental health are and will be overarching and cross sectoral within our responsibilities. As outlined in the Framework, we will need to be intentional in our current work, in identifying how to further leverage what we are already doing and systematically identify new areas for public mental health initiatives. There is a role for everyone.

Commitments of Public Health

Our Public Mental Health Action Framework articulates our five commitments to concepts and investments to improve mental health opportunities for all throughout the Public Health Sudbury & Districts service area.

1. Mental Health for All: Public Health Sudbury & Districts is committed to ensuring that public mental health practice be relevant for everyone, regardless of mental illness diagnoses, with appropriate adaptations. Mental health and mental illness are distinct but related concepts. These concepts intersect and coexist in individuals and populations. Persons with serious mental illness or addiction can experience good mental health. Persons with no mental illness or addiction can experience poor mental health or difficulty coping.

2. Social Determinants of Mental Health: Public Health Sudbury & Districts is committed to understanding mental health from a social determinants of health perspective and to working to improve equity in mental health. The social determinants of mental health are understood to be the same as those determining physical health. They are the societal factors that underpin and drive individual-level risk and protective factors for disease.

3. Anti-stigma and Discrimination: Public Health Sudbury & Districts is committed to understanding and shining a light on systemic and often hidden prejudice in support of opportunities for mental health for all. Many who live with mental health and addictions problems have reported experiencing discrimination at work, from family and friends, within imagery found in the media, while attempting to secure housing, within health services or the justice system. Living with mental health problems or addictions can be accompanied by self-stigma and shame that is further reinforced by societal reactions. ,

4. Voices of People with Lived Experience: Public Health Sudbury & Districts is committed to privileging the voices of those with lived experiences and their families and carers. This will take place through collaboration with people with lived experience, connections with family and carers, transparency and accountability.

5. Hope, Belonging, Meaning and Purpose: Public Health Sudbury & Districts is committed to informing our public mental health practice with the aspiration to build hope, empowerment, and resilience in individuals and communities. This commitment draws us to understand and support mental health from a more holistic and community-based perspective. A perspective that considers mental wellness equally with physical, spiritual, and emotional wellness. We acknowledge the perspective of The First Nations Mental Wellness Continuum Framework.

References

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8. Ministry of Health and Long-Term Care. (2011). Open minds, healthy minds: Ontario's comprehensive mental health and addiction strategy. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdfministry/publications/reports/mentalhealth2011/mentalhealth_rep2011.pdf
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From: Groulx, Francine A (HC/SC) <francinea.groulx@canada.ca> on behalf of Van Loon, James (HC/SC) <james.vanloon@canada.ca>
Sent: Friday, July 26, 2019 1:32 PM
To: Elizabeth Milne
Subject: Re: Plain and Standardized Tobacco Products and Packaging

Dear Trish Fulton and Christopher Mackie:

Thank you for your letter dated May 22, 2019 expressing your support for the *Tobacco Products Regulations (Plain and Standardized Appearance)* published in Canada Gazette, Part II by the Government of Canada on May 1, 2019.

Tobacco packages, and the products they contain, are powerful promotional vehicles for the tobacco industry to communicate brand imagery and to attract new tobacco users.
Research has shown that plain and standardized packaging reduces the appeal and attractiveness of tobacco products, especially to youth. This has been demonstrated by research conducted with both non-smokers and people who smoke in numerous countries, including Canada. The *Tobacco Products Regulations (Plain and Standardized Appearance)*, in association with other tobacco control measures, will help prevent Canadians from tobacco initiation and from becoming lifelong tobacco users.

Thank you for your support, and I look forward to our continued partnership.

Yours sincerely,

James Van Loon
Director General, Tobacco Control Directorate

Emploi et Développement social Canada
Employment and Social Development Canada

Joanne Vanderheyden, Chair
Middlesex-London Board of Health
50 King Street
London (Ontario)
N6A 5L7

24 JUIL. 2019

Dear Joanne Vanderheyden:

On behalf of the Honourable Jean-Yves Duclos, Minister of Families, Children and Social Development, I am responding to your correspondence of September 20, 2018 about food insecurity. I apologize for the delay in responding.

The Minister of Families, Children and Social Development's overarching goal is to increase economic and social security for all Canadians, especially those who are most vulnerable.

As you know, the Government of Canada released Opportunity for All – Canada's First Poverty Reduction Strategy on August 21, 2018. The Strategy offers a bold vision for Canada as a world leader in the eradication of poverty and is aligned with the United Nations Sustainable Development Goal. It establishes, for the first time in Canada's history, an official measure of poverty: Canada's Official Poverty Line, based on the cost of a basket of goods and services that individuals and families require to meet their basic needs and achieve a modest standard of living in communities across the country.

Opportunity for All sets poverty reduction targets based on Canada's Official Poverty Line: a 20 percent reduction in poverty by 2020 and a 50 percent reduction in poverty by 2030, which, relative to 2015 levels, will lead to the lowest poverty rate in Canada's history.

The Strategy brings together new investments of $22 billion that the Government has made since 2015 to support the social and economic well-being of all Canadians. The Government has committed to new investments of over $12 billion for 2019–2020. This funding supports key poverty reduction initiatives, such as the Canada child benefit, the increase to the Guaranteed Income Supplement top-up, and the National Housing Strategy.

The Government's poverty reduction efforts are already showing positive results. Based on Statistics Canada's 2017 Canadian Income Survey data, released on February 26, 2019, Canada has reached its 2020 target to reduce poverty by 20 percent, based on 2015 levels, a full three years ahead of schedule. This represents about 825,000 fewer individuals living in poverty in 2017 relative to 2015. More are expected to be lifted out of poverty as the impacts of these investments are further realized in the years to come.

Through Opportunity for All, a National Advisory Council on Poverty is being put in place to advise the Minister of Families, Children and Social Development on poverty reduction and to publicly report annually on the progress being made on poverty reduction in Canada.

.../2

Canada

In Budget 2018, recognizing the importance of poverty data in evidence-based decision-making by all levels of government, the federal government announced an investment of $12.1 million over five years, and $1.5 million per year thereafter, to address key gaps in poverty measurement in Canada. This includes ensuring that poverty data is inclusive of all Canadians, that data on various dimensions of poverty is captured, and that the data is both robust and timely.

You may be pleased to hear that as part of the Strategy, we have been working with Statistics Canada to improve the data on food security. Starting for the 2018 Canadian Income Survey, which will be released in 2020, data on food security and unmet health care needs will be collected annually in the Canadian Income Survey, in the territories as well as provinces.

On April 8, 2019, the Government tabled in the House of Commons *Budget Implementation Act, 2019, No. 1*, which included the *Poverty Reduction Act*. I am happy to share that the *Poverty Reduction Act* received Royal Assent on June 21, 2019, and entrenches Canada's Official Poverty Line, the targets and the National Advisory Council on Poverty into law.

The Government is committed to continuing the dialogue on how to reduce poverty and reiterates its commitment to find solutions to improve the economic well-being of all Canadian families so they can have a real and fair chance to succeed. To find out more about Opportunity for All – Canada's First Poverty Reduction Strategy, please visit www.canada.ca/reduce-poverty.

Thank you for taking the time to share your thoughts. I hope you find this response informative.

Yours sincerely,

Hugues Vaillancourt
Senior Director
Social Development Policy Division
Social Policy Directorate
Employment and Social Development Canada

From: Info <info@alphaweb.org>
Sent: Wednesday, August 21, 2019 9:09 AM
To: All Health Units
Subject: Public Health cost sharing funding model update

ATTENTION:
CHAIRS, BOARDS OF HEALTH
MEDICAL OFFICERS OF HEALTH
SENIOR MANAGERS, ALL PROGRAMS
****

Dear alPHa members,

Following this week's 2020 public health cost share announcements, we have received clarification from the Ministry of Health regarding the 30% cost share:

Effective January 1,2020, it will include all of the current 100% ministry of health funded programs except:

*** Senior's dental**

*** MOH/AMOH compensation**

*** unorganized territories grants**

We await further details as to the promised one-time funding for 2020 to offset the extra cost to the municipalities. We will share additional information as soon as it is available.

Take Care,

Loretta Ryan
Executive Director
Association of Local Public Health Agencies (alPHa)
647-325-9594

From: Info <info@alphaweb.org>
Sent: Tuesday, August 20, 2019 4:29 PM
To: All Health Units
Subject: Minister Steve Clark's Speech at the Association of Ontario Municipalities 2019 Conference

ATTENTION:
CHAIRS, BOARDS OF HEALTH
MEDICAL OFFICERS OF HEALTH
SENIOR MANAGERS, ALL PROGRAMS
****

Speech

Minister Steve Clark's Speech at the Association of Ontario Municipalities 2019 Conference

August 20, 2019

OTTAWA — Today, Steve Clark, Minister of Municipal Affairs and Housing, delivered the following remarks to delegates at the annual conference of the Association of Municipalities of Ontario:

CHECK AGAINST DELIVERY

Good afternoon everyone. It's great to be here ...

I love the energy of the AMO conference. Delegations are in full swing — almost 900 requests this year — another record-breaker!

And I understand this is Pat Vanini's last AMO conference ... I've known Pat for many years and she has always been a tireless voice for municipalities across the province.

And during my first year as minister, Pat — along with Lynn Dollin and Jamie McGarvey — gave me and my Cabinet colleagues great advice on how we can work together with all of you.

Please join me in thanking Pat for everything she's done over many years to support Ontario's municipalities.

I'd also like to acknowledge my parliamentary assistant for municipal affairs — Jim McDonell. And I'm pleased to introduce Parm Gill, who is my new parliamentary assistant for housing.

It's great to be here with so many of my Cabinet colleagues. Several of them were here last August! And there are some new faces, too.

We are here to listen to your ideas and concerns. To learn from you. And to answer your questions.

Last August I told you that serving as Minister of Municipal Affairs and Housing was my dream job and after a full year — I can tell you, that it still is!

As a former mayor and CAO, I understand the challenges and opportunities you face. And as a former AMO president, I know how important the association is to its members and to government.

Over the last year, of course, I've learned a lot. Including about AMO, Ontario's 444 municipalities and how important it is that we continue to talk, listen and work together.

Things have been moving fast ... but maintaining a strong relationship with AMO and all our municipal partners continues to be a top priority.

On this stage last year, Lynn Dollin and I signed a new Memorandum of Understanding (MOU). That was a proud moment.

But more important than any piece of paper, is that under that MOU, the province has had 11 AMO MOU meetings since then.

Our government takes these meetings seriously. Seventeen Cabinet Ministers and six Parliamentary Assistants have come to the AMO MOU meetings — some of them more than once. And the government has brought 53 agenda items for consultation to that table.

These discussions are confidential, but it's no secret that some of them have been frank — and I think that's a good thing. So, I want to thank the AMO Executive for their hard work and input.

In addition to the AMO MOU table, we're consulting with AMO and its members on a whole host of topics.

For example, my ministry recently launched 140 days of consultation planned for this calendar year on changes to the Planning Act related to community benefits charges.

We want the funds that municipalities recover from community benefits charges to be similar to what they've collected from development charges for discounted services, density bonusing and parkland dedication.

To be clear — our goal is to maintain municipal revenues.

We launched a technical working group on community benefits charges that has already met twice, and we've posted information on the Environmental Registry of Ontario — so I would encourage you to give us your feedback through our consultation.

I'm committed to ensuring that growth pays for growth.

And I understand how important it is for municipalities to have the resources they need to support complete communities — such as parks, daycares and more.

The Premier was here yesterday, as you know, and his remarks and discussion at the recent AMO MOU table is a strong signal that our government is listening and wants to work in collaboration with our municipal partners.

We have a plan to modernize programs to make them more sustainable.

We heard your concerns about the changes to the cost-sharing arrangements — and as the Premier announced — we will be providing you with transitional funding for public health and childcare for your budgeting process in 2020.

As Minister Elliott said yesterday, future changes will build in protections for municipal budgets.

All municipal budgets.

On January 1, 2020, we'll transition municipalities to a 70-30 cost-sharing funding model.

That's 70 for the province, and 30 for municipalities.

And, in the first year, we're going to ensure that no public health unit experiences an increase above 10 per cent of current public health costs.

That's the protection we've built in to ease the transition.

Some municipalities already contribute 30 per cent or more — these municipalities will not be impacted.

We will also be maintaining in-year cost sharing for land ambulances.

In fact, Ontario will not be reducing funding to land ambulance services. Municipalities will receive an average of nearly four per cent more in funding for the 2019 calendar year and will see an increase in 2020.

I'd like to thank my colleague Stephen Lecce for working tirelessly and advocating on your behalf since becoming the Minister of Education.

Child care funding will now be phased in over a three-year period starting in January 2020 — with the changes our partners have advised us will require the most lead time coming into effect last.

We will continue to encourage municipalities to partner with us to support children and families in our communities, but we will also adjust the approach to cost sharing Expansion Plan operating funding ... by committing to provide 80 percent of this funding regardless of the municipal contribution.

All of this will give you more time to plan and find savings and efficiencies before the adjustments come into effect.

Because of this approach, the government will be reinvesting $85.5 million back into child care for 2020, and $36.5 million for 2021.

And as you may have heard in Minister Elliott's plenary yesterday, our government will also launch renewed consultation with municipalities and our partners in public health and emergency health services this fall.

This will be in addition to the work that's being done at already-established technical tables.

Through this consultation process, we will ensure that enough time is provided for thoughtful dialogue and implementation planning.

This next phase of engagement will be supported by an expert advisor. Over the next few weeks, the Ministry of Health will work with this advisor, with input from AMO, to begin a consultation process that will continue through the fall.

