<table>
<thead>
<tr>
<th>Item</th>
<th>Agenda Item</th>
<th>Lead</th>
<th>Expected Outcome</th>
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<tbody>
<tr>
<td>1.0</td>
<td>Call to Order, Recognition of Quorum</td>
<td>Chair</td>
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<td></td>
<td>• Introduction of Guests, Board of Health Members and Staff</td>
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<tr>
<td>1.1</td>
<td>Approval of Agenda</td>
<td>Chair</td>
<td>Decision</td>
</tr>
<tr>
<td>1.2</td>
<td>Reminder to disclose Pecuniary Interest and the General Nature Thereof when Item Arises</td>
<td>Chair</td>
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<tr>
<td>1.3</td>
<td>Reminder that Meetings are Recorded for minute taking purposes</td>
<td>Chair</td>
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</tr>
<tr>
<td>2.1</td>
<td>Approval of Minutes from October 10, 2018</td>
<td>Chair</td>
<td>Decision</td>
</tr>
<tr>
<td>3.1</td>
<td>Annual Report 2017 - KFL&amp;A Public Health</td>
<td>Cynthia St. John</td>
<td>Information Only</td>
</tr>
<tr>
<td>3.2</td>
<td>AMO Policy Update - AMO Recommendations: Bill 36 Ontario Cannabis Statute Law Amendment Act, 2018 October 15, 2018 – AMO Summary: This email communication summarizes the review and advisory work made on the Cannabis Statute Law Amendment Act, provides next step guidance to Municipal Governments as well as a summary of key knowledge from the act.</td>
<td>Cynthia St. John Peter Heywood</td>
<td>Information Only</td>
</tr>
<tr>
<td>3.3</td>
<td>Drug Policy Reform September 27, 2018 – KFL&amp;A Public Health Summary: This letter expresses the health units support to urge the federal government to strike a national advisory committee to consider drug policy reform, which will include the full spectrum of decriminalization options</td>
<td>Peter Heywood</td>
<td>Information Only</td>
</tr>
<tr>
<td>3.4</td>
<td>Smoke-Free Ontario Act July 3, 2018 – Peterborough Public Health September 20, 2018 – Haliburton, Kawartha, Pine Ridge District Health Unit</td>
<td>Peter Heywood</td>
<td>Information Only</td>
</tr>
</tbody>
</table>
October 4, 2018 – Association of Local Public Health Agencies

**Summary:** These letters express the concern for the current Smoke-Free Ontario Act as outdated and needs to reflect the changes since its implementation 12 years ago.

| 3.5 | **Vapour Products Display and Promotion**  
October 22, 2018 - Association of Local Public Health Agencies  
**Summary:** This letter expresses the concerns about the proliferation of the promotion and display of vapour products. | Peter Heywood | Information Only |

| 3.6 | **alPHa – Board of Health Member Update – Executive Summary**  
October 26, 2018 - Association of Local Public Health Agencies  
**Summary:** This summary included a summary of meetings with MPPs regarding public health concerns, a summary from the letter dated October 22nd regarding the Cannabis and Smoke Free Ontario Act, Ministry realignment regarding alPHa, the creation of a webpage to collect information on Public Health ROI, upcoming events and meetings for all Board of Health Members. | Cynthia St. John | Information Only |

| 4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION | None. |
| 5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.ACCEPTANCE.DECISION | None. |
| 5.1 | **Position Statement - Harm Reduction**  
Peter Heywood | Acceptance |
| 5.2 | **Chief Executive Officer’s Report for November 2018**  
Cynthia St. John | Acceptance |

| 6.0 CLOSED SESSION | None. |
| 7.0 RISING AND REPORTING OF THE CLOSED SESSION | None. |
| 8.0 FUTURE MEETINGS & EVENTS | None. |
| 8.1 | **Board of Health Regular Meeting – 2019 Schedule to be determined**  
Chair | Decision |
| 9.0 ADJOURNMENT | None. |
A meeting of the Board of Health for Oxford Elgin St. Thomas Health Unit was held on Thursday, October 10, 2018 at the St. Thomas Site location commencing at 5:30 p.m.

PRESENT:
- Mr. B. Wiehle, Board Chair
- Ms. H. Jackson, Board Member
- Ms. M. Lupton, Board Member
- Mr. L. Rowden, Board Member
- Mr. S. Wookey, Board Member
- Ms. C. St. John, Chief Executive Officer
- Dr. J. Lock, Medical Officer of Health
- Ms. T. Terpstra, Executive Assistant

GUESTS:
- Mr. D. McDonald, Director, Corporate Services & Human Resources
- Mr. P. Heywood, Program Director
- Ms. C. Walker, Program Director
- Ms. S. MacIsaac, Program Director
- Ms. E. Arnett, Program Manager
- Ms. J. Allan, Public Health Nurse
- Ms. J. Deroo, Public Health Nurse
- Ms. J. Magill, Public Health Nurse
- Ms. J. Wyscaver, Public Health Nurse

REGRETS:
- Mr. D. Marr, Board Member
- Mr. D. Mayberry, Board Vice-Chair

REMEMBER OF DISCLOSURE OF PECUNIARY INTEREST AND THE GENERAL NATURE THEREOF WHEN ITEM ARISES
1.1 **AGENDA:**

**Resolution # (2018-BOH-1010-1.1)**
Moved by S. Wookey
Seconded by L. Rowden

That the agenda for the Southwestern Public Health Board of Health meeting for October 10, 2018 be approved as amended.

Carried.

Amendment noted was the addition of a verbal report from MOH concerning Bill 36 and the Cannabis Act.

2.0 **APPROVAL OF MINUTES:**

**Resolution # (2018-BOH-1010-2.1)**
Moved by L. Rowden
Seconded by S. Wookey

That the minutes from the Southwestern Public Health Board of Health meeting held September 20, 2018 be approved.

Carried.

3.0 **CONSENT AGENDA:**

**Resolution # (2018-BOH-1010-3.0)**
Moved by S. Wookey
Seconded by L. Rowden

That the Board of Health for Southwestern Public Health receive and file consent agenda items 3.1 – 3.3.

3.1 Basic Income Letter to Premier/Minister
3.2 Tobacco Control to Minister Elliott
3.3 Cannabis Sales Taxation Endorsement to Premier

4.0 **CORRESPONDENCE RECEIVED REQUIRING ACTION:**

None.

5.0 **CORRESPONDENCE RECEIVED AND FILED:**

None.

6.0 **AGENDA ITEMS FOR INFORMATION.DISCUSSION.DECISION:**
Resolution # (2018-BOH-1010-6.1)
Moved by L. Rowden
Seconded by S. Wookey

That the Board of Health for Southwestern Public Health receive the Cannabis 101 presentation for October 2018 as presented.

Carried.

The Board of Health discussed the importance of having Public Health part of conversations and preliminary planning levels in relation at the municipal council levels when discussing drug strategies and policies.

Resolution # (2018-BOH-1010-6.2)
Moved by S. Wookey
Seconded by L. Rowden

That the Board of Health for Southwestern Public Health receive the World Breastfeeding Week presentation for October 2018 as presented.

Carried.

Resolution # (2018-BOH-1010-6.3)
Moved by L. Rowden
Seconded by S. Wookey

That the Board of Health for Southwestern Public Health accept the Sleep Report for October 2018.

Carried.

Resolution # (2018-BOH-1010-6.5)
Moved by H. Jackson
Seconded by L. Rowden

That the Board of Health for Southwestern Public Health accept the Medical Officer of Health’s Report for October 2018.

Carried.

Dr. Lock noted that the Government of Ontario requested feedback on its amendments (Bill 36) to the SFOA 2017 and the Cannabis Act (2017).

An in-person meeting with government representatives was attended by the president of association of Local Public Health Agencies (alPHa) LPHA and the Chair of the Council of Ontario Medical Officers of Health (COMOH).

Dr. Lock highlighted that the proposed amendments include:
1. Smoke Free Ontario Act (SFOA) will apply to smoking and vaping of all cannabis products, both medicinal and non-medicinal.
2. Prohibition of smoking of cannabis in the same places as smoking and vaping products are prohibited.
3. Restrictions for vapour products display, promotion, and handling that are less restrictive than tobacco products.

Dr. Lock noted that Public Health has concerns regarding Bill 36 including:
- Normalization of smoking, health risks of second hand exposure and impairments;
- Second hand smoke contains many of the same toxic products as tobacco smoke – need extra precautions around those at greater risk - children, pregnant women, older adults and those with pre-existing conditions such as asthma, chronic obstructive pulmonary disease and heart conditions, should avoid exposure;
- Gaps in areas where smoking is prohibited - entranceways to public buildings and workplaces, transit stops, sidewalks in downtown cores, and post-secondary campuses;
- The federal restrictions under the Tobacco and Vaping Products Act does not prohibit displays and advertising for information for non-tobacco vaping products, which will be difficult to enforce, and will not stop the use of 3D displays, signs and posters at retail;
- Public health recommends a precautionary approach to flavoured vapour products by prohibiting flavours that are attractive to youth;
- In store testing and sampling is problematic:
  - Difficult to enforce restrictions,
  - Health effects to employees from second-hand exposure,
  - Health effects from sharing between customers;
- Challenges to PH capacity to respond to complaints and concerns;
- Need for a buffer distance between retail outlets and schools and limit retail density to reduce exposure;
- Need for amendments to Ontario Municipal Act to allow municipalities to create bylaws which further protect public health and safety through greater controls on tobacco, e-cigarette and cannabis use.

Resolution # (2018-BOH-1010-6.4)
Moved by M. Lupton
Seconded by S. Talbot

That the Board of Health for Southwestern Public Health accept the Chief Executive Officer’s Report for October 2018.

Carried.

Resolution # (2018-BOH-1010-6.4A)
Moved by M. Lupton
Seconded by S. Talbot

That the Board of Health for Southwestern Public Health approve the amended terms of reference for the Finance and Facilities Standing Committee.
Resolution # (2018-BOH-1010-6.4C)
Moved by M. Lupton
Seconded by S. Talbot

That the Board of Health for Southwestern Public Health approve the purchase of consultative project management support, equipment, and licensing costs related to the records and information management system for Southwestern Public Health.

Carried.

7.0 TO CLOSED SESSION:

Resolution # (2018-BOH-1010-7)
Moved by M. Lupton
Seconded by S. Talbot

That the Board of Health moves to closed session in order to consider one or more the following as outlined in the Ontario Municipal Act:
(a) the security of the property of the municipality or local board;
(b) personal matters about an identifiable individual, including municipal or local board employees;
(c) a proposed or pending acquisition or disposition of land by the municipality or local board;
(d) labour relations or employee negotiations;
(e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
(f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
(g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act;
(h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;
(i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;
(j) a trade secret or scientific, technical, commercial or financial information that belongs to the municipality or local board and has monetary value or potential monetary value; or
(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board. 2001, c. 25, s. 239 (2); 2017, c. 10, Sched. 1, s. 26.

Other Criteria:
(a) a request under the Municipal Freedom of Information and Protection of Privacy Act, if the council, board, commission or other body is the head of an institution for the purposes of that Act; or
(b) an ongoing investigation respecting the municipality, a local board or a municipally-controlled corporation by the Ombudsman appointed under the Ombudsman Act, an Ombudsman referred to in subsection 223.13 (1) of this Act, or the investigator referred to in subsection 239.2 (1). 2014, c. 13, Sched. 9, s. 22.

Carried.
8.0 RISING AND REPORTING OF CLOSED SESSION:

**Resolution # (2018-BOH-1010-C8)**
Moved by S. Talbot
Seconded by M. Lupton

That the Board of Health rise with a report. 
Carried.

**Resolution # (2018-BOH-1010-1.2C)**
Moved by S. Talbot
Seconded by M. Lupton

That the Board of Health for Southwestern Public Health approve the Chief Executive Officer’s report for October 10, 2018 as presented.
Carried.

**Resolution # (2018-BOH-1010-1.3C)**
Moved by H. Jackson
Seconded by S. Wookey

That the Board of Health for Southwestern Public Health approve the Human Resources Report for October 10, 2018 as presented.
Carried.

