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MONTHLY BOARD PACKAGE







Algoma Public Health's 1st Annual Family BBQ September 1, 2015

FOR THE MEETING DATED:

September 22, 2015

TIME & PLACE:

5:00 P.M.
Algoma Public Health, Sault Ste. Marie,
3rd Floor,
Sault Ste. Marie Room A & B

ALGOMA PUBLIC HEALTH BOARD MEETING
SEPTEMBER 22, 2015 @ 5:00 pm
SAULT STE MARIE ROOM A&B, 1ST FLOOR, APH SSM
A*G*E*N*D*A

1) **Meeting Called to Order** by Mr. L. Mason, Board Chair
   a) Declaration of Conflict of Interest
2) **Adoption of Agenda Items Dated** September 22 , 2015
   Resolution
   THAT the agenda items dated September 22, 2015 be adopted as circulated.
3) **Adoption of Minutes of Previous Meeting Dated**
   Resolution
   THAT the minutes of the meeting dated June 17, 2015 be adopted as circulated; and
   THAT the minutes of the special meeting dated June 29, 2015 be adopted as circulated; and
   THAT the minutes of the special meeting dated August 6, 2015 be adopted as circulated.
4) **Delegations/Presentations.**
   No presentation this month.
5) **Business Arising from Minutes**
   a) Governance Standing Committee TOR
      Resolution
      THAT the Board approves the Terms of Reference for the Governance Standing Committee as presented.

   b) Algoma Public Health Performance Monitoring Plan
      Resolution
      THAT the Board approves the Performance Monitoring Plan as presented.
6) **Reports of Committees**
   a) Finance and Audit Committee
   b) Governance Standing Committee
7) **Reports of Officers/Program Managers**
   a) Acting Medical Officer of Health and Acting Chief Executive Officer — Dr. P. Sutcliffe / Tony Hanlon, Ph.D.
      Resolution
      THAT the report of the Acting Medical Officer of Health and CEO for the month of September 2015 be adopted as presented.

   b) Chief Financial Officer/Director of Operations — Justin Pino
      i) Financial Statements for the Period Ending: August 31, 2015
         Resolution
         THAT the financial reporting for the period ending August 31, 2015 be adopted as presented.

      ii) Annual Reconciliation for Infant Development Program
         Resolution
         THAT the Board approves the annual reconciliation for the Infant Development Program for the year ending March 31, 2015.

8) New Business/General Business

a) Ontario Public Health Organizational Standards Compliance Checklist/Attestation

b) Board Evaluation Summary

c) 02-05-010 – Board Minutes and Packages – Posting/Circulation/Retention – Revised

Resolution

THAT the Board approves changes to policy 02-05-010 Board Minutes and Packages – Posting/Circulation/Retention as presented.

d) 02-05-070 – In-Committee Material – Posting/Circulation/Retention – New

Resolution

THAT the Board approves the new policy 02-05-060 In-Committee Material - Posting/Circulation/Retention as presented.

e) Bylaw 95-1 – To Regulate the Proceedings of the Board of Health – Revised

Resolution

THAT the Board approves the changes to Bylaw95-1 To Regulate the Proceedings of the Board of Health as presented.

f) 02-05-060 – Freedom of Information – New

Resolution

THAT the Board approves the new policy 02-05-060 Freedom of Information as presented.

g) 02-05-030 – Board Member Code of Conduct – For Review and discussion at October Board meeting

h) Healthy Babies Healthy Children Program – Briefing Note

Resolution

WHEREAS the Healthy Babies Healthy Children (HBHC) program is a 100% funded Ministry of Child and Youth Services (MCYS) program provided by all 36 Ontario Boards of Health; and

WHEREAS the HBHC goals are to promote optimal physical, cognitive, communicative and psychosocial development in children through effective prevention and early intervention services for families as well as to act as a catalyst for coordinated, effective, integrated system of services and supports for healthy child development and family well-being though partnership and collaboration with a network of services providers; and

WHEREAS collective agreement settlements, travel costs, pay increments and accommodation costs have increased the costs of implementing the HBHC program, the management and administration costs of which are already offset by the cost-shared budget for provincially mandated programs; and

WHEREAS Algoma Public Health has not received a budget increase in the Healthy Babies Healthy Children (HBHC) Program since 2008; and

WHEREAS the HBHC program has made every effort to mitigate the outcome of the funding shortfall, this has becoming increasingly more challenging and will result in the discontinuation of weekend services in the HBHC program.

THEREFOR BE IT RESOLVED THAT the Algoma District Board of Health supports a letter to the Minister of Children and Youth Services to advocate to fully fund all program costs related to the HBHC Program; and

FURTHER THAT this motion be forwarded to the Association of Local Public Health Agencies, the Chief Medical Officer of Health and all Ontario Boards of Health.

i) Public Health Support for a Basic Income Guarantee – Briefing Note

Resolution

WHEREAS low income, and high income inequality, have well-established, strong relationships with a range of adverse health outcomes; and

WHEREAS 13.9% of Ontarians and 14.4% of Algoma residents live in low income according to the 2011 National Household Survey after-tax low-income measure; and

WHEREAS income inequality continues to increase in Ontario and Canada while current income security programs by provincial and federal governments have not proven sufficient to ensure adequate, secure income for all; and

WHEREAS a basic income guarantee – a cash transfer from government to citizens not tied to labour market participation - ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status; and

WHEREAS basic income resembles income guarantees currently provided in Canada for seniors and children, which have contributed to health improvements in those age groups; and

WHEREAS there was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in Dauphin, Manitoba in the 1970s, which demonstrated several improved health and educational outcomes; and

WHEREAS a basic income guarantee can reduce poverty and income insecurity, and enable people to pursue educational, occupational, social and health opportunities relevant to them and their family; and

WHEREAS the idea of a basic income guarantee has garnered expressions of support from the Canadian Medical Association, Alberta Public Health Association and the Association of Local Public Health Agencies as a means of improving health and food security for low income Canadians; and

WHEREAS there is momentum growing across Canada from various sectors and political backgrounds for a basic income guarantee;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health of Algoma endorses the concept of a basic income guarantee;

AND FURTHER in keeping with APH's endorsement of a basic income guarantee as a poverty reduction strategy, we support the development of a community wide campaign to increase

awareness and action in Algoma;

AND FURTHER that Algoma Public Health supports the recommendations made by a number of Ontario clinical and public health physicians, to the provincial government, advocating for a basic income guarantee demonstration project;

AND FURTHER endorses that a formal letter of support be developed and sent to the Minister of Health and Long-Term Care in this regard.

j) Call to Action - Reducing Smoking Rates in the District of Algoma – Briefing Note

Resolution

WHEREAS Algoma Public Health is committed to preventing disease and promoting the health of individuals and communities in the Algoma District; and

WHEREAS the incidence of lung and bronchus cancer for the district of Algoma is significantly higher than that of the province of Ontario; and

WHEREAS the 2011-2012 cycle of the Canadian Community Health Survey, identifies current smokers, age 12 or older who have smoked at least 100 cigarettes in their lifetime and have smoked in the past 30 days, as 23.6% in Algoma compared to 17.8% for Ontario; and

WHEREAS supporting a call to action to reduce smoking rates by 5% in 5years will bring Algoma's smoking rates more in line with the provincial average and help to reduce health inequities in the prevention of cancer; and

WHEREAS a collaboration with key partners and municipalities to address the smoking rate will promote a systems approach to ensuring access of all residents of Algoma to quit smoking assistance and support a collective impact on reducing smoking rates in Algoma; and

WHEREAS continued efforts to prevent youth from starting to smoke remains vital, the proposed 5% reduction in smoking rates over five years can only be achieved by significantly increasing the successful quit attempts among people who currently smoke; and

WHEREAS Algoma has the potential to become Ontario's "cessation innovation accelerator" where new ideas emerging from stakeholders and from research evidence are tested to meet the challenging goal of reducing smoking rates for Algoma and the Province.

THEREFORE BE IT RESOLVED THAT the Board of Health of Algoma endorses the concept of a district-wide goal to reduce smoking rates by 5% over the next 5years; and

FURTHER THAT in keeping with APH's endorsement of a district-wide goal, supports the development of a strategy that engages community partners including those from health care, education, and the private sector to support the implementation of a 5 year smoking reduction plan across the district; and

FURTHER THAT Algoma Public Health supports the development of an internal and external branded communication strategy directed at smokers to make quit smoking attempts; and

FURTHER THAT the Board of Health of Algoma endorses a proposal submission in partnership with the Ontario Tobacco Research Unit to the Ministry of Health to fund a 5 year smoking reduction strategy; and

FURTHER THAT APH requests municipalities and townships across Algoma to support a district-wide strategy by passing resolutions that support a call to action to reduce smoking rates by 5% over the next 5years.

k) Prenatal Postnatal Nurse Practitioner Program – Briefing Note

Resolution

WHEREAS Algoma Public Health has been operating since June 2014 in the absence of a Prenatal and Postnatal Nurse Practitioner program.

WHEREAS indicators show no recent growth in the number of unique clients, new clients and client visits. Additionally, survey results of Algoma Public Health clients suggest over 80% of pregnant women and women with children under the age of 5 have primary health care coverage.

WHEREAS key stakeholders and residents of Sault Ste. Marie have not expressed a community need for this program at Algoma Public Health.

THEREFORE BE IT RESOLVED that Algoma Public Health recommends the withdrawal of the Prenatal and Postnatal Nurse Practitioner program from Sault Ste. Marie services.

9) Correspondence Items

a) Letter to Hon. Wynne from Perth District Health Unit Re: Health and Physical Education Curriculum
b) Letter to Hon. MacCharles from Sudbury & District Health Unit Re: Healthy Babies Healthy Children Program
c) Letter to Hon MacCharles from Grey Bruce Health Unit Re: Healthy Babies Healthy Children Program
d) Letter to Hon. Hoskins from Sudbury & District Health Unit Re: Enforcement of the Immunization of School Pupils' Act
e) Letter to Hon. Wynne from Sudbury & District Health Unit Re: Northern Ontario Evacuations of First Nations Communities
f) Letter to Hon. Wynne from Grey Bruce Health Unit Re: Northern Ontario Evacuation of First Nations Communities
g) Letter to Hon. Harper from Durham Region Re: National Alcohol Strategy Advisory Committee
h) Letter to Hon. Hoskins from Ontario Physicians Re: Basic Income Guarantee for Ontario
i) Letter to Mr. MacLean, Town of Thessalon from Dr. Hoskins Re: In Support of APH resolution to maintain preventive oral health services
j) Letter to Hon. Hoskins from Grey Bruce Health Unit Re: Smoke Free Multi-Unit Housing

10) Items for Information

a) Association of Local Public Health Agencies (alPHa) News Release – June 19, 2015
b) Memo from Chief Medical Officer of Health - Amendments to Food Safety Protocol
c) Memo from Chief Medical Officer of Health – Amendments to the Emergency Preparedness Protocol
d) Grey Bruce Resolution on Bruce Grey Food Charter
e) New Integrated Dental Program Update
f) Thank you Card from Sandra Laclé

11) Addendum

12) That The Board Go Into Committee

Agenda Items:

a) Adoption of previous in-committee minutes dated June 17, 2015 and August 6, 2015
b) Solicitor Client Privilege

13) That The Board Go Into Open Meeting

14) Resolution Resulting From In-Committee Session

15) Announcements:

Next Board Meeting:
TBD
Sault Ste. Marie Room A&B, 1st Floor, Algoma Public Health, Sault Ste. Marie

16) That The Meeting Adjourn

ALGOMA PUBLIC HEALTH BOARD MEETING
June 17, 2015
PRINCE ROOM, 3RD FLOOR, APH SAULT STE. MARIE
MINUTES

PRESENT:	Ian Frazier	Candace Martin	Lee Mason	Dennis Thompson
REGRETS:	Ron Rody			
TELECONF:	Sue Jensen			

OFFICIALS PRESENT:	Acting Medical Officer of Health	Dr. Penny Sutcliffe
	Acting Chief Executive Officer	Sandra Laclé
	Chief Financial Officer	Justin Pino
	Director of Human Resources and Corporate Services	Antoniette Tomie
	Director of Community Services	Laurie Zeppa
	Board Secretary	Christina Luukkonen
OFFICIALS REGRETS:	Acting Director of Clinical Services	Jonathon Bouma
GUESTS:	Manager of Chronic Disease Prevention, Prevention of Injury & Substance Misuse and Sexual Health	Kristy Harper
	Mayor for the City of Sault Ste. Marie	Mayor Christian Provenzano

1) CALL TO ORDER

Mrs. Luukkonen, Secretary to the Board of Health called the meeting to order at 6:02 pm
Mrs. Luukkonen welcomed staff and guest.

ELECTION OF OFFICERS TO THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT FOR THE REMAINDER OF 2015

Election of Chair

Mrs. Luukkonen called for nominations for the position of Board Chair.

Mr. Thompson nominated Mr. Mason.

Mrs. Luukkonen called for any other nominations.

Mrs. Luukkonen called for any other nominations.

There being no further nominations, the nomination for Algoma Public Health Board of Health Chair for the remainder of 2015 was closed.

Mr. Mason accepted the nomination.

2015-87 Moved: I. Frazier
Seconded: C. Martin
Mr. Lee Mason is duly elected by acclamation as Board Chair for the remainder of 2015.
CARRIED.

Election of Vice-Chair
Mr. Mason called for nominations for the position of Board Vice-Chair.

Mr. Thompson nominated Mr. Frazier.

Mr. Mason called for any other nominations.

Mr. Mason called for any other nominations.

There being no further nominations, the nomination for Algoma Public Health Board of Health Vice-Chair for the remainder of 2015 was closed.

Mr. Frazier accepted the nomination.

2015-88 Moved: D. Thompson
Seconded: C. Martin
Mr. Ian Frazier is duly elected by acclamation as Board Vice-Chair for the remainder of 2015.
CARRIED.

2) **DECLARATION OF CONFLICT OF INTEREST**
Mr. Mason called for conflicts of interest; none were presented.

3) **ADOPTION OF AGENDA** dated June 17, 2015

2015-89 Moved: I. Frazier
Seconded: D. Thompson
THAT the agenda items dated June 17, 2015 be adopted as circulated.
CARRIED.

4) **APPROVAL OF THE MINUTES** dated May 20, 2015

2015-90 Moved: I. Frazier
Seconded: D. Thompson
THAT the minutes of the meeting dated May 20, 2015, be adopted as circulated.
CARRIED.

5) **DELEGATIONS/PRESENTATIONS**

a) Hiring Interim Chief Financial Officer (2013)

Mr. Mason invited Mayor Provenzano, City of Sault Ste. Marie to address the Board. Mayor Provenzano thanked the Board for accepting his request to speak. Mayor Provenzano explained that his reasons for addressing the Board have changed since the release of the Ministry's report. The Ministry's report has answered his questions. He thanked Mrs. Laclé and Dr. Sutcliffe for the leadership that they have provided for APH in the last couple of months and expressed gratitude to the Sudbury and District Health Unit for their support as well. He expressed that the City of Sault Ste. Marie values the work the Board of Health does for our City. He also acknowledged the work of the previous Board members and reinforced that the City of Sault Ste. Marie is committed to working with APH and the Ministry. Mayor Provenzano also expressed great appreciation for the hard work and program commitment the staff has shown to Algoma Public Health and the community.

Mayor Provenzano urged the Board to release the KPMG report but acknowledged that he understands that there are contractual obligations that are preventing the release of the report. S. Laclé spoke regarding the Board's position on releasing the report. APH has received a freedom of information request for the release of the KPMG report and is working through the FOI process as per the legislation. Dr. Sutcliffe thanked to the City of Sault Ste. Marie for their support to APH.

Mr. Mason thanked Mayor Provenzano for coming and speaking with the Board and indicated that the Board looks forward to working with the City of Sault Ste. Marie.

Mr. Mason asked that the Board members introduce themselves.

6) BUSINESS ARISING FROM MINUTES

a) Establishment, Maintenance and Use of a Reserve Fund

Revised documents were provided at the beginning of the meeting. J. Pino highlighted the briefing note and a new policy regarding the creation of a reserve fund. I. Frazier reported to the Board that the Finance and Audit Committee reviewed the briefing note and draft policy at its meeting on June 11, 2015 and is in support of creating a reserve fund.

2015-91 Moved: I. Frazier
Seconded: C. Martin
Therefore be it resolved THAT:

The Board of Health forthwith establish and maintain a reserve fund that is utilized for Working Capital, Human Resources Management, Public Health Initiatives and Response, Corporate Contingencies and Facility and Equipment Repairs and Maintenance; and,

The reserve fund shall be used and applied only to pay for expenses incurred by or on behalf of the Board of Health and the Medical Officer of Health in the performance of their functions and duties under the Health Protection and Promotion Act or any other Act; and,

The reserve fund shall not be used or applied for capital expenditures to acquire and hold real property unless the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit have been first obtained pursuant to section 52(4) of the Act; and,

The Board of Health in each year may provide in its estimate for a reasonable amount to be paid into the reserve fund provided that no amount shall be included in the estimates which is to be paid into the reserve fund when the cumulative balance of the reserve fund in the given year exceeds 15 percent of the regular operating revenues for the Board of Health approved budget for the mandatory cost shared programs and services; and,

All lease revenues, received by the Board of Health under leases of part of its premises, in excess of the actual operating cost attributable to the leased premises, shall be paid annually into the reserve fund; and,

Any over-expenditures in any year shall be paid firstly from the reserve fund and only when the reserve fund shall have been exhausted will the Board of Health seek additional funds from the Municipalities to pay for such over-expenditures; and,

Any excess revenues in any year resulting from an over estimate of expenses shall be paid into the reserve fund; and,

The Medical Officer of Health/Chief Executive Officer shall in each year direct the allocation of excess funds to such reserve fund as the Medical Officer of Health shall decide.
CARRIED.

2015-92 Moved: S. Jensen
Seconded: I. Frazier
THAT the Board approves Policy 02-05-065 Algoma Board of Health Reserve Fund as presented.
CARRIED.

b) Policy for Mitigating Risk of Duplicate Payments – Accounts Payable Invoice Entry
c) Policy for Mitigating Risk of Errors Through the Disbursement of Funds – Accounts Payable Process

These two policies were shared for the information of the Board. The changes made to the policy are on the recommendations from the risk assessment shared with the Board in May as previously identified during the Accountability Agreement submission process.

d) Criminal Reference Checks - Contractors

At the last Board meeting the Board requested staff to check with other publically funded agencies, both provincial and local, to determine what the practice is for contractors/service providers when the service provider does not provide services to APH's clients nor has access to its finances or employee information. J. Pino reported that the results from the provincial and local scan were mixed. Based on this the Board decided to leave the policy as is and revisit the policy during the regular Board policy review process.

7) REPORTS OF COMMITTEES

a) Finance and Audit Committee

Mr. Frazier, chair of the Finance and Audit Committee, updated the Board on the meeting from June 11, 2015. He noted that the Committee's recommendation to staff to create a form that will enable consistent approval process of credit card expenditures for the agency has been complied with. The Finance and Audit Committee will continue to meet over the summer.

b) Governance Standing Committee

Mr. Frazier took the role of chair while Mr. Mason, Chair of the Governance Committee, gave the report from the Governance Standing Committee.

Mr. Mason reported to the Board that the Governance Standing Committee met for the first time on June 15, 2015. The Committee reviewed the MOH/CEO recruitment process. Other items on the agenda were the APH Performance Monitoring Plan and Terms of Reference. Mr. Mason asked the Board members to review the Performance Monitoring Plan, its indicators and the Terms of Reference. Feedback is to be sent to C. Luukkonen by the middle of July. C. Luukkonen will send out a reminder email to Board members.

8) REPORTS OF OFFICERS/PROGRAM MANAGERS:

a) Medical Officer of Health/Chief Executive Officer:

The MOH/CEO report included in the Board package was reviewed. Dr. Peter Donnelly, President and CEO of Public Health Ontario, visited the health unit on June 11, 2015. Staff had the opportunity to attend a presentation by Dr. Donnelly. Dr. Donnelly indicated that was impressed by the work done at APH.

June 7-9, 2015 was the annual alPHa Conference in Ottawa, ON. Dr. Sutcliffe is the president of alPHa and facilitated the conference. Ms. Kirby, former Board member, and S. Laclé attended on behalf of APH. S. Laclé encouraged Board members to attend the Conference. It is a very good opportunity for Board member networking, orientation and training.

Other items highlighted in the report included:

- Community Mental Health Program received funding for a Peer Support position
- Breastfeeding Friendly Initiative - APH received official designation in January 2010 and will be applying for re-designation in the fall of 2015
- MOH recruitment process and results

Dr. Sutcliffe reminded the Board that alPHa is a good resource and support for on-going training for Board members. Also discussed that her contract is reviewed on a monthly basis but will need to have Ministry approval if the appointment is for more than six months. She reminded the Board that will need to be addressed soon as July represents the six month mark.