It's no secret that our government moved quickly when we came into office, but we have listened, and we are committed to working in collaboration with municipalities as we modernize services.

Municipalities are critical partners to our government, and we will work with you to ensure that the transformation of programs and services is informed by your advice and daily realities.

Last year, I mentioned five priorities to you, and I'd like to take a few minutes now to highlight some of the progress we've made by working together.

Let's start with cutting red tape.

This is about getting rid of the duplication and unnecessary steps that stand in the way of building housing, creating jobs and helping you serve your residents in a cost-effective way.

The Premier provided some great examples yesterday, so I won't repeat them.

But, I will add that my ministry is also leading a cross-government review of the development approvals process.

We've been working with municipal planners, building officials, developers and housing providers to identify every step in the development process. And — guess what — it's full of duplication and delays.

We're going to tackle this, with the help of all our partners — including many of you in the room.

Last year, I committed to make a serious dent in the reporting burden municipalities face.

As the Premier said yesterday, we've already identified 94 reports to be eliminated — and consolidated and simplified 27 others. This is good news.

When it comes to arbitration reform, we took some important steps last fall ...

After years of inaction, we amended the interest arbitration process under the Fire Protection and Prevention Act.

We listened when you told us the process in the fire sector led to delays and inefficiencies.

My colleague Monte McNaughton and I are interested in hearing more about how we can further help municipalities with these challenges.

So, we've asked our Parliamentary Assistants to lead an engagement with you this fall.

This will give municipalities an opportunity to provide input on how we can support them in controlling costs.

Here are a few more of the actions we're taking to support you.

Earlier this spring, I announced that we are funding a new $1 million Disaster Assistance pilot project, which will provide eligible communities with up to 15 per cent above the estimated cost of rebuilding damaged infrastructure to make it more resilient to extreme weather.

By building back better, municipalities will also be able to save money over the long-term.

And last week, I joined my colleague Jeff Yurek to announce we're transitioning the cost of the Blue Box program away from municipal taxpayers to make the producers of products and packaging fully responsible, so municipalities can put those funds to better use.

We listened when you told us about the importance of double-hat professional firefighters — and we responded.

We listened when it comes to wastewater capital costs — they will remain 100-per-cent recoverable through development charges.

And I am pleased to share that we're not making any changes to Ontario Works program delivery funding levels in 2020. They will be held at 2018 levels, but we will continue with the transformation of employment services.

Also, for 2020, as the Premier announced, we will be maintaining the current structure of the Ontario Municipal Partnership Fund for an additional year.

And we're going to announce allocations well in advance of the municipal budget year.

And last week, we provided municipalities with the remaining $6.74 million to help with cannabis legalization costs.

At last year's conference, I announced we would be reviewing the regional government system. It's been in place for almost 50 years — and we wanted local input on how to improve governance, decision-making and service delivery.

I've been unequivocal from day one and stated throughout the review — we have no preconceived outcomes.

Ken Seiling and Michael Fenn are finalizing their recommendations — over 8,500 submissions and close to 100 in-person presentations were received — an overwhelming response — and I look forward to receiving their report.

I'll have more to say this fall. For now, I want to thank everyone who participated.

In recent weeks, I've had a chance to get out and announce some of the funding we're providing for supportive and affordable housing.

I'm really proud we're investing $1 billion in 2019-20 to repair and grow our community housing system.

We took some early steps this year to set up the system for success, and we're simplifying the way rent is calculated.

From homelessness, to supportive housing — we need a sustainable community housing system that's ready to help those who need it most. And there is lots of work to do.

One of the highlights of the last year for me was our More Homes, More Choice Act.

Our plan means ...

A better mix of housing, more housing near transit, and more rental housing.

At the end of the day, our plan is about building the right types of homes in the right places — at a price people can afford ...

Not just in Toronto, or here in Ottawa ... but in every community, right across our province.

The last year has been extremely busy, and I've only touched on a few of the highlights today.

We've done a lot together, and we've had many conversations. We've debated ... agreed ... and agreed to disagree.

As our government tackles the big challenges ahead, the lines of communication will stay open. We'll keep talking ... and listening.

It's a privilege to serve as the Minister of Municipal Affairs and Housing, and I understand the vital role municipalities play in the lives of people right across the province.

I know there is no more important partner for our government than the people in this room — our municipal partners who are on the front lines in communities across Ontario.

I'm committed to working with you and bringing your issues and concerns to the Cabinet table.

Thank you very much.

CONTACTS

KFL&A Public Health

August 6, 2019

The Honourable Christine Elliott, Deputy Premier
Minister of Health
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

In this time of public health restructuring in Ontario, it is crucial that we maintain a clear vision for the principles and criteria by which we can design and evaluate the amalgamation process. The Medical Officers of Health from across much of Eastern Ontario, all partners in the Eastern Ontario Wardens Caucus, along with CAOs from their counties, and myself came together on July 8, 2019, to develop a set of principles and criteria we believe should be used to guide the restructuring process at the provincial level. The Board of Health at KFL&A met on July 24, 2019 then to discuss the principles and criteria and agreed to unequivocally support the following below.

Key Principles for Restructuring Local Public Health in Ontario:

1. **Improve population health**: any modernization approaches and changes must protect and enhance population health.
2. **"Say for pay"** must be maintained for municipalities in a meaningful way, meaning the autonomous board must contain a majority of municipal representatives. It must allow for all "obligated municipalities", whether municipal or First Nation (Section 50, HPPA) to have meaningful decision-making to ensure public health remains responsive and accountable to the local communities it serves.
3. As a health unit composed of small urban, rural, and First Nations areas, the structure and delivery of services and programs must **meet the needs of these communities**. Local access and delivery must be maintained despite regionalization of back-office supports and efficiencies.
4. The **funding model and formula** for local public health must take factors into account such as equity, the older age of the population, the rural-urban mix, and must be sustainable.
5. The **best available evidence** should be considered as part of the policy decision making.
6. **Efficiencies will be identified and optimized** wherever possible, without sacrificing the quality and effectiveness of services provided.
7. Any new organizational structure will **build on the current strong collaborative relationships** among the current health units and local public health agencies in Eastern Ontario.
8. Any proposed infrastructure will **build on the assets** of the current local boards of health and respond to their challenges, looking for opportunities to improve public health services.

Kingston, Frontenac and Lennox & Addington Public Health www.kflaph.ca

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KFL&A Public Health

Decision-Making Criteria for Boundary Development:

1. **Alignment with Ministry of Health direction** - proposals must be evaluated considering the directions, vision and outcomes for Public Health as outlined by the Ministry.
2. **Maintenance of current partner alignment –** current relationships and partnerships with proposed Ontario Health Teams, Tertiary Care Centres, Universities/Colleges, neighbouring health units, school boards and other key partners should be maintained whenever possible.
3. **Meaningful governance by "obligated municipalities**" – consistent with the principle of "say for pay", decision-making must consider a meaningful governance model for obligated municipalities who are required to fund public health programs under the Health Protection and Promotion Act.
4. **Inclusion of Indigenous populations and Francophone populations**– amalgamation models need to ensure that Indigenous and Francophone populations are engaged at the governance level and in program planning and delivery.
5. **Efficiencies** – the potential for cost savings and efficiencies is paramount in the evaluation of models including evidence of economies of scale.
6. **Sufficient resources** – resources must be sufficient at the local level for regular programs and surge capacity, including resources to fill key positions including the Medical Officer of Health and other public health experts.

Our Board of Health feels that the current proposal by the Ministry would adversely affect KFL&A Public Health, and further, does not fulfill the key principles and criteria outlined above. Projections of the planned amalgamation estimate a costly process with potential impact on front-line services. A strength that will be lost is our strong working partnerships with both Hastings Prince Edward Public Health and Leeds Grenville Lanark District Health Unit formed through many years facing similar issues across our geography. If these partnerships are maintained, we would be able to achieve a solution that is beneficial for all stakeholders in our region.

We believe that this process should not be rushed to ensure decisions consider evidence and best practices to remove the risk of unintended negative consequences. To achieve our mutual goals, we look forward to the opportunity to directly work with the Ministry on public health reorganization in the promised consultation process and to consider these proposed principles and criteria.

Sincerely,

Denis Doyle, Chair
KFL&A Board of Health

Kingston, Frontenac and Lennox & Addington Public Health www.kflaph.ca

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KFL&A Public Health

Copy to: *Hon. D. Ford, Premier of Ontario*
Hon. H. Angus, Deputy Minister of Health
Ian Arthur, MPP Kingston and the Islands
Daryl Kramp, MPP Hastings-Lennox and Addington
Dr. David Williams, Chief Medical Officer of Health
Loretta Ryan, Association of Local Health Agencies
Ontario Boards of Health
KFL&A Board of Health members
Dr. Piotr Oglaza, MOH, HPEPH
Jo-Anne Albert, Board Chair, HPEPH
Dr. Paula Stewart, MOH, LGLDHU
Doug Malanka, Board Chair, LGLDHU
Warden R. Higgins, County of Frontenac
Warden E. Smith, County of Lennox and Addington
Kelly Pender, CAO, County of Frontenac
Brenda Orchard, CAO, County of Lennox and Addington
Mayor B. Paterson and City Councillors, City of Kingston
Monica Turner, Director of Policy, Association of Municipalities of Ontario

From: Info <info@alphaweb.org>
Sent: Monday, August 19, 2019 4:11 PM
To: All Health Units
Subject: Important Announcement - Public Health Modernization

ATTENTION:
CHAIRS, BOARDS OF HEALTH
MEDICAL OFFICERS OF HEALTH
SENIOR MANAGERS, ALL PROGRAMS
****

Today, at the Association of Municipalities of Ontario annual Conference in Ottawa, the Premier of Ontario, Hon. Doug Ford, and Deputy Premier and Minister of Health, Hon. Christine Elliott we're feature speakers. Of particular interest to alPHa members, the Minister spoke about the government's plans to transform public health in Ontario, including:

* The Minister noted that her staff has been working with AMO, the City of Toronto, and with the Association of Local Public Health Agencies at technical tables since April.

* More time will be given to accommodate changes to cost-sharing arrangements and a commitment to pause any changes to the funding models for 2019.

* Starting January 1, 2020, all municipalities will transition to a 70-30 cost sharing funding model. In the first year, the Minister announced that no public health unit will experience an increase over 10 per cent of current public health costs as a result of this cost-sharing change.

* The government will soon launch renewed consultation with municipalities and partners in public health. This will be in addition to the work that's being done at our already-established technical tables.

* The next phase of engagement will be supported by an expert advisor (name not yet announced). Over the next few weeks, the government will work with this advisor, with input from AMO, to begin this consultation, which we expect to launch this fall.

* This next phase of engagement will include the release of a discussion paper. Among other aspects of the new regional entities, this paper will outline our proposals for boundaries for the new regional public health entities.

Please see the links below for the Premier and Minister's remarks and associated video clips.

alPHa will send an update and further information to the membership later on this week.

Please note: I am at the AMO Conference. Apologies for any formatting issues with the text.

Take Care,

Loretta

Premier Ford's Keynote Address:

Remarks: https://news.ontario.ca/opo/en/2019/08/premier-fords-keynote-address-amo-2019.html?utm_source=ondemand&utm_medium=email&utm_campaign=p

Video: https://youtu.be/t1T45w-U6Vg

Christine Elliott, Deputy Premier and Minister of Health:

Remarks: http://www.amo.on.ca/AMO-PDFs/Events/19/Monday/Christine-Elliott,-Deputy-Premier-and-Minister-of.aspx

Video: https://youtu.be/VFYJG11u5fk

Loretta Ryan
Executive Director
Association of Local Public Health Agencies (alPHa)
647-325-9594

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Ontario

iApprove-2019-01185

AUG 2 0 2019

Ms. Trish Fulton
Chair, Board of Health
Middlesex-London Health Unit
50 King Street
London ON N6A 5L7

Dear Ms. Fulton:

The Ontario government is taking a comprehensive approach to modernize Ontario's health care system which includes a coordinated public health sector that is nimble, resilient, efficient, and responsive to the province's evolving health needs and priorities. While the broader health care system undergoes transformation, a clear opportunity has emerged for us to transform and strengthen the role of public health and its connectedness to communities.

As you are aware, the government made the decision to maintain the current cost-sharing arrangements for boards of health for 2019, to provide municipalities with additional time to find efficiencies that will ensure the sustainability of these critical shared public health services.

As a result, the Board of Health for the Middlesex-London Health Unit will be provided up to $23,143,200 in base funding and up to $10,000 in one-time funding for the 2019-20 funding year, to support the provision of public health programs and services in your public health unit. Dr. David Williams, Chief Medical Officer of Health, will write to the Middlesex-London Health Unit shortly concerning the terms and conditions governing the funding.

While the way in which we are implementing our plan to strengthen public health has changed, the need to do so has not. The current public health structure requires modernization – having 35 independent entities, all with varying capacity, does not facilitate consistent implementation of the core elements of a strong public health system.

Our government has heard that the scale and pace of change is of concern to the public health and municipal sectors. While the modernization of the public health sector remains a priority, the Ministry of Health intends to consult with public health and municipal partners throughout the fall of 2019 to inform the development of Regional Public Health Entities and to ensure that adequate time is provided for thoughtful dialogue and implementation planning.

.../2

Ms. Trish Fulton

In order to support public health unit planning for 2020, municipalities can use a planned funding change to bring the municipal share to 30% for public health programs and services effective as of January 1, 2020. However, to help provide additional stability as municipalities begin to adapt to shifting funding models, our government will also provide one-time mitigation funding to assist all public health units and municipalities to manage this increase while we work to transform the public health system across the province over the next couple of years. While final confirmation of 2020 funding will be provided through the 2020 Budget process, we expect that all municipalities will be protected from any cost increases resulting from this cost-sharing change that exceed 10% of their existing costs.