10.0 ADJOURNMENT:

**Resolution # (2018-BOH-1010-9)**
Moved by S. Talbot
Seconded by M. Lupton

That the meeting adjourns at 7:22 p.m. to meet again on Wednesday, November 14, 2018 at 5:30 p.m.
Carried.

Confirmed: ________________________________
Our agency

KFL&A Public Health is a local public health agency with over 200 staff and 150 volunteers who deliver public health programs and services to the people of the KFL&A area. The underlying goal of our services and programs—from immunization, healthy weights, nutritious eating, food safety, raising healthy babies and children, sexual health, tobacco use reduction, and many other public health areas—is to promote and protect the health of the more than 190,000 residents of the Kingston, Frontenac and Lennox & Addington region.

Vision

Healthy People, Healthy Places
Mission

public's health and strives to reduce health disparities through a skilled and dedicated work force that collaborates with our partners and communities and engages our residents to be as healthy as they can be.

Mandate

We are directed by Ontario's Health Protection and Promotion Act, and the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability. We develop and implement evidence-informed policies, programs, and services to address the public health needs of the residents in the KFL&A region.

2017 Board of Health

- Denis Doyle (Chair) – County of Frontenac
- Wess Garrod (Vice-Chair) – Community Appointee
- Florence Campbell – Community Appointee
- Councillor Mary Rita Holland – City of Kingston
- Councillor Jim Neill – City of Kingston
- Councillor John Wise – County of Lennox & Addington
- Councillor Jeff McLaren – City of Kingston
- Conny Glenn – Community Appointee
- David Pattenden – Community Appointee

Message from KFL&A Board of Health Chair, Denis Doyle

I am pleased to submit this second report as chair of the Kingston, Frontenac and Lennox & Addington Board of Health. It is an honour for me to have been elected as chair in January 2017.

Each year, local public health agencies in Ontario face new and ongoing challenges, and 2017 was no exception. The provincial portion of the budget freeze that began unexpectedly in 2015 for 28 of the 36 local public health agencies in Ontario has continued, leading to cuts that are difficult for all who provide and receive our services. The impact of the provincial freeze has been minimized across our KFL&A region due to the generosity of our eleven municipal partners who provided a 2% inflationary increase in funding. Thus, we have minimized cuts to our programs and staffing and have been able to preserve an appropriate level of public health services to our communities. However, the municipal share of the 2017 cost-shared budget increased to 38.16%, in spite of the fact...
that funding formula suggests the Province of Ontario is to provide 75% of health unit funding and the municipalities only 25%.

In April 2017, the federal government introduced Bill C-45, an Act respecting cannabis and to amend the Controlled Substances Act, the Criminal Act and other Acts. Upon coming into effect on October 17, 2018, the Act will legalize and regulate recreational use of Cannabis nationwide. KFL&A Public health, along with other local public health agencies in Ontario, will work closely with the province to develop public health-focused regulations on cannabis and their enforcement to protect population health and safety. Ensuring the distribution and sale system is meeting the current demand, and not creating a new market, will minimize cannabis-related harms and their attendant costs. KFL&A public health will develop and deliver community prevention and education strategies, including targeted risk communication, allowing more control of the risk factors and a reduction in harm associated with cannabis use.

In December 2016, Ontario passed the Patients First Act to help ensure patients and their families obtain better access to a more local and integrated health care system, improving the patient experience and delivering higher-quality care. The public health system in Ontario is managing the new relationship with the Local Health Integration Networks (LHINs). While the funding and accountability of local Boards of Health ultimately was not in the Patients First Act, the requirement to collaborate on health data from planning health services is part of that act. KFL&A Public Health and other local public health agencies in the South-East are working with the South-East LHIN throughout this process. Additionally, we will continue to strengthen and enhance our collaboration with communities and health system partners and pursue opportunities that foster efficiency and innovation and increase the effectiveness of our services to ensure a greater return on investment.

Finally, I want to thank the Board for their thoughtful leadership, and their support for me as their chair. It is a pleasure to work with you all. Most importantly, I want to thank the very professional, competent and dedicated staff of Kingston, Frontenac and Lennox & Addington Public Health who work so hard day in and day out to improve, and ensure, the health of all residents across our region.

**Message from the Medical Officer of Health, Dr. Kieran Moore**

Over the last year, our agency has been working diligently to address critical health issues in the community: a severe influenza season, tick-borne diseases, lung cancer due to radon exposure in indoor air, the legalization of cannabis, and the opioid epidemic. In collaboration with partners, we have continued to address the opioid epidemic by increasing Naloxone distribution, partnering to open the Overdose Prevention Site, creating a community drug strategy, and educating physicians and the public about the risks of opioids. Significant work is underway to minimize the impact of these new threats on the health of the community.

There are also new initiatives in the provincial public health system. We are now in the implementation phase of the newest revision of the Ontario Public Health Standards (OPHS). As the OPHS are the core work of public health, this revision has important consequences across Ontario’s public health system. For example, there is a new focus on health equity, and our agency has already begun incorporating its principles into daily practices. Our priorities include monitoring and reporting of health inequities, applying proportionate universalism to our programming and services, meeting the needs of vulnerable populations, and working closely with local Indigenous communities.

We have completed the first year of our agency’s new strategic plan, which will continue to run through 2021, and be reviewed in 2019. We have made progress on the five pillars, and will keep working to:

- Provide programs and services of high quality that are supported by the best evidence.
- Champion, support and deliver strategies and initiatives to address health disparities, and priority and emerging health issues.
- Strengthen and enhance our collaboration with communities and partners.
- Invest in a healthy and supportive work environment where everyone lives our values.
- Foster efficiency and innovation to maximize the impact of our resources.

There is still a lot to do to keep our community healthy. Our region needs an integrated vision for health, focusing on prevention and health promotion. Almost 40 years ago, James Fries proposed the concept of “compression of morbidity” in which increased life expectancy would be accompanied by an increased quality of life, and lower incidence of chronic disease. However, over the last two decades, length of life with disease and loss of functional
mobility has increased. The reactionary emphasis on disease treatment and cure has made our system forbiddingly unaffordable. To improve quality of life and the financial security of our health system we need a greater emphasis on health promotion and disease prevention.

We are ever aware of the fiscal reality in Ontario and will strive to increase efficiency, effectiveness and return on investment of public health services. In the realms of public health, a relatively small investment provides our communities with considerable benefit. For example, every $1 invested in immunizing children saves $16 in health care costs; every $1 invested in tobacco prevention saves $20 in future health care costs. For the greatest long-term impact, we must also address the social determinants of health as root causes of disease.

Finally, I would like to thank Dr. Gemmill, who stepped down on June 30, 2017, after more than 20 years of service in this community. His legacy is a well organized and well managed agency, full of hard working health professionals who deliver important services to our community. We look forward to continuing to work with our dedicated Board members and staff to continue to improve the health for all in KFL&A.

KFL&A region at a glance

65.4% of the KFL&A population, ages 12 and over, reported excellent or very good mental health.

The KFL&A region had the highest number of human cases of Lyme disease in 2017 across the entire province (195 confirmed cases). This number was three times higher than that of 2016. The Leeds, Grenville and Lanark region was the only area that had
a higher rate per 100,000 population than KFL&A.

28.1% of mothers in KFL&A exclusively breastfeed their babies until about 6 months of age.

The KFL&A region has not had a case of Hepatitis A since 2011, making our region one of only five in Ontario to boast that statistic.

Rates of chlamydia continue to remain above provincial averages. The KFL&A region had a rate of 452 cases per 100,000 people in 2017 and were only eclipsed by the Northwestern Health Unit with a rate of 713. For comparison, Ontario's overall rate was 313 cases per 100,000 people.

72.7% of the KFL&A population, ages 12 and over, reported that they protect themselves from the sun.
The opioid epidemic that is sweeping across Canada has not spared the KFL&A region. Opioid related deaths remained relatively stable in the region between 2007 and 2015 but in 2016 rose sharply to an average of 8 deaths per 100,000 people, compared to 6.2 deaths per 100,000 in Ontario.

69.6% of youth, ages 12 to 18, in KFL&A reported a very strong or somewhat strong sense of community belonging.

Consumption of sugar-sweetened beverages has a significant impact on the total sugar consumption of Canadians. Sugar-sweetened beverages include soft drinks (i.e., soda or pop), energy drinks, sweetened milk or milk alternatives, and any other beverages to which sugars or syrups are added. As children get older, they often consume more sugar from soft drinks. Consumption is a concern in adolescents, who consume 7 to 8 percent of their daily energy intake in sugar-sweetened beverages alone.

A health communications campaign was developed by KFL&A Public Health to increase awareness of the importance of water and encourage...
parents to offer their children water instead of sugary drinks. The campaign, Choose Water, was launched in July 2017 and ran until October 2017, featuring videos that provided parents with strategies to help make water the easy choice for children, as well as posters and brochures that were distributed by various community agencies and local partners.

The Choose Water message support the agency’s strategic plan priority topic area—healthy eating. Over the next five years, the agency will continue to promote the Choose Water message to parents, working towards the long-term goal of creating a social environment that support healthy choices, allowing parents to confidently utilize strategies to replace sugary drinks with water. Further, phase two of the Choose Water campaign, launching in 2019, will engage youth in the development of messages designed to encourage youth to leave the sugary drinks behind and choose water.

KFL&A Public Health was engaged by the Information Management, Data, and Analytics (IMDA) Branch of the Health System Information Management Division of the Ministry of Health and Long-Term Care (MOHLTC) to develop a prototype Hospital Surge Monitor. The overall project goal was to develop an approach to monitor—and ultimately predict—hospital emergency department (ED) and acute occupancy surge. Additionally, the project sought to provide the technological basis to develop a plan for a single, integrated provincial event repository (or streaming service) of real-time data to support the management of hospital ED and inpatient occupancy surges.

The Surge Monitor was built with two different data feeds that leverage an existing system to minimize duplication and streamline reporting:

1. acute care visits using real-time records reported to the Acute Care Enhanced Surveillance (ACES) System, administered by KFL&A Public Health, to extract relevant data elements to monitor ED volumes in ACES-participating acute care facilities; and

2. the data elements included in the data feeds for the South East Health Integrated Information Portal (SHIIP), also administered by KFL&A Public Health, which may allow for access to the data elements needed to estimate surge capacity for
participating facilities within the South East Local Health Integration Network (SELHIN).

The capacity for real-time assessment of surge varied with the data source, as ACES and SHIIP provide different patient information (e.g., data for ACES includes time of admission, acuity, patient demographics, chief complaint, and disposition). Surge capacity is generally defined as a measurable representation of the ability of a facility to manage a sudden influx of patients, and ACES data provide a high-level view of the movement of patients in and out of the ED but provide no information regarding movement within the different administrative subunits of a specific facility, a parameter which may afford a clearer understanding of surge capacity. SHIIP data elements, on the other hand, enables a deeper dive into the data elements needed to estimate surge capacity (e.g., SHIIP’s databases include multiple data elements for patients as they move between primary, acute, and tertiary healthcare providers). These additional data elements provide the increased measure of granularity regarding patient movement within a facility to estimate and predict surge capacity.

KFL&A Public Health provided the MOHLTC with both real-time data dashboards for provincial, regional, and local assessments of surge with recommendations and lessons learned for further research and product development. KFL&A Public Health is currently working with the SELHIN to develop a local product to provide surge capacity monitoring for our hospitals, to improve emergency management and simplify inter-hospital communications.

Performance indicators

Percentage of Class A pools inspected while in Operation: 92.3%

Percentage of personal service settings inspected annually: 70.7%

Percentage of high risk food premises inspected once every 4 months: 95.8%
Percentage of tobacco vendors in compliance with youth access legislation at the time of last inspection: 100%

Percentage of tobacco retailers inspected once per year for compliance with display, handling, and promotion sections of the Smoke-Free Ontario Act: 100% non-seasonal and 100% seasonal

Financial Report
Public health programs revenue: $23,728,522
### Operating expenditures

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<th>Amount</th>
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<td>Small drinking water systems</td>
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<td>Enhanced food safety/safe water</td>
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<td>Public health nurses initiative</td>
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<td>Hospital surge monitoring</td>
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<td>Preschool Speech and Infant Hearing program</td>
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<td>Private sewage program</td>
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<td><strong>Provincial grants</strong></td>
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<td><strong>City of Kingston</strong></td>
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<td><strong>City of Frontenac</strong></td>
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<td><strong>County of Lennox and Addington</strong></td>
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<td><strong>Other revenues</strong></td>
<td><strong>8%</strong></td>
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<td>Special project expenses</td>
<td>$956,004</td>
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<td>Ontario Works program</td>
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For a copy of the full financial report, please contact Alida Moffat, Manager, Finance

**Contact Us**

**Kingston**

KFL&A Public Health  
221 Portsmouth Avenue  
Kingston, ON  
K7M 1V5  
Telephone: 613-549-1232  
Toll Free: 1-800-267-7875  
Fax: 613-549-7896

Hours of operation  
Monday to Friday: 8:30 a.m. to 4:30 p.m.