2015-93 Moved: D. Thompson
Seconded: C. Martin
THAT the report of the Acting Medical Officer of Health and Acting Chief Executive Officer for the month of June 2015 be adopted as presented.
CARRIED.

b) Chief Financial Officer/Director of Operations:

i) Financial Statements for the Period Ending: April 30, 2015

J. Pino reviewed the Financial Report that was included in the Board package. A revised page 4 was provided at the beginning of the Board meeting.

Mr. Frazier informed the Board that the Finance and Audit Committee reviewed the reports on June 11, 2015 and the Committee supports the report as presented.

2015-94 Moved: C. Martin
Seconded: D. Thompson
THAT the Board accepts the Algoma Public Health Financial Statements for the period ending May 31, 2015 for the following programs:

Public Health Programs
Public Health
Public Health (Capital)

Community Health Programs
Healthy Babies Healthy Children
HBHC Screening Liaisons
Child Benefits Ontario Works
Dental Benefits Ontario Works

Early Years Development (NP Clinic11)
Miscellaneous Calendar
Healthy Community Partnership
Northern Ontario Fruit and Vegetable Program
Brighter Futures for Children
Infant and Child Development
Preschool Speech and Language
Nurse Practitioner
Genetics Counselling
Community Mental Health
Community Alcohol and Drug Assessment
Remedial Measures
Diabetes
Miscellaneous Fiscal

CARRIED.

2015-95 Moved: I. Frazier
Seconded: C. Martin

THAT the financial reporting for the period ending May 31, 2015 be adopted as presented.

CARRIED.

9) **New Business/General Business**

a) Draft Bylaw 2015-1 – To Provide for the Management of Property

A new bylaw on providing for the management of property was presented. Board members suggested minor changes to the bylaw. The amendments will be made by the Board secretary and a final copy will be provided to the Board members to be included in their binders.

2015-96 Moved: D. Thompson
Seconded: I. Frazier

WHEREAS, the Health Protection and Promotion Act states that a board of health may acquire and hold real property for the purposes of carrying out the functions of the board and may sell, exchange, lease, mortgage or otherwise charge or dispose of real property owned by it. R.S.O. 1990, c.H.7, s. 52 (3), and

WHEREAS, the Board of Health owns real property (294 Willow Avenue, Sault Ste. Marie, On) as of the 26th day of May, 2014 based on the Surrender of Lease Agreement between the Corporation of the City of Sault Ste. Marie, The Board of Health for the District of Algoma Health Unit and the Sault College of Applied Arts and Technology, and

WHEREAS, the Health Protection and Promotion Act (current 56. (1)) require that a board of health shall pass a by-law respecting (a) the management of its property,

THEREFORE, be it resolved that the Board of Health approves the Property Management by-law 2015-1 dated the 17th, of June 2015 as presented.

CARRIED.

b) Revised Bylaw 95-2 – To Provide for the Banking and Finance

Board of Health bylaws and policies are reviewed every two years. The Finance and Audit committee recommended the changes to Bylaw 95-2. J. Pino reviewed these changes with the Board. Many questions were asked. The bylaw speaks to registering the health unit as a charitable organization. Questions were asked if we have a number and how this works. J. Pino explained that we only need to register once. Also a question was asked about maximizing the HST. J. Pino explained that every two years the health unit procures the service of an auditor that reviews our invoices and submits for any rebates. Changes to be made and final copy to be provided to Board members for their binders.

2015-97 Moved: I. Frazier
Seconded: D. Thompson
THAT the Board accepts the changes to Bylaw 95-2 as amended.
CARRIED.

Mr. Mason called for any nominations for position of 4th signing authority. Mr. Mason nominates the vice-chair Mr. Frazier. As there are no other nominations. Mr. Frazier is acclaimed.

2015-98 Moved: C. Martin
Seconded: D. Thompson
WHEREAS By-Law 95-2 identifies that signing authorities for all accounts shall be restricted to:

i) the Chair of the Board of Health
ii) one other Board member, designated by Resolution
iii) the Medical Officer of Health/Chief Executive Officer
iv) the Chief Financial Officer; and

WHEREAS the Chair of the Board of Health, the Medical Officer of Health/Chief Executive Officer and the Chief Financial Officer have previously been designated with signing authority;

SO BE IT RESOLVED that signing authority is provided to Mr. Ian Frazier as the one other Board member, designated by Resolution until the next election of Officers.
CARRIED.

c) Revised Bylaw 95-3 – To Provide for the Duties of the Auditor

J. Pino highlighted the changes in job titles within the bylaw. As per the Health Protection and Promotion Act, auditors for public health units are the auditors for the largest municipality. In the case of Algoma Public Health, the largest municipality is Sault Ste. Marie. Final copies will be provided for the Board member to include in their binders.

2015-99 Moved: C. Martin
Seconded: D. Thompson
THAT the Board accepts the changes to Bylaw 95-3 as presented.
CARRIED.

d) Public Health and First Nations Communities

S. Laclé presented the First Nations report titled MNO BMAADZIIDAA – The Good Life for information. The report was included in the Board package. This report is based on a collaborative project between APH and North Shore Tribal Council First Nations. One-time funding had been provided for this project.

2015-100 Moved: C. Martin
Seconded: D. Thompson
THAT the Board of Health for Algoma receive the report MNO BMAADZIIDAA –

The Good Life" for information; and

THAT the Board of Health for Algoma support continued conversation-dialogue to build relationships with First Nations communities in the Algoma district as referenced in the recommendations in the report.
CARRIED.

10) **CORRESPONDENCE/ITEMS FOR INFORMATION:**

a) Letter to Honourable Kathleen Wynne from Northwestern Health Unit Re: Bill 45 Making Healthier Choices Act Letter to Hon. Hoskins from Perth District Health Unit Re: Smoke-Free Multi-Unit Housing
b) Letter from Ministry of Health and Long-Term Care Re: Amendments to the Protocol under the Ontario Public Health Standards - Institutional/Facility Outbreak Prevention and Control Protocol, 2015
c) Letter to Various Canadian and Ontario Ministers Re: Basic Income Guarantee
d) Disclosure of the KPMG audit (May 19th, 2015)
e) Correspondence to Mayor Provenzano and all Municipal Mayors & Reeves

Mr. Mason reviewed the various correspondence items that were received for the Board. Copies were provided in the Board package. S. Laclé highlighted for the Board 10d) Disclosure of the KPMG audit.

11) **ITEMS FOR INFORMATION**

a) Making Healthier Choices Act (MHCA) Bill 45 Good News
b) Algoma Public Health Annual Report 2014 (Report Provided at the BOH meeting)
c) Policy Criminal Reference Check for Staff
d) Policy Complaints and Concerns
e) Updates to the Board of Health E-Learning Module

S. Laclé highlighted 11b) APH Annual Report was distributed at the beginning of the meeting. The report showcases examples of the work we do and features community partners and clients. Following the Board meeting this evening it will be posted on our website and shared with our stakeholders, ministry agencies and our community partners. Also highlighted was 11e). alPHa has an e-learning module available to all BoH members. S. Laclé strongly recommends that all Board members review the module over the summer as an important part of their Board orientation process.

Questions were asked regarding 11d) Policy Complaints and Concerns regarding the process and steps taken. During the interview process for Mr. Scott's report he identified some areas of concern. Changes were made in response to his verbal recommendations and a new policy was developed. Specifically Mr. Scott recommended that all staff have the opportunity to express their complaint to their manager or their Director of Human Resources at any step of the process. Further recommendations were made by the Board members.

12) **ADDENDUM:**

2015-101 Moved: D. Thompson
Seconded: C. Martin
THAT the Board accepts the items on the addendum.

a) Governance Standing Committee Terms of Reference
b) Performance Monitoring Plan
c) Finance and Audit Committee Minutes dates May 20, 2015
d) Assessor's Report on Algoma Public Health (April 24, 2015)
e) Ministry Actions and Executive Summary Assessment Report (June 16, 2015)
f) MOHLTC Letter to Chair, Board of Health, Algoma Public Health (June 16,

2015)
g) Algoma Public Health Reaction to Release of Assessor's Report (June 16, 2015)
h) Board of Health Member Letter of Resignation (June 16, 2015)
i) Board of Health Member Letter of Resignation (June 17, 2015)
j) Board of Health Member Letter of Resignation (June 17, 2015)

CARRIED.

a) Governance Standing Committee Terms of Reference

Mr. Mason spoke to this item during his report to the Board in 7b).

b) Performance Monitoring Plan

Mr. Mason spoke to this item during his report to the Board in 7b).

c) Finance and Audit Committee Minutes dates May 20, 2015 – *For Information*

d) Assessor's Report on Algoma Public Health (April 24, 2015)
e) Ministry Actions and Executive Summary Assessment Report (June 16, 2015)
f) MOHLTC Letter to Chair, Board of Health, Algoma Public Health (June 16, 2015)
g) Algoma Public Health Reaction to Release of Assessor's Report (June 16, 2015)

Copies of the Assessor's Report, Executive Summary, letter to the Board chair and news release were provided for the Board members at the beginning of the meeting in their addendum package. Mr. Frazier requested that the Board of Health be provided with a copy of the previous Ministry report Provincial Assessment Report (2014) and also the KPMG Report stemming from the June 2013 incident.

Questions were asked regarding the recommendations in Mr. Scott's report. Dr. Sutcliffe acknowledged that there are still many questions outstanding and that the Executive Committee will be participating in a teleconference with the Ministry late Monday to discuss expectations and anticipated process changes. Special Board meetings will be arranged, as required, prior to the regularly scheduled meeting in September.

Dr. Sutcliffe addressed the recommendation in the report for a merger between APH & SDHU. At this time the option is still there but the Ministry is focusing on the rebuilding the Board as a skills-based Board.

To date we have received three letters of resignation from Board members. Copies of the letters were included in the addendum package. Mr. Mason acknowledged that it is with regret that he accepts the letters of resignations.

The Board chair requested that a letter be sent to the Sudbury & District Health Unit's Board of Health expressing the Board's appreciation for their continued support to APH through the last 5 months.

13) **THAT THE BOARD GO INTO COMMITTEE: 7:40 pm**

Agenda items:

a) Adoption of previous in-committee minutes dated May 15, 2015
b) Proposed or Pending Rental Property
c) Solicitor Client Privilege
d) Labour Negotiations

2015-102 Moved: I. Frazier
Seconded: D. Thompson
THAT the Board goes into committee.

CARRIED.

Attending staff, executive members and media left the meeting for the In-committee session.

14) **THAT THE BOARD GO INTO OPEN MEETING: 9:13 pm**

2015-104 Moved: I. Frazier

Seconded: D. Thompson

THAT the Board goes into open meeting.

CARRIED.

15) **Resolution Resulting From In-Committee Session**

There were three resolutions resulting from In-committee.

2015-105 Moved: C. Martin

Seconded: D. Thompson

THEREFORE be it resolved:

THAT the Board of Health for the District of Algoma Health Unit (APH) enter into a lease agreement with Elliot Lake and North Shore Corporation for Business Development (ELNOS); and,

THAT the Board of Health authorizes the allocation of the final insurance settlement funds to be used for required renovations/leasehold improvements, and

THAT for any renovations/leasehold amounts above the final insurance settlement funds up to a total loan of $600,000 ,the Board of Health authorizes the acquisition of a short term loan; the term will coincide with the date that APH's mortgage comes due in September 2016, and

THAT the Board of Health for the District of Algoma Health Unit approve refinancing Algoma Public Health's current term loan(mortgage) on its due date of September 1, 2016 to incorporate any outstanding amounts owing on the short term loan, and

THAT the Board of Health for the District of Algoma Health Unit, as per the parameters of the scope/duties of APH's Finance Committee, direct the Finance Committee to review the project and its developments. This shall include, but not limited to, participating in the Request for Proposal process of the Architectural/Engineering Services, monitoring project costs, scope and schedule.

CARRIED.

2015-106 Moved: D. Thompson

Seconded: I. Frazier

Whereas on May 8th, 2015 APH received a Freedom of Information (FOI) request for the KPMG Forensic Audit (2015), and

Whereas the Board has considered its obligations under Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) to disclose as much information as possible that is not exempt, keeping in mind the purposes of the Act which promotes the accountability and transparency of government institutions, such as APH, and

Whereas the Board of Health has considered legal advice received,

Therefore be it resolved that the Board of Health having considered option 1- Non-Disclosure and No Notification to Third Parties and Option 2 - Disclosure and Notification to Third Parties directs staff to action Option 2 - Disclosure and Notification to Third Parties.
CARRIED.

2015-107 Moved: I. Frazier
Seconded: C. Martin
THAT the Board of Health ratifies the memorandum of settlement that was ratified by the nurses on June 15, 2015

16) **ANNOUNCEMENTS:**
Next Board Meeting:
Wednesday, September 16 , 2015
Prince Room, 3rd Floor, APH SSM

17) **THAT THE MEETING ADJOURN: 9:42 pm**
2015-108 Moved: C. Martin
Seconded: D. Thompson
THAT the meeting adjourns.
CARRIED.

_____ _____
Lee Mason, Chair **Christina Luukkonen, Secretary**

_____ _____
Date **Date**

ALGOMA PUBLIC HEALTH SPECIAL MEETING OF THE BOARD

JUNE 29, 2015 - 4:00 PM

SAULT STE MARIE ROOM B, 1ST FLOOR, APH SAULT STE. MARIE

MINUTES

PRESENT:	Ian Frazier	Candace Martin	Lee Mason
REGRETS:			
PRESENT BY TELECONFERENCE:	Dr. Penny Sutcliffe	Sue Jensen	Dennis Thompson

OFFICIALS PRESENT:	Acting Chief Executive Officer	Sandra Laclé
	Chief Financial Officer	Justin Pino
	Director of Human Resources and Corporate Services	Antoniette Tomie
	Director of Community Services	Laurie Zeppa
	Board Secretary	Christina Luukkonen

1) **CALL TO ORDER**
Mr. Mason called the meeting to order at 4:01 pm.

2) **DECLARATION OF CONFLICT OF INTEREST**
Mr. Mason called for conflicts of interest; none were presented.

3) **ADOPTION OF AGENDA** dated June 29, 2015

2015-109 Moved: I. Frazier
Seconded: C. Martin
THAT the agenda items dated June 29, 2015 be adopted as circulated.
CARRIED.

4) **APPROVAL OF THE MINUTES** N/A

5) **BUSINESS ARISING FROM MINUTES**

c) Management Update and Recommendation: Provincial Assessor's Report – MOH/CEO Recruitment

S. Laclé summarized the briefing note provided in the Board package. Ms. Laclé's secondment agreement is ending at the end of August and she will be returning to the Sudbury & District Health Unit (SDHU) at that time. A resolution was presented to the Board to issue a Request For Proposals (RFP) to engage an interim executive search firm to provide APH with an interim chief executive officer. Advertising to date has been for a MOH/CEO combined position.

2015-110 Moved: D. Thompson
Seconded: C. Martin
THEREFORE BE IT RESOLVED THAT the Board of Health for the District of Algoma Health Unit delegate authority to its Chair and Vice-Chair to work with the Acting MOH and Acting CEO to issue a request for proposals/quotes (RFP/RFQ) for an interim executive search firm to provide Algoma Public Health with an interim chief executive officer beginning September 1, 2015 or sooner for a period

of up to a year, pending the successful appointment by the Board and approval by the Minister and Chief Medical Officer of Health of a Medical Officer of Health/Chief Executive Officer, and

FURTHER THAT the Board of Health for the District of Algoma Health Unit delegate authority to its Chair and Vice-Chair to ensure the appointment of an Acting Medical Officer of Health per section 69 of the Health Protection and Promotion Act
CARRIED

6) **ITEMS FOR INFORMATION**

f)Board of Health Member Resignation Letter (June 18, 2015)

7) **ADDENDUM:**

Mr. Mason reminded Board members of the upcoming Finance and Audit Committee Meeting on July 22, 2015 at 10:30 am and the Governance Standing Committee Meeting on August 24 at 1:00 pm. Board members were also reminded to send in their feedback for the Governance Standing Committee Terms of Reference and the Draft Performance Management Plan.

8) **THAT THE MEETING ADJOURN: pm**

2015-111 Moved: I. Frazier
Seconded: C. Martin
THAT the meeting adjourns.
CARRIED.

_____	_____
Lee Mason, Chair	**Christina Luukkonen, Secretary**
_____	_____
Date	**Date**

ALGOMA PUBLIC HEALTH SPECIAL MEETING OF THE BOARD
AUGUST 6, 2015
PRINCE ROOM, 3RD FLOOR, APH SAULT STE. MARIE
MINUTES

PRESENT:	Ian Frazier	Lee Mason	
TELECONF:	Sue Jensen	Candace Martin	Dennis Thompson

OFFICIALS PRESENT:	Acting Chief Executive Officer	Sandra Laclé
	Director of Human Resources and Corporate Services	Antoniette Tomie
	Acting Director of Clinical Services	Jonathon Bouma
	Board Secretary	Christina Luukkonen
OFFICIALS REGRETS:	Acting Medical Officer of Health	Dr. Penny Sutcliffe
	Chief Financial Officer	Justin Pino
	Director of Community Services	Laurie Zeppa

1) **CALL TO ORDER**

Mr. Mason, Board Chair called the meeting to order at 5:03pm

2) **DECLARATION OF CONFLICT OF INTEREST**

Mr. Mason called for conflicts of interest; none were presented.

3) **ADOPTION OF AGENDA** dated August 6, 2015

2015-112 Moved: C. Martin
Seconded: I. Frazier
THAT the agenda items dated August 6, 2015 be adopted as circulated.
CARRIED.

4) **ADOPTION OF MINUTES OF PREVIOUS MEETING – N/A**

5) **NEW BUSINESS/GENERAL BUSINESS**

There was no new business to report.

6) **BUSINESS ARISING**

a) Elliot Lake Office

Mr. Frazier, Chair of the Finance and Audit Committee summarized the briefing note provided in the Board package regarding the new Elliot Lake Office. On July 22, 2015 the Finance and Audit Committee met to open all bids that were submitted in response to the RFP issued. David ELLIS Architect Incorporated was the successful bid.

b) Governance

S. Laclé summarized the briefing note provided in the Board package regarding the meetings that have taken place with the Ministry of Health and Long-Term Care. A letter was sent to Mr. Mason, Board Chair, informing him that a compliance checklist for the Organizational Standards needs to be completed and submitted to the Ministry by August 21, 2015. A copy of the letter and form were included in the Board package.

Mr. Mason introduced a Board Competency Matrix that he would like all Board members to complete. A copy of the matrix was included in the Board package. The matrix is a self-evaluation of skills/competencies and will help assess the Board's strengths and weaknesses to assist with the appointment of future Board members. Completed forms need to be submitted to C. Luukkonen by August 21, 2015.

Questions were asked by Board members and answered to their satisfaction.

7) **ITEMS FOR INFORMATION**

There were no items for information.

8) **THAT THE BOARD GO INTO COMMITTEE: 5:30 pm**

2015-113 Moved: I. Frazier
Seconded: S. Jensen
THAT the Board goes into committee.
CARRIED.

J. Bouma left the meeting at this time. A. Tomie stayed for the in-committee session.

9) **THAT THE BOARD GO INTO OPEN MEETING: 6:30 pm**

2015-115 Moved: S. Jensen
Seconded: C. Martin
THAT the Board goes into open meeting.
CARRIED.

Resolution Resulting From In-Committee Session

There is one resolutions resulting from In-committee.

2015-116 Moved: I. Frazier
Seconded: D. Thompson
THAT the Board of Health for Algoma Public Health appoints Tony Hanlon, PhD as its Interim Chief Executive Officer under the terms and conditions specified in the employment agreement dated o this day, and
FURTHER that the Board of Health recognized Ms. Sandra Laclé for her leadership as Acting Chief Executive Officer and looks forward to establishing a positive and productive working relationship with Tony Hanlon in this role
CARRIED.

Mr. Hanlon expressed his appreciation for the opportunity to work with Algoma Public Health Board and all employees.

S. Laclé thanked the Board for their governance leadership and support during her time here.

10) **ADDENDUM**

No items on the addendum

11) **THAT THE MEETING ADJOURN: 6:37 pm**

2015-117 Moved: S. Jensen
Seconded: I. Frazier
THAT the meeting adjourns.
CARRIED.

Lee Mason, Chair	**Christina Luukkonen, Secretary**
Date	**Date**

BOARD OF HEALTH FOR ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE
TERMS OF REFERENCE

O: September 22, 2015

The following Terms of Reference are in accordance with By-Law No. 95-1. The Committee is advisory to the Board unless the Board expressly delegates authority to the Committee on a particular matter.