We continue to rely on your strong leadership to build a modern and sustainable public health sector. Thank you for the important service that your public health unit provides to Ontarians, and your ongoing dedication and commitment to addressing the public health needs of Ontarians.

Sincerely,

Christine J. Elliott

Christine Elliott
Deputy Premier and Minister of Health

c: Dr. Christopher Mackie, Medical Officer of Health, Middlesex-London Health Unit

Structure of public health:

A literature review

August 21, 2019

Please use the following citation when referencing this document:

Region of Peel – Public Health. Structure of public health: A literature review. Mississauga, ON: Region of Peel – Public Health; 2019.

1 Issue & Context

The 2019 provincial budget proposed substantive changes to the public health sector in Ontario.[1] These include:

- Establishing 10 regional public health entities and 10 new regional boards of health (BOHs) with one common governance model by 2020-2021.
- Adjusting the provincial-municipal cost-sharing of public health programs.
- Streamlining the Ontario Agency for Health Protection and Promotion (Public Health Ontario) to enable greater flexibility with respect to non-critical standards based on community priorities.[1]

Currently there are 35 local public health units in Ontario operating under different governance models (e.g., autonomous, regional/municipal, semi-autonomous). The *Ontario Public Health Standards* (2018) outline the requirements with respect to the core public health functions of:

- assessment and surveillance;
- health promotion and policy development;
- health protection;
- disease prevention; and
- emergency management.[2]

The provincial government has proposed geographic boundaries for the 10 regional public health entities (RPHEs), including:

- six large, urban RPHEs with a population over one million;
- one Toronto RPHE; and
- three rural/northern RPHEs with a population less than one million.

The intent is to have autonomous BOHs for the 10 new RPHEs in place by April 1, 2020.

As part of a Council of Medical Officers of Health (COMOH) working group, Peel Public Health (PPH) conducted this literature review to prepare for upcoming consultations with the public health sector.

2 Literature Review Question

What components of public health organization or structure contribute to public health performance (e.g. achievement of core public health functions and/or impact on population health status)?

3 Literature Search

An iterative search of published literature was conducted to scope the evidence and refine search terms. Frequently used subject headings (e.g., MeSH terms) to index public health services and systems research were identified. Due to time constraints these terms were used to focus the search.

The final search was conducted on June 14, 2019. Databases searched were: Cochrane Database of Systematic Reviews, Evidence-Based Practice and Health Technology Assessment, National Health Service (NHS) Economic Evaluation Database, Global Health, Ovid Healthstar, MEDLINE, MEDLINE In-Process, Cumulative Index of Nursing and Allied Health Literature (CINAHL), and Health Business Elite.

The search was limited to English-language and articles published in the past 10 years. A filter for synthesized literature was applied to all databases.

A search of unpublished (grey) literature was conducted on June 20, 2019. Resources searched were: McMaster Health Forum, Health Systems Evidence, Public Health Services and Systems Research, the National Institute for Health and Care Excellence (NICE) Evidence Search, Turning Research into Practice (TRIP) database, Australian National University – Research School of Population Health publications, Sax Institute, Ontario Public Health Libraries Association (OPHLA) Customized Google Search Engine, Google and DuckDuckGo.

Key informants with expertise in systematic reviews, public health, and/or health systems research were contacted. Authors of relevant documents were also contacted to request more information about their review methodology and to suggest additional evidence. Reference lists of relevant documents were scanned (Appendix A).

4 Relevance Assessment

Search results were assessed using the following relevance criteria:

- **Inclusion criteria**
  - public health context
  - describes organizational, structural or institutional components of public health organizations, agencies or systems (e.g. jurisdiction, governance, infrastructure, workforce, leadership)
  - performance outcome (e.g. achievement of public health functions, delivery of effective public health interventions, efficient use of resources, equitable access to services and/or population health status)
  - setting similar to Canada (e.g. United States, United Kingdom, New Zealand, Australia)
  - synthesized literature (e.g. reviews or "review of reviews")

- **Exclusion criteria**
  - discussion paper or commentary

Two reviewers (JM and RS) independently screened the titles and abstracts of the published literature. One reviewer (RS) screened the titles of grey literature hits while conducting the search. Any potentially relevant results were then screened by two independent reviewers (JM and RS). Disagreements were discussed until consensus was reached or in consultation with a third reviewer (BB).

5 Results of the Search

The searches yielded 1105 results. After removal of duplicates, the titles and abstracts of 1102 documents were assessed for relevance, of which 1090 were excluded. Twelve articles were reviewed in full by two independent reviewers (JM and BB). Two review of reviews, one by Brownson and collegues[3] and one by Hyde and Shortell[4], were relevant. One systematic review by Dilley and colleagues [5] was also relevant. Two literature reviews that incorporate expert consultation were also identified.[6,7] Despite a lack of detailed methods, the review team determined that these documents by Carlson et al.[6] and

Naylor and Buck[7] provided valuable information relevant to the review question and they were included (Appendix B).

Overlap of the studies/reviews included in these relevant documents was assessed. One review of reviews by Brownson and colleagues[3] included two of the other relevant articles by Hyde and Shortell[4] and Dilley and collagues.[5] The review team decided to extract data on all three documents[3,4,5] since they provide additional detail not available in the review of reviews by Brownson et al.[3]

6 Critical Appraisal

Two reviewers (JM and RS) independently appraised the quality of two review of reviews and the one systematic review using the Health Evidence™ Quality Assessment tool.[8] Disagreements were discussed until consensus was reached. Both review of reviews by Brownson et al.[3] and Hyde and Shortell[4] rated moderate (5/10). The systematic review by Dilley et al.[5] received a weak rating (4/10). Limitations of all three documents were: a lack of quality assessment of included studies/reviews, unclear weighting and failure to consistently provide the data from included studies/reviews when describing the findings.

There was not a suitable tool to appraise the two literature reviews.[6,7] These documents lacked: a transparent description of the search strategy and selection of included papers, quality assessment, and consistent description of all included evidence. Some information about the search strategy was provided by the author of one literature review upon request.[7] Overall both documents should be considered of weaker methodological quality.

7 Description of Included Documents

The most synthesized documents are presented first.

Brownson, R et al. (2012): Fostering more-effective public health by identifying administrative evidence-based practices: A review of the literature[3]

The objective of this moderate quality review of reviews was to identify administrative evidence-based practices (A-EBPs) associated with local public health performance. A-EBPs were defined as agency level structures and practices positively associated with public health performance. Outcomes included performance of the local health department or public health system in the National Public Health Performance Standards Program in the United States (US), implementation of evidence-based practices, workforce capability, achieving service objectives for specific program areas (e.g., maternal/child health, immunization etc.) and population health outcomes. Details were not provided about how outcomes were defined or measured. Thirty reviews and 65 single studies were included. Almost all studies were conducted in the US. The designs of included studies were not described. The quality of included reviews and studies was not assessed.

The included evidence was synthesized narratively into macro (system)-level A-EBPs and micro (local)-level A-EBPs. Macro-level referred to the infrastructure for local public health practice. Micro-level A-EBPs were described as administrative or management practices that are modifiable in any local public health system. Micro-level A-EBPs were the focus of this article and these were further categorized into high and moderate priority. High priority A-EBPs were associated with an outcome of interest in numerous studies or at least one review article; focused on local-level administrative or management change; and deemed modifiable in a short (<1 year) or medium (1-3 years) time frame for a reasonable

cost. Moderate priority A-EBPs were associated with an outcome of interest in at least one study but no reviews; or were deemed to require a longer time frame to modify (Appendix C).

Hyde, J & Shortell, S. (2012): The structure and organization of local and state public health agencies in the US: A systematic review[4]

The objective of this moderate quality review of reviews was to describe the organization and structure of local and state public health agencies in the US and determine the influence of organizational and structural characteristics on public health performance and/or health outcomes. Health outcomes were assessed using population health status data. Performance outcomes were defined as the capacity to provide the 10 essential public health services that were measured through national performance standard surveys or investigator-developed surveys. There was variation across studies in the type and number of indicators used for each essential service. Seven reviews and 54 single studies were included. All included studies were conducted in the US. Most studies were cross-sectional (n=36) in addition to some with longitudinal (n=8) or case study designs (n=10). The quality of included reviews and studies was not assessed.

The included evidence was synthesized narratively into three categories: 1) descriptions of the structure and organization of governmental public health agencies; 2) associations between public health structure, organization, and performance; and 3) relationship between public health organization and health outcomes. Only evidence from the second and third category was relevant to this report (Appendix C).

Dilley, J et al. (2012): Quality improvement interventions in public health systems: A systematic review[5]

The objective of this weak quality systematic review was to identify quality improvement (QI) initiatives implemented in the US public health system. Performance was assessed through practice improvements or population health outcomes. Details were not provided about how these outcomes were defined or measured. Fifteen single studies about 18 separate QI interventions were included. All studies were conducted in the US at state-level or large public health units. The designs of included studies were not described. The quality of included studies was not assessed.

The included evidence was synthesized narratively into three categories: 1) organization wide QI interventions (Big QI) that used a systems approach to influence numerous programs and services; 2) QI targeting specific program or services (small QI); and 3) QI of administrative or management practices (mix of Big and small QI). (Appendix C)

Carlson, V et al. (2015): Defining the functions of public health governance.[6]

The objective of this literature review was to determine if accepted governance functions continue to reflect the role of public health governing entities in the US. The desired outcome was a list of governance functions that describes how governing entities support and guide public health service. This could be used use alongside public health core functions and services to provide insight into how governing entities participate in the public health system. Two categories of literature were reviewed: foundational works (n = 3) and additional works that address board of health functions (n = 44, including the three reviewed under foundational works). Eighteen orientation manuals from public health governing entities were also reviewed to support data triangulation. The quality of included evidence was not assessed.

Six themes were identified that concerned the roles and responsibilities of governing boards. These were sent to individuals with expertise in public health governance or health department operations for review. Feedback was received through facilitated discussion and consensus was built to create the final list of public health governance functions and their definitions (Appendix C).

Naylor, C. and Buck, D. (2018): The role of cities in improving population health: International insights.[7]

The objective of this report was to explore how England's cities can govern more effectively to influence population health. This report drew on the experience of several international cities and included specific examples of how these cities have approached complex health issues such as: obesity, HIV, air quality and mental health. The findings of this report were derived from: 50 in-depth qualitative interviews (25 focused on London and 25 focusing on other international cities); a literature review of relevant evidence and data; and roundtable discussion with experts to validate the findings.

Findings were synthesized into two components necessary for cities to influence population health: 1) governance arrangements and 2) functions that cities or their partners can perform (Appendix C).

8 Synthesis of Findings

A conceptual framework by Handler and colleagues[9] was adapted to organize the findings of this literature review. The review team also considered two articles that built on this framework[10,11]

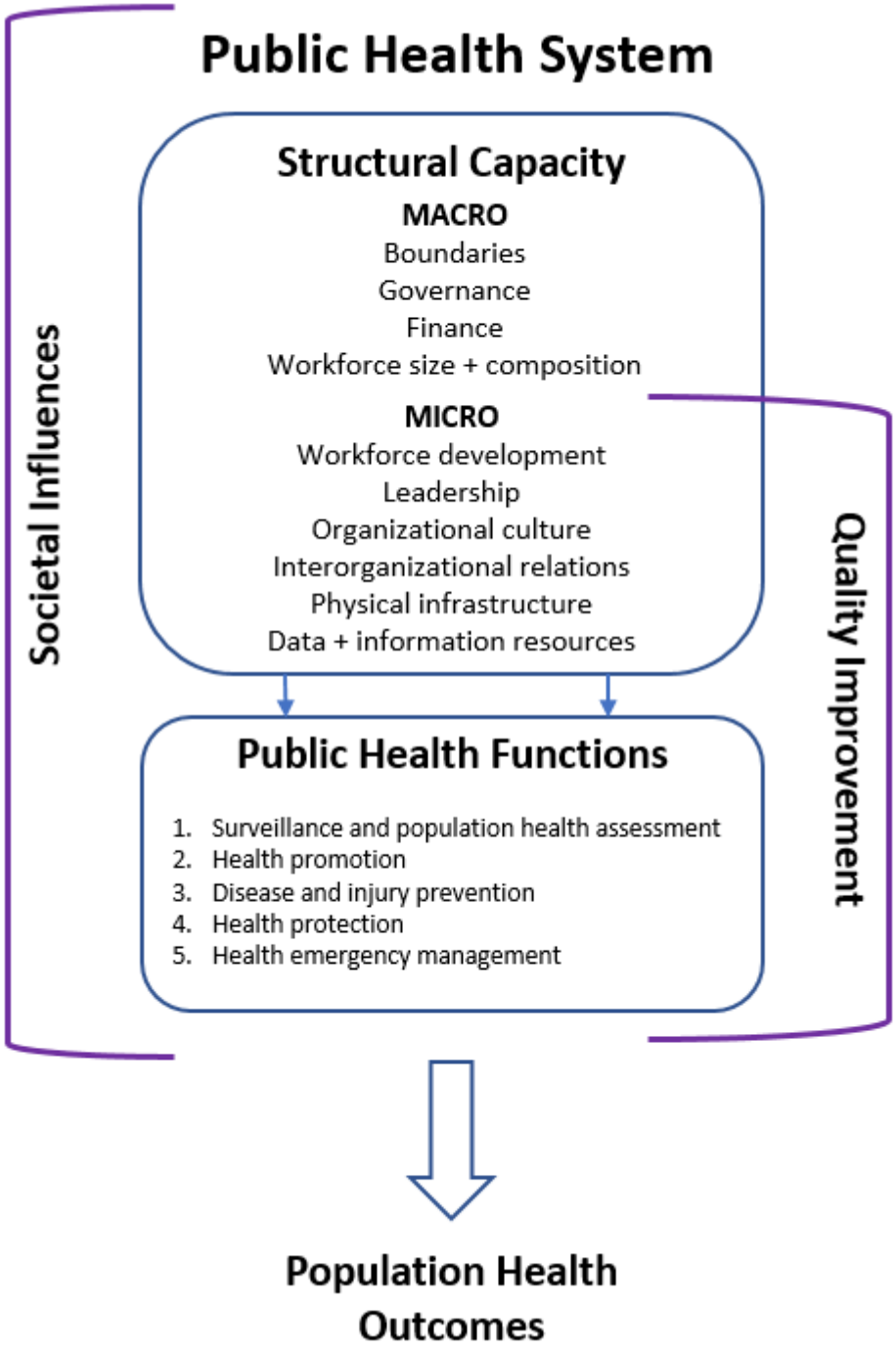

Figure 1 Adapted from Handler (2001),[9] Meyer (2012)[10] and Guyon (2016)[11]