**Napanee**

KFL&A Public Health  
99 Advance Avenue  
Napanee, ON  
K7R 3Y5  
Telephone: 613-354-3357  
Fax: 613-409-6267

Hours of operation  
Monday to Friday: 8:30 a.m. to 4:30 p.m.  
Closed for lunch between 12:00 p.m. and 1:00 p.m.

**Cloyne**

KFL&A Public Health  
P.O. Box 59  
14209 Highway 41  
Cloyne, ON  
K0H 1K0  
Telephone: 613-336-8989  
Fax: 613-336-0522

Hours of operation  
Monday to Friday: 8:30 a.m. to 4:30 p.m.  
Closed for lunch between 12:00 p.m. and 1:00 p.m.

**Sharbot Lake**

KFL&A Public Health  
P.O. Box 149  
1130 Elizabeth Street
Bill 36 Ontario Cannabis Statute Law Amendment Act – Ready for Legislative Approval

Next Steps for Municipal Governments

A. What is Happening?

The Standing Committee on Social Policy completed its work today and the Bill will be report to the Legislature for 3rd Reading and anticipated Royal Assent for October 17th. Many groups, including AMO recommended changes to clarify elements of the framework, the Committee made only one change. It clarifies that the amount of cannabis sold at one time to an individual is limited to 30 grams, in line with individual possession limits under federal legislation.

Bill 36 will be the framework for sales, retailer licensing, store licensing, places of use and other cannabis rules on Wednesday, barring any unforeseen events. While the Committee did not accept the amendments AMO proposed, AMO will now focus on the regulation-making process to try to safeguard municipal input to the AGCO on siting and buffers from sensitive sites. For more information on AMO’s Submission to the Committee, see AMO’s Recommended Amendments to Bill 36.

B. What Do You Need To Do? Next Steps for Municipal Governments

Municipal staff need to become familiar with Bill 36 and the legal framework for recreational cannabis. Municipal staff need to understand the Bill and be ready to respond to inquiries about where people are able to use cannabis in
public and manage nuisance complaints. See AMO’s Cannabis Briefing for more on the Smoke Free Ontario Act and how it deals with places to smoke. A council may review its bylaw to be more restrictive.

Staff should also begin to research the information needed by council to take a decision on whether to opt-out of retail licensing which is required before January 22, 2018. To ensure sufficient time is available for council’s decision-making, staff will need to consider a work-back schedule taking into account the council meeting schedule and procedural by-law. AMO will continue to inform members of any significant developments that affect municipal council decisions and local services including the status and content of any regulations that put the legislative framework into effect.

Remember, Bill 36 exempts retail stores from municipal business licensing and land use planning. The Standing Committee chose not to explicitly require only areas zoned for commercial use as eligible for cannabis retail operations. We are hopeful that we can achieve this in the days ahead and a clear process for input to AGCO on cannabis retail store siting. In the meantime, AMO recommends that the appropriate municipal staff begin looking at siting considerations.

Ontario municipal governments will share at least $40 million of the provincial portion of the federal cannabis excise tax to help manage the transition to legal recreational cannabis. Individual municipalities will have access to at least $10,000 and more if cannabis retail stores are to be located in their communities. The no opt out contribution is a rate per household. AMO is seeking clarity on the amount and hold back for those that may opt out initially but opt in sometime in the future.

It is likely that municipal costs for legal recreational cannabis may exceed the municipal allocation of $40 million as front line policing (e.g., roadside and illegal dispensary), public health, by-law enforcement, paramedic and other services feel impacts. Ontario municipalities will share on a 50-50 basis with the province if the federal cannabis excise tax is above $100 million in the first two years of legalization.

C. What Else Do You Need To Know?
On October 17th, the federal government will lift criminal prohibitions on cannabis subject to certain limits. In Ontario, people will be able to grow, possess and use cannabis as set out in federal and provincial laws. People in Ontario can smoke or vape cannabis anywhere they can currently smoke tobacco. Public Health Units are responsible for enforcing places of cannabis and tobacco use including prohibitions on use in enclosed workplaces, near playgrounds and restaurant and bar patios, among others. Municipal governments are able to set stricter rules for use of tobacco and cannabis. Councils will need to consider community needs along with likely increase enforcement costs where more restrictions occur.

Retail establishments, licensed by the Alcohol and Gaming Commission of Ontario (AGCO), will open on or after April 1, 2019. AGCO operator license applications open in December 2018 with store site licenses to follow after councils decide whether to ban sales. Police forces are responsible for unlicensed storefronts. Current storefront operators that wish to avoid legal action or to obtain a license must close by the Wednesday to be eligible for an AGCO license.

Ontarians can buy cannabis on-line from the Ontario Cannabis Store (OCS) starting this Wednesday. The OCS will deliver cannabis to adults 19 and over anywhere in Ontario, including municipalities that choose not to host a retail store. Identification checks are required for delivery and packages cannot be left at the door. The OCS has created a cannabis learning resource for Ontario residents that focuses on the health and biological effects of the drug to help people better understand the risks of the product. It offers a great deal of information.

**AMO Contact:**

Craig Reid, Senior Advisor, creid@amo.on.ca, 416-971-9856 ext. 334.
THIS MESSAGE IS FOR THE USE OF THE INTENDED RECIPIENT(S) ONLY AND MAY CONTAIN INFORMATION THAT IS PRIVILEGED, PROPRIETARY, CONFIDENTIAL, AND/OR EXEMPT FROM DISCLOSURE UNDER ANY RELEVANT PRIVACY LEGISLATION. No rights to any privilege have been waived. If you are not the intended recipient, you are hereby notified that any review, re-transmission, dissemination, distribution, copying, conversion to hard copy, taking of action in reliance on or other use of this communication is strictly prohibited. If you are not the intended recipient and have received this message in error, please notify me by return e-mail and delete or destroy all copies of this message.
Dear Prime Minister Trudeau:

RE: Drug Policy Reform

Stakeholders across Canada are working tirelessly to address the ravages of the opioid overdose crisis. There have been many in-roads, and the Government of Canada should be applauded for supporting some of the foundational pieces necessary to address this issue which has resulted from the suffering of many Canadians including those who experience structural inequalities, untreated pain, and mental illness and addictions. However, the opioid crisis continues without relief.

The current policy framework in Canada continues to be oriented to prohibition and the criminalization of illegal substances. This policy approach has resulted in health and social harms including:

- institutionalized organized crime, illegal markets, corruption, and criminal organizations that produce crime, violent injuries, and deaths;
- spread of infectious diseases such as HIV and hepatitis by inhibiting the provision of harm reduction programs and services for various populations (e.g., people who are incarcerated or homeless);
- enforcement activities that drive people who use illegal drugs away from preventive and treatment programs and services, towards high risk environments and behaviours;
- increased availability and potency of illegal drugs resulting in hospitalizations and overdose deaths from concentrated and contaminated products;
- decreased access to basic needs such as nutrition, housing, transportation, etc. because of a lack of personal resources (e.g., employment);
- increased stigmatization, discrimination and marginalization of people who use drugs and the resulting health and social inequities;
- challenges to the criminal justice system’s capacity because of unsustainably high arrest, prosecution, and incarceration rates, and the lost opportunity costs of scare resources; and
- property damage and community disruption.

Drug policy reform needs to be considered as an alternate and compassionate approach to substance use in our communities. This policy reform needs to be informed by people with lived
experience and Indigenous communities, focused on upstream approaches, and take a harm reduction approach to substance use. Illicit drug decriminalization needs to be considered as a fundamental element of comprehensive drug policy reform.

At the September 26, 2018 meeting of the KFL&A Board of Health, the following motion was passed:

THAT the KFL&A Board of Health urge the federal government to strike a national advisory committee to consider drug policy reform, which will include the full spectrum of decriminalization options that may have the potential to address the opioid overdose crisis, and that are best supported by evidence informed prevention, harm reduction and treatment interventions, and send correspondence to:

1) The Right Honourable Justin Trudeau, P.C, M.P., Prime Minister of Canada
2) Honourable Ginette Petitpas Taylor, Minister of Health
3) Honourable Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada
4) Mark Gerretsen, MP Kingston and the Islands
5) Scott Reid, MP Lanark-Frontenac-Kingston
6) Mike Bossio, MP Hastings-Lennox and Addington
7) Loretta Ryan, Association of Local Public Health Agencies
8) Ontario Boards of Health.

The Government of Canada has introduced important legislative changes and its leadership in trying to address the current opioid crisis is applauded. However, these changes are insufficient to address this escalating crisis. Drug Policy Reform, which includes an examination of the full spectrum of decriminalization options, is required to make the necessary in-roads to save lives. The KFL&A Board of Health urges the Government of Canada to strike a national advisory committee to identify drug policy reform options without delay.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: Honourable Ginette Petitpas Taylor, Minister of Health
Honourable J. Wilson-Raybould, Minister of Justice and Attorney General of Canada
M. Gerretsen, MP Kingston and the Islands
S. Reid, MP Lanark-Frontenac-Kingston
M. Bossio, MP Hastings-Lennox and Addington
L. Ryan, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health.
July 3, 2018

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

Dear Minister Elliott:

The Smoke-Free Ontario Act has been in force for 12 years, but much has changed since it was first drafted. E-cigarettes were not captured in the original legislation, which is why the Board of Health for Peterborough Public Health was encouraged by the Executive Steering Committee’s “Smoke-Free Ontario Modernization” report. The comprehensive evidence base of the report and recommendations to modernize the Smoke-Free Ontario Strategy to include vaping are important contributions to our understanding of the health impacts of these products. Not only were emerging products like e-cigarettes identified in the updated legislation, the tobacco and vaping industries are recognized as vectors of disease.

There is consensus among health professionals and independent researchers alike that e-cigarettes are less harmful than conventional cigarettes, however, that does not make them inherently harmless. The National Academies of Science, Engineering and Medicine recently published the most thorough evidence review to date, detailing the impact of e-cigarettes on both the user and the bystander. Highlights from the report “Public Health Consequences of E-Cigarettes” demonstrate that:

- “there is conclusive evidence that in addition to nicotine, most e-cigarettes contain and emit numerous potentially toxic substances”;
- “there is substantial evidence that e-cigarette use results in symptoms of dependence on e-cigarettes”; and that
- “there is substantial evidence that e-cigarette use increases risk of ever using combustible tobacco cigarettes among youth and young adults.”

Recognizing the potential benefits and documented risks of e-cigarettes, a measured response is needed that both protects Ontarians and promotes cessation. The Smoke-Free Ontario Act, 2017 regulations that were set to come into force on July 1, 2018, do exactly that and we urge you to reconsider the pause that was placed on their coming into force.

A delay in fully modernizing the Smoke-Free Ontario Act will result in more young people developing an addiction to nicotine and expose residents that don’t vape or smoke to harmful airborne toxins.

The recommendations proposed by the Executive Steering Committee are in the range of strategies that are critical to meeting Ontario’s goal of having the lowest rates of commercial tobacco use in Canada and meeting the tobacco endgame target of less than 5% of the population using tobacco products by 2035. Let’s work together to implement these strategies to eliminate the 13,000 preventable deaths from tobacco use annually and achieve the end goal of tobacco-wise living.
Yours in health,

*Original signed by*

Henry Clarke  
Chair, Board of Health

C: Mr. Dave Smith, MPP, Peterborough-Kawartha  
Ms. Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock  
Mr. David Piccini, MPP Northumberland-Peterborough South  
The Honourable Doug Ford, Premier of Ontario
Laura Pisko, Director  
Health Protection Policy and Programs Branch  
Ministry of Health and Long-Term Care  
393 University Avenue, Suite 2100  
Toronto, ON M7A 2S1

Re: EBR Proposal 18-HLTC024, Smoke-Free Ontario Act, 2017 Regulation 268/18

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing today to provide our feedback on the amendments to the Smoke-Free Ontario Act that have been proposed as noted above.