Name:	Board of Health Governance Standing Committee
Purpose/Goal:	To fulfill the following functions on behalf of the Board: • Governance – To support the Board in fulfilling its commitment to and responsibility for sound and effective governance of Algoma Public Health • Nominations - To manage the process to identify potential provincial nominees for the Board to recommend for appointment to the Board (subject to the requirements of the Health Protection and Promotion Act and Provincial Public Appointments Process) • Orientation and Education – To support the Board by ensuring that new Directors receive adequate and appropriate orientation and that all Directors are provided ongoing education to assist them in fulfilling their duties effectively. • Performance accountability – To support the Board in overseeing key elements required to achieve its vision and mission.
Chair:	The Governance Standing Committee shall elect a chair amongst them. The Board Vice-Chair may be appointed as Committee chair. The Committee chair is responsible for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The Committee chair may be appointed for a term that is not longer than his or her term as a Director and may be reappointed for as many terms as the Board determines.
Recorder:	The secretary to the Board will act as recorder for the Governance Standing Committee.
Roles & Responsibilities:	These Governance functions are fulfilled through the following roles and responsibilities: **Governance Effectiveness** • Enable the Board to meet its fiduciary obligations by defining APH's approach to governance and supporting processes and practices that promote a leading-edge governance culture; • Recommend the development and oversee the implementation of governance structures, processes and protocols that enable the Board to fulfill its governance role effectively; • Support the Board of Directors in fostering a positive relationship with its key stakeholders; • Support a high standard of Board conduct.

	Mandate • Recommend, where appropriate, changes to the mandate of the Board of Directors, each of its Committees, the Board Chair and committee chairs based on the needs of APH and evolving governance standards (subject to requirements of the HPPA and Municipal Acts). **Board of Health By-laws, policies and procedures** • Review on a regular basis, and at a minimum of every two years, and make recommendations to the Board. **Evaluation** • Recommend and oversee the implementation of a governance review/ evaluation process regarding the performance of the Board, the Board Chair, committee chairs, committees and individual Directors; • Recommend procedures for the ongoing assessment of Board and Committee meeting effectiveness; • Recommend changes to address effectiveness issues arising out of these evaluations; • Assess the adequacy of the quality and timeliness of information provided to the Board of Directors and its Committees and make recommendations to the Board of Directors for change where appropriate. **Performance Accountability** • Approve and monitor various measures of performance accountability on a regular basis. **MOH/CEO review** • Support the Chair of the Board of Health with MOH/CEO review as requested; • Oversee succession planning for the MOH/CEO, including development of a clear and transparent process to recruit and select a future MOH/CEO. **Nominations** • Recommend, in consultation with the Board Chair, nominees for all Board Committees including Committee chairs . **Orientation and Education** • Ensure that there is an appropriate orientation and education program for new Directors and continuing education for all Directors including making recommendations on methods to improve Directors' knowledge of Algoma Public Health and their responsibilities as Directors; • Oversee the implementation of orientation and education programs for Directors to ensure these are undertaken effectively. **Other** • The Committee shall study and make recommendations to the Board on any matter as directed by the Board.
Delegation of Authority from the Board:	No authority is delegated by the Board through these terms of reference. However, the Board may from time to time delegate specific responsibilities to the Committee by resolution of the Board.

Reporting and Accountability to the Board:	The Committee will keep brief decision minutes of its meetings in which shall be recorded all matters considered at each meeting. These minutes will be circulated to the full Board once approved by the Committee. The Committee chair will report to the Board on recommendations from the Committee, including a brief outline of the issue, the options considered, the conclusions and recommendations arrived at and the implications and risks associated with the recommendations. In the absence of the Committee chair, this responsibility may be delegated to another Director member of the Committee or to staff.
Membership:	The Committee shall have a minimum of three and a maximum of five members, all of whom shall be Directors. The Board Vice-Chair normally shall be a member of the Committee. The Board Chair may member of the Committee. Chairs of other standing committees normally would not be appointed as members of the Committee. Committee members will be appointed for a term not exceeding their term as a Director and may be reappointed at the discretion of the Board
Reporting to:	Algoma Public Health Board of Health
Frequency:	The Committee will meet at least four times a year. Meetings may be more frequent in the first year. The Committee may meet on other occasions at the call of the Committee chair.
Committee Operations:	Quorum for Committee meetings is a majority of the members of the Committee. The Committee shall operate in accordance with the procedures for Board meetings as set out in By-Law No. 95-1 The Committee may, with the approval of the Board, establish sub-committees.
Distribution of Minutes:	Distribute to committee members and the Board of Health members.

Signature of Board of Health Chair

Date

TERMS OF REFERENCE MEMBERSHIP

	Name	Position	Agency
1	Tony Hanlon	CEO	Algoma Public Health
2	Antoniette Tomie	Director of Human Resources and Corporate Services	Algoma Public Health
3	Ian Frazier	Board Member	Board of Health for Algoma Public Health
4	Lee Mason	Board Member	Board of Health for Algoma Public Health
5	Candace Martin	Board Chair	Board of Health for Algoma Public Health
Ad hoc (performance monitoring item)			
7			
8			
9			
10			
11			
12			
13			
14			
15			

Guide for Completing Terms of Reference

- Please complete each section of the terms of reference (TOR) form.
- None of the sections should be blank.
- Ensure a copy of the previous TOR accompanies the newly edited TOR with the changes highlighted.

Name:	Indicate the name of the committee
Purpose/Goal:	Indicate the end result that the committee's plan is intended to achieve. Use round bullets to identify individual points.
Objectives:	Previously Goals/Responsibilities Indicate the activities, objectives, responsibilities that the plan will take in order to achieve the goal, e.g., To discuss…To review…To create…To facilitate, etc. Use round bullets to identify individual points.
Chair:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Recorder:	Indicate position title or if the recorder rotates, indicate: 'Rotation System'.
Membership:	Indicate position titles not specific names. If necessary, complete the Terms of Reference Membership and attach to the TOR. Include the Chair's title in this section. If the chair rotates, indicate: 'Chair rotates'
Reporting to:	Indicate position title or name of committee, e.g., Management Committee, to whom the committee reports and who will act on committee recommendations/ suggestions.
Frequency:	Indicate the number of times the committee will meet, e.g., once per month for one-hour session. Quorum is not required to hold a meeting.
Term:	Indicate the length of time members remain on the committee, e.g. membership will change every two years.
Decision-making Format:	Indicate consensus/ majority/ not applicable, etc. Consensus is preferred where possible. Quorum is required (50 percent participation plus 1 individual).
Distribution of Minutes:	Indicate the 'Reporting to' individual(s), committee, etc. along with who will benefit from the Committee. Membership will automatically appear.

Algoma Public Health

Performance Monitoring Plan

2015-2017

Introduction

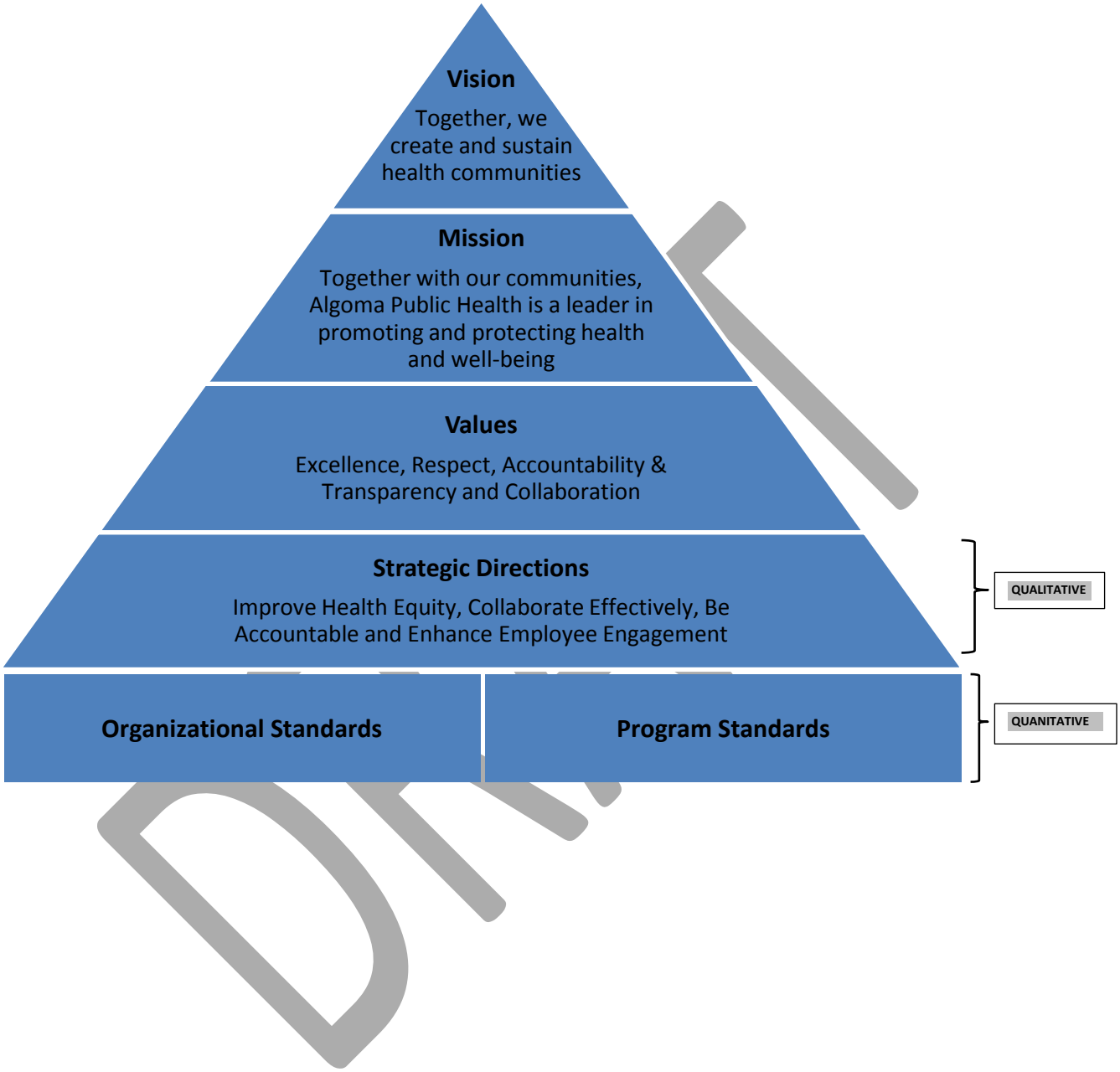
This performance framework provides an overarching view of Algoma Public Health's key areas of performance in fulfillment of its strategic plan and mandate.

APH's performance is assessed in relation to a defined set of indicators and associated performance measures. The development of indicators is an evergreen process. As implementation plans are developed and refined for each of the organizational standards, performance measures will continue to be developed and or refined in order to be able to report on APH's progress towards meeting the goals. Similarly as new program accountability indicators are introduced they will be included to report on APH's progress towards meeting its program goals.

Performance in public health is often challenging to describe using quantitative methods or numbers alone. The performance framework includes qualitative measures, such as narratives or impact stories related to each of the strategic directions.

The Algoma Public Health Performance Monitoring Plan will be reviewed every 2 years by the Board of Health. It will be the responsibility of the Governance Committee to ensure this review takes place.

Algoma Public Health's Performance Framework



O: September 22, 2015

Performance Reporting Schedule

Qualitative reports or narratives will describe through stories the impact of the strategic directions on programming at APH. Impact stories will be reviewed by the Governance Committee and presented to the Board of Health by the Governance Committee chair, or delegate, for information in October and January of each year.

An annual quantitative reports or numbers dashboard will be reviewed by the Governance Committee and presented to the Board of Health, by the Governance Committee chair, or delegate, for information in March of each year.

Time Line

The MOH/CEO will recommend performance/accountability indicators for the Governance Committee's review and consideration. For its inaugural report, the following indicators are recommended for the Governance Committee's consideration.

Strategic Directions – Qualitative Report (Narratives or Stories)

1. Improve Health Equity – a descriptor of how a team improved health equity
2. Collaborate Effectively – a descriptor of how staff collaborated effectively
3. Be Accountable – an example of how the organization has been accountable
4. Enhance Employee Engagement – a descriptor from staff of how they have engaged

Note: throughout this document staff refers to staff and management: all employees of Algoma Public Health

Organizational Standards – Quantitative/Statistical Report – A Dashboard

1. Leadership and Trustee Excellence
    i. BOH Commitment Index. Four measures of commitment: uninterrupted BOH membership, attendance of BOH members at meetings, quorum at meetings, completion of the annual BOH self-evaluation questionnaire. (Baseline year 2015 then annual corresponding with the calendar year)

    ii. Number of Program-related Board of Health Motions passed (Baseline year, June – December 2015 then annual reporting based on the calendar year)

    iii. BOH Member's Satisfaction Index. Three measures of satisfaction: individual performance, Board processes and overall Board performance. (Baseline year 2015. Then December 2016, December 2017, etc.)

2. Community Engagement and Responsiveness
    i. Website Usage Status (Baseline year, 2015 then annual reporting)

    ii. Number of External Partnership Effectiveness Reviews (Baseline year, 2015)

3. Organizational Excellence
    i. Employee Engagement (Baseline year, 2015, based on Employee Engagement results within the Guarding Minds survey then every 3 years)

4. Service Excellence
    i. Emergency Preparedness Index: sub indicators each weighted equally with a final score out of 100 (Baseline year, 2016, then annual reporting)

    ii. Service Integration (Baseline year, 2015, then annual reporting)
        (1) Number of examples of Community funded Program education and referrals integrated into Public Health funded programs.
        (2) Number of examples of Public Health funded Programs education and referrals integrated into Community Funded programs.

Program Standards (OPHS) – Qualitative – Narrative

1. Health Protection
    i. 16 Health Protection accountability indicators each weighted equally based on achievement with agreed upon ministry target with a final score out of 100. Reported annually. (Baseline year, 2015, then annual reporting)

2. Health Promotion
    i. 7 Health Promotion indicators each weighted equally based on achievement with agreed upon ministry target with a final score out of 100. Reported annually. (Baseline year, 2015, then annual reporting)

    ii. 3 indicators each weighted equally based on achievement with agreed upon ministry target with a final score out of 100. Reported every 3 years. (Baseline year, TBD based on data availability and subsequent Ministry requirements)

Accountability Agreement Indicators (2014-2016)

Health Protection

1. % of high risk food premises inspected once every 4 months while in operation
2. % of moderate risk food premises inspected once every 6 months while in operation
3. % of Class A pools inspected while in operation
4. % of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection
5. % of public spas inspected while in operation
6. % of personal services settings inspected annually
7. % of suspected rabies exposures reported with investigation initiated within 1 day of PHU notification
8. % of confirmed gonorrhea cases where initiation of follow-up occurred with 2 days
9. % of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case
10. % of confirmed gonorrhea cases treated according to recommended Ontario treatment guidelines
11. % of salmonella cases where one or more risk factor(s) other than "Unknown" was entered into iPHIS
12. % of influenza vaccine wasted that is stored/administered by the PHU
13. % of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection (new)
14. % of school-aged children who have completed immunizations for hepatitis B
15. % of school-aged children who have completed immunizations for HPV
16. % of school-aged children who have completed immunizations for meningococcus

Health Promotion (i)

1. % of tobacco vendors in compliance with youth access legislation at the time of last inspection
2. % of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act
3. % of tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act
4. % of tobacco retailers inspected once per year for compliance with display, handling and promotion sections of the Smoke-Free Ontario Act
5. Oral Health Assessment and Surveillance: % of all JK, SK and Grade 2 students screened in publicly funded schools
6. Implementation of NutriStep® Preschool Screen
7. Baby Friendly Initiative Status

Health Promotion (ii)

1. % of population (19+) that exceeds the Low-Risk Drinking Guidelines
2. Fall-related emergency visits in older adults aged 65+ (rate per 100,000 per year)
3. % of youth (ages 12-18) who have never smoked a whole cigarette

Appendix A

2015 Algoma Public Health Board of Health
Member Self-Evaluation of Performance

As part of this Board's commitment to good governance, continuous quality improvement, compliance with the Ontario Public Health Organizational Standards, and in accordance with 02-05-000 and 02-05-055 of the Board of Health Manual, all Board members are encouraged to individually complete this Self-Evaluation of Performance. Your participation is voluntary. Your responses will be kept anonymous and all responses will be presented through aggregated results.

Please complete prior to June 17, 2015, in confidence to the attention of Christina Luukkonen by mail, by email at cluukkonen@algomapublichealth.com or by fax at (705) 759-2540. Time will be allocated for Board members to complete the survey during the June Board meeting.

Part 1: Individual Performance **Compliance with Individual Roles and Responsibilities as a Board of Health Member.**					
	Strongly Agree	**Agree**	**Disagree**	**Strongly Disagree**	**Not Applicable**
1. As a BOH member, I am satisfied with my attendance at meetings.					
2. As a BOH member, I am satisfied with my preparation for meetings.					
3. As a BOH member, I am satisfied with my participation in meetings.					
4. As a BOH member, I understand my roles and responsibilities.					
5. As a BOH member, I understand current public health issues.					
6. As a BOH member, I have input into the vision, mission and strategic direction of the organization.					
7. As a BOH member, I am aware and represent community perspective during board meetings.					
8. As a BOH member, I provide input into policy development and decision-making.					
9. As a BOH member, I represent the interests of the organization at all times.					

Do you have any other comments or suggestions pertaining to your role as a Board of Health member?

_____

_____

_____

O: September 22, 2015

Part 2: Board of Health Processes Effectiveness of policy and process					
	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
1. The BOH is compliant with all applicable legislation and regulations.					
2. The BOH ensures members are aware of their roles and responsibilities through orientation of new members.					
3. The BOH is appropriately informed about financial management, procurement policies and practice, risk management and human resources issues.					
4. The BOH holds meetings frequently enough to ensure timely decision-making.					
5. The BOH bases decision making on access to appropriate information with sufficient time for deliberations.					
6. The BOH is kept apprised of public health issues in a timely and effective manner.					
7. The BOH sets bylaws and governance policies.					
8. The BOH remains informed with issues pertaining to organizational effectiveness through performance monitoring and strategic planning.					

Do you have any other comments or suggestions pertaining to Board of Health policy and process?

_____

_____

_____

Part 3: Overall Performance of the Board of Health					
	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
1. The BOH contributes to high governance and leadership performance					
2. The BOH oversees the development of the strategic plan					
3. The BOH ensures planning processes consider stakeholder and community needs.					
4. The BOH ensures a climate of mutual trust and respect between themselves and the Medical Officer of Health (MOH/CEO).					
5. The BOH as a governing body is achieving its strategic outcomes.					

Do you have any other comments or suggestions pertaining to overall performance of the Board of Health?

_____

_____

_____

Algoma
PUBLIC HEALTH
Santé publique Algoma

MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER
BOARD REPORT
September 2015

Prepared by Tony Hanlon Ph.D., CEO and Dr. Penny Sutcliffe, Acting MOH

Table of Contents

SUMMARY/INTRODUCTION

Dr. Tony Hanlon Ph.D. has been appointed as CEO for a 12 month period commencing August 31, 2015 while we continue our search for a new MOH/CEO.

We are pleased to announce the hiring of a permanent Director of Clinical Services, Sherri Cleaves.

Elliot Lake update – Floor plans are finalized and the Architect is preparing construction tender documents.

We met with MPP the Honourable David Orazietti and then Mayor Provenzano on August 31, 2015 to update APH. A meeting is scheduled for September 25 with MPP Michael Mantha in Elliot Lake.

T. Hanlon had an introductory meeting with Ron Gagnon, CEO, SAH and received a tour of the hospital. We plan to work together on areas where there is mutual interest and opportunities for cost savings, for example, professional development.

The Attestation document has been submitted to MOHLTC and the Ministry has accepted the document. The Executive Team will continue to monitor our compliance standards and address areas where improvement is needed.

PROGRAM HIGHLIGHTS

CHRONIC DISEASE PREVENTION

Topic: Five in Five Smoking Cessation Campaign

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables:

- Comprehensive Tobacco Control - requirement 1
- Cessation - Requirement 3, 9, 10 and 12

This report addresses the following Strategic Directions:

- Collaborate Effectively
- Improve health Equity

Algoma Public Health is planning a call to action to develop an innovative, integrative, collaborative and comprehensive strategy to get Algoma smokers to quit. Algoma Public Health and the Province of Ontario are committed to reducing the prevalence of smoking by five percentage points over five years. This ambitious direction will require an "all hands on deck" approach that includes community leaders, employers, healthcare providers and citizens in order to have success.

The 2015 Algoma Cancer Report ranks the lung cancer rates and smoking rates as significantly higher in Algoma than Ontario. About 23.6% of Algoma residents are current cigarette smokers and there has been no measurable decline since 2005. Although continued efforts to prevent youth from starting to smoke remains vital, the proposed 5% reduction in smoking rates over five years can only be achieved by significantly increasing the successful quit attempts among people who currently smoke. Rough estimates suggest that 100,000 cumulative quit attempts by the approximately 22,000 smokers in Algoma are needed to achieve a five percentage point reduction in prevalence over a five year period.

The Ontario Tobacco Research Unit is providing consultation support to Algoma Public Health in assessing the cessation plan and is leading an Algoma Partnership in submitting a proposal to the Ministry of Health for funding. With such a bold, multiyear, district-wide cessation strategy additional fiscal support will be valuable to the success of this call to action.