Macro-level structural capacity

Governance

Public health governance functions and structures vary. Public health governing bodies can support and guide public health performance through six functions of public health governance:

1. leading or contributing to policy development;
2. ensuring adequate resources are available;
3. monitoring improvements;
4. engaging with partners;
5. exercising legal authority; and
6. assuming responsibility for public health performance.[6]

Governance structures were identified as an important factor influencing a city's ability to have an impact on population health.[7] Centralized governance models have the potential to be more efficient, coordinated and allow for costs to be shared and resources to be redistributed.[7] In contrast, this could decrease engagement with community members and responsiveness to local needs.[7]

Consistent with some of the functions of public health governance described above, effective partnerships between local, city and regional tiers of government are required for cities to have an impact on population health.[7] In addition, city leaders must understand and use the regulatory powers within their control to impact population health.[7]

The relationship between governance and public health performance is inconclusive

A governing board of health with a policy making role was positively associated with performance of essential public health services.[4] The review authors note this finding may be limited to larger jurisdictions with a population ≥100,000 people.[4] Organizational control in public health organizations can be centralized, decentralized or mixed.[4] There were varied findings on the impact of organizational control on public health performance. In some studies, centralization of authority was associated with better public health performance compared to decentralized or mixed structures.[4] In other studies shared state and local authority was associated with improved public health performance.[4] There were also studies that found no relationship between organizational control and public health performance.[4]

Boundaries

Jurisdictional size predicts public health performance

In many studies, the size of the jurisdiction served by a public health organization had a strong association with public health performance.[3,4] Overall, public health organizations with larger jurisdictions performed better than smaller ones.[4] When public health organizations served a larger population they had increased capacity to provide essential services.[4] Most included studies did not report an optimal jurisdictional size, however in studies that did, population size ranged from ≥50,000 to 100,000 people.[4] In one included study, population size was positively associated with performance up to 500,000 people but beyond that public health performance declined.[4] There was not enough evidence to determine whether regionalization of public health services is associated with improved public health capacity and performance.[4]

Finance

Per capita funding and public health expenditures predict public health performance

Public health finances have a strong association with public health performance.[3] Financial considerations occur both at the macro and micro levels of public health systems.[3] At the macro-level, both expenditures per capita and expenditures per staff full-time equivalents (FTEs) are associated with improved public health performance.[3,4] At the micro-level, funding allocation and fiscal priorities can influence public health performance.[3] These can include allocation of resources to quality improvement, innovation, information access, and training.[3]

Workforce size and composition

Workforce size and composition are associated with public health performance

Public health organizations with more staff perform better than organizations with fewer staff.[3,4] Specifically, a public health workforce with a high proportion of staff relative to the size of the population served is associated with better performance for most essential services.[3,4] A workforce with a mix of disciplines and diverse experience and training is also positively associated with performance.[3] The distribution of public health expertise at various levels of the public health system is another important consideration when trying to influence population health.[7]

Micro-level structural capacity

Workforce Development

Workforce development can support public health performance

At the micro-level, a skilled and competent workforce is essential to the performance of public health organizations.[3] Providing staff with opportunities for professional development and access to technical assistance are considered high priorities.[3] Workforce training is often on-the-job and competency-based.[3] The educational background(s) and competencies of the public health workforce must be considered.[3]

Leadership

The relationship between leadership and public health performance is inconclusive

Leadership is frequently cited as having an important influence on public health performance however findings are mixed.[4] The association between the educational training of public health leaders and public health performance is inconclusive.[4] Several leadership characteristics were identified as high priority.[3] This included public health leaders' skills and background; values and expectations; and use of participative decision-making.[3]

At the city level, leaders can have significant impact on the social determinants of health through formal and informal powers.[7] Outside of formal governance structures and powers, leaders can influence population health by networking, partnering with others, and creating a culture of learning, innovation and continuous improvement.[7] Leadership style and skills should fit with the model of governance (e.g. consensus-based decision-making).[7]

Organizational culture

Organizational culture can support public health performance

Organizational culture was identified as a high priority element of structural capacity that can influence public health performance.[3] Leaders help to shape organizational culture through free flow of information, support for innovation and creating a learning organization.[3]

Interorganizational relations

Interorganizational relationships can support public health performance

Relationships and partnerships are essential to a strong public health system.[3,4] Involving outside organizations in the planning and provision of public health services is associated with improved public health performance.[3,4] This could include schools, hospitals, social services, community organizations, businesses, law enforcement and academic organizations.[3]

Cities need to be able to link parts of the system internally as well as connect to other cities and external partners to impact population health.[7] These connections are useful to exchange lessons learned or to address shared problems.[7]

Infrastructure

Physical infrastructure (e.g. facilities and equipment) is essential to public health capacity. However, the evidence reviewed did not include research on the relationship between infrastructure and public health performance.

Data and information sources

Access to information for evidence-informed decision-making is an element of structural capacity that influences public health performance.[3] The are other important information sources and technologies that could impact the structural capacity of public health, however the evidence reviewed did not include research on the effect of these on public health performance.

Quality improvement

Quality improvement (QI) processes are essential to assessing public health performance.[5] QI interventions can be used to "improve the efficiency or effectiveness of a program, process or organization."[5] QI processes require careful consideration of the measures of public health performance being examined.[5] Most included studies did not link public health performance directly to population health outcomes.[5] There is a need to establish whether achievement of a public health performance measure will improve population health.[5]

9 Limitations

This literature review was conducted within a short time frame. The search of unpublished (grey) literature was not exhaustive. The search strategy for published literature was narrowed using subject headings and further refined with keywords. This could have missed potentially relevant articles that were not indexed using these headings.

The search was limited to synthesized evidence and most of the included reviews were published in 2012. Newer single studies relevant to this topic (published since 2012) would not have been identified through this literature review.

The findings of this review are predominantly based on cross-sectional studies which cannot establish causal relationships. Additionally, the quality of the studies included in each article was not assessed.

The included articles did not consistently provide: detail about how public health performance was defined and measured; or data from the studies/reviews that they included.

Most single studies included in this evidence were conducted in the US. The generalizability of this research to the Canadian context is unclear. There was also a lack of research available about public health structure for small or rural public health departments.[4]

10 Conclusions

The macro-level elements of structural capacity in a public health system must be considered when restructuring public health in Ontario. These include:

- Governance function and structure
- Jurisdictional size and boundaries
- Finance
- Workforce size and composition

In addition, micro-level elements of structural capacity will need to be considered when forming regional and local public health entities. These include:

- Workforce development
- Leadership
- Organizational culture
- Interorganizational relations
- Infrastructure
- Data and information systems

11 Acknowledgements

This literature review was conducted and written by staff at Peel Public Health

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Appendices

Appendix A: Search Strategy

Appendix B: Literature Search Flowchart

Appendix C: Data Extraction Tables

Appendix A: Search Strategy

Database: EBM Reviews - Cochrane Database of Systematic Reviews <2005 to June 5, 2019>, EBM Reviews - Health Technology Assessment <4th Quarter 2016>, EBM Reviews - NHS Economic Evaluation Database <1st Quarter 2016>, Global Health <1973 to 2019 Week 23>, Ovid Healthstar <1966 to April 2019>, Ovid MEDLINE(R) <1946 to June Week 2 2019>, Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations <1946 to June 12, 2019>

Search Strategy:

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1 exp Public Health Administration/ (29186)

2 exp Public Health/og [Organization & Administration] (40582)

3 Community Health Services/og [Organization & Administration] (17085)

4 ("organiz*" or "organisation*" or "system*" or "structur*" or "config*").ti,ab. (8295105)

5 ("review*" or "meta-analys*" or "synth*" or "overview*" or "guideline*").ti,ab,pt. (8414547)

6 ("performance*" or "effective*" or "efficien*" or "equit*").ti,ab. (5378336)

7 1 or 2 or 3 (85195)

8 4 and 6 and 7 (7727)

9 5 and 8 (2588)

10 remove duplicates from 9 (1291)

11 limit 10 to english language [Limit not valid in CDSR; records were retained] (1177)

12 limit 11 to yr="2009 -Current" (615)

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Appendix A: Search Strategy (continued)

Search of CINAHL and Health Business Elite using EBSCO platform

S10	S6 AND S8	**Limiters** - Published Date: 20090101-20191231; English Language; Exclude MEDLINE records **Search modes** - Boolean/Phrase	View Results (399)
S9	S6 AND S8	**Search modes** - Boolean/Phrase	View Results (1,197)
S8	S4 AND S5 AND S7	**Search modes** - Boolean/Phrase	View Results (4,116)
S7	S1 OR S2 OR S3	**Search modes** - Boolean/Phrase	View Results (61,995)
S6	("review*" OR "meta-analys*" OR "synth*" OR "overview*" OR "guideline*")	**Search modes** - Boolean/Phrase	View Results (773,395)
S5	("performance*" OR "effective*" OR "efficien*" OR "equit*")	**Search modes** - Boolean/Phrase	View Results (597,736)
S4	("organiz*" OR "organisation*" OR "system*" OR "structur*" OR "config*")	**Search modes** - Boolean/Phrase	View Results (1,110,453)
S3	(MH "Community Health Services")	**Search modes** - Boolean/Phrase	View Results (18,345)
S2	(MH "Public Health")	**Search modes** - Boolean/Phrase	View Results (40,947)
S1	(MH "Public Health Administration")	**Search modes** - Boolean/Phrase	View Results (4,687)

Appendix A: Search Strategy (continued)

Grey Literature Final Results

Search terms: ("public health" or "population health") AND (structur* OR organization* OR organisation*)

Source	# Hits Scanned	# Primary Potentially Relevant Hits	Full-Text Review
Health Systems Evidence https://www.healthsystemsevidence.org/?lang=en	20	0	0
McMaster Health Forum https://www.mcmasterforum.org/	53	0	0
Public Health Services and Systems Research (USA) http://publichealthsystems.org/	363	3	0
NICE Evidence Search https://www.evidence.nhs.uk/	50	14	1
Turning Research into Practice (TRIP) database https://www.tripdatabase.com/	0	0	0
Australian National University: Research School of Population Health publications http://rsph.anu.edu.au/research/centres-departments/australian-primary-health-care-research-institute/projects	0	0	0
Sax Institute https://www.saxinstitute.org.au/publications/implementation-research-publications/	50	0	0
Google Custom Search Engine (Ontario Public Health Libraries Association) https://cse.google.com/cse?cx=007843865286850066037:3ajwn2jlweq	40	0	0
Google Search	50	0	0
DuckDuckGo Search	20	0	0

Appendix A: Search Strategy (continued)