We have expressed our strong support for harmonizing the rules about the sale, promotion, display and consumption of tobacco, vape products and combustible cannabis in public places. Not only is it sound public health policy, but it also reduces confusion among the public, allows for consistent public health messaging and simplifies related compliance and enforcement activities.

We are pleased with the decision to retain and extend legislated protections from exposure to cannabis smoke in enclosed spaces, based on the known health risks of inhaling smoke of any kind. We are also pleased that similar restrictions on vaping have been retained while the possible negative health impacts of exposure and long-term use are assessed. These harmonized and stringent restrictions will reinforce public health’s ongoing efforts to reduce the use of tobacco and its associated or analogous products.

On the subject of such exposure, we are disappointed with the ongoing exclusion of water pipes from the provisions of the Smoke-Free Ontario Act. Also known as "hookah" or "shisha", the negative health impacts of smoking herbal concoctions through these devices are more clearly demonstrated than those of vaping. Ontario’s ongoing permission of the use of water pipes in enclosed public places is already inconsistent with the aims of the Smoke-Free Ontario Act, and this inconsistency is only magnified by placing stricter limitations on vaping. Please find attached alPHa Resolution A13-5, which provides more background on this issue. We strongly urge you take this opportunity to add these devices to the proposed amendments.

Public health agencies and associations in Ontario have been vocal and consistent about the need for strong regulations for the sale, promotion and use of e-cigarettes and other vape products. We are becoming increasingly aware of the appeal and popularity of these products among children and youth, and there can be no argument that the wide array of available baked-goods and candy-flavoured vape juices are aimed at a younger demographic. Use of vape products among youth has risen sharply over the past two years and will continue to do so without strict prohibitions on their promotion and marketing.
We are therefore strongly supportive of restoring restrictions that will prevent youth exposure to such marketing, as has already been achieved with tobacco. We disagree completely with the decision to relax requirements related to the display and promotion of vape and e-cigarette products and strongly recommend that these be subject to the same limitations currently placed on the display, sale and promotion of tobacco. Our position on this is only reinforced by the increasing availability of addictive nicotine-infused vape liquids in the Ontario market.

Once the new regulations are in place, Tobacco Enforcement Officers in Ontario’s public health units will have enforcement responsibilities for certain provisions, and we also ask that these responsibilities be consistent with those related to existing tobacco control activities and that consideration be given to the resources that may be required to ensure enforcement capacity.

Earlier this year, our Council of Ontario Medical Officers of Health (COMOH) endorsed a position that local boards of health should be empowered by the province to enforce consumption prohibitions in the Ontario Cannabis Act (OCA) in locations that correspond to where tobacco smoking and vaping is prohibited under the SFOA, but not any of the other provisions within the OCA such as cannabis seizure, or age and medical use verification. As part of this position, COMOH also calls for centralized training resources, proprietor and public awareness and education, and the provision of additional resources to local public health to successfully carry out its responsibilities under the new regulatory regime.

The Smoke-Free Ontario Act remains a worldwide standard for effective tobacco control, and we are pleased that the Government of Ontario has recognized its value as a framework to address the emerging public health issues of vaping and cannabis use. We hope that the feedback we have provided will strengthen the next iteration of this important legislation. We also hope that you will give careful consideration to the responses that are being provided individually by our member boards of health as they will almost certainly address some of the operational implications of the proposed amendments in more detail.

Please contact Loretta Ryan, Executive Director, aPHa at 647-325-9594 or loretta@alphaweb.org should you have any questions or require further information regarding this submission.

Yours sincerely,

Dr. Robert Kyle,
aPHa President

COPY: Hon. Christine Elliott, Minister of Health and Long-Term Care  
Helen Angus, Deputy Minister, Health and Long-Term Care  
Dr. David Williams, Chief Medical Officer of Health  
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division (Health and Long-Term Care)  
France Gélinas, Health Critic, New Democratic Party of Ontario

ENCL.
TITLE: Provincial Legislation to Prohibit the Use of Waterpipes in Enclosed Public Places and Enclosed Workplaces

SPONSOR: Simcoe Muskoka District Health Unit

WHEREAS the emerging use of waterpipes in enclosed public places and enclosed workplaces has the potential to undermine the success of the Smoke-Free Ontario Act; and

WHEREAS tobacco-free (“herbal”) waterpipe smoke has been demonstrated to have concentrations of toxins comparable to tobacco waterpipe smoke\(^1\); and

WHEREAS the environmental smoke from waterpipe use in indoor public places and workplaces has been demonstrated to contain toxins at harmful concentrations\(^2\); and

WHEREAS the alleged “herbal” preparations are poorly regulated and often contain tobacco even when they are labelled tobacco free\(^3\); and

WHEREAS the Tobacco Strategy Advisory Group report recommends an amendment of the Smoke-Free Ontario Act, with “the addition of controls on the indoor use of waterpipes such as hookahs”;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHA) advocate for provincial legislation to be enacted to prohibit the use of waterpipes (regardless of the substance being smoked) in all enclosed public places and enclosed workplaces.

ACTION FROM CONFERENCE: Resolution CARRIED

References
1 Shidadeh A; Salman R; Jaroud E; Saliba N; Sepetdijian E; Blank M; Does switching to a tobacco-free waterpipe reduce toxicant intake? A crossover study comparing CO, NO, PAH, volatile aldehydes, tar and nicotine yields. Food and Chemical Toxicology Journal Vol. 50, Issue 5, 2012.
The Honorable Christine Elliott
Minister of Health and Long-Term Care
Hepburn Block 10th Floor
80 Grosvenor St.
Toronto ON M7A 2C4
(Sent via email: christine.elliottco@ola.org)

September 20, 2018

Dear Minister Elliott

Re: Smoke-Free Ontario Act, 2017

First, on behalf of the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit please accept our congratulations on your appointment as Minister of Health and Long-Term Care. The Board is passionate about the role that it plays in protecting and promoting the health of our community and looks forward to working with you and your staff to protect and promote the health of all Ontarians.

While we know that tobacco use is declining, tobacco continues to be the number one cause of death in Ontario, causes significant illness and therefore utilization of the provincial health care system and is an unnecessary economic burden to the province.

We understand that implementation of the Smoke-Free Ontario Act, 2017 (SFOA), which was to replace the existing SFOA and the Electronic Cigarettes Act on July 1, 2018, specifically the new regulations related to vaping, has been delayed. We are very concerned about this delay as we believe that harmonizing the rules about the consumption of tobacco, e-cigarettes and combustible cannabis in public places is sound public policy. We agree with other Ontario boards of health, the Association of Local Public Health Agencies (alPHA) and the Council of Ontario Medical Officers of Health (COMOH) (as attached), in supporting the placement of restrictions on vaping while the possible negative health impacts of exposure and long-term use are assessed. The new restrictions will reinforce ongoing efforts to reduce the use of tobacco and its associated or analogous products.
We respectfully urge the Government of Ontario to implement the *Smoke-Free Ontario Act, 2017* without delay so all Ontarians can benefit from reduced risks of illness and death associated with tobacco, e-cigarettes, and combustible cannabis use; and to work with the public health community in current and future reviews of tobacco control policy.

Sincerely

**BOARD OF HEALTH FOR THE HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT**

Mark Lovshin  
Chair, Board of Health

LM/ALN:ed

cc (via email): Hon. Doug Ford, Premier of Ontario  
Ms. Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock  
Mr. David Piccini, MPP Northumberland-Peterborough South  
Andrea Horwath, MPP, Hamilton Centre, Leader of the Opposition, Ontario  
John Fraser, MPP Ottawa South, Interim Liberal Leader, Ontario  
Helen Angus, Deputy Minister, Health and Long-Term Care  
Dr. David Williams, Chief Medical Officer of Health  
Roselle Martino, ADM, Population and Public Health Division (Health and Long-Term Care)  
Ontario Boards of Health  
Loretta Ryan, Association of Local Public Health Agencies  
Pegeen Walsh, Ontario Public Health Association
Hon. Christine Elliott  
Minister of Health and Long-Term Care  
10th Flr, 80 Grosvenor St,  
Toronto, ON M7A 2C4  

Dear Minister Elliott,  

Re: Vapour Products Display and Promotion  

On behalf of the Association of Local Public Health Agencies (alPHA) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing to express concerns about the proliferation of the promotion and display of vapour products.  

While research is accumulating that shows vaping is less harmful than smoking tobacco, this same research shows that vaping still does introduce poisonous substances into the body. Vaping causes inflammation and has negative health impacts in a similar way to smoking tobacco.  

Ontario has seen an increase in youth vaping over the past two years. This will likely continue without strict prohibitions on their promotion and marketing. We are concerned that without this action young people will be seriously harmed. The provisions that already exist within the legislation need to be strengthened and enforced.  

With the recent proliferation of billboards, point-of-sale promotions and other ads for vapour products visible to children and youth in our communities, the restrictions on display and promotion under the Smoke-Free Ontario Act, 2017 and Regulation 268 have fallen demonstrably short of their intentions.  

Section 4.1 of the Smoke-Free Ontario Act, 2017 clearly prohibits the display and promotion of vapour products in any place where vapour products are sold or offered for sale, except in accordance with the regulations (RSO 2018, c. 12, Sched. 4, s. 3). Regulation 268 sets out exemptions from this section for tobacconists, specialty vape shops, cannabis retailers and manufacturers, but not for other types of retailers that are accessible to minors such as convenience stores.  

We were therefore surprised to see the following clarification in an October 17, 2018 memo regarding the amended Act and implementation supports issued by the office of the Assistant Deputy Minister, Population and Public Health Division (emphasis added):  

“Retailers that are not specialty vape stores (e.g., convenience stores) cannot display vapour products, and can only promote vapour products if the promotion complies with federal law”.  

This sends a mixed message that is in our estimation is not in keeping with measures that are built into the legislation to ensure that minors are not exposed to marketing and promotion of vapour products.
The appeal and popularity of these products among children and youth is well established, and there can be no argument that the wide array of available baked-goods and candy-flavoured vape juices are aimed at a younger demographic. Our concerns are magnified by the increasing availability of addictive nicotine-infused vape liquids in the Ontario market.

The predatory marketing tactics of tobacco companies – especially as they relate to enticing young people - were recognized decades ago and the effectiveness of banning their display and promotion has been clearly demonstrated. Allowing the manufacturers of vapour products (many of which are also tobacco companies) to engage in those same predatory tactics is a leap backwards for public health in general and a threat to children, in particular. We therefore strongly urge you to ensure that the restrictions on promotion and display of vape products that are built in to the Smoke-Free Ontario Act and its regulations are reinforced.

I would be pleased to meet with you to discuss our positions in more detail. Please contact Loretta Ryan, Executive Director, alPHa at 647-325-9594 or loretta@alphaweb.org to make arrangements for a meeting.

Yours sincerely,

Dr. Robert Kyle,  
alPHa President  
Dr. Chris Mackie  
Chair, COMOH

COPY:  Robin Martin, Parliamentary Assistant, MHLTC  
Effie Triantafilopoulos, Parliamentary Assistant, MHLTC  
Helen Angus, Deputy, MHLTC  
Dr. David Williams, Chief Medical Officer of Health  
Dianne Alexander, Director, Health Promotion and Prevention Policy and Programs Branch  
Nina Arron, Director, Health Protection and Surveillance Policy and Programs Branch  
Loretta Ryan, Executive Director, alPHa

Enclosed: A photo taken October 2018 of a billboard advertising vaping located at Yonge Dundas Square. The ad fronts onto both Yonge Street and the square and it is the length and width of the building. This is located immediately across from a movie theatre that features many child-friendly films.
VYPE ePEN 3
"GENIUS. CLICK & VAPE."