Algoma has the potential to become Ontario's "cessation innovation accelerator" where new ideas emerging from stakeholders and from research evidence are tested to meet this challenging goal for Algoma and the Province.

This strategy requires:

1. Commitment from district community partners to engage in and to seek out innovative and new ideas for the strategy;
2. Using a combined population approach with a special focus on priority groups with higher smoking rates, all smokers will have feasible access to current best practices in cessation counseling, Nicotine Replacement Therapy and appropriate prescription medication in varied settings.
3. A fully integrated cessation system, including EMRs, data collection, monitoring, and developmental evaluation with real-time feedback to ensure innovations are sustainable throughout the community will be developed.
4. An advanced and detailed ongoing outcome monitoring system.
5. A significant (paid and earned) branded communication strategy will be developed.

The SFO Coordinator and a team of APH staff will be leading this initiative. The 5 in 5 strategy will be announced to the community during the Tobacco Awareness Week in January 2016.

CHRONIC DISEASE PREVENTION

Topic: Ontario Healthy Kids Community Challenge

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables:

- Chronic Disease Prevention – Requirement 6, 7, and 11
- Child Health – Requirement 4, 5, and 7

This report addresses the following Strategic Directions:

- Collaborate Effectively
- Health Equity

Ontario's Healthy Kids Community Challenge – "The Challenge"

Childhood obesity is now a crisis in Canada and Ontario. About 30% of our children and youth are now an unhealthy weight. Children and youth who are overweight or obese are more likely to grow up to be overweight or obese adults and struggle with their weight throughout their lives. They are also at present and future risk of adverse health consequences including, heart disease, type 2 diabetes, and many cancers (No Time to Wait: The Healthy Kids Strategy).

The Healthy Kids Community Challenge is a community-led program where partners from different sectors (i.e. municipal, public health, education, recreation, and local businesses) work together to implement activities to promote healthy weights for kids. Under the leadership of

municipalities, the selected communities receive funding and supports from the Ministry of Health and Long Term Care (MOHLTC) and will be asked to implement local activities related to healthy eating and physical activity. The Challenge is based on the Ensemble Prevenons l'Obesite des Enfants – Together Let's Prevent Childhood Obesity (EPODE) methodology. EPODE is recognized by the World Health Organization as a best practice in implementing effective and sustainable strategies to prevent childhood obesity.

Algoma Public Health is a community partner and helped with the completion of 2 municipal applications, one for the municipality of Sault Ste. Marie and the other for Thessalon and surrounding municipalities. Both of these applications were successful.

The goal and objectives of the project include developing and implementing programs, policies and supports though community-led planning and action that to contribute to the achievement of: reducing the prevalence of childhood overweight and obesity, creating supportive environments to enable healthy behaviours in children, increasing community capacity and improving community collaboration related to planning and promoting healthy weights. These goals and objectives align very nicely with the mandate of public health and as such, Algoma Public Health will continue to be an involved community partner throughout the activities of The Challenge.

The Project in the City of Sault Ste. Marie

The City of Sault Ste. Marie and Algoma Public Health will have a unique partnership throughout this project. The City of Sault Ste. Marie will be completing a transfer payment agreement with Algoma Public Health for employing and housing the project manager and implementing The Challenge. Algoma Public Health will be working very closely with the City of Sault Ste. Marie as well as many other community partners throughout this project. Initial activities will include: conducting a comprehensive needs assessment to identify gaps and opportunities, engaging local champions to raise awareness, developing action plans, establishing multi-sectorial partnerships, and participating in the evaluation process of The Challenge.

The project manager position has recently been advertised and we are hopeful to have a successful candidate in this position soon. This will begin the process of launching of The Challenge.

RISK MANAGEMENT

VACCINE PREVENTABLE DISEASE

Topic: Vaccine Fridge Replacement

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables: Vaccine Preventable Diseases Program Standard Requirement #11: The board of health shall promote vaccine inventory management in all premises where provincially funded vaccines are stored in accordance with the *Vaccine Storage and Handling Protocol*"

This report addresses the following Strategic Directions: Be Accountable

Risk	APH owns several vaccine fridges that store publicly funded vaccine for APH use and distribution to health care providers. The typical lifespan of a vaccine fridge is approximately 10 years. APH owns two vaccine fridges that are 15 and 16 years old, respectively. These older fridges are at an increased risk of failure, thus potentially putting publicly funded vaccine at risk.
Recommendations	APH should purchase two new vaccine fridges to replace these older fridges. One for the Sault Ste. Marie office and the other for Blind River office.
Key Points	• Vaccine fridges are expensive to purchase • One Time Funding Requests can be made to the ministry for the purchase of new vaccine fridges • One of the aging fridges is housed in the Blind River office, and is the only fridge in the office, so it is essential that it be reliable.
Analysis	Although new vaccine fridges are expensive, the risk of a vaccine fridge failure in an aging fridge is high, which puts tens of thousands of dollars of publicly funded vaccine at risk. The One Time Funding Request is available to offset the cost of the purchase. In the past, these requests have been approved.
Action	A One Time Funding Request is being submitted to the ministry to request funding to purchase two new vaccine fridges to replace our aging fridges.
Financial Implications	None, if One-time Funding Request is approved by the ministry.
Staffing Implications	None.

PARTNERSHIPS

Group Health Centre

As flu season approaches, APH is again partnering with Group Health Centre to continue delivering flu clinics at our main SSM office. Group Health Centre nurses will be working alongside APH nurses to deliver this service.

NEXT STEPS

T. Hanlon will be visiting each district office to meet with staff over the next couple of weeks and will be reaching out across the district to meet with many mayors and reeves for the municipalities.

T. Hanlon will be seeking input from Directors on an individual basis to assess from their point of view current strengths and areas of improvement regarding the organization structure as it relates to program & service delivery, achieving strategic directions and compliance with MOHLTC standards. After this information is collected and analyzed and if it appears changes are advisable he will work with the Executive Team and Dr. Sutcliffe on consultation processes with staff through the fall before decisions are made on implementation of any changes.

Respectfully submitted,

Tony Hanon, Ph.D., CEO and Dr. Penny Sutcliffe, Acting MOH

Algoma Public Health
Financial Statements
For the period ending: August 31, 2015

Algoma Public Health
Statement of Operations and Fund Balances
For the period ending: **August 2015**

	Actual YTD 2015	Budget YTD 2015	Variance Bgt to Actual 2015	Annual Budget 2015	2015 YTD Actual/ YTD Budget %
Revenue					
Municipal Levy -public health	$ **2,467,186**	$ 2,168,926	$ 298,260	$ 3,253,389	114%
Provincial Grants -public health	**6,573,285**	$ 6,536,400	$ 36,885	$ 9,804,600	101%
Grants/Levies - Capital	$ -	-	$ -	-	
Provincial Grants - community health	**3,881,339**	3,447,062	$ 434,278	7,463,339	113%
Fees, other grants and recovery of expenditures	**406,387**	549,469	$ (143,082)	824,204	74%
	$ 13,328,197	$ 12,701,857	$ 626,341	$ 21,345,532	105%
Expenditures					
Public Health Programs					
Public Health	$ **8,917,379**	$ 9,254,795	$ 337,416	$ 13,882,192	96%
Public Health (Capital)	**0**	-	-	-	
Community Health Programs					
Healthy Babies and Children	**705,332**	$ 712,007	6,675	1,068,011	99%
HBHC Screening Liais(Combined with HBHC for 2015)	**0**	$ -	-	-	
Child Benefits Ontario Works	**13,672**	$ 13,333	(339)	20,000	103%
Dental Benefits Ontario Works	**214,549**	$ -	-	-	
Early Years Development (NPClinic II)	**1,000**	$ 92,667	91,667	139,000	1%
Misc Calendar	**733**	$ -	(733)	-	
		$ -		-	
Healthy Community Partnership	**2,480**	$ -	(2,480)	-	
Northern Ontario Fruit & Vegetable Program	**38,018**	$ 47,579	9,561	117,400	80%
Brighter Futures for Children	**33,401**	$ 47,268	13,867	113,448	71%
Infant Development	**282,753**	$ 281,661	(1,092)	675,986	100%
Preschool Speech and Languages	**252,227**	$ 255,940	3,713	614,256	99%
Nurse Practitioner	**52,353**	$ 51,189	(1,164)	122,853	102%
Genetics Counseling	**117,517**	$ 153,253	35,736	367,806	77%
Community Mental Health	**1,217,860**	$ 1,322,499	104,639	3,173,998	92%
Community Alcohol and Drug Assessment	**295,560**	$ 282,613	(12,948)	678,260	105%
Remedial Measures	**81,834**	$ 81,547	(288)	122,320	
Diabetes	**48,301**	$ 62,500	14,199	150,000	77%
Misc Fiscal	**58,779**	$ 41,667	(17,113)	100,000	141%
	$ **12,333,748**	$ 12,700,517	$ 581,317	$ 21,345,531	97%
Excess of revenues over expenses - CH	**464,970**	1,340		1	
Excess of revenues over exp. - Public Health	**529,479**	0		-	
Operating fund balance, beginning of year	**3,009,266**				
Operating fund & capital, end of month (Note 1)	$ **4,212,393**				4,212,393

Note 1:
The operating fund balance consists of a public health reserve and amounts owed to the Gov't of Ontario as of the report date.

Algoma Public Health
Revenue Statement
For the Eight Months Ending August 31, 2015

	Current YTD	Budget YTD	Variance	YTD Actual to Annual Bgt %	Annual Budget	Comparison Prior Year: YTD Actual 2014	YTD BGT 2014	Variance 2014
MOH Public Health Funding	4,996,611	5,012,733	(16,122)	66%	7,519,100	4,995,822	4,998,533	(2,711)
MOH Funding- Needle Exchange	29,860	33,800	(3,940)	59%	50,700	29,860	29,868	(8)
MOH Funding Haines Food Safety	16,353	16,400	(47)	66%	24,600	16,353	16,355	(2)
MOH Funding CINOT/Healthy Smiles	285,026	273,733	11,293	69%	410,600	285,024	285,028	(4)
MOH Funding - Social Determinants of Health	120,292	120,333	(41)	67%	180,500	117,937	117,940	(3)
MOH Funding Vector Bourne Disease	72,403	72,467	(64)	67%	108,700	72,403	72,408	(5)
MOH Funding Chief Nursing Officer	80,934	81,000	(66)	67%	121,500	79,349	79,355	(6)
MOH Funding Safe Water	46,371	46,400	(29)	67%	69,600	46,371	46,375	(4)
MOH Enhanced Funding Safe Water	10,325	10,333	(8)	67%	15,500	10,325	10,333	(8)
MOH Funding Unorganized	290,593	333,533	(42,940)	58%	500,300	284,896	284,896	0
IC Prevention & Control Week	0	0	-	0%	0	0	0	0
CINOT Expanded Funding	17,738	22,667	(4,929)	52%	34,000	9,296	15,000	(5,704)
MOH Funding Infection Control	208,185	208,267	(82)	67%	312,400	207,013	207,022	(9)
Levies Sault Ste Marie	1,489,148	1,312,972	176,176	76%	1,969,458	1,456,090	1,233,263	222,826
Levies Sault Ste Marie Capital	192,990	195,747	(2,757)	66%	293,620	192,989	192,989	(0)
Levies Vector/ SDWS	43,969	43,970	(1)	67%	65,955	0	39,594	(39,594)
Levies District	658,369	536,284	122,085	82%	804,427	602,837	523,578	79,259
Levies District Capital	82,710	79,953	2,757	69%	119,929	82,710	82,710	0
Recoveries from Programs	5,030	6,707	(1,677)	50%	10,061	7,679	6,707	971
Program Fees	142,994	164,762	(21,768)	58%	247,143	112,765	164,762	(51,997)
Land Control Fees	96,935	106,667	(9,732)	61%	160,000	94,080	106,667	(12,587)
Program Fees Immunization	132,455	106,667	25,788	83%	160,000	112,740	106,667	6,073
HPV Vaccine Program	867	6,667	(5,800)	9%	10,000	1,292	6,667	(5,375)
Influenza Program	760	40,000	(39,240)	1%	60,000	7,190	40,000	(32,810)
Meningococcal C Program	255	6,667	(6,412)	3%	10,000	298	6,667	(6,369)
Interest Revenue	7,109	1,333	5,776	355%	2,000	1,457	1,333	124
Other Revenues	19,982	110,000	(90,018)	12%	165,000	22,183	50,000	(27,817)
Funding Holding	(0)	0	(0)	100%	0	0	0	0
Funding Ontario Tobacco Strategy	286,380	304,733	(18,353)	63%	457,100	280,530	283,733	(3,203)
Elliot Lake Office Relocation	0	0	-	0%	0	0	0	0
Panorama	0	0	-	0%	0	70,392	0	70,392
IT Platform Stabilization - One Time	0	0	-	0%	0	0	500,000	(500,000)
First Nations Inititative -One Time	112,214	0	112,214	100%	0	0	100,000	(100,000)
	$ 9,446,858	$ 9,254,795	$ 192,063		$ 13,882,193	$ 9,199,880	$ 9,608,451	$ (408,571)
Summary								
Levies	2,467,186	2,168,926	298,260	114%	3,253,389	2,334,625	2,072,135	262,491
Funding Grants	6,573,285	6,536,400	36,885	101%	9,804,600	6,505,571	7,046,847	(541,276)
Fees & Recoveries	406,387	549,469	(143,082)	74%	824,204	359,684	489,469	(129,786)
	$ 9,446,858	$ 9,254,795	192,063	102%	$ 13,882,193	$ 9,199,880	$ 9,608,451	$ (408,571)

Algoma Public Health

Expense Statement- Public Health

For the Eight Months Ending August 31, 2015

	Current YTD	Budget YTD	Variance	YTD Actual to Annual Bgt %	Annual Budget	Comparison Prior Year: YTD Actual 2014	YTD BGT 2014	Variance 2014	
Salaries & Wages	$ 5,159,370	$ 5,419,975	260,605	63%	$ 8,129,963	$ 5,275,031	$ 5,519,557	$ 244,526	1
Benefits	1,278,476	1,353,330	74,854	63%	2,029,995	1,332,725	1,379,888	47,163	2
Travel - Car Allowances	39,322	41,307	1,985	63%	61,960	72,677	99,122	26,445	3
Travel - Mileage	85,773	83,631	(2,141)	68%	125,447	72,372	94,053	21,681	3
Travel - Other	44,963	84,205	39,242	36%	126,308	82,952	88,205	5,253	3
Program	646,124	482,833	(163,292)	89%	724,249	518,835	572,491	53,656	4
Program Equipment Purchased			-	0%		307	333	27	
Office	37,115	87,967	50,852	28%	131,950	58,356	113,467	55,111	4
Computer Services	474,583	513,153	38,569	62%	769,729	469,493	544,833	75,341	4
Telephone Charges	15,467	32,175	16,708	32%	48,263	30,453	71,175	40,722	5
Telecommunications	97,204	113,974	16,770	57%	170,961	116,100	95,333	(20,767)	5
Program Promotion	69,366	141,055	71,689	33%	211,583	55,530	134,823	79,293	4
Facilities Expenses	473,953	506,068	32,115	62%	759,102	566,780	500,735	(66,046)	6
Renovations			-	0%		116,013	43,333	(72,680)	
Fees & Insurance	252,551	186,327	(66,224)	90%	279,490	161,545	145,333	(16,212)	7
Special Projects			-	0%		(380)	0	380	
Debt Management	304,000	304,000	-	67%	456,000	303,904	304,000	96	
Recoveries	(60,889)	(95,205)	(34,316)	43%	(142,808)	(44,916)	(98,233)	(53,317)	8
Elliot Lake Relocation	0		-	0%		79,828	0	(79,828)	
	$ 8,917,379	$ 9,254,795	$ 337,416		$ 13,882,192	$ 9,267,605	$ 9,608,451	$ 340,846	

Notes to Financial Statements – August 2015

Reporting Period

The August 2015 financial reports include eight months of financial results for Public Health and the following calendar programs, Healthy Babies, Child and Dental Benefits Ontario Works and Early Years Nurse Practitioner II program. All other programs are reporting five month results from operations year ended March 2016.

Public Health – Statement of Operations (see page 1)

General Comments

Algoma Public Health received the 2015 Program-Based Grants approval letters from the Ministry on September 4th, 2015. APH will be receiving an additional $86,923 in additional base funding and $44,800 in one-time funding. This equates to a zero dollar increase in mandatory programs and $86,923 in related Public Health programs. APH requested a 2.5% increase in mandatory programs. The budget has been adjusted to reflect the 0% increase in mandatory programs.

One-time funding is summarized below:

- *2 Public Health Inspector Practicum requested $20k (100% provincially funded) – received $10K or 1 Inspector Practicum*
- *Nicotine Replacement Therapy requested $10k (100% provincially funded) – received $7.5k*
- *Human Resource Software Upgrade requested $15k (75% provincially funded) – received $11.3k which is 75% of $15k*
- *Electronic Cigarettes Act Protection and Enforcement (100% provincially funded) – received $16k*
- *Elliot Lake Office Relocation requested $90k (75% provincially funded) – received $0*

As of August 31st 2015, Public Health programs are reporting a surplus of approximately $529k. On the Revenue side, $298k positive variance is attributable to the timing of receipts of municipal levies from the City of Sault Ste. Marie and the District. There is a positive $36k variance associated with Provincial Grants. Offsetting these positive variances is a $143k negative variance related to the timing of the collection of Program Fees & Recoveries.

There is a positive variance of $337k related to Public Health Expenses being less than budgeted. This is primarily due to gapping of two vacant positions as a means of safeguarding against uncertainty surrounding approval of the Provincial portion of the 2015 budget. The inherent time lag in filling positions within the agency is also contributing to this variance.

Community Health programs are reporting a surplus of $464k. $91k of the variance noted is attributable to a vacant position within APH's Nurse Practitioner Clinic. In addition, there is a $104k positive variance associated with the Community Mental Health Program. The program received additional funding for positions related to transitional case management. The lag in time to fill these positions is driving the noted variance.

Notes Continued…

Revenue (see page 2 for details)

Public Health funding revenues are indicating a positive variance of $192k. Driving this is a $298k positive variance related to the timing of receipts of the municipal levy from the City of Sault Ste. Marie and the District. Funding Grants are also contributing to the variance. Fees and Recoveries are offsetting this positive variance. Land Control Fees are typically collected in the summer months while Influenza Program fees are typically collected in the fall. Relative to last month, the variance related to Land Control Fees is reducing. In an effort to balance the budget, recognition of deferred revenue was planned for 2015. Management will determine if this is required as the year progresses. This is impacting the negative $90k variance related to Other Revenues.

Public Health Expenses Budget (see page 3)

Note 1/2– Salaries/Benefits

The positive variance of $260k is a result of two vacant positions which have yet to be filled within the agency. The inherent time lag in filling positions within the agency is also contributing to this variance.

The two vacant positions are driving the positive variance of $74k with regards to benefits.

Note 3 –Travel (Car Allowance, Mileage, Other)

Car allowance is operating relatively within budget.

Mileage is showing a negative $2k variance. This is anticipated to be within budget as the year progresses.

Travel - Other is showing a positive $39k variance. Staff tends to travel between the spring and fall months of the year.

Note 4 - Program, Office, Computer Services, Program Promotion

Program expenses are indicating a negative variance of $163k. The purchased services for the Acting CEO and MOE role are driving the noted variance.

Office expense is showing a positive $50k variance as a result of timing of office supply expenditures not yet incurred.

Computer Services is showing a positive variance of $38k. This is a result of planned equipment purchases not yet incurred (laptop/desktop replacements).

Notes Continued…

Program Promotion is showing a positive variance of $71k due to timing of expenditures not yet incurred.

Note 5 – Telephone Charges/Telecommunications

Telephone Charges are indicating a positive variance of $16k. This is due to timing of expenditures not yet incurred.

Telecommunications is indicating a positive variance of $16k. This is due to timing of expenditures not yet incurred.

Note 6 – Facilities Expenses/Renovations

Facilities Expenses is showing a positive variance of $32k. This is a result of the timing of expenditures not yet incurred. Budgeted facility maintenance expenses will be occurring throughout the balance of the year which will reduce this positive variance noted.

Note 7 – Fees & Insurance

Fees & Insurance is indicating a negative variance of $66k. This is due to the $86k payment of the annual insurance premium paid in full during the month of March. In addition, APH has incurred incremental auditing and legal fees which are impacting the negative variance noted.

Note 8 – Recoveries

Recoveries are indicating a negative variance of $34k. This is a result of entries not yet posted into the General Ledger.

Community Programs (see page 1)

All community programs are operating without budget issues.

Financial Position - Balance Sheet (see page 7)

Our cash flow position continues to be stable and the bank has been reconciled to July 2015. Cash includes $.698 million in short-term investments.

There are no collection concerns for accounts receivable.