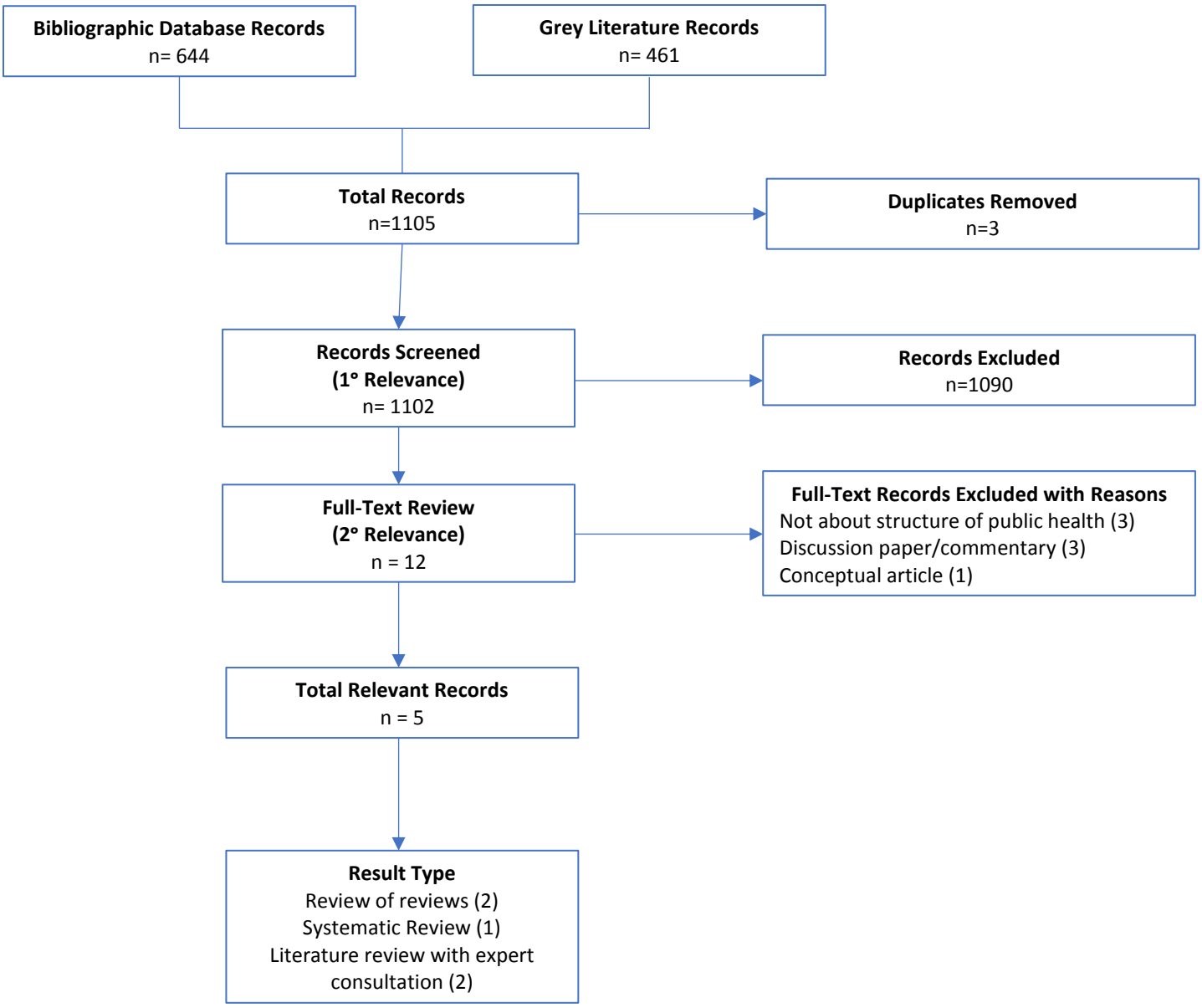
Resources/Websites Solicited from Experts

Key Informant	Organization/Position	Date Contacted	Method	Response? (Y/N)	Recommended Resource(s)
Dr. Maureen Dobbins	Scientific Director of the National Collaborating Centre for Methods & Tools and Health Evidence, McMaster University	07-Jun-19	email & phone	Y	Knowledge broker at NCCMT conducted a search for literature on regionalization and population health outcomes – didn't find any relevant review evidence but forward the following: • Van Aerde (2016) Has regionalization of the Canada health system contributed to better health? (Not a review) • Denis (2015) Is there a future for regionalization in Canada? Presentation at CAHSPR conference (Not a review. Seems to be focused on regionalization of entire health care system and is not public health specific) • Hays et al. (2012) Public health governance and population health outcomes. (Not a review – single study)
Dr. Mike Wilson	Assistant Director, McMaster Health Forum, McMaster University	03-Jun-19	email & phone	Y	Confirmed that McMaster Health Forum does not have the capacity at this time to create a rapid response brief for our question. Provided orientation to searching Health Systems Evidence repository. No relevant records identified. Shared masters thesis about public health systems: • Jarvis (2017) Defining public health systems: A critical interpretive synthesis of how public health systems are defined and classified. (not relevant – not about org or structure of PH)
Dr. Ross Brownson	Professor, Institute for Public Health, Washington University, St. Louis, Missouri	12-Jun-19	email	Y	Provided a data extraction table from his review of reviews. Also recommended the following articles: • Aarons et al. (2014) Aligning leadership across systems and organizations to develop a strategic climate for EBP implementation. (not relevant – not about org or structure of PH)

Key Informant	Organization/Position	Date Contacted	Method	Response? (Y/N)	Recommended Resource(s)
					• DeCorby-Watson et al. (2018) Effectiveness of capacity building interventions relevant to public health practice: a systematic review (not relevant – not about org or structure of PH) • Duggan et al. (2014) What influences the use of administrative evidence-based practices in local health departments? (not a review – single study & duplicate) (not relevant – not about org or structure of PH) • Gyllstrom et al. (2015) Local health department factors associated with performance in the successful implementation of community-based strategies (not a review – single study) • Hyde & Shortell (2012) The structure and organization of local and state public health agencies in the US: A systematic review (duplicate) • Hilliard & Boulton (2012) Public health workforce research in review: A 25-year retrospective (not relevant – not about org or structure of PH) • Nguyen et al. (2019) Factors associated with continuous improvement by local boards of health (not a review – single study) • Xiao et al. (2018) Development of a survey to assess local health department organizational processes and infrastructure for supporting obesity prevention (not a review – single study)
Dr. Justeen Hyde	Institute for Community Health and Harvard Medical School	12-Jun-19	email	N	Requested data extraction tables from her relevant systematic review. No response
Dr. Glen Mays	Director, National Coordinating Center for Public Health Services and Systems Research and Public Health Practice-Based Research Networks, University of Kentucky	12-Jun-19	email	N	No response

Key Informant	Organization/Position	Date Contacted	Method	Response? (Y/N)	Recommended Resource(s)
Chris Naylor	Senior Fellow, Policy, The Kings Fund	25-Jun-19	email	Y	Provided additional information about the literature review methods for the report: The role of cities in improving population health Searched: TKF IKS database https://koha.kingsfund.org.uk/cgi-bin/koha/opac-main.pl PubMed Google Scholar Provided search terms used on each site but no inclusion/exclusion criteria

Appendix B: Literature Search Flowchart



Appendix C: Data Extraction Tables

Brownson et al. (2012) Fostering more-effective public health by identifying administrative evidence-based practices: A review of the literature	
Type of Article (Design)	Review of reviews
Quality Rating	5/10 • Quality assessment of included articles not completed • Table of characteristics of included articles and outcome data not included • Weighting of evidence unclear • Findings not consistently linked to the supporting evidence and referenced
Objective(s)	To identify agency level structures and practices (administrative evidence-based practices) associated with performance measures (e.g. achieving core public health functions or carrying out evidence-based interventions) for local public health (PH)
Included Evidence	• Reviews (n=30) ○ Most reviews were of studies conducted in the USA but also included some evidence from Canada, UK, Australia and Europe ○ Three reviews included studies from the UK only, two reviews included studies from Australia only • Single studies (n=65) ○ USA (n=62) ○ Canada (n=2) ○ Australia (n=1) • Quality of included reviews and studies is unknown
Structural/Organizational Elements	Administrative evidence-based practices (A-EBPs) A-EBPs were not clearly specified, but included: • Organizational size and structure • Organizational climate • Leadership • Facilities • Setting (urban, rural, suburban) • Finances • Resources

Brownson et al. (2012) Fostering more-effective public health by identifying administrative evidence-based practices: A review of the literature	
	• Workforce • Partnerships • Barriers and facilitators to evidence-based practice
Outcomes	Any outcome linked to evidence-based decision making Outcomes were not clearly specified, but included: • Performance of the local health department or public health system in the National Public Health Performance Standards Program in the United States • Implementation of evidence-base practices • Achieving service objectives for specific program areas (e.g. maternal/child health, immunization etc.) • Performance of core public health functions and/or CDC's 10 essential public health services • Partnership effectiveness • Workforce capability • Population health status *No further details were provided about outcomes or how they were defined or measured*
Findings	**Macro (system)-level administrative evidence-based practices (A-EBPs)** **1. Health department oversight & infrastructure** <u>Jurisdiction</u> ○ Population size ○ Type (county, city) <u>Governance & authority</u> ○ Presence of local board of health ○ Policy-making role (not advisory role) for local board of health (especially in jurisdictions with large population) ○ Centralization of authority at state level or shared state & local control **2. Financial processes** <u>Allocation and expenditure of resources</u> ○ Local health department (LHD) expenditures per capita ○ LHD expenditures per staff FTE ○ Diverse funding sources ○ Per capita taxes or allocation percentage of local taxes to PH **3. Workforce size and composition** ○ Staff FTEs per capita

Brownson et al. (2012) Fostering more-effective public health by identifying administrative evidence-based practices: A review of the literature	
	○ Pre-service educational background, licensing and certification ○ Mix of disciplines Review authors classified micro A-EBPs as: **High priority (H) -** associated with an outcome of interest in numerous studies or at least one review article; focused on a micro-level administrative or management change; and deemed modifiable **Moderate priority (M)** - associated with an outcome of interest in one study but no reviews; or was deemed to take longer to modify **Micro (local) modifiable A-EBPs** **1. Workforce development** Training (H) ○ Quality improvement (QI) or EBP in-service training ○ Skills-based training ○ Multidisciplinary in-service training ○ Alignment of training with essential services and usual job responsibilities Access to technical assistance (H) ○ Access to and use of knowledge brokers ○ Use of process-improvement activities ○ Face-to-face meeting to share lessons, experiences and updates Staff Composition (M) ○ Master's degree or higher Staff Competencies (M) ○ Ability to communicate research to policymakers ○ Economic evaluation skills Staff Incentives (M) ○ Use of incentives & rewards **2. Leadership** Skills & Background (H) ○ Leadership skill development ○ Leadership experience

Brownson et al. (2012) Fostering more-effective public health by identifying administrative evidence-based practices: A review of the literature	
	○ Leadership quality ○ Leadership influence ○ Competency to manage change Values & expectations (H) ○ Support for QI, performance standards, EBP, innovation, accreditation ○ Intent to hire educated, experienced staff including specialists Participatory decision-making (H) ○ Management team ○ Leaders and middle managers seek and incorporate employee input ○ Non-hierarchical decision-making **3. Organizational climate, culture & infrastructure** Access and flow of information (H) ○ Communication flow ○ Tailored messaging for EBP ○ Ready access to high quality information ○ 360-degree employee performance reviews geared to EBP (with extensive feedback) Support of innovation & methods (H) ○ Leadership and employee training in EBP including new methods ○ Employees' perception that management supports innovation ○ Conscious creation of environments conducive to innovation ○ Organizational capacity to continue "business as usual" and be in a state of exploration Learning orientation (H) ○ Shared employee perceptions ○ Project management teams that encourage communication and collaboration ○ Presence of multi-disciplinary, diverse management teams Organization climate (M) ○ Common language and terminology LHD accreditation (M) ○ Identification of gaps ○ Participation in accreditation Information systems (M) ○ Tools for EBP

Brownson et al. (2012) Fostering more-effective public health by identifying administrative evidence-based practices: A review of the literature	
	○ Tools for more rapid access to evidence Health department evidence (M) ○ High job satisfaction & morale ○ LHD staff certification ○ Common language for EBP ○ Use of incentives & rewards **4. Relationships and Partnerships** Interorganizational relationships ○ Build and/or enhance partnerships with schools, hospitals, social services, community organizations, law enforcement, private businesses and universities (H) ○ Cooperative agreements with state and/or local health departments regarding QI (H) ○ Number & diversity of types of collaborating organizations (M) ○ Percentage of local public health services & activities provided by non-LHD organizations (M) ○ Distribution of authority and effort among collaborating organizations (M) Vision and mission of partnerships ○ Clear vision and aligned mission of partnerships (H) ○ Capacity building over time (H) **5. Financial processes** Allocation and expenditure of resources ○ Outcome based contracting (H) ○ Resources allocated to QI, EBP, innovation, information access, training and implementation (H) ○ Diverse funding sources (H) ○ Program financial risk (program expenditures/program revenues) (M) Financial Accountability ○ Financial transparency practices (M) Important to recognize the potential interaction of macro-level elements identified above with the micro-level A-EBPs
Author's Conclusions	**Macro (system)-level A-EBPs** • Allocation and expenditure of resources (per capita spending in local health departments) is the strongest predictor of public health performance

Brownson et al. (2012) Fostering more-effective public health by identifying administrative evidence-based practices: A review of the literature	
	• Number of full-time equivalents, population size of health department jurisdiction, and presence of a governing board of health were positively associated with public health performance. • Centralization of authority within state health department or shared state and local authority had mixed effects on public health performance. • To influence these macro-level factors, systems change would be required to governance of local health departments; federal, state and local funding, and/or changes to how schools train public health professionals. (no further details or supporting data provided) **Micro (local) modifiable A-EBPs** Five key domains 1. Workforce development 2. Leadership 3. Organization climate & culture 4. Relationships & partnerships 5. Financial processes Across all five domains, organizational-level strategies to increase implementation of A-EBPs could include: • Performance and quality improvement (QI) initiatives • Health department accreditation This would require: • Workforce training • Leadership support • Reliable and valid measures of A-EBPs
Limitations	<u>Limitations</u> • Search of published literature only • Did not conduct an exhaustive search of complementary disciplines (e.g. business, organizational psychology) • No quality assessment of included studies or reviews • Majority of studies were cross-sectional • Only one reviewer screened for relevance and extracted data