Available at GOVYPE.CA and these leading retailers.
Update to Board of Health Members
October 26, 2018

2018-2019 alPHa Boards of Health Section Executive

The BOH Section Executive Committee of alPHa is comprised of the board of health representatives across seven regions on the alPHa Board of Directors. Each representative holds a seat on the alPHa Board for a two-year term. At the Annual Conference this past June, the 2018-2019 BOH Executive was confirmed as follows (click their names for a short bio):

Position | Representative
--- | ---
Chair/North West | Trudy Sachowski, Northwestern BOH
Central East | David Pickles, Durham BOH
Central West | Terry Whitehead, Hamilton BOH
South West | Carmen McGregor, Chatham-Kent
North East | Gilles Chartrand, Porcupine BOH
East | Wess Garrod, KFL&A BOH
Toronto | Stacey Berry, Toronto BOH

MPP Meetings

alPHa’s Executive Committee have met with a number of Members of Provincial Parliament (MPPs) over the past several months to introduce the association and raise awareness of public health concerns, including the 2018 municipal election policy priorities. MPPs include former alPHa president Lorne Coe, health care critic France Gélinas, and Jeff Yurek, the Minister of Natural Resources and Forestry. Through membership on the Ontario Chronic Disease Prevention Alliance, alPHa has also met with other MPPs to build awareness about the Alliance and build relationships with political representatives from all parties.

alPHa Activities on Cannabis and Smoke Free Ontario Act

In a letter dated October 22nd, alPHa expressed its concerns to the Minister of Health and Long-Term Care about the proliferation of the promotion and display of vapour products, and the detrimental effects on children and youth (see here). On October 11, alPHa president Dr. Robert Kyle presented before the Ontario Legislature’s Standing Committee on Social Policy regarding Bill 36, Cannabis Statute Law Amendment Act. His deputation to the Standing Committee (download here*) received media coverage focusing on "unforeseen consequences" of the new law (see here and here). More recently, Dr. Kyle was interviewed by CBC Radio and spoke about the potential effects of Bill 36 and the impacts of normalizing cannabis on children and youth (listen here). On October 8, alPHa and the COMOH Section had made written submissions on the Smoke Free Ontario Act's proposed amendments (click here).

*The transcript of the deputation can be found after the deputation in this link.
Ministry Realignment

On October 18, the Ministry of Health and Long-Term Care announced it had made a number of structural changes and released an updated organizational chart to stakeholders (see here). The changes will “clarify and simplify lines of accountability and allow [the] organization to be more nimble and outcome focused”. Of particular note is the alignment of the Chief Medical Officer of Health with population and public health oversight. As the Chief Medical Officer of Health and Population and Public Health, Dr. David Williams will be reporting directly to Deputy Minister Helen Angus. Former associate deputy minister Sharon Lee Smith will now lead in ministry Indigenous engagement efforts while former assistant deputy minister Roselle Martino will continue to advise on the opioid strategy.

Public Health ROI

alPHa has created a web page to collect information on public health return on investment (ROI) (see here). Health units have been invited to submit information for uploading to the website. They have also been given the link to access and download the ROI information. alPHa is currently reaching out to Public Health Ontario to determine if they have done work in this area or if they have data that may be shared with the alPHa membership.

Of interest

- Dr. Theresa Tam, Canada’s Chief Public Health Officer, releases her annual report on the State of Public Health in Canada, 2018: Preventing Problematic Substance Use in Youth. This report provides a snapshot of the health of Canadians and emphasizes the importance of preventing problematic substance use in youth. 2018/10/23

- Ontario government announces the continuation of supervised consumption services and overdose prevention sites under a new Consumption and Treatment Services model for those addicted to drugs and opioids. The news comes after a review to determine whether such facilities would continue to operate in the province. 2018/10/22

Upcoming Events and Meetings for All Board of Health Members

**February 21, 2019:** alPHa Winter Symposium (morning) and Boards of Health Section Meeting (afternoon), Chestnut Conference Centre, 89 Chestnut St., Toronto, Ontario.


**June 11, 2019** (during alPHa Annual Conference): alPHa Boards of Health Section Meeting

This update was brought to you by the Boards of Health Section Executive Committee of the alPHa Board of Directors. alPHa provides a forum for member boards of health and public health units in Ontario to work together to improve the health of all Ontarians. Any individual who sits on a board of health that is a member organization of alPHa is entitled to attend alPHa events and sit on its various committees.
MOTION:
That the Board of Health of Southwestern Public Health endorse the Harm Reduction Position Statement presented on November 14, 2018.

Recommendation:
The CEO recommends that:

1. The Board of Health of Southwestern Public Health endorse the Harm Reduction Position Statement attached.

Accountability
The goal of the Substance Use and Injury Prevention Program Standard of the Ontario Public Health Standards (OPHS) is to reduce the burden of preventable injuries and substance use. It also includes several program outcomes relevant to this motion, including:
Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with the prevention of injuries, preventing substance use, and reducing harms associated with substance use. There is increased public awareness of the benefits of and access to harm reduction programs and services.

**Purpose/Approach**
To clearly articulate SWPH’s position on harm reduction strategies associated with needle syringe programs, opioid substitution therapies, naloxone distribution, sharps management strategies, and supervised consumption sites.

Recently the Ontario Government announced they will continue to fund supervised injection and overdose prevention sites, but changes will be made on how they are operated. The terms ‘supervised consumption services and overdose prevention sites’ will be phased out and replaced by “consumption and treatment services.” It is anticipated all sites will be in place by April 2019. Public Health staff are closely monitoring the situation and are waiting for further information and direction from the Ministry of Health & Long-Term Care.

**Evidence/Data**
Refer to attached Harm Reduction Position Statement.

**Background/Analysis**
Harm reduction refers to policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use. Its cornerstones are public health, human rights and social justice. It benefits people who use drugs, their families and communities. Harm Reduction ensures that people who use psychoactive substances are treated with respect and are not stigmatized, and that substance-related problems and issues are addressed systemically.

**Achievements**
- Needle syringe programs currently operate in St. Thomas, Elgin and Oxford County.
- An education session was held in September 2018 for primary care physicians and nurse practitioners from Oxford, Elgin, and St. Thomas on opioids, including substitution therapies.
- Naloxone distribution continues in both Elgin-St. Thomas and Oxford County. Recently, the St. Thomas Elgin General Hospital Emergency Department began to distribute naloxone to patients (families) deemed to be at risk upon discharge. St. John’s Ambulance has adopted SWPH’s service level agreement for naloxone distribution as its provincial standard.
- SWPH is working with community and municipal partners to develop a comprehensive sharps management strategy in our respective communities.
Client/Community Focused Feedback

A client satisfaction survey has been developed and is awaiting research ethics approval so that we may seek input from the clients utilizing our Needle Syringe Program.

A concerned member of the community has led the creation of a grassroots, community initiative to recruit volunteers to do needle retrieval pick up in our community. Approximately 15 people attended the first information session. The immediate goals are to recruit interested individuals who will be educated on how to safely retrieve and dispose of discarded needles. They will then form volunteer teams that will sweep the downtown core and known areas where people go to use drugs.

Budget Impacts/Monitoring

We will continue to monitor the political climate as it relates to harm reduction funding in Ontario. The development of a comprehensive sharps’ management strategy is part of the 2019 program planning cycle.

Risk/Concerns

There is political uncertainty in Ontario as it relates to harm reduction funding and support.

As the volume of needles being distributed continues to increase, members of the community and municipal elected officials have expressed concerns that the sharps management strategy work has not kept pace.

Next Steps

Board of Health endorsement of this position statement will provide the foundational framework for key program plans proposed for 2019, including mobile outreach services, sharps management and broader naloxone distribution.

References:

1 Canadian harm reduction network. www.canadianharmreduction.com
Position Title: Harm Reduction

Approved by:
Cynthia St. John, Chief Executive Officer
Dr. Joyce Lock, Medical Officer of Health
Board of Health for Oxford Elgin St. Thomas Health Unit

Date Approved: Pending
Date Effective: 
Date Revised: 
Contact: 

Position of Southwestern Public Health

1. **Needle Syringe Programs (NSPs)** provide supplies and services to people who inject or inhale drugs to prevent or decrease the risk of harms associated with these behaviours such as infection and overdose. Attendance at NSPs and increased needle availability are associated with decreases in injecting risk behaviours (re-using/sharing) and decreases in blood borne infections (HIV, Hepatitis C, Hepatitis B). The availability of NSPs increases the likelihood that people who use drugs will become involved in treatment and prevention interventions. NSPs are cost effective because they help to prevent significant healthcare costs incurred for the care and treatment of blood borne infections, and other injection drug use-related health concerns.

2. **Inappropriate disposal of community sharps** may pose a health and safety risk to the public, city and county employees, waste contractors, and resource recovery operators involved with municipal waste and recycling. While the risk of infection - such as human immunodeficiency virus (HIV) or hepatitis B or C - following a needle stick injury is very low, any needle stick injury potentially exposes the person to the risk of acquiring a blood-borne virus. This can cause anxiety about the possibility of contracting an infection. Well managed community sharps programs where people have reasonable access to safe disposal facilities can contribute to the health and safety of communities and prevent the transmission of blood-borne viruses by improving access to public health programs such as the Needle Syringe Program (NSP). A comprehensive sharps strategy provides a coordinated approach and shared accountability between municipalities who manage waste and public health.
3. Take home naloxone distribution programs expand access to this life saving medication to people who use opioids, their families and friends, as well as community service providers who interact with people who use opioids. The program provides comprehensive training on overdose prevention, recognition and response to an overdose. Naloxone is an easy-to-use, lifesaving antidote to overdose from heroin or other opioids. Used in hospitals for decades, the medication has no abuse potential and can be administered with basic training. The distribution of naloxone is foundational to a comprehensive harm reduction strategy to address drug misuse and its associated harms.

4. Opioid agonist therapy (OAT) is an effective treatment for addiction to opioid drugs such as heroin, oxycodone, hydromorphone (Dilaudid), fentanyl, and Percocet. The therapy involves taking the opioid agonists methadone (Methodone) or buprenorphine (Suboxone). These medications work to prevent withdrawal and reduce cravings for opioid drugs. People who are addicted to opioid drugs can take OAT to help stabilize their lives and to reduce the harms related to their drug use. Methadone and buprenorphine are long-acting opioid drugs that are used to replace the shorter-acting opioids used by the person who is addicted. Long-acting means that the drug acts more slowly in the body, for a longer period of time. By acting slowly, it prevents withdrawal for 24 to 36 hours without causing a person to get high. OAT also helps to reduce or eliminate cravings for opioid drugs. Treatment works best when combined with other types of support, such as individual or group counselling.

5. Supervised consumption sites (SCS) are part of Canada’s drugs and substances strategy. Canadian and international evidence shows that they help save lives and improve health. Research also shows they are cost effective and do not increase drug use or crime in the surrounding area. SCSs are an entry point to treatment and social services for people who are ready to stop or reduce their use of substances. The key goal of SCS is to prevent overdose deaths.

Rationale

Harm reduction refers to policies, programs and practices that aim to reduce the negative health, social and economic consequences that may ensue from the use of legal and illegal psychoactive drugs, without necessarily reducing drug use. Its cornerstones are public health, human rights and social justice. It benefits people who use drugs, families and communities. Harm Reduction ensures that people who use psychoactive substances are treated with respect and without stigma, and that substance-related problems and issues are addressed systemically. Harm reduction is an approach rooted in public health and human rights. It aims to improve the lives of people who are affected by drugs or drug policies through evidence-informed programming. There are numerous drug-related harms that have health, social and economic impacts for individuals and communities. Recognizing that licit and illicit psychoactive substances will always be used, public health approaches try to prevent or reduce the potential negative consequences that may arise. Examples
include ‘designated driver’ campaigns to avoid drunk driving, increasing accessibility to nicotine replacement gums and patches accessible to people who smoke and implementing needle and syringe exchange programs for people who inject drugs. 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, and supervised consumption sites are essential to reducing these harms and improving the health of the people who use drugs.2

Needle syringe programs (NSP)

Hepatitis C has been called “the silent killer” because individuals often do not have symptoms until many years after they are infected and the virus has already caused liver damage leading to more severe health problems.

According to Public Health Ontario, people who inject drugs have the highest incidence of hepatitis C.3 Repeated injections increase their risk of getting the hepatitis C virus. As a result, it is important for Canada to implement programs such as the needle exchange program to prevent the transmission of hepatitis C as well as detect hepatitis C earlier.