Long term debt of $5.897 million is held by the Royal Bank @ 2.76% for a 20 year term. The loan matures on September 1, 2016.

Algoma Public Health
Statement of Financial Position

Date: As of August 2015	August 2015	December 2014
Assets		
Current		
Cash & Investments	$ **2,064,035**	$ 2,289,828
Accounts receivable	**525,585.19**	413,625
Receivable from municipalities	**77,307**	12,840
Receivable from Province of Ontario	**2,774**	
Subtotal Current Assets	***2,669,701***	*2,716,292*
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,210,874**	1,698,086
Payable to Gov't of Ont/Municipalities	**99,058**	701,964
Deferred Revenue	**611,715**	555,359
Employee Future Benefit Obligations	**2,417,999**	2,417,999
Capital Lease Obligation	**322,339**	539,027
Term Loan	**6,114,240**	6,114,240
Subtotal Current Liabilities	**10,776,225**	12,026,675
Net Debt	**(8,106,524)**	(9,310,383)
Non-Financial Assets:		
Building Construction in Progress	**22,732,421**	22,732,421
Furniture & Fixtures	**1,914,772**	1,914,772
Leasehold Improvements	**892,431**	892,431
IT	**3,029,040**	3,029,040
Automobile	**29,740**	29,740
Accumulated Depreciation	**-6,118,846**	-6,118,846
Subtotal Non-Financial Assets	**22,479,558**	22,479,558
Accumulated Surplus	**14,373,034**	13,169,175

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION I: SUMMARY, CERTIFICATION and VERIFICATION

SERVICE PROVIDER / DELIVERY AGENT: Algoma Public Health
FOR THE YEAR ENDED: March 31, 2015
SERVICE CONTRACT/CFSA APPROVAL NUMBER: 0

PART A: SUMMARY

LINE	SERVICES		Executive and Allotment Control	Total Eligible Expenditures (pending final Ministry review and approval)	Total Approved Ministry Funding	Summary of Revised Ministry Funding after Financial Flexibility (pending final Ministry review and approval)
100	Detail Code #	Service (Detail Code) Name				
101	A476	Infant Development	CYSEX034-AL09	$ 620,206	$ 621,935	$ 620,206
102	A771	Community Capacity Building	CYSEX032-AL02	$ 44,051	$ 44,051	$ 44,051
103	0			$ -	$ -	$ -
104	0			$ -	$ -	$ -
105	0			$ -	$ -	$ -
106	0			$ -	$ -	$ -
107	0			$ -	$ -	$ -
108	0			$ -	$ -	$ -
109	0			$ -	$ -	$ -
110	0			$ -	$ -	$ -
111	0			$ -	$ -	$ -
112	0			$ -	$ -	$ -
113	0			$ -	$ -	$ -
114	0			$ -	$ -	$ -
115	0			$ -	$ -	$ -
116	0			$ -	$ -	$ -
117	0			$ -	$ -	$ -
118	0			$ -	$ -	$ -
119	0			$ -	$ -	$ -
120	0			$ -	$ -	$ -
121	0			$ -	$ -	$ -
122	0			$ -	$ -	$ -
123	0			$ -	$ -	$ -
124	0			$ -	$ -	$ -
125	0			$ -	$ -	$ -
126	0			$ -	$ -	$ -
127	0			$ -	$ -	$ -
128	0			$ -	$ -	$ -
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130	0			$ -	$ -	$ -
131	0			$ -	$ -	$ -
132	0			$ -	$ -	$ -
133	0			$ -	$ -	$ -
134	0			$ -	$ -	$ -
135	0			$ -	$ -	$ -
136	0			$ -	$ -	$ -
137	0			$ -	$ -	$ -
138	0			$ -	$ -	$ -
139	0			$ -	$ -	$ -
140	0			$ -	$ -	$ -
141	0			$ -	$ -	$ -
142	0			$ -	$ -	$ -
TOTAL				$ 664,257	$ 665,986	$ 664,257

PART B: CERTIFICATION BY SERVICE PROVIDER / DELIVERY AGENT AUTHORITY

I hereby certify that, to the best of my knowledge, the financial data in the Transfer Payment Annual Reconciliation to which this certification is attached, is true, correct, agrees with the books and records of the organization and has been prepared in accordance with the Technical Instructions and ministry financial policies provided by the Ministry of Community and Social Services and the Ministry of Children and Youth Services.

Signature of Service Provider / Delivery Agent Authority (LINE 143)

Sandra Lacle
Name of Service Provider/Delivery Agent Authority (LINE 143)

Algoma Public Health
Title of Service Provider/Delivery Agent Authority (LINE 143)

Date (dd/mm/yy) (LINE 150)

PART C: VERIFICATION BY THE BOARD OF DIRECTORS

The above certification, together with the Transfer Payment Annual Reconciliation, was received and approved by:

the Board of Directors on the _____ day of _____, _____. **(LINE 160)**

Chairperson of the Board of Directors: _____ **(LINE 170)**
Signature

Kenneth Mason
Name of Chairperson or Designate

Board Chair
Title

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION iV: AUDITED FINANCIAL STATEMENT RECONCILIATION

SERVICE PROVIDER / DELIVERY AGENT:	Algoma Public Health
FOR THE YEAR ENDED:	March 31, 2015
SERVICE CONTRACT/CFSA APPROVAL NUMBER:	0

LINE				
400	TOTAL GROSS REVENUES PER AUDITED FINANCIAL STATEMENTS		$	675,873
401	LESS: Non Funded Ministry (MCYS) Revenue (i.e. funding from other sources not related to ministry servic		$	9,887
402	Adjustments for Revenues from Ministry Funding calculation			
403		Less: Non Retainable Revenues		
404		Specify (e.g. Expenditure Recoveries)	$	-
405		Specify (e.g. Offsetting Revenues)	$	-
406		Specify (e.g. Specific Operating Donations)	$	-
407		Specify (e.g. Inter-Agency Chargebacks)	$	-
408		Less: Amortization of Deferred Revenue	$	-
409		Less: Other (specify)_____	$	-
410		Less: Other (specify)_____	$	-
		Subtotal	$	-
411		Add: One-Time Capital Expenditures Approved & not included in Revenue	$	-
412		Add: Other (specify)_____	$	-
413		Add: Other (specify)_____	$	-
414		Subtotal	$	-
415	Total Revenue Reported (Line 400 - Line401 - Line 404 to Line 410 + Line 414)		$	665,986
420	Total Approved Ministry Funding (Total of LINE 223) *(Lines 415 and 420 should equal)*		$	665,986
440	TOTAL GROSS EXPENDITURES PER AUDITED FINANCIAL STATEMENTS		$	674,144
441	LESS: Non Funded Ministry (MCSS) Expenditures (i.e. expenditures from other services not related to ministry services)		$	-
442	Adjustments for inadmissible Expenditures related to Ministry Funded Programs			
443		Less: Accruals (Payables greater than 30 day i.e. Vacation/Sick Accrual)	$	-
444		Less: Appropriations	$	-
445		Less: Amortization on Capital Assets	$	-
446		Less: Donations to Individuals or Organizations	$	-
447		Less: Fundraising Costs	$	-
448		Less: Loans to Clients or Staff	$	-
449		Less: Retainer Fees	$	-
450		Less: Provisions for Bad Debt	$	-
451		Less: In Kind	$	-
452		Less: Other (specify)_____	$	-
453		Less: Other (specify)_____	$	-
		Subtotal	$	-
	LESS: Other Adjustments			
455		Less: Expenditure Recoveries/ Offsetting Revenues		
456		Less: Other (specify)_____	$	9,887
457		Less: Other (specify)_____	$	-
		Subtotal	$	9,887
460	ADD: Adjustments for Admissible Expenditures, attach prior approval documentation			
461		Add: One-Time Capital Expenditures Approved & Capitalized	$	-
462		Add: Other (specify)_____	$	-
463		Add: Other (specify)_____	$	-
		Subtotal	$	-
475	Total Ministry (MCYS) Eligible Expenditures reported in the Audited Financial Statements		$	664,257
480	Total Eligible Expenditures (Total of LINE 269)		$	664,257
490	Variance		$	(0)

Variance Explanation:

491	Retained Earning	$	-
492	Total Assets	$	-
493	Total Debt	$	-

(Please attach additional sheets if necessary or if the space is insufficient to complete the above reconciliation)

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION II: MINISTRY FUNDING RECONCILIATION

SERVICE PROVIDER / DELIVERY AGENT: Algoma Public Health
FOR THE YEAR ENDED: March 31, 2015
SERVICE CONTRACT/CFSA APPROVAL NUMBER: 0

SERVICE PROVIDER / DELIVERY AGENT: Algoma Public Health
FOR THE YEAR ENDED: March 31, 2015
SERVICE CONTRACT/CFSA APPROVAL NUMBER: 0

SERVICE PROVIDER / DELIVERY AGENT: Algoma Public Health
FOR THE YEAR ENDED: March 31, 2015
SERVICE CONTRACT/CFSA APPROVAL NUMBER: 0

SERVICE PROVIDER / DELIVERY AGENT: Algoma Public Health
FOR THE YEAR ENDED: March 31, 2015
SERVICE CONTRACT/CFSA APPROVAL NUMBER: 0

SERVICE PROVIDER / DELIVERY AGENT:
FOR THE YEAR ENDED:
SERVICE CONTRACT/CFSA APPROVAL NUMBER:

		Allocated Central Administration																						
200	DETAIL CODE		A476	A771	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
0201	TPBE #		037674	037674																				
202	SERVICE NAME		Infant Development	Community Capacity Building																				
203	IFIS LINE-SUBLINE #		B078-B200	B074-B156																				
204	LEGISLATION		CFSA / LSEF	CFSA / LSEF																				
205	EXECUTIVE & ALLOTMENT CONTROL		CYSEX034-AL09	CYSEX032-AL02																				
206	DESCRIPTION		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
210	FUNDING RECEIVED																							
211	Provincial Funding Received on Account - Current Year		$ 621,935	$ 44,051																				
212	ADD: Prior Year Reconciliation Recoveries*																							
213	DEDUCT: Prior Year Payments																							
215	TOTAL of Funding Received - Current Year		$ 621,935	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	* Only applicable if provincial funding received recorded net of recoveries																							
220	APPROVED FUNDING																							
221	Total Approved Net Expenditures (Service Contract: Budget Schedule - LINE M)		$ 621,935	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
223	TOTAL Approved Ministry Fiscal Funding (Service Contract: Budget Schedule - Line P)		$ 621,935	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
230	EXPENDITURES																							
231	Salaries	$ -	$ 405,763	$ 33,670	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
232	Benefits	$ -	$ 101,663	$ 8,415	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
233	SUBTOTAL - Salaries & Benefits	$ -	$ 507,426	$ 42,085	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
234	Travel	$ -	$ 30,446	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
235	Communication	$ -	$ 6,313	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
236	SUBTOTAL - Transportation & Communication	$ -	$ 36,759	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
237	Rent/ Lease/ Mortgage Interest	$ -	$ 50,354	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
238	Mortgage Principal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
239	Utilities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	Staff Training	$ -	$ 3,622	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
241	Advertising and Promotion	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
242	Services related to Repairs and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
243	Professional/Contracted-out Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
244	Professional/Contracted-out IT Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
245	Purchased Client Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
246	Purchased Client Services - OPR	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
247	Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
248	Other Services	$ -	$ 4,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
249	SUBTOTAL - Services	$ -	$ 67,976	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
250	Supplies, Equipment related to Repairs and Maintenance	$ -	$ 660	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
251	IT - Supplies and Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
252	Other Supplies and Equipment	$ -	$ 11,272	$ 1,966	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
253	SUBTOTAL - Supplies & Equipment	$ -	$ 11,932	$ 1,966	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
254	OTHER TRANSACTIONS	$ 16,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
255	GROSS EXPENDITURES	$ 16,000	$ 614,093	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
256	Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
257	Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
258	Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
259	Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
260	Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
261	SUBTOTAL - In-Year Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	DEDUCT: OFFSETTING REVENUE																							
262	Offsetting Revenue (-)	$ -	$ (9,887)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
263	ADJUSTED SERVICE EXPENDITURES	$ 16,000	$ 604,206	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
264	Allocated Central Administration	$ (16,000)	$ 16,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
265	ADJUSTED GROSS EXPENDITURES	$ -	$ 620,206	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
266	Approved Capitalized Asset Acquisition																							
267	EXPENDITURES ELIGIBLE FOR OPERATING FUNDING		$ 620,206	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
268	Ministry Funding as per Legislated Share Funding Percentage		100%	100%																				
269	TOTAL ELIGIBLE EXPENDITURES		$ 620,206	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
223	TOTAL Approved Ministry Fiscal Funding		$ 621,935	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
270	Ministry Funding Payable (LESSER OF LINE 223 or 269)		$ 620,206	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
215	Ministry Funding Received - Current Year		$ 621,935	$ 44,051	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
280	VARIANCE (MAY BE ELIGIBLE FOR FINANCIAL FLEXIBILITY)		$ 1,729	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

TRANSFER PAYMENT ANNUAL RECONCILIATION	Algoma Public Health	SERVICE PROVIDER / DELIVERY AGENT:	Algoma Public Health	SERVICE PROVIDER / DELIVERY AGENT:	Algoma Public Health	SERVICE PROVIDER / DELIVERY AGENT:	Algoma Public Health	SERVICE PROVIDER / DELIVERY AGENT:	Algoma Public Health											
SECTION II: MINISTRY FUNDING RECONCILIATION	March 31, 2015	FOR THE YEAR ENDED:	March 31, 2015	FOR THE YEAR ENDED:	March 31, 2015	FOR THE YEAR ENDED:	March 31, 2015	FOR THE YEAR ENDED:	March 31, 2015											
	0	SERVICE CONTRACT/CFSA APPROVAL NUMBER:	0	SERVICE CONTRACT/CFSA APPROVAL NUMBER:	0	SERVICE CONTRACT/CFSA APPROVAL NUMBER:	0	SERVICE CONTRACT/CFSA APPROVAL NUMBER:	0											
200 DETAIL CODE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
0201 TPBE #																					
202 SERVICE NAME																					
203 IFIS LINE-SUBLINE #																					
204 LEGISLATION																					
205 EXECUTIVE & ALLOTMENT CONTROL																					
206 DESCRIPTION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
210 FUNDING RECEIVED																					TOTAL
211 Provincial Funding Received on Account - Current Year																					$ 665,986
212 ADD: Prior Year Reconciliation Recoveries*																					$ -
213 DEDUCT: Prior Year Payments																					$ -
215 TOTAL of Funding Received - Current Year	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 665,986
* Only applicable if provincial funding received recorded net of recoveries																					
220 APPROVED FUNDING																					
221 Total Approved Net Expenditures (Service Contract: Budget Schedule - L	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 665,987
223 TOTAL Approved Ministry Fiscal Funding (Service Contract: Budge	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 665,987
230 EXPENDITURES																					
231 Salaries	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 439,433
232 Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 110,078
233 SUBTOTAL - Salaries & Benefits	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 549,511
234 Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 30,446
235 Communication	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,313
236 SUBTOTAL - Transportation & Communication	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -												$ 36,759
237 Rent/ Lease/ Mortgage Interest	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 50,354
238 Mortgage Principal	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
239 Utilities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240 Staff Training	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,622
241 Advertising and Promotion	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
242 Services related to Repairs and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
243 Professional/Contracted-out Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
244 Professional/Contracted-out IT Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
245 Purchased Client Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
246 Purchased Client Services - OPR	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
247 Insurance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
248 Other Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,000
249 SUBTOTAL - Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 57,976
250 Supplies, Equipment related to Repairs and Maintenance	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 680
251 IT - Supplies and Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
252 Other Supplies and Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,236
253 SUBTOTAL - Supplies & Equipment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,916
254 OTHER TRANSACTIONS	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,000
255 GROSS EXPENDITURES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 674,144
256 Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
257 Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
258 Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
259 Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
260 Adjustments / Recoveries:	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
261 SUBTOTAL - In-Year Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DEDUCT: OFFSETTING REVENUE																					
262 Offsetting Revenue (-)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (9,987)
263 ADJUSTED SERVICE EXPENDITURES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 674,144
264 Allocated Central Administration	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
265 ADJUSTED GROSS EXPENDITURES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 674,144
266 Approved Capitalized Asset Acquisition																					$ -
267 EXPENDITURES ELIGIBLE FOR OPERATING FUNDING	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 674,144
268 Ministry Funding as per Legislated Share Funding Percentage																					
269 TOTAL ELIGIBLE EXPENDITURES	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 684,257
223 TOTAL Approved Ministry Fiscal Funding	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 665,987
270 Ministry Funding Payable (LESSER OF LINE 223 or 269)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 684,257
215 Ministry Funding Received - Current Year	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 665,986
280 VARIANCE (MAY BE ELIGIBLE FOR FINANCIAL FLEXIBILITY)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,729

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION III: FINANCIAL FLEXIBILITY TRANSFERS/SUMMARY OF NET FUNDING RECONCILIATION

SERVICE PROVIDER / DELIVERY AGENT: Algoma Public Health
FOR THE YEAR ENDED: March 31, 2015
SERVICE CONTRACT/CFSA: 0

PART I:
The following four criteria must be MET when considering ANSWERING "YES" or "NO" to financial flexibility:
1. Program/Policy Directions and Priorities
- Service targets must be substantially met to the satisfaction of the ministry office
2. Funding Policies and Guidelines
3. Conditions
4. Realignment
Funds may be realigned if ALL the following conditions are met
- within the same Executive and Allotment Transfer Control AND
- within the same service contract or CFSA Approval AND
between Detail Codes that have not been identified as **exceptions** to financial flexibility
PLEASE SEE FULL MINISTRY POLICY and TECHNICAL INSTRUCTIONS. THIS IS A SUMMARY.

Enter "YES" or "NO" PART 1: LINE 310 for each detail code

PART II: FINANCIAL FLEXIBILITY TRANSFERS
If PART I was answered "YES", funds may only be realigned, according to Section 4 "Realignment".
If ALL of the conditions are met :
- Transfer Funding Surplus and Funding Deficit in the appropriate columns in PART II, please enter all numbers as positive from Column C & D in LINES 311 and 312.
- Funding Deficits transferred can only be up to the amount identified as a Funding Surplus. See technical instructions for full instructions and an example.
- Please provide details of how much and from what are being transferred to and from.

Transfer Surplus or Deficit as a **POSITIVE (+)** number only on LINE 311 or 312

PART III: SUMMARY OF NET FUNDING
The Total Net Surplus/ (Deficit) calculated represents the net difference between the Total OVERfunded and Total UNDERfunded amounts. This section will be automatically calculated based on the information entered in PART II.

This amount is subject to the Ministry's Executive Controls and therefore subject to ministry review and final approval.

- A positive(+) Net Funding represents a possible Recoverable Funding due to the Government of Ontario.

- A negative (-) Net Funding represents possible additional funding due to the Service Provider/Delivery Agent, if under payment.

PARTIE I :
La prise en considération des quatre éléments suivants est OBLIGATOIRE avant de RÉPONDRE « OUI » ou « NON » à la question de savoir si la marge de manœuvre financière est applicable :
1. Les orientations et priorités en matière de politiques/programmes
- Le bureau du ministère doit être satisfait que les objectifs relatifs aux services ont été pour l'essentiels
2. Les politiques et directives relatives au financement.
3. Les conditions.
4. La réaffectation de fonds.
La réaffectation des fonds peut avoir lieu si TOUTES les conditions suivantes sont remplies
• les fonds relèvent d'un même contrôle de gestion et d'affectation;
• les fonds relèvent du même contrat de services ou de la même approbation de services L réaffectation se fait entre des codes d'identification qui ne constituent pas des **exceptions** à la marge de manœuvre financière.
CECI N'EST QU'UN RÉSUMÉ. PRIÈRE DE CONSULTER LA POLITIQUE INTÉGRALE ET LES INSTRUCTIONS TECHNIQUES DU MINISTÈRE.

Entrer « OUI » ou « NON » à la LIGNE 310 pour chaque code d'identification

PARTIE II : TRANSFERTS EN APPLICATION DE LA MARGE DE MANŒUVRE FINANCIÈRE
Si vous avez répondu « OUI » à la PARTIE I, la réallectation de fonds peut avoir lieu dans la mesure où l'ENSEMBLE des conditions suivantes sont replies :
- inscrire les transferts de fonds excédentaires et de déficits consignés dans les colonnes appropriées de la partie II comme nombres positifs aux LIGNES 311 et 312 des colonnes C et D;
- veiller à ce que les transferts de déficits n'excèdent pas le montant de l'excédent établi. Les instructions techniques contiennent d'autres explications et un exemple;
- détailler les montants transférés, d'où ils proviennent et à quoi ils sont réaffectés.

Transférer l'excédent ou le déficit sous forme de nombre **POSITIF (+)** à la LIGNE 311 ou 312

PARTIE III : SOMMAIRE DU FINANCEMENT NET
Le « Total » Excédent/(Déficit) net » établi représente la différence nette entre le total des montants de financement EN TROP et le total des montants de financement EN MOINS. Cette section sera calculée automatiquement en fonction des données entrées à la PARTIE II.