Hyde & Shortell (2012) The structure and organization of local and state public health agencies in the US: A systematic review	
Type of Article (Design)	Systematic review/Review of reviews
Quality Rating	5/10 • Quality assessment of included articles not completed • Table of characteristics of included articles and outcome data not included • Weighting of evidence unclear • Findings not consistently linked to the supporting evidence
Objective(s)	To describe the organization and structure of local and state public health agencies in the USA and determine the influence of organizational characteristics on public health performance and/or health status Three key questions: 1. What is known about the governance, finance and geographic coverage of public health agencies in the USA? 2. What is the relationship between organization and structure of public health agencies and capacity or performance? 3. What is the relationship between organization and structure of public health agencies and population health outcomes? Only data answering questions 2 & 3 are relevant and were extracted for this literature review
Included Evidence	• Reviews (n=7) • Single studies (n=54) ○ USA (n=54) ○ Cross-sectional (n=36) ○ Longitudinal (n=8) ○ Descriptive/case studies (n=10) - Quality of included studies is unknown Studies specific to PH structure & organization and capacity to provide public health services • Reviews (n=1) • Single studies (n=20) Studies specific to PH infrastructure, performance and health outcomes • Single studies (n=4)
Structural/Organizational Elements	• Local public health or state infrastructure • Public health systems

Hyde & Shortell (2012) The structure and organization of local and state public health agencies in the US: A systematic review	
	• Partnerships • Financing *No further details provided about organizational or structural characteristics that were relevant, or how they were defined or measured.*
Outcomes	• Performance was measured as the capacity to provide the 10 essential public health services: 1. Monitor health status to identify and solve community health problems 2. Diagnose and investigate health problems and health hazards in the community 3. Inform, educate and empower people about health issues 4. Mobilize community partnerships and action to identify and solve health problems 5. Develop policies and plans that support individual and community health efforts 6. Enforce laws and regulations that protect health and ensure safety 7. Link people to needed personal health services and ensure the provision of health care when otherwise unavailable 8. Ensure competent public and personal healthcare workforce 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services 10. Research for new insights and innovative solutions to health problems • Measured through national performance standards surveys or investigator-developed surveys • Indicators for each essential service and the number of indicators used to measure performance varied across studies • Any health outcome *No further details provided about outcomes or how they were defined or measured*
Findings	**Public Health Structure, Organization & Performance** • **Jurisdictional size** ○ Strongest predictor of performance (10 studies) ○ Larger jurisdictions performed better than smaller ones. Most studies did not report an optimal jurisdictional size. In studies that did, it ranged from populations of ≥50,000 to ≥100,000 ○ Population size was positively associated with performance up to 500,000 at which time performance began to decrease (1 study) ○ There was no relationship between population size and performance in one study • **Staffing patterns and characteristics**

Hyde & Shortell (2012) The structure and organization of local and state public health agencies in the US: A systematic review	
	○ More staff associated with better performance when compared to samples with fewer staff ○ A higher proportion of staff per population served associated with better performance on most essential services • **Leadership** ○ Inconclusive findings on the association between educational background of local health directors and PH performance ▪ Having a public health director with masters or bachelor's degree in PH was the strongest predictor of performance on 6/10 essential services (1 study) ▪ Having female director (1 study) or a director with a nursing degree (1 study) were the positively associated performance on 5/10 essential services ○ Diversity (not all PH training) and experience of staff was positively associated with performance • **Organizational control** ○ Mixed findings on the association between organizational control and performance ○ Local PH departments with centralized organizational control had significantly higher mean performance compared to organizations with decentralized or mixed structures (2 studies) ○ Mixed or hybrid organizational structures were associated with better performance (2 studies) ○ No relationship found in other studies • **Governance** ○ Jurisdictions governed by local board of health with policy making authority positively associated with performance of some essential services (3 studies) ▪ This relationship may not be true for smaller jurisdictions (population ≤ 100,000) (1 study) • **Funding Resources and types** ○ Mixed findings on the association between public health finances and performance ○ Greater taxes per capita associated with performance on 6/10 essential services (1 study) ○ Local health department spending a modest predictor of performance in 9/10 essential services (1 study) ○ Substantial increases in local government expenditures (1 study) or per capita spending (3 studies) associated with better performance ○ Public health spending as a ratio of FTEs in local health departments associated with increased performance (1 study) ○ No relationship was found between state and local funding and public health performance at the local level (2 studies) • **Partnerships** ○ Partnerships with universities and businesses associated with improved performance (1 study)

Hyde & Shortell (2012) The structure and organization of local and state public health agencies in the US: A systematic review	
	○ Participation of outside agencies in PH planning and provision of PH services associated with performance (1 study) **Public Health Structure, Organization & Health Outcomes** ○ For each 10% increase in expenditures per capita, infectious disease morbidity decreased by 1.82% (p=0.037) (1 study) ○ For each 10% increase in FTEs per capita, cardiovascular disease (CVD) mortality declined by 0.65% (p=0.014) (1 study) ○ Positive associations between local public health performance and county health status (e.g. colon cancer, lunch cancer, CVD, motor vehicle accidents and homicide) (2 studies) ○ Public health network structure was associated with adolescent and senior health in rural communities. The network analysis examined the relationship between PH system network density and organizational centrality, public health governance and community size in rural communities (1 study)
Author's Conclusions	• Greater population size served by a public health department associated with increased capacity to provide essential services ○ Fragmentation in structure may contribute to inefficiencies in performance of core PH functions. ○ Limited evidence available to determine whether regionalization would improve PH performance and capacity. • Strong evidence that public health expenditures and per capita funding positively associated with performance • Influence of other structural characteristics such as organization control, leadership, jurisdiction and partnerships on performance and outcomes was mixed • Lack of research on small and rural public health departments. In general, they are often found to provide fewer essential services due to lack of infrastructure and geographic isolation • Link between organizational structure and performance and health outcomes is unclear. Complex to study due to influence of organizational, contextual, economic, political and sociocultural factors • Overall, available evidence is limited, and more research is needed
Limitations	• Reliance on published literature • No quality assessment of included studies or reviews • Majority of studies were cross-sectional, and more than half relied on the same national profile surveys in the US. Not all local or state health departments participate in these surveys. • Outcome were not defined or measured in the same way • Only one reviewer extracted data and coded findings

Dilley et al. (2012) Quality improvement interventions in public health systems: A systematic review	
Type of Article (Design)	Systematic review
Quality Rating	4/10 • Search was not comprehensive • Study designs/level of evidence not reported • Quality assessment of included articles not completed • Weighting of evidence unclear • Findings not consistently linked to the supporting evidence
Objective(s)	• To identify quality improvement (QI) initiatives implemented in the US public health system and associations with public health performance or health outcomes
Included Evidence	• Single studies (n=15) ○ Included 18 separate QI interventions ○ USA (n=15) • Design of included studies is unknown • Quality of included studies is unknown
Structural/Organizational Elements	• Quality improvement (QI) interventions ○ QI interventions seek to improve the efficiency and effectiveness of public health programs, services and organizations
Outcomes	• Public Health performance improvements • Health outcomes *Details not provided about outcomes or how they were defined or measured*
Findings	Three categories of QI interventions 1. Organization wide QI (Big QI) 2. Specific program/service-oriented QI (small qi) 3. Administrative/management QI (mix of Big & small QI) • **Organization wide QI interventions** (7 studies) ○ Systems approach (such as having a dedicated team or standard approach to QI) associated with improvements in programs (e.g. reduced documentation time in tuberculosis clinic), health predictors (e.g. receipt of fluoride treatment) or health indicators (e.g. improvements in 11/14 key health indicators following statewide QI intervention) ○ Organization-wide QI intervention associated with increase in systemwide integration of QI (e.g. increase in programs meeting the public health standard for establishing quantifiable performance indicators; or

Dilley et al. (2012) Quality improvement interventions in public health systems: A systematic review	
	improvements in program evaluation plans) • **Program or service-related improvement interventions** (7 studies) o QI initiatives targeted a specific program or service such as decreasing wait times for clients, improving information documented in a communicable disease reporting system, or processes improvements for an influenza responses system. • **Administrative or management function QI activities** (4 studies) o QI interventions targeting administrative or management practices was associated with some improvements ▪ Reorganizing staffing structure to reduce costs led to reduction in supervisory staff positions by 3.5 FTE (1 study) ▪ Providing continuing education training for most common skill deficiencies in non-supervisory staff associated with improved knowledge and skills for specific competencies (1 study) Findings were promising but not supported by data for: ▪ Change from activity-based to outcome-based contracting processes improved service delivery (1 study) ▪ Use of a 360-degree feedback model for performance reviews for staff (1 study)
Author's Conclusions	• Only a small number of studies linked QI interventions to proven predictors of health and these provided weak evidence that QI interventions improve population health outcomes. Themes from QI intervention research: • Detailed assessment of current practice ("process mapping") is the first step to QI o Provides a baseline against which improvements could be measured o Helps to identify points for intervention, opportunities to increase efficiencies and where weaknesses exist • Engaging leadership is key to success for QI and a barrier when not present or with leadership change. o Manager engagement could include adding QI or program evaluation to job descriptions or individual outreach to managers about QI projects • Engaging staff and/or QI experts (e.g. QI team or external advisors) essential to planning and implementing QI activities
Limitations	• Clearly valid and reliable measures of improvement were not always provided o Data used to measure improvement varied across studies and included measures of service or adherence to standards; subjective measures of satisfaction; or process descriptions or subjective feedback • All studies (except one) did not measure progress against an external comparison group o Two studies measured progress in a group receiving a QI intervention compared to a group that did not

Dilley et al. (2012) Quality improvement interventions in public health systems: A systematic review	
	○ One study used pre and post tests ○ Other studies used internal comparisons to measure progress forward from baseline against a goal • Relevant evidence may have been missed since grey literature was not searched and literature relevant to QI could be misclassified or described using numerous terms

Carlson et al. (2015) Defining the functions of public health governance	
Type of Article (Design)	• Literature review with expert consultation (published)
Quality Rating	• Unable to critically appraise • Not a systematic review
Objective(s)	• To validate, refine, and update the public health governance functions.
Included Evidence	• Articles (n=44) • Board of health orientation manuals (n=18) • Study design or type of included articles is unknown Quality of included evidence unknown
Structural/Organizational Elements	• Authors developed draft definitions of governance functions based on the literature review which were sent to individuals with PH backgrounds to review and provide feedback. A second draft was developed and reviewed by the same stakeholders (n = 100). Consensus was achieved for the final list of functions and their definitions.
Outcomes	• List of governance functions and associated definitions.
Findings	Six Functions of PH Governance: 1. **Policy Development** – Lead and contribute to the development of policies that protect, promote, and improved public health while ensuring that the agency and its components remain consistent with laws and rules. 2. **Resources Stewardship** – Assure the availability of adequate resources (legal, financial, human, technological and material) to perform essential PH functions. 3. **Continuous Improvement** – Routinely evaluate, monitor and set measurable outcomes for improving community health status and the PH agency's or governing body's own ability to meet its responsibilities. 4. **Partner Engagement** – Build and strengthen community partnerships through education and engagement to ensure the collaboration of all relevant stakeholders in promoting and protecting the community's health. 5. **Legal Authority** – Exercise legal authority as applicable by law and understand the roles, responsibilities, obligations, and function of the governing body, health officer and agency staff. 6. **Oversight** – Assume ultimate responsibility for PH performance in the community by providing necessary leadership and guidance to support the PH agency in achieving measurable outcomes.
Author's Conclusions	Defined the 6 functions of PH governance so they could be used by PH governing entities alongside the existing, overarching PH materials, such as the 3 core functions and 10 essential PH services, and to provide insight into how a governing entity supports and guides health agency service provision and participation in the PH system.

Limitations	Lack of systematic exploration of relationship between PH governing entities and performance of health agency. Lack of data specific to PH governing entities and their performance required that development of the 6 functions be grounded in work done with hospital, education and non-profit boards. Convenience sample for included board of health orientation manuals. • Included body of knowledge relating to state boards of health for literature review but majority of effort focused on local PH governing entities.

Naylor & Buck (2018) The role of cities in improving population health	
Type of Article (Design)	• Literature review with expert consultation (grey literature) Three methodological components: 1. 50 interviews 2. Literature review 3. Expert roundtable discussion
Quality Rating	• Unable to critically appraise • Not a systematic review
Objective(s)	• Examine what a place-based approach to population health might look like in a city context. • Explore the range of roles that city governments can play in improving population health (directly and indirectly), and the underlying conditions needed for effective urban health governance.
Included Evidence	• 50 interviews (25 based in London, England; 25 international) • Number of articles and attendees at roundtable not reported
Findings	Themes were identified in 3 areas: **1. Why Cities Matter for Health** • City leaders have significant influence over the social determinants of health • Cities are where most of the population live • Cities contain significant health needs and inequalities • Cities are playing a growing role in national and international politics • Cities are becoming increasingly well connected 2. **Conditions for Successful Health Governance in Cities** • Governance – decision-making processes, partnerships, collaboration across and beyond city boundaries • Leadership – bold, willingness to invest in championing health; understanding that elected leaders have soft powers beyond formal responsibilities and the ability to use these • Powers – full use of regulatory and other powers available; devolution of powers for national government to cities • Expertise – adequate resourcing of PH functions; distribution of PH expertise • Connectivity – work with and learn from other cities

	3. **Roles for City Governments in Population Health** • Co-ordinating system-wide action – on population health and adequate investment in program management; explicit methodology for collaborating effectively • Promoting innovation – full use of assets available in a city; explore way to stimulate innovation; develop mechanism for sharing learnings • Using regulatory and legislative levers – evidence-based; know the law and have access to legal advice; use as one component of broader strategy • Mobilising the population – see communities as an asset and empower citizens; engage people in civic decision-making Using planning powers to create healthy places – use evidence and data to make informed decisions about the use of public spaces
Author's Conclusions	This report illustrates the important and distinctive role that cities can play in relation to population health improvement. City governments and their partners are well placed to co-ordinate cross-sectoral activities; create an environment that fosters innovation; mobilise communities to pursue citizen-led improvement; and to use regulatory levers and planning powers to create health promoting environments. At their best, cities have the clout to bring about change at scale while managing to retain the local responsiveness and agility that national policy-making can sometimes lack.
Limitations	• None identified by authors • Methods not identified • Literature not identified or appraised

August 27, 2019

The Right Honorable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6

Re: Smoke-Free Multi-Unit Dwellings

On June 28, 2019 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached motion from Windsor-Essex County Health Unit in regards to reducing the exposure of second-hand smoke in multi-unit housing. The following motion was passed:

GBHU BOH Motion 2019-43

Moved by: Anne Eadie Seconded by: David Shearman
"THAT, the Board of Health support the resolution from Windsor-Essex County Health Unit with respect to Smoke-Free Multi-Unit Dwellings."