Needle Syringe Programs give people who inject drugs access to free, sterile needles and other harm reduction as well as education about how to reduce the spread of hepatitis C and other Bloodborne Infections (BBIs) such as HIV and hepatitis B. Testing for these BBIs is available and offered to clients who access Southwestern Public Health’s NSP program. Therefore, hepatitis C can be detected early; it can be treated with antiviral medications and in most cases be cured. If high risk individuals wait until symptoms appear to get tested, their hepatitis C may have already progressed to be more severe and they may need more invasive treatment. This can result in higher health care costs and more deaths.

NSPs also help prevent wound infections, heart infections and unintentional overdoses.

The World Health Organization (WHO) states 71 Million people globally have chronic hepatitis C infection.4 An estimated 250,000 Canadians are infected. The Canadian Liver Foundation states the number of Canadians with Chronic Hepatitis with Cirrhosis and advanced liver disease is on the rise and estimate the number will climb by 23% by 2035.5

Liver related deaths, liver cancer, and cirrhosis are the most common health complications associated with hepatitis C and it is estimated they will increase significantly by 2035.

In relation to this estimated increase of hepatitis C, The Canadian Liver Foundation estimates health care costs will increase by 60% in 2032, costing the health care system $258.4 Million in 2032.
To avoid this future toll, The Canadian Liver Foundation expresses the importance of implementing antiviral treatment. They state that “75% of Hepatitis C patients have early stage disease at any given time - an ideal opportunity to intervene with new antiviral therapy”.

Treating hepatitis C patients with antiviral therapy will help decrease health care costs by preventing the need for high cost invasive treatments. In order to treat with antiviral treatment patients must get tested and diagnosed before it is too late. NSP programs allow nurses and harm reduction workers to provide health teaching and hepatitis C testing.

According to 2016 national HIV estimates published by Public Health Canada, 14.3% of all new HIV infections in Canada may have been acquired through injection drug use.6

The number of new HIV infections (incidence) in people who inject drugs may have increased since 2014. According to 2016 national HIV estimates:

- The number of new HIV infections attributable to injection drug use in 2016 (244 new infections) is slightly higher than the number in 2014 (219 new infections).
- The number of new HIV infections attributable to the combined category of sex between men or injection drug use in 2016 (66 infections) is higher than in 2014 (47 new infections). 6

St. Thomas and the counties of Elgin and Oxford face unique challenges in relation to serving people with substance misuse concerns due to the communities' blends of small urban and rural areas, including transportation barriers. At present, harm reduction programs are primarily based in the small urban centres.

Best practice harm reduction guidelines recommend optimizing service delivery by providing needle syringe program services using a variety of program delivery models (i.e., fixed sites, mobile sites, pharmacy-based distribution, peer-based outreach, and vending machines) that are convenient for clients in terms of geographic location (e.g., urban, rural areas) and time of day, and tailored to reach subpopulations (e.g., youth, women, sex workers, LGBTQ, Indigenous groups, and those who are new to injecting).7

**Sharps Management Strategy**

Inappropriate disposal of community sharps may pose a health and safety risk to the general public, municipal employees, waste contractors, and resource recovery operators involved with municipal waste and recycling. While the risk of infection - such as HIV or hepatitis B or C - following a needle stick injury is very low, any needle stick injury potentially exposes the person to the risk of acquiring a blood-borne virus. This can cause anxiety about the possibility of contracting an infection. Well managed community sharps where people have reasonable access to safe disposal facilities can contribute to the health and safety of communities and prevent the transmission of blood-borne viruses.
Community sharps are generated from a number of sources, including:
- People who inject illicit drugs;
- People with medical conditions that involve regular self-injection in the home, including diabetes, multiple sclerosis, renal failure, infertility, allergies and vitamin deficiencies; and
- Vaccination and medical procedures for livestock and pets.

Barriers to safe disposal include:
- Knowledge about safe sharps disposal;
- Access to disposal facilities including local pharmacies;
- Stigma associated with NEP; and
- Fear of police involvement.

Inappropriate disposal of community sharps may indicate the need for a more coordinated and flexible approach to community sharps disposal that relies on a shared accountability model. A community sharps management plan can identify ways to:
- Discourage disposal of community sharps in household bins; and
- Manage community sharps that are inappropriately disposed in public and private places by educating the public about safe handling/disposal of needles

**Naloxone distribution**

The number of opioid overdoses is increasing in Canada. According to a September 2017 report from the Canadian Institute for Health Information (CIHI), opioid poisonings have resulted in an average of 16 hospitalizations a day in Canada in 2016-2017. Between 2007–2008 and 2016–2017, the rate of hospitalizations due to opioid poisoning increased by 53%. The report also found that the rate of emergency department visits due to opioid poisoning increased by 50% in Ontario between 2012–2013 and 2016–2017 (the only provinces for which this information is available). According to the Government of Canada, there were 3,987 apparent opioid related deaths in Canada in 2017 of which 92% were unintentional/accidental.

Naloxone is a drug that can temporarily reverse the effect of opioids in the case of an opioid overdose. It is a competitive opioid antagonist with rapid onset and very short duration of action. Once administered, naloxone displaces the opiate from brain receptors, effectively reversing potentially fatal opiate effects, such as respiratory depression, within a few minutes. This temporary reversal of opioid overdose allows time for emergency intervention. Naloxone has been used to reverse the effects of a wide range of natural, semi-synthetic, and synthetic opioids in both pre-hospital (community settings) and hospital settings.

In October of 2016, Health Canada approved the nasal spray formulation of naloxone, NARCAN Nasal Spray, for marketing in Canada. To address the increasing harms due to opioid poisoning, several policy and program changes are taking place in Canadian jurisdictions to improve access to naloxone. This includes establishing take-home naloxone programs to make the potentially life-saving drug available to those who are at risk of opioid overdose.
risk of an opioid overdose.

**Opioid Agonist Therapies**

Opioid agonist (substitution) treatment such as Methadone and Suboxone can offer synergies with infectious disease treatment and prevention. Substance abuse treatment reduces drug injecting and needle sharing, and it facilitates access to HIV testing as well as access and adherence to antiretroviral therapy for HIV disease. Recent innovations in HIV prevention through antiretroviral treatment and emerging treatment options for hepatitis C can further increase the health benefits of opioid substitution treatment.

The treatment has also been deemed highly cost-effective, if not cost saving. Often the costs of treatment are more than offset by reductions in acquisitive crime (theft or burglary) and in the use of health resources related to transmissions of HIV or hepatitis C. The treatment also results in improvements in health-related quality of life. Substitution treatment may be even greater if potential increases in workplace productivity are realized, resulting in additional economic benefits outside of the health care sector.

Methadone maintenance treatment is the most common opioid substitution treatment worldwide.

In March 2017, the Canadian Medical Association released their national practice guideline for the management of opioid use disorder.

Key points include:

- Opioid use disorder is often a chronic, relapsing condition associated with increased morbidity and death; however, with appropriate treatment and follow-up, individuals can reach sustained long-term remission.
- This guideline strongly recommends opioid agonist treatment with buprenorphine–naloxone as the preferred first-line treatment when possible, because of buprenorphine’s multiple advantages, which include a superior safety profile in terms of overdose risk.
- Withdrawal management alone is not recommended, because this approach has been associated with elevated risks (e.g., syringe sharing) and death from overdose in comparison to providing no treatment, and high rates of relapse when implemented without immediate transition to long-term evidence-based treatment.
- This guideline supports using a stepped and integrated care approach, in which treatment intensity is continually adjusted to accommodate individual patient needs and circumstances over time, and recognizes that many individuals may benefit from the ability to move between treatments.

**Supervised consumption sites (SCS)**

SCS are part of Canada’s harm reduction approach, as stated in the Canadian drugs
and substances strategy. 22

Canadian and international evidence shows clearly that SCS help to save lives and improve health. Research also shows that SCS are cost effective and do not increase drug use and crime in the surrounding area. SCS are an entry point to treatment and social services for people who are ready to stop or reduce their use of substances.

People will use SCS for several reasons. They provide:

- a safe, clean place to consume substances;
- less risk of violence or confrontation with police;
- drug checking to detect adulterants using methods such as fentanyl test strips;
- emergency medical care in case of overdose, cardiac arrest or allergic reaction (anaphylaxis);
- basic health services, such as wound care;
- testing for infectious diseases like HIV, Hepatitis C and Sexually Transmitted Infections (STIs);
- access to sterile drug use equipment and a place to safely dispose of it after use; and
- health professionals and support staff, including for overdose intervention.

They also offer:

- education
  - on harms of drug use
  - safer consumption practices
  - safer sex
- referrals to or information on
  - health and social services including
  - drug treatment and rehabilitation (detoxification or drug substitution therapy)
  - housing services
  - primary health care
  - mental health treatment
  - community services
  - social welfare programs
  - needle exchange programs

The key aims of SCS are to:

- prevent overdose deaths
- facilitate entry into drug treatment services
- reduce the risk of disease transmission (such as Hepatitis C and HIV) caused by unhygienic practices, such as needle sharing
- reduce public disorder from public consumption of illegal substances and publicly discarded consumption equipment
- connect people who use drugs with basic health and social services
- reduce impact on Emergency Medical Services attending to drug overdoses.

Health and social services include:
- drug treatment
- counselling
- withdrawal management
- access to detoxification for people that who are at a stage of readiness to seek treatment
- housing services.

To be effective, SCS are set up in areas where there is public drug use. They are aimed at sub-populations of people who:
- inject drugs
- have limited contact with the health care system.

These may include those who are homeless or living in insecure accommodation or shelters.

**Implications for Southwestern Public Health**

Southwestern Public Health will:

1. Investigate and implement broader service delivery models for NEP beyond fixed site model;
2. Engage municipalities to develop a sustainable sharps management strategy for our communities that relies on a shared accountability approach;
3. Continue to support distribution of take home naloxone kits and provide kits from our fixed NEP sites as well as through community partnerships and outreach;
4. Engage with primary care physicians to educate on the use of Opioid Agonist Therapy for management of opioid use disorder based on the Canadian Medical Association National Practice Guideline;
5. Advocate with Ontario Provincial Government to commit to funding for Overdose Prevention Sites and Supervised Consumption Sites and collaborate with appropriate partner agencies that are interested in proceeding with an application.

**References:**

1. Canadian harm reduction network. [www.canadianharmreduction.com](http://www.canadianharmreduction.com)
5. Canadian Liver Foundation [https://www.liver.ca/](https://www.liver.ca/)
6. Canadian Liver Foundation [https://www.liver.ca/](https://www.liver.ca/)
9. Canadian Agency for Drugs and Technologies in Health (CADTH)
15. Volkow ND, Montaner J. The urgency of providing comprehensive and integrated treatment for substance abusers with HIV. Health Aff (Millwood) 2011;30(8):1411–9. [PMC free article] [PubMed]
1) General Update (Receive and File & Decision):

1.1 General Matters

1.1.1 Temporary Overdose Prevention Site - Clinic Tour (Receive and File):
On October 11, 2018, several members of the SWPH Board of Health attended a tour of the Temporary Overdose Prevention Site located on 186 King Street, London, Ontario. Our neighbouring health unit, Middlesex London Health Unit assisted with setting up this opportunity to learn more about this public health work.

The tour included staff of the site sharing their experiences as well as answering questions from the board members. A basic principle of public health work is to meet clients where they are at in their life and this tour exemplified this.

I would encourage Board members who attended the tour, to share their experience at the November Board meeting.
1.2 Financial Matters

1.2.1 Third Quarter Financial Statements (Decision):
The Finance and Facilities Standing Committee is recommending approval of the third quarter financial reports. The Committee has reviewed the financials at its meeting November 5, 2018. The Committee discussed the variance to budget. The variance is the result of the merger in which much of the focus was on transition. Timing is also a factor.

All program expenses and variances are reviewed monthly. At the end of September, it is anticipated that all budgeted funds will most likely not be spent by year end due to the focus of the merger work. SWPH has prepared and submitted a written request on behalf of the Board of Health to the Ministry to obtain permission to carry over maximum base funds from the end of the fiscal year (December 31, 2018) to the end of the Ministry fiscal year (March 31, 2019). As per our most recent Amending Agreement (#8) received May 7, 2018, the Ministry indicated that they will entertain such a request. The extension of these funds will allow us to complete several projects and programs that were not achieved earlier in the year.