Ce montant est soumis aux contrôles de gestion du ministère, et donc à l'examen final et à l'approbation de ce dernier.

- Une subvention nette positive (+) représente un montant recouvrable par le gouvernement de l'Ontario;

- Une subvention nette négative (-) représente un montant additionnel dû au fournisseur de services ou à l'agent de prestation, en cas de sous-paiement.

LINE 200 Detail Code	LINE 203 IFIS Line-Subline	LINE 204 Legislation	LINE 205 Executive and Allotment Control	LINE 223 Column A Total Approved MCYS Fiscal Funding	LINE 258 Column B Total Eligible Expenditures	LINE 305 Column C Funding Surplus (A-B)	LINE 306 Column D Funding (Deficit) (A-B)	PART I: LINE 310 Does the Calculated Funding (Deficit) meet Financial Flexibility Criteria (Y/N)?	PART II: Financial Flexibility Transfers — Transfer of Eligible Funding Surplus LINE 311 Please enter all numbers as positive from Column C	Transfer of Eligible Funding (Deficit) LINE 312 Please enter all numbers as positive from Column D	Transfer Notes Please provide details of how much and from what detail codes funds are being transferred to and from.	Revised MCYS Funding (Approved Ministry Funding +/- Financial Flexibility Transfers) Subject to ministry review and approval	LINE 315 Actual MCYS Funding Payments Received - Current Year	PART III: SUMMARY OF NET FUNDING (SUBJECT TO MINISTRY REVIEW AND APPROVAL) OVERfunded LINE 320	UNDERfunded LINE 325
A478	B078-B200	CFSA / LSEF	CYSEX034-AL09	$ 621,935	$ 620,206	$ 1,729	$ -		$ -	$ -		$ 620,206	$ 621,935	$ 1,729	$ -
A771	B074-B156	CFSA / LSEF	CYSEX032-AL02	$ 44,051	$ 44,051	$ -	$ -		$ -	$ -		$ 44,051	$ 44,051	$ -	$ -
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				$ 665,986	$ 664,257	$ 1,729	$ -		$ -	$ -		$ 664,257	$ 665,986	$ 1,729	$ -
														Total Net Surplus/(Deficit)	$ 1,729

ONTARIO PUBLIC HEALTH ORGANIZATIONAL STANDARDS COMPLIANCE CHECKLIST

Board of Health: Board of Health for the District of Algoma Health Unit

INSTRUCTIONS

Use the drop-down list to indicate your board of health's current compliance with each requirement of the Ontario Public Health Organizational Standards (OPHOS). Where "no" is selected, you must indicate a date by which you will be in compliance with the requirements. If a requirement does not apply to your board structure indicate N/A. Wherever applicable, please provide evidence to support your statement of compliance. Please note, evidence should be 25 charcters in length or less. Please submit the completed and approved checklist to PHUIndicators@ontario.ca by **Friday, August 21, 2015**. Additional documentation may be submitted as separate documents.

	Organizational Standards Sections and Requirements	Currently meeting all board of health requirements (yes/no/N/A)	If no, indicate date by which you will be in compliance with the requirements (DD/MM/YY)	Provide evidence where applicable (e.g. # of members; date of last update; name of policy)
1	Board Structure			
1.1	Definition of a board of health	yes		See policy 02-05-000
1.2	Number of members on a board of health	no	Working with MOHLTC	
1.3	Right to make provincial appointments	yes		See policy 02-05-000
1.4	Board of health may provide public health services on reserve	N/A		No PH agreements
1.5	Employees may not be board of health members	yes		See policy 02-05-015
1.6	Corporations without share capital	yes		See by-law 95-2
1.7	Election of the board of health chair	yes		See by-law 95-1
1.8	Municipal membership	yes		See policy 02-05-000
2	Board Operations			
2.1	Remuneration of board of health members	yes		See policy 02-05-025
2.2	Informing municpalities of financial obligations	yes		See attached document
2.3	Quorum	yes		See by-law 95-2
2.4	Content of by-laws	yes		Documents attached
2.5	Minutes, by-laws and policies and procedures	yes		Documents attached
2.6	Appointment of a full-time medical officer of health (i.e., minimum 35 to 40 hours per week or 0.8 FTE)	no	Currently recruiting for a full-time MOH/CEO. Acting MOH is available 24/7. Also CEO,1.0 FTE, currently on staff	
2.7	Appointment of an acting medical officer of health	yes		Documents attached
2.8	Dismissal of a medical officer of health	yes		See by-law 95-1
2.9	Reporting relationship of the medical officer of health to the board of health	yes		See by-law 95-1
2.10	Board of health policies	yes		Policies attached
3	Leadership			
3.1	Board of health stewardship responsibilities	yes		
3.2	Strategic plan	yes		Strategic Plan
4	Trusteeship			
4.1	Transparency and accountability	yes		See attached document
4.2	Board of health member orientation and training	yes		See attached document
4.3	Board of health self-evaluation	yes		See attached document
5	Community Engagement and Responsiveness			
5.1	Community engagement	yes		Annual Report
				Strategic Plan
				Cancer Report
5.2	Stakeholder engagement	yes		See attached document
5.3	Contribute to policy development	yes		See attached document
5.4	Public reporting	yes		Annual Report
5.5	Client service standards	yes		See attached document
6	Management Operations			
6.1	Operational plan	yes		Program plans can be provided
6.2	Risk management	yes		See attached document
6.3	Medical officer of health provides direction to staff	yes		See attached document
6.4	Eligibility for appointment as a medical officer of health	yes		See attached document
6.5	Educational requirements for public health professionals	yes		See attached document
6.6	Financial records	yes		See attached document
6.7	Financial policies and procedures	yes		See attached document
6.8	Procurement	yes		See policy 02-04-030
6.9	Capital funding plan	yes		See bylaw 2015-1
6.10	Service level agreements	N/A		N/A
6.11	Communications strategy	no	15/06/2016	Within program plans. See Strategy attached.
6.12	Information management	yes		See attached policies
6.13	Research ethics	yes		See attached document
6.14	Human resources strategy	no	15/06/2015	See attached document
6.15	Staff development	no	15/06/2015	See attached document. Student placements supported.
6.16	Professional practice support	yes		See attached document

APPROVED BY CHAIR OF THE BOARD OF HEALTH:

NAME: Lee Mason

DATE: 21/08/2015

SIGNATURE: Lee Mason

Board of Health Member Self-Evaluation of Performance
Year: 2015 January - June

Part1: Individual Performance Compliance with individual Roles and Responsibilities as a Board of Health Member	Stongly Agree	Agree	Disagree	Stongly Disagree	Not Applicable
1 As a BoH member, I am satisfied with my attendane at meetings	1 1 1 1	1	1	**1**	
2 As a BoH member, I am satisfied with my preparation for meetings	1 1	1 1 1	1 1		
3 As a BoH member, I am satisfied with my participation in meetings	1 1 1	1 1 1 1			
4 As a BoH member, I understand my roles and responsiblities	1 1	1 1 1 1 1			
5 As a BoH member, I understand current public health issues	1	1 1 1	1 1 1		
6 As a BoH member, I have input into the vision, mission, and strategic direction of the organization	1	1 1 1 1	1 1		
7 As a BoH member, I am aware and represent community perspective during Board meetings	1	1 1 1 1 1 1			
8 As a BoH member, I provide input into policy development and decision-making	1	1 1 1 1 1	1		
9 As a BoH member, I represent the interests of the organization at all times	1 1	1 1 1 1			

Board of Health Member Self-Evaluation of Performance
Year: 2015 January - June

Part 2: Board of Health Processes Effectiveness of policy and process		Stongly Agree	Agree	Disagree	Stongly Disagree	Not Applicable
1	The BoH is compliant with all applicable legislation and regulations	1	1 1 1 1 1	1		
2	The BoH ensures members are aware of their roles and responsibilities through orientaion of new members	1 1	1 1 1 1 1			
3	The BoH is appropriately informed about financial management, procurement policies and practice, risk management and human resources issues		1 1 1 1 1	1		
4	The BoH holds meetings fequently enough to ensure timely decision-making	1 1	1 1 1 1 1			
5	The BoH bases decision making on access to appropriate information with sufficient time for deliberations	1	1 1	1 1 1	1	
6	The BoH is kept apprised of public health issues in a timely and effective manner.	1	1 1 1 1 1	1		
7	The BoH sets bylaws and governance policies	1	1 1 1 1	1 1		
8	The BoH remains informed with issues pertaining to organizational effectiveness through performance monitoring and strategic planning	1	1 1 1 1	1 1		

Board of Health Member Self-Evaluation of Performance
Year: 2015 January - June

Part 3: Overall Performance of the Board of Health	Stongly Agree	Agree	Disagree	Stongly Disagree	Not Applicable
1 The BoH contibutes to high governance and leadership performance	1	1 1 1 1 1 1			
2 The BoH oversees the development of the strategic plan		1 1 1	1 1		1
3 The BoH ensures planning processes consider stakeholder and community needs		1 1 1 1 1 1	1		
4 The BoH ensures a climate of mutal trust and respect between themselves and the MOH/CEO	1 1 1 1	1 1 1			
5 The BoH as governing body is achieving its strategic outcomes		1 1 1 1 1 1	1		

Board of Health Monthly Meeting Evaluation
Month: May Year: 2015

Please select one response for each question in the following grid. If the question is not relevant please select "not applicable".	Stongly Agree	Somewhat Agree	Somewhat Disagree	Stongly Disagree	Not Applicable
1 The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.	1 1 1	1 1 1			
2 The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.	1 1 1 1 1	1			
3 The MOH/CEO report was informative, timely and relevant to my governance role.	1 1 1 1 1	1			
4 Overall, the Board meeting was conducted in an active, informative, and responsible manner with decisions made that advance the APH vision and mission.	1 1	1 1 1 1			
5 There is alignment with items that were included in the Board agenda package and the APH's 2015-2020 Strategic Plan.	1	1 1 1			
6 Board members' conduct was professional, cordial and respectful.	1 1 1 1	1 1			

Board of Health Monthly Meeting Evaluation
Month: June Year: 2015

Please select one response for each question in the following grid. If the question is not relevant please select "not	Stongly Agree	Somewhat Agree	Somewhat Disagree	Stongly Disagree	Not Applicable
1 The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.	1 1	1 1 1			
2 The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.	1 1	1			1 1
3 The MOH/CEO report was informative, timely and relevant to my governance role.	1 1 1 1	1			
4 Overall, the Board meeting was conducted in an active, informative, and responsible manner with decisions made that advance the APH vision and mission.	1 1	1 1 1	1		
5 There is alignment with items that were included in the Board agenda package and the APH's 2015-2020 Strategic Plan.	1	1 1 1			
6 Board members' conduct was professional, cordial and respectful.	1 1 1 1	1			

Board of Health Monthly Meeting Evaluation
Month: June 29 Year: 2015

Please select one response for each question in the following grid. If the question is not relevant please select "not	Stongly Agree	Somewhat Agree	Somewhat Disagree	Stongly Disagree	Not Applicable
1 The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.	1	1			
2 The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.		1			1
3 The MOH/CEO report was informative, timely and relevant to my governance role.	1				1
4 Overall, the Board meeting was conducted in an active, informative, and responsible manner with decisions made that advance the APH vision and mission.	1 1				
5 There is alignment with items that were included in the Board agenda package and the APH's 2015-2020 Strategic Plan.	1 1				
6 Board members' conduct was professional, cordial and respectful.	1 1				

Board of Health Monthly Meeting Evaluation
Month: August 6 Year: 2015

Please select one response for each question in the following grid. If the question is not relevant please select "not	Stongly Agree	Somewhat Agree	Somewhat Disagree	Stongly Disagree	Not Applicable
1 The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.	1 1 1	1 1			
2 The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.	1 1	1			1 1
3 The MOH/CEO report was informative, timely and relevant to my governance role.	1				1 1 1 1
4 Overall, the Board meeting was conducted in an active, informative, and responsible manner with decisions made that advance the APH vision and mission.	1 1 1 1	1			
5 There is alignment with items that were included in the Board agenda package and the APH's 2015-2020 Strategic Plan.	1 1 1	1	1		
6 Board members' conduct was professional, cordial and respectful.	1 1 1 1 1	1			

Algoma Public Health – GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-010
DATE:	O: February 12, 1996 Reviewed: March 21, 2012 Revised: June 17, 2014 Revised: September 22, 2015	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	Board Minutes/Packages – Posting/Circulation/Retention

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POLICY:

Algoma Public Health Board meeting packages will be posted to the APH website. Minutes will be marked as draft. Once the minutes have been approved by the Algoma Public Health Board, the draft minutes will be replaced with the approved minutes on the website. Access, storage and retrieval of this information will be in accordance with general standards of APH and the Municipal Act.

PROCEDURES:

Secretary to the Board of Health:

1) Will post the Board package to the Algoma Public Health Website and the email the link to municipalities one week prior to the Board meeting. In-committee documentation will not be included.(See Policy 02-05-060)

2) Maintain a binder of original signed approved Board minutes plus signed resolutions by the Board Chair for each Board meeting on a yearly basis.

Algoma Public Health – GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-070
DATE:	O: September 22, 2015 R:	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	"In Committee" material – Posting/Circulation/Retention

POLICY:

Algoma Public Health Board "In Committee" documentation will be posted to the APH Secure Board website along with the Board Meeting Package to allow Board Members time to become familiarized with information prior to meetings. Minutes will be marked as **Confidential**. Access, storage and retrieval of this information will be in accordance with general standards of APH and the Municipal Act section 239.2 and Section 239.3.

PROCEDURES:

Board:

1) Has access to "In Committee" documentation through the APH Secure Board Webpage when the Board Meeting package is posted.

2) The "In Committee" documentation will be posted as a separate hyperlink after the Board Meeting package hyperlink.

3) "In Committee" documentation will be available to the Board Members until the close of the meeting, and then will be removed from the Secure Board Webpage.

4) Board members may review the "In Committee" documentation online, but should not make copies, save to desktop, photograph, or download in any format any version of the documentation to save.

5) Minutes of "In Committee" sessions will be passed while in the next "In Committee" session

6) Paper copies of the "In Committee" documentation (with the confidential watermark) will be made available for the Board members during the meeting and collected after the session is over.

Secretary to the Board of Health:

7) Maintain a binder of agenda and minutes of the "In Committee" sessions including motion to enter, people present during "In Committee" session, directives given to Staff, reports referenced and motion to exit.

8) Allow onsite access to Board of Health members to review the "In Committee" binder as required with reasonable notice.

Algoma Public Health - GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**BY-LAW #:**	95-1
DATE:	O: December 13, 1995 R: September 22, 2015	**SECTION:**	Board
PAGE:	1 of ~~9~~8	**SUBJECT:**	To Regulate the Proceedings of the Board of Health

The Board enacts as follows:

Interpretation

1. In this By-law:

a) "Act" means the Health Protection and Promotion Act. S.D. Ontario 1983, Chapter 10 as amended;

b) "Board" means THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT, as prescribed;

c) "Chair" means the person presiding at the meeting of the Board;

d) "Chair of the Board" means the Chair elected under Section 56 of the Act which reads:

i) A Board of Health shall hold its first meeting of each year not later than the 1st day of February

ii) At the first meeting of the Board of Health in each year, the members of the Board shall elect one of the members to be Chairman and one to be Vice-chairman of the Board for the year;

e) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

f) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

g) "Meeting means a meeting of the Board;

h) "Member" means a member of the Board;

i) "Quorum" means a majority of members of the Board;

j) "Secretary" means the Secretary of the Board of Health;

k) Words that indicate singular masculine gender only shall include plural and/or feminine gender.

General

2. The Board shall hold the first meeting of each year not later than the first day of February. At the first meeting of the Board in each year, members of the Board shall elect one member to be Chair and one to be Vice-chair of the Board for the year.

3. The Board shall consist of the members as prescribed under the Act;

    a) Where a vacancy occurs in the Board by death, disqualification, resignation or removal of a member, the person or body that appointed the member shall appoint a person forthwith to fill the vacancy for the remainder of the term of the member.

4. In all the proceedings at or taken by this Board, the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committee (s) thereof.

5. Except as herein provided, Carswell's *Procedures for Meetings and Organizations* shall be followed for governing the proceedings of the Board and the conduct of its members.

6. A person who is not a member of the Board shall not be ~~allowed~~ permitted to address the Board except upon invitation of the Chair subject to written request to the Secretary at least two weeks prior to the scheduled meeting.

7. In unusual circumstances persons who have not requested in writing to address the Board may address the Board provided two-thirds of the Board are in agreement.

~~8. No person shall smoke in any meeting.~~

Meetings

~~9.~~8. Regular Meetings:

a) The regular meetings shall be held at a date and time as determined by the Board at its first regular meeting of the year;

b) The Board may, by resolution, alter the time, day or place of any meeting;

c) It is expected that commitments to regularly scheduled Board meetings be honoured by the Board members;

d) Three consecutive absences from regular Board meetings by a member of the Board will be reviewed by the Chair of the Board with the member in question; following which, notification may be forwarded to the appropriate municipality or council.

~~10.~~9. Special Meetings:

a) A special meeting of the Board shall not be called for a time which conflicts with a regular meeting previously called of (participating) council(s) or municipality(s).

b) A special meeting may be called by the Chair of the Board of Health.

c) The Secretary shall call a special meeting upon receipt of a petition signed by the majority of Board members, for the purpose and at the time mentioned in the petition.

~~11.~~10. Notice of Meetings:

a) The Secretary shall give notice of each regular and special meeting of the Board and of each committee to the members thereof and to the heads of departments concerned with such meeting.

b) The notice shall be accompanied by the agenda and any other matter, so far as is known, to be brought before such meeting.

c) The notice for a regular meeting shall be delivered or sent by ordinary mail or courier to the residence or place of business of each member so as to be received not later than three working days prior to the day of the meeting.

d) The notice for a special meeting may be sent by telephone or by electronic means with the Secretary confirming receipt.

e) No errors or omissions in giving such notice for the meeting shall invalidate it or any action taken.

f) The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

~~12.~~11. Preparation of the Agenda:

a) The Secretary shall have prepared for the use of members at the regular meetings, the Agenda as follows:

i. Call to Order
ii. Declaration of Conflict of Interest
iii. Adoption of Agenda
iv. Adoption of Minutes of Previous Meeting
v. Business Arising from Minutes
vi. Delegations/Presentations
vii. Reports of Committees
viii. Reports of Officers/Program Managers
ix. Correspondence/Items for Information
x. Addendum
xi. Announcements
xii. New Business/General Business
xiii. In-Committee Session
xiv. Return to Open Meeting
xv. Adjournment

b) For special meetings, the Agenda shall be prepared when and as the Chair of the Board may direct or, in default of such direction, as provided in the last preceding section so far as is applicable.

c) The business for each meeting shall be taken up in the order in which it stands upon the Agenda, unless otherwise decided by the Board.

~~13.~~12. Commencement of Meetings:

a) As soon as there is a quorum after the hour fixed for the meeting, the Chair of the Board or Vice-chair of the Board, if the Chair is not present shall take the chair and call the members to order.

b) If the Chair or Vice-chair is not present, or their duly appointed representative, but a quorum is otherwise achieved, the Secretary shall call the members to order and a presiding officer shall be appointed by the Secretary to preside during the meeting or until the arrival of the person who ought to preside.

c) If there is no quorum with 15 minutes after the time appointed for the meeting, the Secretary shall call the roll and take down the names of the members then present. If an absence of an expected Quorum occurs due to a health emergency or to weather conditions and business must be expedited, the Board shall have the privilege of designating items of business as essential to be expedited at that meeting. Under these conditions the Board shall have the privilege of conducting the necessary items of business but such items shall be confirmed at the next meeting of the Board

Rules of Debate and Conduct of Members of the Board

~~14.~~13. The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on point of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

~~15.~~14. Each deputation will be allowed a maximum of one speaker for a maximum of 10 minutes, but a member of the Board may introduce a deputation in addition to the speaker or speakers. Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

a) The Board shall render its decision in each case within five (5) working days after deputations have been heard.

~~16.~~15. If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall call on another member, prior to the beginning of the debate, to fill his place until he resumes the chair.

~~17.~~16. Every member, prior to speaking to any question or motion, shall be acknowledged by the Chair.

~~18.~~17. When two or more members ask to speak, the Chair shall name the member who, in his opinion, first asked to speak.

~~19.~~18. A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

~~20.~~19. A motion for introducing new matter shall not be presented without notice unless the Board, without debate, dispenses with such notice by a majority vote and no report requiring action of the Board shall be introduced to the Board unless a copy has been placed in the hands of the members at least one day prior to the meeting, except by a majority vote, taken without debate.

~~21.~~20. Every motion presented to the Board shall be written.

~~22.~~21. Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

~~23.~~22. When a matter is under debate, no motion shall be received other than a motion:

a) to adopt,
b) to amend,
c) to defer action,
d) to refer,
e) to receive,
f) to adjourn the meeting, or
g) that the vote be now taken.