Carried

Sincerely,

Mitch Twolan
Chair, Board of Health
Grey Bruce Health Unit

Encl.

Cc: The Honourable Christine Elliot, Minister of Health, Deputy Premier
Larry Miller, MP Bruce-Grey-Owen Sound
Kellie Leitch, MP Simcoe-Grey
Benn Lobb, MP Huron-Bruce
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Association of Local Public Health Agencies
Ontario Health Units

WINDSOR-ESSEX COUNTY HEALTH unit
Bureau de santé de Windsor-comté d'Essex

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Leamington 33 Princess Street, Leamington, ON N8H 5C5

May 21, 2019

The Right Honorable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6
Justin.trudeau@parl.gc.ca

Dear Prime Minister Trudeau:

On May 16, 2019, the Windsor-Essex County Board of Health passed the following Resolution regarding **Smoke-Free Multi-Unit Dwellings** to reduce the exposure of second-hand smoke in multi-unit housing:

Whereas, the federal government has passed the Cannabis Act, 2017 to legalize non-medical cannabis, coming into effect on October 17th, 2018, and

Whereas, cannabis smoke contains many of the same carcinogens, toxins, and irritants found in tobacco smoke with the added psychoactive properties of cannabinoids like THC, and

Whereas, Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported, and

Whereas, indoor air studies show that, depending on the age and construction of a building, up to 65% of the air in a private residence can come from elsewhere in the building and no one should be unwillingly exposed or forced to move due to unwanted second-hand smoke exposure,

Now therefore be it resolved that the Windsor-Essex County Board of Health endorse the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

1. Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties and explicitly include cannabis smoke and vaping of any substance in the definition of smoking;

2. All future private sector rental properties and buildings developed in Ontario should be vape and smoke-free from the onset;

3. Encourage public/social housing providers to voluntarily adopt no-smoking and/or vaping policies in their units and/or properties;

4. All future public/social housing developments in Ontario should be smoke and vape-free from the onset.

5. Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.

AND FURTHER that this resolution be shared with the Honorable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Doug Ford, Premier of Ontario
Hon. Christine Elliott, Minister of Health & Long-Term Care
Hon. Ginette Petitpas Taylor, Minister of Health
Hon. David Lametti, Minister of Justice and Attorney General of Canada
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Centre for Addiction and Mental Health
Association of Local Public Health Agencies – Loretta Ryan
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Cheryl Hardcastle, Tracy Ramsey

August 27, 2019

The Honourable Christine Elliot
Ministry of Health
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto ON M7A 1E9

Re: Smoke/Vape Free Outdoor Spaces

On July 26, 2019 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached motion from Windsor-Essex County Health Unit regarding Smoke/Vape Free Outdoor Spaces. The following motion was passed:

GBHU BOH Motion 2019-56

Moved by: Anne Eadie Seconded by: David Shearman
"THAT, the Board of Health support the resolution from Windsor-Essex County Health Unit with respect to Smoke-Free Multi-Unit Dwellings."

Carried

Sincerely,

Mitch Twolan
Chair, Board of Health
Grey Bruce Health Unit

Encl.

Cc: The Honourable Doug Ford, Premier of Ontario
Larry Miller, MP Bruce-Grey-Owen Sound
Kellie Leitch, MP Simcoe-Grey
Benn Lobb, MP Huron-Bruce
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Association of Local Public Health Agencies
Ontario Health Units

WINDSOR-ESSEX COUNTY HEALTH UNIT
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July 2, 2019

The Honorable Christine Elliott
Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

On June 20, 2019, the Windsor-Essex County Board of Health passed the following Resolution regarding **Smoke-Free – Smoke/Vape Free Outdoor Spaces** to reduce the exposure of second-hand smoke in outdoor spaces:

Whereas, the legalization of cannabis came into effect October 17, 2018 and the addition of vapour products and cannabis to the *Smoke-Free Ontario Act, 2017*, and

Whereas, outdoor sport and recreation areas, parks, beaches, trails, and playgrounds are intended to promote the health and well-being for all Windsor-Essex County residents, and

Whereas, entrances/exits of municipal buildings, and transit shelters/stops, are other areas of exposure to second-hand smoke, cannabis and vaping, and

Whereas, second-hand smoke has proven to be harmful in particular for vulnerable populations such as youth, and

Whereas, youth are increasingly susceptible to the influence of social normalization, and

Whereas, youth uptake of vaping and exposure to cannabis consumption is increasing.

Now therefore be it resolved that the Windsor-Essex County Board of Health encourages municipalities to prohibit the smoking or vaping of any substance on all municipally owned outdoor sport and recreation properties, as well as parks, beaches, trails, playgrounds, at minimum, 9m from entrances/exits of municipal buildings, transit shelters, and transit stops.

Further, that the Windsor-Essex County Board of Health encourages all Windsor-Essex municipalities to update and adopt smoking by-laws to explicitly prohibit the use of cannabis in public spaces including streets and sidewalks.

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Doug Ford, Premier of Ontario
Hon. Ginette Petitpas Taylor, Minister of Health
Hon. David Lametti, Minister of Justice and Attorney General of Canada
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Centre for Addiction and Mental Health
Association of Local Public Health Agencies – Loretta Ryan
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Cheryl Hardcastle, Tracy Ramsey

August 27, 2019

The Honourable Christine Elliott
Ministry of Health
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto ON M7A 1E9

Re: Protecting York Region's School Children through Immunization

On June 28, 2019 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached report from York Region regarding a seamless immunization registry. The following motion was passed:

GBHU BOH Motion 2019-44

Moved by: Brian O'Leary Seconded by: Selwyn Hicks
"THAT, the Board of Health support the correspondence from York Region with respect to Protecting York Region's School Children through Immunization."

Carried

Sincerely,

Mitch Twolan
Chair, Board of Health
Grey Bruce Health Unit

Encl.

Cc: Dr. David Williams, Chief Medical Officer of Health
Larry Miller, MP Bruce-Grey-Owen Sound
Kellie Leitch, MP Simcoe-Grey
Benn Lobb, MP Huron-Bruce
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Association of Local Public Health Agencies
Ontario Health Units

York Region

Regional Clerk's Office
Corporate Services

May 17, 2019

Mitch Twolan
Grey Bruce Health Unit
101 - 17th Street East
Owen Sound, ON N4K 0A5

Dear Mr. Twolan:

Re: Protecting York Region's School Children through Immunization

On May 16, 2019 Regional Council adopted the following recommendations:

1. Regional Council endorse the position of the Council of Ontario Medical Officers of Health in support of a seamless immunization registry whereby health care providers directly input immunization information at the time of vaccine administration.

2. The Regional Clerk circulate this report to the Minister of Health and Long-Term Care, the Chief Medical Officer of Health, York Region Members of Provincial Parliament, the Association of Municipalities of Ontario, the Association of Local Public Health Agencies, the Council of Ontario Medical Officers of Health, the other 34 Ontario Boards of Health and the local municipalities.

The original staff report is enclosed for your information.

Please contact Marjolyn Pritchard, Director, Infectious Disease Control at 1-877-464-9675 ext. 74120 if you have any questions with respect to this matter.

Sincerely,

Christopher Raynor
Regional Clerk

Attachments

The Regional Municipality of York

Committee of the Whole
Community and Health Services
May 2, 2019

Report of the Commissioner of Community and Health Services and Medical Officer of Health

Protecting York Region's School Children through Immunization

1. Recommendations

It is recommended that:

1. Regional Council endorse the position of the Council of Ontario Medical Officers of Health in support of a seamless immunization registry whereby health care providers directly input immunization information at the time of vaccine administration.

2. The Regional Clerk circulate this report to the Minister of Health and Long-Term Care, the Chief Medical Officer of Health, York Region Members of Provincial Parliament, the Association of Municipalities of Ontario, the Association of Local Public Health Agencies, the Council of Ontario Medical Officers of Health and the other 34 Ontario Boards of Health.

2. Summary

This report outlines York Region Public Health's (Public Health) efforts in enforcing the *Immunization of School Pupils Act* (the Immunization Act) – an Ontario law requiring children under age 18 years attending school to have up-to-date immunization records (or valid exemptions) on file with their public health unit for a designated subset of publicly-funded childhood immunizations.

Key Points:

- Administration and enforcement of the Immunization Act is an important tool for: improving immunization coverage among school-age children; understanding trends and patterns in vaccine coverage; and supporting public health interventions in the event of a vaccine-preventable disease case or outbreak
- Administration of the Immunization Act in York Region would be enhanced if the provincial government were to create a provincial Electronic Medical Record and merge this record with the existing Digital Health Immunization Repository so that any time a health care provider administers a vaccine, it is captured in a central provincial registry

3. Background

Ontario's publicly-funded immunization program prevents diseases that could otherwise cause illness and death

Immunization is one of the most successful and cost-effective public health interventions available. It protects an individual from the negative health impacts of vaccine-preventable diseases like measles or pertussis, and further protects the community at large including those who cannot receive a particular vaccine due to their age or a medical condition.

York Region's immunization program is governed by the *Immunization of School Pupils Act* (the Immunization Act) for school-aged children, and the *Child Care and Early Years Act* for children attending licensed child care centres. Program specific requirements are detailed in the Ontario Public Health Standards, including the requirement to assess, maintain records, and report on the immunization status of children enrolled in schools and licensed child care centres.

Under the Immunization Act, parents or guardians of school-aged children are required to provide Public Health with proof of immunization or a valid exemption (medical or conscience/religious belief). These immunizations include diphtheria, tetanus, polio, measles, mumps, rubella, meningococcal disease, pertussis (whooping cough), and varicella (chickenpox). Most of these vaccine-preventable diseases are highly contagious and can have serious health consequences, including death.

York Regional Council as the Board of Health in York Region supports the activities of Public Health in promoting immunization among school age children

On February 18, 2016 Council endorsed Public Health's role in enforcement of the Immunization Act. The report detailed the administration and enforcement, discussed the benefits of publicly-funded immunization programs and outlined ongoing community efforts to improve immunization uptake and compliance among the Region's students. On April 20, 2017, an update on enforcement of the Immunization Act in York Region was received by Council, including details regarding the approach Public Health would take to improve Immunization Act-related activities in York Region private schools.

Currently, immunization information is not shared between primary health care providers and Public Health

Under the current system, children receive most childhood vaccinations by their primary care provider, who will then typically update the child's personal paper immunization record (the "yellow card"). Immunization information is also recorded in the electronic or paper-based medical record held by their primary care provider. It is then the responsibility of parents or guardians to provide their child's immunization record to Public Health in order for their immunization information to be updated within the provincial Digital Health Immunization Repository.

The Digital Health Immunization Repository is the provincial electronic immunization database that houses all student immunization information. Public Health can input and access student immunization information through this database however, primary health care providers who administer vaccines to children do not have access to the system.

There have been previous attempts to create online portals where patients and health care providers could securely submit immunization information to the Digital Health Immunization Repository. For example, Immunization Connect Ontario developed a platform for both the public as well as primary health care providers to enter information. However, there have been barriers to universal adoption of Immunization Connect Ontario by primary health care providers and public health units across Ontario.

The provincial government recently announced plans to create a provincial Electronic Medical Record and merge it with the Digital Health Immunization Repository

A provincial immunization registry would allow for the seamless reporting of immunization information by primary health care providers at the time of administration.

4. Analysis

Public Health employs a number of strategies to promote immunization among school-aged children

A number of activities occur to support parents and guardians in ensuring their children follow Ontario's publicly-funded immunization schedule (Attachment 1). Public Health sends letters to parents detailing the Immunization Act process and ensures local clinicians are aware of the immunization requirements for school-aged children. Through the school immunization program, Public Health nurses administer three publicly-funded vaccines to grade 7 (twelve year old) students: hepatitis B (two doses), meningitis (one dose, required under the Immunization Act), and human papillomavirus virus (HPV) (two doses). Over the course of the calendar year, community clinics are also held where students can receive publicly funded vaccines.

Public Health responds to vaccine education requests from the community, and proactively raises awareness among the community and local clinicians about the benefits of immunization.

The Immunization Act enforcement process occurs yearly, with Catholic, Public, French and private school boards

The process begins with merging the student demographic information, provided by the schools, with the provincial immunization database and the Digital Health Immunization Repository to identify which students do not have up-to-date records or valid exemptions on file.

Students aged 7 to 17 who are not up-to-date on their immunizations are identified. At least two reminder letters are sent out to parents or guardians and students, which:

- provide information on the benefits of vaccination
- provide the process for submitting updated immunization records to Public Health and how students can receive immunizations they have missed
- notify parents or guardians and students of any pending enforcement activities

Parents or guardians and students have two months after receiving the reminder letters to update their records with Public Health

The Immunization Act provides authority for Public Health to suspend a student for up to a maximum of 20 school days if he/she does not provide up-to-date records or a valid exemption. School principals are responsible for implementing a suspension order. Suspending students is a last resort for Public Health.