The financial statements are attached for your review.

**MOTION: 2018-BOH-1114-5.2A**
That the Board of Health for Southwestern Public Health approve the financial statements for the period ending September 30, 2018 as recommended by the Finance and Facilities Standing Committee.

1.2.2 Appointment of Auditors (Decision):
Each year the Board of Health is required to formally appoint the auditors for the next fiscal period. This will be the first audit of Southwestern Public Health and it will cover the period of May 1, 2018 to December 31, 2018. The Finance and Facilities Committee is recommending that Graham Scott Enns be appointed the auditors for this fiscal year. They are a firm that is local, within the geographic area serving SWPH, they have experience working with the existing public health finance staff, and they have a thorough understanding of the dozens of funding streams for public health. Working with GSE will assist in the transition of the audit process for the newly formed organization.

**MOTION: 2018-BOH-1114-5.2B**
That the Board of Health for Southwestern Public Health appoint Graham Scot Enns as the auditor for the period of May 1, 2018 to December 31, 2018.

1.3 Ministry of Health and Long-Term Care Matters

1.3.1 Structural Changes at the Ministry of Health and Long-Term Care (Receive and File):
On October 18th, Helen Angus, Deputy Minister, Ministry of Health and Long Term Care announced a Ministry realignment. With respect to specific public health impact, the Assistant Deputy Minister (ADM) for the population and public health portfolio will be led by Dr. David
Williams, the existing Chief Medical Officer of Health. Roselle Martino, the former ADM of this division, is now solely assisting the Opioid file. The Ministry communiqué and organizational chart can be found using this link.

1.4 Strategic Priority Matters

1.4.1 Building the New SWPH (Receive and File):
As of this writing, it has been six (6) months since Southwestern Public Health was formed. Since May 2018, there has been considerable work in administration developing new systems, policies, and procedures. Front line staff have done incredible work developing their program plans for 2019, particularly during a time when teams are still forming and getting to know one another. The development of the new Ontario Public Health Standards and the implementation timing coincides nicely with this work. Our work in the communities we serve, with our partners and our clients continued without interruption during this merger which is a considerable success.

Several strategic initiatives are now underway including the development of a new Strategic Plan including the new organization’s values statements, mission, and vision. An important aspect of this work is a community engagement strategy. The Board will be involved in the major milestones of this initiative noting that a final strategic plan is really the Board’s commitment and roadmap for public health in the community.

On the Board of Health front, two new Board Committees were formed, and they have been meeting regularly with full work plans. With the election now concluded, the organization will say goodbye to board members who have given so much of their time and their expertise to public health over the years. You will most definitely be missed.

Given this merger is measured in years, not weeks or months, there are obstacles still to overcome and many successes still to be told. It has been and will be an exciting journey.

2) Governance Standing Committee (Decision & Receive and File):

2.1.1 Orientation for new Board Members (Decision):

As per Board policy BOH-GOV-070 Board Member Orientation, Board members are required to be aware of their roles and responsibilities and emerging issues to effectively discharge their duties as Board members.

The Governance Standing Committee, at its November meeting, approved an outline for the Board orientation program and the outline includes the following:

- Administration
  - Complete required documentation
  - Complete Board Assessment Tool (Competency Matrix)
  - Tour of Southwestern Public Health Building Sites (St. Thomas & Woodstock)
• Access (Building & Board Portal)

• Public Health Overview
  o What is Public Health?
  o Ontario Public Health Standards
    ▪ Protocols & Guidelines
  o Health Protection and Promotion Act
  o Board of Health and Local Health Integration Network Engagement Guideline

• Board of Health
  o Accountability & Transparency
  o Responsibilities of Board members
  o Guidelines
  o Good Governance and Management Practices
  o Accountability Agreement
  o By-laws
  o Policies & Procedures
  o Standing Committees
    ▪ Finance & Facilities
    ▪ Governance
  o Meeting Frequency

• Southwestern Public Health
  o Mission, Vision Values
  o Organizational Chart
    ▪ Senior Leadership and Leadership Team Structure
  o Annual Report
  o Financial Statements and Budgeting
  o Strategic Planning
  o Risk Management Framework

• Training in the Making
  o Health in All Policies Approach
  o Health Equity
  o Deliverables of Programs and Services
  o Team Management Profile
  o How the Board wants to be
  o Emergency Management Training
  o Basic Emergency Management (BEM)

The Governance Standing Committee recommends that the Board of Health approve the orientation program as listed above for implementation effective immediately.

In addition to this Orientation above, Oxford County’s CAO has reached out to me and asked if I would consider giving a high-level introduction to public health at their upcoming Council meeting with members and members-elect. Joyce and I will attend that meeting next week.
**MOTION: 2018-BOH-1114-5.2C**
That the Board of Health for Southwestern Public Health approve the Board of Health Orientation outline as presented.

### 2.1.2 Frequency of Meetings *(Receive and File):*

Following a discussion at the September Board of Health meeting, the Committee, at its November meeting also discussed the matter of frequency of meetings for 2019. In their discussion, the Committee considered:

- there will be new members of the board next year
- the length of time it takes to really understand public health from a governance lens
- the ideal length of meetings
- how presentations and reports can be presented and discussed
- the challenges around scheduling meetings, particularly special meetings at the call of the chair

The Committee is recommending that the 2019 Board of Health meet monthly with board orientation/training/education included in those meetings and spread out over a period of months. The Committee encourages monthly meetings, at least for 2019, with a review of the frequency at the end of the year.

The Committee agreed that it was important to reach out to the municipalities to ask them to consider appointing board of health members as soon as possible in light of the upcoming key strategic initiatives, Board of Health committee appointments, and imminent Ministry deadlines. SWPH will strive to convene the first Board of Health meeting before the end of the year.

**MOTION: 2018-BOH-1114-5.2**
That the Board of Health for Southwestern Public Health accept the Chief Executive Officer’s Report for November 2018.
### Southwestern Public Health

**Period Ended Sept 30, 2018**

**2018 Fiscal Year**

<table>
<thead>
<tr>
<th>Standard - Section / Program</th>
<th>Budget (at 100%) Jan 1 - Dec 31</th>
<th>YTD Actual (at 100%)</th>
<th>Forecast (at 100%) Oct 1 - Dec 31</th>
<th>Total (at 100%) Jan 1 - Dec 31</th>
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<td>96,617</td>
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</tr>
<tr>
<td>Climate Change</td>
<td>85,588</td>
<td>49,810</td>
<td>35,778</td>
<td>85,588</td>
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<tr>
<td>Health Hazard Investigation and Response</td>
<td>246,651</td>
<td>167,319</td>
<td>79,332</td>
<td>246,651</td>
<td>68%</td>
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<tr>
<td><strong>Healthy Environments Total</strong></td>
<td>428,855</td>
<td>274,466</td>
<td>154,389</td>
<td>428,855</td>
<td>64%</td>
</tr>
<tr>
<td><strong>Healthy Growth and Development</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>298,523</td>
<td>239,355</td>
<td>59,168</td>
<td>298,523</td>
<td>80%</td>
</tr>
<tr>
<td>Parenting</td>
<td>395,823</td>
<td>261,407</td>
<td>134,416</td>
<td>395,823</td>
<td>66%</td>
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<tr>
<td>Reproductive Health/Healthy Pregnancies</td>
<td>352,945</td>
<td>285,330</td>
<td>67,615</td>
<td>352,945</td>
<td>81%</td>
</tr>
<tr>
<td><strong>Healthy Growth and Development Total</strong></td>
<td>1,047,291</td>
<td>786,091</td>
<td>261,200</td>
<td>1,047,291</td>
<td>75%</td>
</tr>
<tr>
<td>Standard - Section / Program</td>
<td>Budget (at 100%) Jan 1 - Dec 31</td>
<td>YTD Actual (at 100%) Jan 1 - Sept 30</td>
<td>Forecast (at 100%) Oct 1 - Dec 31</td>
<td>Total (at 100%) Jan 1 - Dec 31</td>
<td>% Spent</td>
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</tr>
<tr>
<td><strong>Immunization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization Management (includes influenza)</td>
<td>147,608</td>
<td>71,053</td>
<td>76,555</td>
<td>147,608</td>
<td>48%</td>
</tr>
<tr>
<td>Vaccine Storage and Handling</td>
<td>101,603</td>
<td>59,221</td>
<td>42,382</td>
<td>101,603</td>
<td>58%</td>
</tr>
<tr>
<td><strong>Immunization Total</strong></td>
<td>249,211</td>
<td>130,275</td>
<td>118,936</td>
<td>249,211</td>
<td>52%</td>
</tr>
<tr>
<td><strong>Infectious and Communicable Diseases Prevention and Control</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Communicable Disease</td>
<td>231,077</td>
<td>175,361</td>
<td>55,716</td>
<td>231,077</td>
<td>76%</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control</td>
<td>186,626</td>
<td>136,392</td>
<td>50,234</td>
<td>186,626</td>
<td>73%</td>
</tr>
<tr>
<td>Infection Prevention and Control Nurses Initiation</td>
<td>180,200</td>
<td>134,751</td>
<td>45,449</td>
<td>180,200</td>
<td>75%</td>
</tr>
<tr>
<td>Infectious Diseases Control Initiative</td>
<td>389,000</td>
<td>283,527</td>
<td>105,473</td>
<td>389,000</td>
<td>73%</td>
</tr>
<tr>
<td>Needle Exchange</td>
<td>60,900</td>
<td>44,483</td>
<td>16,417</td>
<td>60,900</td>
<td>73%</td>
</tr>
<tr>
<td>Rabies Prevention and Control and Zoonotics</td>
<td>179,737</td>
<td>115,015</td>
<td>64,722</td>
<td>179,737</td>
<td>64%</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>791,133</td>
<td>573,176</td>
<td>217,957</td>
<td>791,133</td>
<td>72%</td>
</tr>
<tr>
<td>Tuberculosis Prevention and Control</td>
<td>65,348</td>
<td>37,419</td>
<td>27,929</td>
<td>65,348</td>
<td>57%</td>
</tr>
<tr>
<td>Vector-Borne Diseases</td>
<td>159,433</td>
<td>68,420</td>
<td>91,013</td>
<td>159,433</td>
<td>43%</td>
</tr>
<tr>
<td><strong>Infectious and Communicable Diseases Prevention and Control Total</strong></td>
<td><strong>2,243,454</strong></td>
<td><strong>1,568,545</strong></td>
<td><strong>674,909</strong></td>
<td><strong>2,243,454</strong></td>
<td><strong>70%</strong></td>
</tr>
<tr>
<td><strong>Safe Water</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhanced Safe Water Initiative</td>
<td>31,000</td>
<td>25,016</td>
<td>5,984</td>
<td>31,000</td>
<td>81%</td>
</tr>
<tr>
<td>Small Drinking Water Systems</td>
<td>40,934</td>
<td>30,462</td>
<td>10,472</td>
<td>40,934</td>
<td>74%</td>
</tr>
<tr>
<td>Water</td>
<td>215,353</td>
<td>162,197</td>
<td>53,156</td>
<td>215,353</td>
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<tr>
<td><strong>Safe Water Total</strong></td>
<td><strong>287,287</strong></td>
<td><strong>217,675</strong></td>
<td><strong>69,613</strong></td>
<td><strong>287,287</strong></td>
<td><strong>76%</strong></td>
</tr>
<tr>
<td><strong>School Health - Oral Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Smiles Ontario</td>
<td>1,008,100</td>
<td>680,839</td>
<td>327,261</td>
<td>1,008,100</td>
<td>68%</td>
</tr>
<tr>
<td>School Screening and Surveillance</td>
<td>222,047</td>
<td>161,259</td>
<td>60,787</td>
<td>222,047</td>
<td>73%</td>
</tr>
<tr>
<td><strong>School Health - Oral Health Total</strong></td>
<td><strong>1,230,147</strong></td>
<td><strong>842,098</strong></td>
<td><strong>388,049</strong></td>
<td><strong>1,230,147</strong></td>
<td><strong>68%</strong></td>
</tr>
<tr>
<td><strong>School Health - Vision</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Screening</td>
<td>40,122</td>
<td>26,619</td>
<td>13,503</td>
<td>40,122</td>
<td>66%</td>
</tr>
<tr>
<td><strong>School Health - Vision Total</strong></td>
<td><strong>40,122</strong></td>
<td><strong>26,619</strong></td>
<td><strong>13,503</strong></td>
<td><strong>40,122</strong></td>
<td><strong>66%</strong></td>
</tr>
<tr>
<td><strong>School Health - Immunization</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School Immunization</td>
<td>1,070,390</td>
<td>692,906</td>
<td>377,484</td>
<td>1,070,390</td>
<td>65%</td>
</tr>
<tr>
<td><strong>School Health - Immunization Total</strong></td>
<td><strong>1,070,390</strong></td>
<td><strong>692,906</strong></td>
<td><strong>377,484</strong></td>
<td><strong>1,070,390</strong></td>
<td><strong>65%</strong></td>
</tr>
<tr>
<td><strong>School Health - Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive School Health</td>
<td>875,860</td>
<td>597,868</td>
<td>277,992</td>
<td>875,860</td>
<td>68%</td>
</tr>
<tr>
<td><strong>School Health - Other Total</strong></td>
<td><strong>875,860</strong></td>
<td><strong>597,868</strong></td>
<td><strong>277,992</strong></td>
<td><strong>875,860</strong></td>
<td><strong>68%</strong></td>
</tr>
<tr>
<td>Standard - Section / Program</td>
<td>Budget (at 100%) Jan 1 - Dec 31</td>
<td>YTD Actual (at 100%) Jan 1 - Sept 30</td>
<td>Forecast (at 100%) Oct 1 - Dec 31</td>
<td>Total (at 100%) Jan 1 - Dec 31</td>
<td>% Spent</td>
</tr>
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<td>-----------------------------------------------------------------</td>
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<td>---------</td>
</tr>
<tr>
<td>Substance Use and Injury Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls Prevention</td>
<td>119,457</td>
<td>67,747</td>
<td>51,711</td>
<td>119,457</td>
<td>57%</td>
</tr>
<tr>
<td>Harm Reduction Enhancement</td>
<td>300,000</td>
<td>180,520</td>
<td>119,480</td>
<td>300,000</td>
<td>60%</td>
</tr>
<tr>
<td>Road Safety</td>
<td>86,911</td>
<td>51,453</td>
<td>35,458</td>
<td>86,911</td>
<td>59%</td>
</tr>
<tr>
<td>Smoke Free Ontario Strategy: Prosecution</td>
<td>17,400</td>
<td>7,400</td>
<td>10,001</td>
<td>17,400</td>
<td>43%</td>
</tr>
<tr>
<td>Smoke Free Ontario Strategy: Protection and Enforcement</td>
<td>278,500</td>
<td>171,452</td>
<td>107,048</td>
<td>278,500</td>
<td>62%</td>
</tr>
<tr>
<td>Smoke Free Ontario Strategy: Tobacco Control Coordination</td>
<td>200,000</td>
<td>146,901</td>
<td>53,099</td>
<td>200,000</td>
<td>73%</td>
</tr>
<tr>
<td>Smoke Free Ontario Strategy: Youth Tobacco Use Prevention</td>
<td>160,000</td>
<td>125,267</td>
<td>34,733</td>
<td>160,000</td>
<td>78%</td>
</tr>
<tr>
<td>Smoke Free Ontario Strategy: E-Cigarette enforcement</td>
<td>28,100</td>
<td>12,500</td>
<td>15,600</td>
<td>28,100</td>
<td>44%</td>
</tr>
<tr>
<td>Substance misuse prevention</td>
<td>126,227</td>
<td>82,431</td>
<td>43,797</td>
<td>126,227</td>
<td>65%</td>
</tr>
<tr>
<td><strong>Substance Use and Injury Prevention Total</strong></td>
<td>1,316,596</td>
<td>845,670</td>
<td>470,926</td>
<td>1,316,596</td>
<td>64%</td>
</tr>
<tr>
<td>Direct Costs Total</td>
<td>11,376,924</td>
<td>7,739,976</td>
<td>3,636,947</td>
<td>11,376,924</td>
<td>68%</td>
</tr>
<tr>
<td>Indirect Expense</td>
<td>4,854,001</td>
<td>3,291,404</td>
<td>1,562,597</td>
<td>4,854,001</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Indirect Costs Total</strong></td>
<td>4,854,001</td>
<td>3,291,404</td>
<td>1,562,597</td>
<td>4,854,001</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>16,230,925</td>
<td>11,031,380</td>
<td>5,199,545</td>
<td>16,230,925</td>
<td>68%</td>
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</tbody>
</table>