~~24.~~23. a) A motion to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.
b) A motion to refer shall require direction as to the body to which it is being referred and is not debatable.
c) A motion to defer must include a reason and a time period for the deferral and is not debatable.

~~25.~~24. When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

~~26.~~25. Any member, including the Chair, may propose or second a motion and all members including the Chair shall vote on all motions except when disqualified by reasons of interest or otherwise; a tie vote shall be considered lost. When the Chair proposes a motion, he shall vacate the chair to the Vice-chair during debate on the motion and reassume the chair following the vote.

Duties of the Secretary for the Board

~~27.~~26. It shall be the duty of the Secretary:

a) to attend or cause an assistant to attend all meetings of the Board;

b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of By-laws and Resolutions passed by it; and

c) to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same.

d) to give all notices required to be given to the members.

Appointment and Organization of Committees

~~28.~~27. At the first meeting in any year, the Board shall appoint the members required by the Board to standing committees(s) (Finance Committee, Governance Committee). ~~(Property Committee)~~

~~29.~~28. The Board may appoint committees from time to time to consider such matters as specified by the Board.

Conduct of Business in Committees

~~30.~~29. The rules governing the procedure of the Board shall be observed in the Committees insofar as applicable.

~~31.~~30. It shall be the duty of the Committee:

a) to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

b) to report to the Board the number of meetings called during a year, at which a quorum was present, and the number of meetings attended by each member of the Committee; and

c) to forward to the incoming Committee for the following year any matter undisposed of.

Procedures of the Board Covered by other By-laws

~~32.~~31. The procedures of the Board with respect to:

a) incurring of liabilities and paying of accounts;
b) authority for expenditures;
c) audits;
d) budgets and settlements;

Shall be in accordance with the By-laws #95-2 and #95-3.

Corporate Seal

~~33.~~32. The corporate seal of the Board shall be in the form impressed hereon and shall be kept by the Chief Executive Officer or the Business Administrator.

Short Name

~~34.~~33. The Board will use the short name Algoma Public Health for signage, communications and promotional messaging and other matters as warranted.

Execution of Documents

~~35.~~34. The Board may at any time and from time to time, direct the manner in which and the person or persons who may sign on behalf of the Board and affix the corporate seal to any particular contract, arrangement, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, conveyances, mortgages, obligations or documents.

~~36.~~35. In general, unless changed by a resolution of the Board under clause 34 of this By-law, the following applies:

a) Budgets and Settlement Forms will be signed by the combination of Board member(s) and staff of the agency as required by Ministry specifications;

b) Leases for real estate will be signed by the Chair of the Board and by the Medical Officer of Health or Chief Executive Officer;

c) Leases or purchase agreements for vehicles, as approved in budgets, will be signed by the Director/~~Business Administrator~~ Chief Financial Officer and/or the Medical Officer of Health or Chief Executive Officer (should two signatures be necessary);

d) Purchase of service agreements with service providers for programs will be signed by the Medical Officer of Health and by the appropriate program ~~Administrator or~~ Director.

~~d)~~e) Purchase of service agreements with service providers for financial, building and corporate services will be signed by the Medical Officer of Health or Chief Executive Officer and by the appropriate administrative manager or Director/Chief Financial Officer.

Duties of Officers

~~37.~~36. The Chair of the Board shall:

a) preside at all meetings of the Board;

b) represent the Board at public or official functions or designate another Board member to do so;

c) be ex-officio a member of all Committees to which he has not been named a member;

d) complete an annual performance appraisal of the Medical Officer of Health using input from the Medical Officer of Health and the members of the Board, with the results of this appraisal being shared with the Board members in camera;

e) perform such other duties as may from time to time be determined by the Board.

~~38.~~37. The Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of the Chair of the Board, together with such powers and duties, if any, as may be from time to time assigned by the Board.

Amendments

~~39.~~38. Any provision contained herein may be repealed, amended or varied, and additions may be made to this By-law by a majority vote of members present at the meeting at which such motion is considered to give effect to any recommendation contained in a Report to the Board and such report has been transmitted to members of the Board prior to the meeting at which the report is to be considered. No motion for that purpose may be considered, unless notice thereof has been received by the Secretary two weeks before a Board meeting and such notice may not be waived and in any event no bill to amend this By-law shall be introduced at the same meeting as that at which such report or motion is considered.

Dismissal of Medical Officer(s) of Health

~~40.~~39. A decision by the Board of Health to dismiss a Medical Officer of Health from office is not effective unless:

a) the decision is carried by the vote of two-thirds of the members of the Board; and

b) the Minister consents in writing to the dismissal.

~~41.~~40. The Board of Health shall not vote on the dismissal of a Medical Officer of Health unless the Board has given to the Medical Officer of Health:

a) reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;

b) a written statement of the reason for the proposal to dismiss the Medical Officer of Health; and

c) an opportunity to attend and to make representation to the Board at the meeting.

Reporting of Medical Officer of Health to the Board of health

1. The medical officer of health of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other Act. The medical officer of health of a board of health is responsible to the board for the management of the public health programs and services under this or any

other Act. (HPPA, s.67(1) and (3))

2. The medical officer of health of a board of health is entitled to nitice of and to attend each meeting of the board and every committee of the board, but the board may require the medical offier of health to withdraw from any part of a meeting at which the board of a committee of the board intends to consider a matter related to the remuneration or the performance of the duties of the medical officer of health. (HPPA, s70)

Enacted and passed by the Algoma Health Unit Board this 13th day of December, 1995.

Original signed by
I. Lawson, Chair
G. Caputo, Vice-chair

Revised and passed by the Algoma Health Unit Board this 18th day of November 1998
Revised and passed by the Algoma Public Health Board February 2011
Revised and passed by the Algoma Public Health Board on this 16th day of September 2015

Algoma Public Health – GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-060
DATE:	O: September 22, 2015 R:	**SECTION:**	Board of Health
PAGE:	1 of 2	**SUBJECT:**	Freedom of Information

POLICY:

Board of Health meetings are open to the public.

In accordance with Section 239 of the *Municipal Act,* which also applies to local boards or committees of local boards, a meeting or part of a meeting may be **closed** to the public if the subject matter being considered is:

- the security of the property of the Algoma Public Health (APH);
- personal matters involving one or more identifiable individuals, including employees or prospective employees;
- proposed or pending acquisition, rent or disposition of land or realty;
- reports on charges which have been laid for contravention of by-laws or regulations, but which have not yet been dealt with in court;
- labour relations or employee negotiations;
- litigation or potential litigation, including matters before administrative tribunals, affecting the board;
- advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act; and
- for the purpose of educating or training the members (reference section 239, Subsection 3.1 of the *Municipal Act.)*

A meeting shall be closed to the public if the subject matter relates to the consideration of 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.
(1990, c. 25, s. 239 (3))

Before holding a meeting or part of a meeting that is to be closed to the public, a municipality or local board or committee of either of them shall state by resolution,

(a) the fact of the holding of the closed meeting and the general nature of the matter to be considered at the closed meeting; or

(b) in the case of education or training sessions, the fact of the holding of the closed meeting, the general nature of its subject-matter and that it is to be closed under article 239 subsection 3.1 of the *Municipal Act.*

Minutes of Board of Health, Finance Committee and Governance Committee meetings will be posted on Algoma Public Health's Website and emailed to each municipal clerk in Algoma Public Health's catchment area. Unapproved minutes will be marked unapproved and will be replaced with approved minutes when approved at the subsequent meeting.

Copies of Board records in the possession or under the control of the Secretary to the Board may also be made available to members of the public and shall be processed in accordance with the General Administrative Manual (GAM) policy for information requests. Payment of the costs of photocopying shall be in accordance with the Algoma Public Health fee schedule.

Municipal Freedom of Information and Protection of Privacy Act does not apply to a record of a meeting closed under subsection (3.1). 2006, c. 32, Sched. A, s. 103 (3) of the Municipal Act.

In the event that the APH receives a complaint relating to a closed Board of Health meeting the APH will utilize the services of the Ombudsman Ontario as the investigator when required in accordance with s.239 of the Municipal Act. (reference 03-08).

The Secretary to the Board of Health will ensure that members of the media covering Board meetings have access to relevant information.

Algoma Public Health – GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-030
DATE:	O: June 20, 2007 Reviewed: March 17, 2010 Reviewed: May 16, 2012 Reviewed; June 17, 2014	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	Board Member Code of Conduct

POLICY:

Each member of the Board of Health shall comply with the Code of Conduct for the District of Algoma Health Unit (operating as Algoma Public Health) to the best of their ability.

CODE OF CONDUCT:

As a member of the Board of Health for the District of Algoma Health Unit, the following code of conduct will be followed to ensure the efficient and effective discharge of duties while a member of the Board.

Board Members shall:

1) Adhere to all Board of Health bylaws and policies.

2) Represent the best interests of public and community health and the respective programs of Algoma Public Health.

3) Comply with conflict of interest guidelines and declare conflicts on agenda matters as appropriate.

4) Maintain confident, all matters of agency business except where permitted by law to disclose information publicly.

5) Interact with agency staff only through the Medical Officer of Health or the Chair of the Board.

6) Be prepared for meetings and participate productively.

7) Recognize that the Board of Health Chair speaks for the Board on public disclosures.

8) Interact with each other with respect and dignity.

9) Agree that the Board of Health Chair will mediate any disputes between Board members.

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: The Board of Health of Algoma

From: Tony Hanlon, Chief Executive Officer

Date: September 22, 2015

Re: Healthy Babies Healthy Children Program

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Algoma Public Health has not received a budget increase in the Healthy Babies Healthy Children (HBHC) Program since 2008. It is becoming more difficult to maintain the services required by the HBHC program. All mothers at risk are to be called within 48 hours of discharge from hospital. This program also includes coverage on weekends and holidays; however, without an increase in the budget the weekend services in the HBHC program may have to be removed to maintain the current budget.

RECOMMENDED ACTION:

That the Algoma District Board of Health supports a letter to the Minister of Children and Youth Services to advocate to fully fund all program costs related to the HBHC Program.

BACKGROUND:

The Healthy Babies Healthy Children (HBHC) program is a 100% funded Ministry of Child and Youth Services (MCYS) program provided by all 36 Ontario Boards of Health. Established in 1998, HBHC goals are to promote optimal physical, cognitive, communicative and psychosocial development in children through effective prevention and early intervention services for families as well as to act as a catalyst for coordinated, effective, integrated system of services and supports for healthy child development and family well-being though partnership and collaboration with a network of services providers. MCYS HBHC funding has been the subject of longstanding concern for many boards of health. HBHC has received no funding increase since 2008, which would reduce the programs ability to meet MCYS expectation for service.

Key components of HBHC include:

1. **Screening** of all families with children (prenatal to age 6) for any risks to healthy child development.
2. **Assessment** of families with children (prenatal to age 6) for level of risk to healthy child development.
3. **Postpartum support services,** including a phone call to all consenting families with newborns, the offer of a home visit, counseling, support, and information about community services on parenting and healthy child development.
4. **Referrals and/or Recommendations** to other services for families with children (prenatal to age 6) at risk of problems with healthy child development.
5. A blended model of **home visiting** service for families with children (prenatal to age 6) at high risk of problems with healthy child development, that includes visits from peer or lay home visitors as well as from public health nurses.
6. **Service planning and co-ordination** for families with children (prenatal to age 6) at high risk of problems with healthy child development.

In 2012, the HBHC protocol was enhanced resulting in several changes to programming including: a new HBHC screening tool, expansion of the HBHC database and increased targets. In 2013 there was the addition of 1.0 FTE Public Health Nurse (PHN) to achieve the new requirements associated with the HBHC Screen and liaison role, but due to the tasks associated with this PHN within the new protocol, there was no relief for the service delivery pressures within the program.

ASSESSMENT OF RISKS AND MITIGATION:

To this date we have delivered all expected services but have not been able to meet all projected targets with the ministry. The ministry has stated the targets are only benchmarks but in 2015 we were required to submit a Continuous Quality Improvement (CQI) form stating our plans for meeting the service targets. The proposed CQI plan supports increasing the targets which in turn increases workload without any increase in funding.

FINANCIAL IMPLICATIONS:

Without an increase in the budget for HBHC the weekend services may have to be removed.

OPHS STANDARD:

Family Health Program Standards

Reproductive and Child Health: Disease Prevention

The board of health shall provide all the components of the HBHC Protocol (2008) (or as current (Ministry of Child and Youth Services)

The 2012 HBHC Protocol has certain requirements under the Ontario Public Health Standards (OPHS) for the boards of health including:

1. Help ensure all the components of the HBHC program are implemented based on the OPHS HBHC Protocol and within their allocated resources.
2. Comply with the financial, administrative and program requirements of the service contract with the provincial government.
3. Manage the funds provided by the provincial government.
4. Hire, train and supervise Public Health Nurse and other professionals and lay home visitors who deliver the components of the HBHC program.
5. Co-ordinate with other professionals, agencies, and other organizations to ensure HBHC services are provided.
6. Develop effective working relationships/referral protocols with other professionals, agencies, and organizations (in particular hospitals), children's protection services and other partners.
7. Provide data and information required for regional or provincial monitoring and evaluations.
8. Monitor and analyze HBHC services and identify and resolve issues.
9. Participate and support a network of early years health and social service providers.
10. Promote the integration of early years programs and services within the community.

STRATEGIC DIRECTION:

The recommendations cited in this briefing note align to the Improve Health Equity, Collaborate Effectively, and Be Accountable strategic directions

CONTACT:

Leslie Wright Program Manager

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: Mr. Lee Mason, Chair, of the Algoma Board of Health

From: T. Hanlon, Chief Executive Officer

Date: September 22, 2015

Re: **Basic Income Guarantee - Resolution**

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Algoma Public Health (APH) recognizes that low income individuals and families face significant disparities in health status and overall opportunity, as compared to their higher income counterparts. In Algoma, 14.4% of residents live in low income situations, as compared to 13.9 % of Ontarians (2011 National Household Survey, after tax low income measure). Efforts to reduce poverty, such as providing a Basic Income Guarantee (BIG), will improve health for all people across the lifespan. APH believes that an important role of public health is to advocate for policy change and thereby supports the growing provincial and national movement to institute BIG as a poverty reduction strategy.

The purpose of this briefing note is to provide context and recommendations for the next steps to advocate for a basic income guarantee to advance health equity in Algoma.

RECOMMENDED ACTION:

1. That the Board of Health for Algoma receives the letter dated August 17, 2015 to Minister Eric Hoskins, from a group of 194 clinical and public health physicians asking that Ontario be considered for a BIG demonstration project.
2. That the Board of Health for Algoma endorses the resolution to support the recommendations outlined in the letter to Minister Hoskins.
3. That the Board of Health for Algoma endorses an internal and external community awareness campaign around promoting BIG as a poverty reduction strategy in Algoma.

BACKGROUND:

Basic income guarantee (BIG), also known as a guaranteed annual income, is a cash transfer from government to citizens not tied to labour market participation (Pasma and Mulvale, 2009; Basic Income Canada Network, 2015). It ensures income at a level sufficient to meet basic needs and live with dignity, regardless of work status (Basic Income Canada Network, 2015). Basic income is premised on the vision of universal income security through ensuring that everyone receives a modest, but adequate income (Pasma and Mulvale, 2009). There are a number of models for implementing BIG.

Income inequality continues to increase in Ontario and Canada, while current income security programs by provincial and federal governments have not proved sufficient to ensure adequate, secure income for all. Basic income resembles income guarantees currently provided in Canada for seniors (Old Age Security) and children (National Tax Benefit), which have contributed to health improvements in those age groups. A basic income guarantee ensures that everyone has sufficient income to meet basic needs and live with dignity, regardless of work status.

SUMMARY

Basic income guarantee is gaining momentum across Canada from various sectors and political backgrounds. The Association for Local Public Health Agencies, among other provincial and national organizations, have endorsed BIG as an effective poverty reduction strategy.

Sending a letter of support to Minister Hoskins and endorsing a BIG awareness campaign in Algoma will assist our public health counterparts in building their case.

FINANCIAL IMPLICATIONS:

The current allocated health equity PHN time will support actions outlined in the Basic Income Guarantee resolution.

OPHS STANDARD:

“A key component of the requirements outlined in the Ontario Public Health Standards is to identify and work with local priority populations``. (OPHS 2008)

STRATEGIC DIRECTION:

The recommendations cited in this briefing note align to the Enhancing Health Equity and Collaborate Effectively strategic directions.

CONTACT:

Laurie Zeppa, Director of Community Services and Chief nursing Officer

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: The Board of Health

From: Tony Hanon, Ph.D., Chief Executive Officer

Date: September 22, 2015

Re: Reducing Smoking Rates by 5% in 5years in the District of Algoma

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☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Algoma Public Health recognizes that lung cancer rates and smoking prevalence are significantly higher in Algoma than in Ontario. The 2011-2012 cycle of the Canadian Community Health Survey, identifies current smokers, age 12 or older who have smoked at least 100 cigarettes in their lifetime and have smoked in the past 30 days, as 23.6% in Algoma compared to 17.8% for Ontario. Smoking prevalence for the district is also higher than our north eastern health unit counterparts in North Bay and Sudbury. There has been no measurable decline in Algoma's smoking rates since 2005.

RECOMMENDED ACTION:

1. That the Board of Health for Algoma endorses the call to action outlined in the 2015 Cancer report, to reduce smoking rates across the district of Algoma by 5% over the next 5years in order to bring them more in line with the provincial average and help to reduce health inequities in the prevention of cancer
2. That the Board of Health endorses a strategy that engages community partners including those from health care, education, and the private sector to support the implementation of a 5 year smoking reduction plan across the district
3. That the Board of Health for Algoma endorses the development of an internal and external branded communication strategy directed at smokers to make quit smoking attempts
4. That the Board of Health for Algoma endorses a proposal submission in partnership with the Ontario Tobacco Research Unit to the Ministry of Health to fund a 5 year smoking reduction strategy
5. That the Board of Health for Algoma endorses a request to municipalities and townships across the district of Algoma to pass resolutions that support a call to action and district-wide strategy to reduce smoking rates by 5% over the next 5years

BACKGROUND:

- The 2015 Cancer Report released by Algoma Public early in 2015 highlighted the necessity for aggressive action to combat the districts high lung cancer rates
- The report released to the public and key stakeholders emphasized a "Call to Action" by Algoma Public Health to set and work towards a goal to reduce smoking rates by 5% in 5 years
- The Ontario Tobacco Research Unit was enlisted to provide consultation support to Algoma Public Health in completing a situation assessment and plan
- Rough estimates suggest that 100,000 cumulative quit attempts by the approximately 22,000 smokers in Algoma are needed to achieve a five percentage point reduction in prevalence over a five year period.
- Algoma Public Health has reached out to key stake holders from healthcare, education and the private sector from across Algoma to join a collaborative partnership that would together develop a strategy to reach this ambitious goal
- The OTRU is leading this Algoma Partnership in submitting a proposal to the Ministry of Health for funding. With such a bold, multiyear, district-wide cessation strategy additional fiscal support will be valuable to the success of this call to action
- Although continued efforts to prevent youth from starting to smoke remains vital, the proposed 5% reduction in smoking rates over five years can only be achieved by significantly increasing the successful quit attempts among people who currently smoke.

ASSESSMENT OF RISKS AND MITIGATION:

No conceivable risks are identified at this time

FINANCIAL IMPLICATIONS:

- The request for funding proposal being submitted by the Ontario Tobacco Research Unit(OTRU) on behalf of a partnership initiative with Algoma Public Health is due on September 26, 2015
- Any monies received from this joint submission for funding from the Ministry to support a 5% in 5years smoking reduction strategy will be managed by the Ontario Tobacco Research Unit
- Funds would flow from OTRU to Algoma Public Health to support the initiative outlined in the proposal's work plans.
- The strategy would be lead locally by the existing tobacco control coordinator and a team of staff including the communication specialist, epidemiologist and those with expertise in supporting smoking cessation across communities in Algoma

OPHS STANDARD:

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

- Comprehensive Tobacco Control - requirement 1
- Cessation - Requirement 3, 9, 10 and 12

STRATEGIC DIRECTION:

Strategic Directions: Collaborate Effectively, Improve health Equity

CONTACT:

Laurie Zeppa, Director of Community Services and Chief Nursing Officer

Algoma PUBLIC HEALTH
Santé publique Algoma

www.algomapublichealth.com

Briefing Note

To: The Board of Health of Algoma

From: Tony Hanlon, Chief Executive Officer

Date: September 22, 2015

Re: Prenatal & Postnatal Nurse Practitioner Program (PPNP)

☒ For Information ☒ For Discussion ☒ For a Decision

ISSUE:

In June 2014, Algoma Public Health's Prenatal and Postnatal Nurse Practitioner (PPNP) services were discontinued as the nurse practitioner at the time resigned. The position remains unfilled to this date, due to a lack of applicants and little to no community demand.