Between 2015 and 2018, approximately 82,000 student records were assessed for compliance, resulting in approximately 1,200 suspensions (Table 1). For those students who were suspended, almost all were permitted to return to school within a few days.

Table 1

Results of the Act Enforcement, 2015/16 to 2017/18 School Years, York Region

School Year	Number of student records assessed	Number of students received first letter*	Number of students received second letter	Number of suspension orders sent	Number of students suspended (% of students assessed)
2015/2016[1] First year of Digital Health Immunization Repository	19,415	8,893	5,050	3,098	356 (1.8%)
2016/2017[2]	26,540	17,640	10,696	6,860	273 (1.0%)
2017/2018[3]	36,935	23,866	15,752	12,159	649 (1.8%)

Notes:
1. Only 17 year olds attending York Region Catholic and public high schools were assessed
2. 7 and 17 year olds attending York Region Catholic, public and French schools were assessed
3. 7 and 17 year olds attending York Region Catholic and public schools and 7 to 17 year olds attending York Region private and French schools were assessed
* refers to the total number of students who were non-compliant at the onset of enforcement

In 2012/2013, Public Health set out to build relationships with each of the private schools and their respective boards. This has been a major undertaking because the private schools are not unified by one all-encompassing board like the Catholic, French and Public boards. Public Health recently partnered with York Region's 71 private schools to administer the Immunization Act. This work resulted in 100 per cent compliance with the Act among private

school students age 7 to 17 during the 2017/18 school year within the 70 schools who provided student demographic records that year. Since that time, the additional private school has provided Public Health with their student demographic information. Immunization data for all 71 private schools will be captured in 2018/2019.

Under the Ontario Public Health Standards, Public Health is required to maintain immunization records for children in licensed child care centres

In York Region, licensed child care centre operators collect and retain immunization information from parents, and provide it to Public Health upon request. In the event of a vaccine-preventable disease occurring in a licensed child care centre, Public Health can assess each child's records to decide who to exclude and who can safely remain in the child care centre.

Immunization information for children currently in licensed child care centres is captured in the Immunization Act school enforcement activities when the children turn seven. Moving forward, Public Health will focus on collecting information from younger cohorts since most of the publicly-funded immunizations recommended for children are to be given before school entry (Attachment 1). The earlier Public Health can ensure up-to-date records, the more streamlined the Immunization Act process is once children are enrolled in school.

Parents or guardians are able to obtain a medical or conscience/religious belief exemption if they choose not to immunize their child

Medical exemptions are available to children who are unable to receive a vaccine for medical reasons. Parents may request a medical exemption for a child who has a life-threatening allergy and cannot receive a vaccine that contains the allergy-inducing component, or for a child who is undergoing certain treatments for cancer. A written statement from a physician or a nurse practitioner outlining medical reason(s) why the child should not be immunized must be provided to public health to obtain a medical exemption. For the 2017/18 school year, less than one per cent of 7 year-old students in York Region obtained a medical exemption.

A non-medical exemption may be obtained when a parent or guardian has chosen not to vaccinate their child based on conscience or religious belief. Parents or guardians wishing to file a non-medical exemption must complete a "statement of conscience or religious belief" form, have their exemption form signed and affirmed before a lawyer or notary public, and submit to Public Health. In addition, the Immunization Act requires parents or guardians who are requesting an exemption based on conscience or religious beliefs to attend an education session developed by the Ministry of Health and Long-Term Care (Ministry). Public Health provides these sessions at the immunization clinic located at the Newmarket Health Centre. For the 2017/18 school year, approximately one per cent of 7 year-old students in York Region obtained a religious or conscience (non-medical) exemption. Previous Ontario data suggest that non-medical exemptions are increasing over time, however, the absolute proportion remains low, at less than 2.5 per cent on average for the province.

Public Health uses immunization data from the age seven cohort to estimate immunization coverage

Health units across Ontario report data for the age 7 cohort because most childhood vaccines are administered by this age. Seven year-old students in York Region have higher than average immunization coverage rates compared to the rest of the province. For example, for the 2017/18 school year, the proportion of 7 year-old students (those born in 2010) who are up-to-date for immunizations under the Act in York Region is 86.9 per cent, compared to the provincial average of 79.5 per cent. For specific diseases, York Region students have immunization coverage comparable to the provincial average for the 2016/17 school year (Table 2).

Table 2

Immunization Coverage Estimates[1] (%) for 7 year-olds for Key Childhood Vaccines, 2016/17 school year

	Measles	Mumps	Rubella[2]	Tetanus	Pertussis	Polio
York Region	90.7	90.5	94.1	84.8	84.7	84.9
Ontario	91.2	91.1	96.2	84.7	84.6	85.0

Notes:
1. more robust estimates of vaccine coverage are not available because Ontario does not have a provincial immunization registry
2. the Provincial definition of up-to-date is ≥1 valid dose of rubella compared to ≥2 valid doses for measles and mumps

Public Health is well-positioned to respond in the event of a vaccine-preventable disease case or outbreak in a school, such as measles

Measles has been in the news recently with outbreaks in New York City, Vancouver, and recently, a report of an infected individual being in a public place in York Region. In the event of a measles case in a York Region school, Public Health can quickly determine those students whose records indicate inadequate protection (based on immunization history or exemptions). For students who are under-immunized, the measles vaccine can be administered within 72 hours of exposure to help prevent them from becoming sick, or they can be removed from school to ensure their safety and the safety of others.

Public Health has implemented an eight-year strategic program plan for implementation of the Immunization Act

York Region has the third largest student population in Ontario, with 194,082 students in 408 schools. Immunization information recorded in the Digital Health Immunization Repository covers approximately 83 per cent of students aged 4 to 17, and 95 per cent of students, aged 7 to 17, attending schools in York Region. By June 2023 the annual student record

assessment and the Act enforcement expansion will include all York Region students aged 7 to 17 and moving forward will continue to include every student within this age range, with the exception of the age 12 cohort, which currently receive immunizations directly from Public Health through the grade 7 program.

Once the immunization records of all students, aged 7 to 17 have been collected, Public Health will begin collecting immunization records for school aged children less than seven years of age. Currently, immunization information captured in the Digital Health Immunization Repository covers approximately 33 per cent of students aged four to six. Under Ontario's publicly-funded immunization schedule, two vaccines are administered between the ages of four to six; however immunization records are not captured until age seven when Public Health collects student demographic information from the schools under the Immunization Act.

York Region Public Health and the Council of Ontario Medical Officers of Health strongly support creation of an immunization registry

A major challenge to administration of the Immunization Act is the lack of a provincial immunization registry to seamlessly transfer immunization information from primary health care providers at the time the vaccine is administered, to the Digital Health Immunization Repository. Self-reporting of immunization information without verification is the standard across all Ontario health units. Public Health Units across Ontario do not have a process to verify the "yellow card" with primary health care providers since this would be immensely labour intensive and costly. It is possible some inaccuracies exist in records collected by Public Health because of the reliance on parents to provide immunization information themselves.

In March 2019, the Council of Ontario Medical Officers of Health – a subgroup of the Association of Local Public Health Agencies representing Associate Medical Officers of Health and Medical Officers of Health across the province – wrote to the Minister of Health and Long-Term Care supporting the Ministry's proposed plan to develop a provincial Electronic Medical Record and merge it with the Digital Health Immunization Repository (Attachment 2). This Electronic Medical Record - Digital Health Immunization Repository integration project would allow for the seamless reporting of immunizations from primary health care providers at the time of vaccine administration directly to local public health.

Public Health is very supportive of the recommendation made by the Council of Ontario Medical Officers of Health that the Ministry assume the role of the health information custodian for the Digital Health Immunization Repository. The Ministry has previously assumed this role with the Ontario Laboratory Information System and the Digital Health Repository. The Ministry taking on the role of the health information custodian, instead of 35 Medical Officers of Health doing so would mean a more consistent approach in obtaining consent for the collection of vaccine information not covered under the Immunization Act.

Immunization Act enforcement supports the corporate strategic goal of supporting community health, safety and well-being

The York Region *2019 to 2023 Corporate Strategic Plan: From Vision to Results* articulates the corporate priority of supporting community health, safety and well-being. Enforcing the Immunization Act among designated cohorts of students supports this priority.

5. Financial

In 2018, activities related to enforcement of the Immunization Act were managed within the Public Health Branch council approved budget of $65.7 million. Table 3 provides a summary of the budget for Public Health in 2018. In 2019, program activities related to the enforcement of the Act will continue to be managed within the approved Public Health Branch budget of $68.4 million

Table 3

Public Health Branch 2018 Financial Summary

	2018 Budget ($'000)	2019 Budget ($'000)
Gross expenditures	65,750	68,365
Provincial funding	(48,746)	(49,962)
Net Levy	17,004	18,403

6. Local Impact

There is no direct impact from these recommendations on local municipalities. Enforcement of the Immunization Act relies heavily on partnerships with the local public, Catholic, and French school boards and individual private schools to support suspension orders. Enforcement will continue on a yearly basis to ensure students comply with the legislation and to ensure that students are vaccinated as they move through the publicly-funded immunization schedule, before they reach their 18th birthday when they no longer fall within the requirements of the Immunization Act.

7. Conclusion

York Region Public Health protects the health of the community by preventing vaccine-preventable diseases among our growing population. In light of recent media reports of vaccine-preventable disease outbreaks and issues relating to our current system of

immunization data collection, Public Health will continue to collaborate with parents, local school boards, and individual schools to ensure compliance of the Act, improve immunization rates and protect the health of our communities. Moving toward a seamless immunization registry would increase efficiencies and result in more accurate information about vaccine coverage in the population, supporting public health interventions in the event of a school outbreak or exposure to a vaccine-preventable disease.

For more information on this report, please contact Marjolyn Pritchard, Director, Infectious Disease Control at 1-877-464-9675 ext. 74120. Accessible formats or communication supports are available upon request.

Recommended by: **Katherine Chislett**
Commissioner of Community and Health Services

Dr. Karim Kurji
Medical Officer of Health

Approved for Submission: **Bruce Macgregor**
Chief Administrative Officer

April 17, 2019
Attachments (2)
#9309454

Publicly Funded Immunization Schedules for Ontario – December 2016

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

Routine Schedule: Children Starting Immunization in Infancy

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

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

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

ATTACHMENT 1

Ontario

ATTACHMENT 2

coMOH
Council of Ontario
MEDICAL OFFICERS OF HEALTH

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The Council of Ontario Medical Officers of Health (COMOH) is a Section of

alPHa
Association of Local PUBLIC HEALTH Agencies

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

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

March 14, 2019

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

Dear Minister Elliott,

Re: Support of Immunizations and the Electronic Medical Record (EMR) and Digital Health Immunization Repository (DHIR) Integration Project

On behalf of the Council of Ontario Medical Officers of Health, I am writing to express our thanks for the Minister's support of immunizations and the immunization programs in Ontario. Getting the public support of the Minister in the face of so much misinformation on vaccines is very valuable and appreciated.

We would also like to provide our full support to the Ministry for moving forward with online health records for patients, and in particular, the Electronic Medical Record (EMR) and Digital Health Immunization Repository (DHIR) Integration Project, namely the seamless reporting of immunizations from health care providers directly to local public health. This will reduce the considerable burden on parents to manually report their child's immunizations to local public health units. It will also be more efficient and ensure more accurate vaccine records. If done well, it could also serve as a model for future digital integration between electronic medical record solutions and other provincial health digital assets, supporting the Ontario government's priorities for digitization.

Public health uses vaccination records in the DHIR to prevent and stop outbreaks of infectious diseases such as measles. When EMR integration with the DHIR is established, in order for a vaccination record to be shared between a patient's physician and public health, consent from the patient or their guardian would be required. We would like to encourage the Ministry to consider removing the need for individual informed consent to share vaccine records to improve the efficiency for public health to prevent the spread of infectious diseases.

The Ministry might also consider being the Health Information Custodian for immunization records in the DHIR, administering the DHIR in a manner similar to other Ministry assets like the Ontario Laboratory Information System (OLIS) and the Digital Health Drug Repository. This would further simplify the system by eliminating the need for individual agreements between each of the 35 local public health units and the Ministry and streamline the current process where each local PHU must verify immunization records as they are added to the DHIR.

If the Ministry prefers that local medical officers of health remain the health information custodians for the immunization records of their respective health units, a new consent form would be required. A Ministry-approved, IPC-compliant consent form for the collection of non-ISPA/CCEYA information would be needed for use by all 35 public health units prior to the project being implemented.

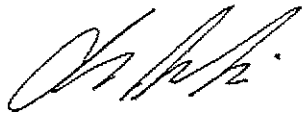
Having one database containing the immunization records for all Ontarians would also provide added protection and benefit when outbreaks of infectious diseases occur: quickly identifying those that are susceptible and vulnerable and inform the provision of timely vaccinations to interrupt transmission.

Vaccine wastage or inappropriate administration could also be managed by permitting patients and health care providers across the province to easily access recorded immunization histories.

The proposed project is also consistent with the mention in "Ending Hallway Medicine" to consider technology solutions to improve health outcomes for patients, to integrate care at the local level, and to identify options for integrated health information systems that would facilitate smooth transfers between care settings, in this case from doctor's offices to local public health.

To that end, we thank you again for your announced commitment to this project and look forward to working with your office towards an efficient health care system that meets the needs of Ontarians.

Yours sincerely,



Dr. Chris Mackie
Chair, Council of Ontario Medical Officers of Health

COPY: Dr. David Williams, Chief Medical Officer of Health
Dr. Rueben Devlin, Chair, Premier's Council on Improving Healthcare and Ending Hallway Medicine