**One-Time Funding**

<table>
<thead>
<tr>
<th>One-Time Funding</th>
<th>Budget (at 100%)</th>
<th>YTD Actual (at 100%)</th>
<th>Forecast (at 100%)</th>
<th>Total (at 100%)</th>
<th>% Spent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elgin-Oxford Merger Costs</td>
<td>1,900,000</td>
<td>619,210</td>
<td>1,280,790</td>
<td>1,900,000</td>
<td>33%</td>
</tr>
<tr>
<td>Public Health Inspector Practicum</td>
<td>22,000</td>
<td>12,850</td>
<td>9,150</td>
<td>22,000</td>
<td>58%</td>
</tr>
<tr>
<td>School Health Screening Coordination</td>
<td>81,000</td>
<td>-</td>
<td>81,000</td>
<td>81,000</td>
<td>0%</td>
</tr>
<tr>
<td>Oral Health</td>
<td>137,800</td>
<td>7,932</td>
<td>129,868</td>
<td>137,800</td>
<td>6%</td>
</tr>
<tr>
<td>Harm Reduction/Needle Exchange</td>
<td>7,200</td>
<td>-</td>
<td>7,200</td>
<td>7,200</td>
<td>0%</td>
</tr>
<tr>
<td>Increase in Base Funding for Needle Exchange</td>
<td>17,160</td>
<td>-</td>
<td>17,160</td>
<td>17,160</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,165,160</td>
<td>639,992</td>
<td>1,525,168</td>
<td>2,165,160</td>
<td>30%</td>
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<tr>
<td>Program</td>
<td>Budget (at 100%)</td>
<td>YTD Actual (at 100%)</td>
<td>Forecast (at 100%)</td>
<td>Total (at 100%)</td>
<td>% Spent</td>
</tr>
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<tr>
<td></td>
<td>Jan 1 - Dec 31</td>
<td>Jan 1 - Sept 30</td>
<td>Oct 1 - Dec 31</td>
<td>Jan 1 - Dec 31</td>
<td></td>
</tr>
<tr>
<td>Land Control Environmental</td>
<td>89,300</td>
<td>68,678</td>
<td>20,622</td>
<td>89,300</td>
<td>77%</td>
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<td>Healthy Babies Healthy Children</td>
<td>1,653,539</td>
<td>1,139,898</td>
<td>513,641</td>
<td>1,653,539</td>
<td>69%</td>
</tr>
<tr>
<td>Pre and Post Natal Nurse Practitioner</td>
<td>139,000</td>
<td>103,410</td>
<td>35,590</td>
<td>139,000</td>
<td>74%</td>
</tr>
<tr>
<td>School Nutrition Program</td>
<td>115,275</td>
<td>86,044</td>
<td>29,231</td>
<td>115,275</td>
<td>75%</td>
</tr>
<tr>
<td>Healthy Kids Challenge</td>
<td>87,500</td>
<td>87,428</td>
<td>72</td>
<td>87,500</td>
<td>100%</td>
</tr>
<tr>
<td>Public Health Agency of Canada</td>
<td>166,500</td>
<td>32,333</td>
<td>134,167</td>
<td>166,500</td>
<td>19%</td>
</tr>
<tr>
<td>Low German Speaking Partnership Study</td>
<td>80,000</td>
<td>22,047</td>
<td>57,953</td>
<td>80,000</td>
<td>28%</td>
</tr>
<tr>
<td><strong>Total Programs Funded by Other Ministries, Agencies and Local Initiatives</strong></td>
<td><strong>2,331,114</strong></td>
<td><strong>1,539,839</strong></td>
<td><strong>791,275</strong></td>
<td><strong>2,331,114</strong></td>
<td><strong>66%</strong></td>
</tr>
</tbody>
</table>
October 18, 2018

MEMORANDUM TO: Health Sector Partners

FROM: Helen Angus
Deputy Minister
Ministry of Health and Long-Term Care

RE: Ministry Realignment

We are all committed to a patient-centred health care system that is effective and efficient and delivers high quality care for patients. Many of you are rethinking your care pathways and processes to put the patient at the centre of your organization. I believe there is great value in the ministry also organizing itself in a way that better reflects how the health system is organized, making it easier for you and patients to interact with us.

I want you to be aware of some structural changes announced today that will clarify and simplify lines of accountability and allow our organization to be more nimble and outcome focused by:

- Aligning acute and emergency services, bringing hospitals, provincial programs and emergency services together;
- Bringing together community and mental health and addictions services, including integrating youth mental health services;
- Ensuring end-to-end planning and implementation for long-term care homes;
- Integrating capital, workforce and system capacity planning;
- Aligning the Chief Medical Officer of Health with population and public health oversight;
- Combining public drug programs and assistive devices;
- Better connecting the Provincial Chief Nursing Officer with policy to provide strategic clinical nursing expertise on a broad range of health care policy and transformation initiatives. Aligning our policy, research, and innovation work to ensure patient-focused outcomes; and
- Centralizing the responsibilities for LHIN-managed health services under an Associate aligned with key capacity, workforce and planning functions allowing for end-to-end management of health services for better outcomes and improved integration.
Associate Deputy Minister, Health Services (renamed from Delivery and Implementation) Melanie Fraser, who recently joined our ministry, will have the following divisions reporting to her:

- **Acute and Emergency Services** led by Melissa Farrell, Assistant Deputy Minister, including hospitals, quality improvement, provincial programs and emergency health services.
- **Capacity Planning and Capital** led by Michael Hillmer, Assistant Deputy Minister on an interim basis, including health capital investment, capacity planning, health workforce planning and regulatory affairs.
- **Community, Mental Health and Addictions and French Language Services** led by Tim Hadwen, Assistant Deputy Minister, including local health planning and delivery, primary care and home care, as well as child, youth, forensic and justice mental health services. Transfer of programs from the Ministry of Children, Community and Social Services will be effective October 29.
- **Long-Term Care Homes**, led by Brian Pollard, Assistant Deputy Minister, including long-term care home renewal.

Divisions now reporting directly to me as the Deputy Minister include:

1. **Drugs and Devices**, led by Suzanne McGurn, Assistant Deputy Minister, including assistive devices.
2. **Ontario Health Insurance Plan**, led by Lynn Guerriero, Assistant Deputy Minister, including claims services.
3. **Chief Medical Officer of Health and Population and Public Health**, led by Dr. David Williams, including all population and public health programs and services.
4. **Strategic Policy and Planning**, led by Patrick Dicerni, Assistant Deputy Minister, including the Provincial Chief Nursing Officer, health workforce regulatory oversight, and health innovation to embed innovation earlier in the development of our strategic direction.
5. **Corporate Services**, led by Peter Kaftarian, CAO, on an interim basis.
6. **Secretariat for Ending Hallway Medicine**, led by Fredrika Scarth, Director.
7. **Associate Deputy Minister and Chief Information Officer**, led by Lorelle Taylor, Associate Deputy Minister and Chief Information Officer.
8. **Communications and Marketing**, led by Jean-Claude Camus, Assistant Deputy Minister.

As we transition, Sharon Lee Smith, Denise Cole and Roselle Martino will stay on with the ministry on assignments to support priority areas. Sharon Lee will lead the ministry Indigenous engagement efforts ensuring there is stability in our key relationships and addressing any critical issues. Denise will lead the ministry in setting up an expedited review of legislation and regulation to identify impediments to more effective and efficient operations of the health system and the ministry in its oversight role. Roselle will continue to advise on the opioid strategy.
Included in this email is a link to our new organizational chart.

I would like to take this opportunity to thank you in advance for your partnership and collaboration. Today’s announcement will ensure we are ready to work with you on the challenges and opportunities ahead.

Sincerely,

Helen Angus