RECOMMENDED ACTION:

To discontinue the PPNP program offered at Algoma Public Health in Sault Ste. Marie.

BACKGROUND:

The Prenatal and Postnatal Nurse Practitioner (PPNP) program was first established in 2001 to support the provision of primary health care by a nurse practitioner (NP) through public health units in under serviced areas where there were barriers to accessing primary care services for pregnant women and parents/caregivers and families with children under the age of 6.

In 2003, Algoma Public Health secured program funding through the Ministry of Children and Youth Services (MCYS) to implement a local PPNP program in Sault Ste. Marie.

Until June 2014, when the nurse practitioner resigned, APH provided full time NP services to pregnant women and those women with children under the age of 6. After the NP's resignation, a recruitment phase was undertaken but no applications were received.

In November 2014, an inquiry was made about the position. At that point, a scan of calls received on the Parent Child Information Line (PCIL) and anecdotal information received from both the hospital liaison and 48hr home visiting public health nurses indicated that there was little to no community demand for primary care from pregnant women and women with children under the age of 5. Additionally, contact was made with the Group Health Centre who confirmed that there were "many" family practitioners within our community accepting newborn patients.

In February and March 2015 conversations with the MCYS and APH representatives, including Director of Community Services occurred to discuss the status of Sault Ste. Marie's PPNP program. Expansion of the program was mentioned however it was not an option at that time. It was agreed upon that we would collaborate with our internal epidemiologist to evaluate available client data, consider anecdotal information and develop a client survey to best inform the next steps.

In June 2015 a survey using convenience sampling was administered by APH staff working in program areas where women who were currently accessing services were likely to be pregnant or have children under the age of 5. Of the 66 respondents, 81% of women confirmed having a primary care provider for both themselves and their children, 4.8% confirmed having a primary care provider for their children but not themselves, and 14.3% pregnant women reported not having access to a primary care provider.

Reports were generated using our internal electronic health records for clients accessing NP services from April 2012 to March 2014. These showed a decrease in client visits, new clients, and unique clients, and an increase in prenatal client visits. However, prenatal client visits were almost exclusively for the purposed of obtaining a referral to an OB/GYN.

On September 10, 2015 APH engaged in a second conversation with MCYS to review current data and discuss options to explore expansion of current services. At this time MCYS indicated that they are not in a position to change the policy of this program.

ASSESSMENT OF RISKS AND MITIGATION:

Some of the potential risks associated with discontinuing the PPNP program:

- A small percentage of potential clients that fit the PPNP criteria will need to access other options for primary health care.
- Staff reduction will not need to be addressed as APH does not currently have a nurse practitioner in this position. However, this will be a loss of a specific ONA position.

FINANCIAL IMPLICATIONS:

No financial implications exist for APH as this is a program that is 100% funded through the Ministry of Children and Youth Services.

STRATEGIC DIRECTION:

The recommendations cited in this briefing note align to the Improve Health Equity and Collaborate Effectively strategic directions.

CONTACT:

Laurie Zeppa, Director of Community Services and Chief Nursing Officer

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
(519) 271-7600 • www.pdhu.on.ca

Hon. Kathleen O. Wynne, Premier
Legislative Bldg Rm 281
Queen's Park
Toronto, ON
M7A 1A1

June 19, 2015

Dear Premier Wynne,

RE: Ontario Grades 1-12 Health and Physical Education Curriculum "Human Development and Sexual Health" Content

On behalf of the Board of Health of the Perth District Health Unit, I am writing this letter to congratulate your government for releasing the new Ontario Grades 1-12 Health and Physical Education Curriculum, including the updated "Human Development and Sexual Health" content.

The proposed curriculum changes primarily relate to creating awareness and a culture of respect regarding diversity, including visible and invisible differences, sexual orientation, and gender identity. Since 1998, there have been numerous reports written that support the critical need for education and awareness-raising on diversity, and for the elimination of bullying related to visible and invisible differences. Ontario must support the development of positive self-concept in all our children and youth.

In relation to the sexual health content of the new curriculum, it focuses on developing skills amongst children and youth to navigate the pressures they will be exposed to in our society. The prevention of sexually transmitted infections and the promotion of healthy sexuality are priorities for public health, and this curriculum utilizes the most current understanding in these areas.

We support the "Human Development and Sexual Health" content as proposed and thank you sincerely for your perseverance in addressing challenges. Locally, we have collaborated with our partner school board to create a low literacy information sheet to allay the anxieties of our Anabaptist population (enclosed). We will also be participating in a community information meeting to respond to questions and concerns.

Respectfully yours,

Dr. Miriam Klassen
Medical Officer of Health

Ms. Teresa Baressi
Board Chair

MK/mr

c. Hon. Liz Sandals, Minister of Education
Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
ADM (Acting) Martha Greenberg, Health Promotion Division
Parliamentary Assistant, Ministry of Children and Youth Services
Mr. Randy Pettapiece, MPP Perth-Wellington
Boards of Health of Ontario Public Health Units

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June 30, 2015

VIA ELECTRONIC MAIL

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th floor, 56 Wellesley StreetWest
Toronto, ON M5S 2S3

Dear Minister MacCharles:

Re: Healthy Babies Healthy Children Program

The Healthy Babies Healthy Children (HBHC) program is a 100% funded Ministry of Child and Youth Services (MCYS) program provided by all 36 Ontario Boards of Health. Established in 1998, HBHC supports healthy child development by identifying vulnerable families and providing or connecting them with appropriate supports.

As with many boards of health across the province, the Sudbury & District Board of Health has been increasingly challenged to meet Ministry expectations for HBHC service provision within the l00% funding envelope. At its meeting on June 18, 2015, the Board of Health carried the following resolution #28-15:

> *WHEREAS the Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and*
>
> *WHEREAS the Healthy Babies Healthy Children program is a mandatory program for Boards of Health; and*
>
> *WHEREAS in 1997 the province committed to funding the Healthy Babies Healthy Children program at 100% and the HBHC budget has been flat-lined since 2008; and*
>
> *WHEREAS collective agreement settlements, travel costs, pay increments and accommodation costs have increased the costs of implementing the HBHC program, the management and administration costs of which are already offset by the cost-shared budget for provincially mandated programs; and*
>
> *WHEREAS the HBHC program has made every effort to mitigate the outcome of the funding shortfall, this has becoming increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided.*

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health direct staff to prepare a budget and program analysis of the HBHC program, outlining pressures and options for mitigation, detailing program and service implications of these options as compared against MCYS expectations; and

FURTHER THAT the Sudbury & District Board of Health advocate strongly to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.

FURTHER THAT this motion be forwarded to the Association of Local Public Health Agencies, the Chief Medical Officer of Health and all Ontario Boards of Health.

It remains our priority to ensure that the HBHC program can effectively identify and support children and families most in need throughout the Sudbury/Manitoulin District. We look forward to further dialogue with MCYS on how we can best achieve this goal together.

Thank you for your attention to this important public health issue.

Sincerely,

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

cc: Chief Medical Officer of Health (Acting)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

August 6, 2015

The Honourable Tracy MacCharles
Minister of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto ON M5S 2S3

Dear Minister MacCharles:

Re. Healthy Babies Healthy Children Program

On July 24, 2015 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached resolution from Sudbury District Health Unit regarding the Healthy Babies Healthy Children Program. The following motion was passed:

Motion No: 2015-62

Moved by: David Shearman **Seconded by: Gary Levine**

"That the Board of Health for the Grey Bruce Health Unit supports the resolution from Sudbury and District Health Unit advocating to the Minister of Children and Youth Services to fully find all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs."

Carried

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: All Ontario Boards of Health

Encl.

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June 30, 2015

VIA ELECTRONIC MAIL

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th floor, 56 Wellesley StreetWest
Toronto, ON M5S 2S3

Dear Minister MacCharles:

Re: Healthy Babies Healthy Children Program

The Healthy Babies Healthy Children (HBHC) program is a 100% funded Ministry of Child and Youth Services (MCYS) program provided by all 36 Ontario Boards of Health. Established in 1998, HBHC supports healthy child development by identifying vulnerable families and providing or connecting them with appropriate supports.

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WHEREAS the Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and

WHEREAS the Healthy Babies Healthy Children program is a mandatory program for Boards of Health; and

WHEREAS in 1997 the province committed to funding the Healthy Babies Healthy Children program at 100% and the HBHC budget has been flat-lined since 2008; and

WHEREAS collective agreement settlements, travel costs, pay increments and accommodation costs have increased the costs of implementing the HBHC program, the management and administration costs of which are already offset by the cost-shared budget for provincially mandated programs; and

WHEREAS the HBHC program has made every effort to mitigate the outcome of the funding shortfall, this has becoming increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided.

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health direct staff to prepare a budget and program analysis of the HBHC program, outlining pressures and options for mitigation, detailing program and service implications of these options as compared against MCYS expectations; and

FURTHER THAT the Sudbury & District Board of Health advocate strongly to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.

FURTHER THAT this motion be forwarded to the Association of Local Public Health Agencies, the Chief Medical Officer of Health and all Ontario Boards of Health.

It remains our priority to ensure that the HBHC program can effectively identify and support children and families most in need throughout the Sudbury/Manitoulin District. We look forward to further dialogue with MCYS on how we can best achieve this goal together.

Thank you for your attention to this important public health issue.

Sincerely,

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

cc: Chief Medical Officer of Health (Acting)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

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June 30, 2015

VIA ELECTRONIC MAIL

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

Dear Minister Hoskins:

Re: Enforcement of the Immunization of School Pupils' Act (ISPA)

Enforcement by the Sudbury & District Board of Health of the July 2014 legislative changes to the ISPA has highlighted significant challenges for local public health with respect to duplicate and incomplete immunization records. This is in part due to the fact that health care providers are not required to report immunizations to the Medical Officer of Health.

At its meeting on June 18, 2015, the Sudbury & District Board of Health carried the following resolution #25-15:

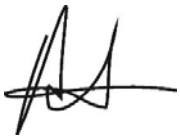
> *WHEREAS each public health unit in Ontario is required to enforce the Immunization of School Pupils Act by assessing and maintaining immunization records of school pupils (students) each year; and*
>
> *WHEREAS parents/guardians whose child(ren) receive vaccine at a health care provider other than public health are required to provide notification of their child's immunizations to their local public health unit; and*
>
> *WHEREAS healthcare providers are not required under the provisions of the Health Protection and Promotion Act to report immunizations to the Medical Officer of Health; and*
>
> *WHEREAS incomplete immunization records create significant challenges to the enforcement of the ISPA indicated by the numbers of students suspended from attendance at school under the Act, as well as parental and guardian frustration;*
>
> *THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health recommend to the Minister of Health and Long Term Care that amendments to provincial regulations be made requiring health care providers to report to the Medical Officer of Health all immunizations administered to patients under 18 years of age.*

FURTHER THAT the Sudbury & District Board of Health advocate to the Minister of Health and Long Term Care for the integration of all health care provider electronic immunization records onto a common electronic data base to ensure efficient and accurate sharing of immunization records.

FURTHER THAT this motion be forwarded to the Association of Local Public Health Agencies, and to Ontario Boards of Health.

The Board of Health for the Sudbury & District Health Unit takes seriously its responsibility to promote and protect the health of children. The Board believes that measures to enable the accurate and timely reporting of immunizations by all health care providers for all children attending school in Ontario will greatly assist in the effectiveness and efficiency of the Board's responsibility.

Sincerely,



Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health

cc: Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

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June 30, 2015

VIA ELECTRONIC MAIL

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
Email: premier@ontario.ca

Dear Premier Wynne:

Re: Northern Ontario Evacuations of First Nations Communities

At its meeting on June 18, 2015, the Sudbury & District Board of Health carried the following resolution #32-15:

WHEREAS the evacuation and relocation of residents of a number of First Nations communities in Northwestern Ontario and along the James Bay Coast, is required on a close to annual basis due to seasonal flooding and risk of forest fires; and

WHEREAS a safe, effective, and efficient temporary community relocation is challenging within the current reactive model; and

WHEREAS a proactive, planned and adequately resourced evacuation system would ensure the maintenance of quality evacuation centers in pre-selected host municipalities, as well as appropriate infrastructure to ensure the health and safety of evacuees in a culturally acceptable manner; and

WHEREAS the Thunder Bay District Board of Health passed a motion on March 18, 2015, and has submitted a letter dated April 10, 2015 to the Honourable Kathleen Wynne requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires;

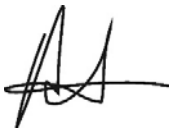
THEREFORE BE IT RESOLVED THAT the Sudbury and District Board of Health support the Thunder Bay District Board of Health's resolution 50-2015 dated March 18, 2015; and

FURTHER THAT a copy of this motion be forwarded to the Premier of Ontario, Ministers responsible for Health and Long-Term Care, Community Safety and Correctional Services, Aboriginal Affairs, Northern Development and Mines, Natural Resources and Forestry, local area Members of Provincial Parliament and all Ontario Boards of Health.

It is the Board's hope that you will seriously consider the need for a proactive, planned and adequately resourced evacuation system which would ensure the safe, efficient and effective temporary relocation of First Nation communities in Northwestern Ontario and the James Bay coast when these communities are threatened by seasonal flooding and risk of forest fires.

Thank you for your attention to this important public health issue.

Sincerely,



Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Yasir Naqvi, Minister Community Safety and Correctional Services
Hon. David Zimmer, Minister of Aboriginal Affairs
Hon. Michael Gravelle, Minister of Northern Development and Mines
Hon. Bill Mauro, Minister of Natural Resources and Forestry
Hon. Glenn Thibeault, MPP Sudbury
Hon. France Gélinas, MPP Nickel Belt
Linda Stewart, Executive Director, Association of Local Public Health Agencies

August 6, 2015

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

Dear Premier Wynne:

Re. Northern Ontario Evacuations of First Nations Communities

On July 24, 2015 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached resolution from Sudbury District Health Unit regarding Evacuations of First Nations Communities in Northern Ontario. The following motion was passed:

Motion No: 2015-63

Moved by: David Shearman Seconded by: Gary Levine

"WHEREAS the Thunder Bay District Board of Health passed a resolution on March 18, 2015, and has submitted a letter dated April 10, 2015 to the Honorable Kathleen Wynne requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires; and

WHEREAS the Sudbury District Health Unit supported this resolution at its meeting on June 18, 2015;

THEREFORE BE IT RESOLVED that the Board of Health for the Grey Bruce Health Unit support the Thunder Bay District Board of Health's resolution 50-2015 dated March 18, 2015"

Carried

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: All Ontario Boards of Health

Encl.

Sudbury & District

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June 30, 2015

VIA ELECTRONIC MAIL

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
Email: premier@ontario.ca

Dear Premier Wynne:

Re: Northern Ontario Evacuations of First Nations Communities

At its meeting on June 18, 2015, the Sudbury & District Board of Health carried the following resolution #32-15:

WHEREAS the evacuation and relocation of residents of a number of First Nations communities in Northwestern Ontario and along the James Bay Coast, is required on a close to annual basis due to seasonal flooding and risk of forest fires; and

WHEREAS a safe, effective, and efficient temporary community relocation is challenging within the current reactive model; and

WHEREAS a proactive, planned and adequately resourced evacuation system would ensure the maintenance of quality evacuation centers in pre-selected host municipalities, as well as appropriate infrastructure to ensure the health and safety of evacuees in a culturally acceptable manner; and

WHEREAS the Thunder Bay District Board of Health passed a motion on March 18, 2015, and has submitted a letter dated April 10, 2015 to the Honourable Kathleen Wynne requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires;

THEREFORE BE IT RESOLVED THAT the Sudbury and District Board of Health support the Thunder Bay District Board of Health's resolution 50-2015 dated March 18, 2015; and

FURTHER THAT a copy of this motion be forwarded to the Premier of Ontario, Ministers responsible for Health and Long-Term Care, Community Safety and Correctional Services, Aboriginal Affairs, Northern Development and Mines, Natural Resources and Forestry, local area Members of Provincial Parliament and all Ontario Boards of Health.

It is the Board's hope that you will seriously consider the need for a proactive, planned and adequately resourced evacuation system which would ensure the safe, efficient and effective temporary relocation of First Nation communities in Northwestern Ontario and the James Bay coast when these communities are threatened by seasonal flooding and risk of forest fires.

Thank you for your attention to this important public health issue.

Sincerely,

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Yasir Naqvi, Minister Community Safety and Correctional Services
Hon. David Zimmer, Minister of Aboriginal Affairs
Hon. Michael Gravelle, Minister of Northern Development and Mines
Hon. Bill Mauro, Minister of Natural Resources and Forestry
Hon. Glenn Thibeault, MPP Sudbury
Hon. France Gélinas, MPP Nickel Belt
Linda Stewart, Executive Director, Association of Local Public Health Agencies

DURHAM REGION

June 25, 2015

The Regional Municipality of Durham

Corporate Services Department - Legislative Services

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Matthew L. Gaskell
Commissioner of Corporate Services

The Right Honourable Stephen Harper
Prime Minister
House of Commons
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RE: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated June 4, 2015 re: National Alcohol Strategy Advisory Committee (NASAC) (Our File No. P00)

Honourable Sir, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on June 24, 2015 Council adopted the following recommendations of the Committee:

"A) That the correspondence dated May 7, 2015 from Peterborough's Board of Health's Chair, urging the Government of Canada to continue to support the work of the NASAC be endorsed; and

B) That the Prime Minister of Canada, Minister of Health Canada, Durham's MPs, and all Ontario Boards of Health be so advised."

Deb Bowen

D. Bowen, AMCT
Regional Clerk/Director of Legislative Services

DB/np

c: The Honourable Rona Ambrose, Minister of Health
Dr. Colin Carrie MP(Oshawa)
Ms Pat Perkins, MP (Whitby/Oshawa)
The Honourable Chris Alexander, MP (Ajax/Pickering)
Mr. Corneliu Chisu, MP (Pickering/Scarborough East)
Mr. Barry Devolin MP (Haliburton/Kawartha Lakes/Brock)
Mr. Erin O'Toole, MP (Durham – Clarington/Scugog/Uxbridge)
Ontario Boards of Health
R.J. Kyle, Commissioner & Medical Officer of Health

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

"Service Excellence for our Communities"

Peterborough County-City
HEALTH UNIT
...because health matters!

May 7, 2015

The Right Honourable Stephen Harper
Prime Minister of Canada
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Hon. Rona Ambrose, P.C., M.P.
Minister of Health
Brooke Claxton Building, Tunney's Pasture
Postal Locator: 0906C
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Dear Prime Minister Harper and Minister Ambrose:

Re: Continued support for the implementation of Canada's National Alcohol Strategy

On behalf of the Board of Health of the Peterborough County-City Health Unit in Ontario, I am writing to express appreciation for your commitment to the prevention of harms caused by the use and misuse of alcohol and to encourage continued and enhanced support.

The work of the National Alcohol Strategy Advisory Committee (NASAC) has been made possible mainly via Health Canada's support. The resources provided have been integral to the achievements made by the NASAC which enhances the success of organizations with similar mandates, such as ours, across Canada.

Since 2008, the NASAC has undertaken the multifaceted and intricate task of reducing alcohol-related harms through their efforts to implement the 41 recommendations of Canada's National Alcohol Strategy. This initiative allows all stakeholders to take collective action through multi-sector partnerships and a shared responsibility. As a result, duplication is avoided and reach and impact are maximized. Even though the efforts of the NASAC take a national scope, their approach also serves as a model for stakeholders at provincial, regional or municipal levels to emulate. The province of Ontario is taking this approach through the report called Addressing Alcohol Consumption and Related Harms at the Local Level and the Peterborough County-City Health Unit is following suit working to create a local strategy to address alcohol in our community that is complimentary to this work.

It is well established that alcohol is no ordinary commodity and that it is associated with considerable health and social costs that impacts individuals, communities and populations. Therefore, it is vital to understand the risks involved and how to minimize those risks. The path

10 Hospital Drive, Peterborough, ON K9J 8M1 P: (705) 743-1000 or 1-877-743-0101 F: (705) 743-2897 www.pcchu.ca

August 17, 2015

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

Dear Minister Hoskins:

We, the undersigned, are 194 physicians providing clinical and public health services in Ontario. We are seeking your leadership in advancing consideration by the Ontario government for introducing a basic income guarantee (BIG) for the people of Ontario. More specifically, we ask for you to encourage the Ontario government, in support of the Poverty Reduction Strategy and the health of Ontarians, to establish a BIG trial program or demonstration project. We would welcome a meeting with you to discuss a BIG for Ontarians and options for advancing this idea, e.g., striking an experts group to study basic income in depth and to help design a trial program or demonstration project.

The government's commitment to poverty reduction positions Ontario to model basic income for Canada, and the world, in the 21st century. We are confident that a BIG trial or demonstration would be highly complementary to the government's current array of measures to combat poverty and social exclusion in Ontario.

As physicians we regularly witness what the Canadian Medical Association has attested, that "income is the great divide when it comes to Canadians' health."[1] So profound is the income-health nexus that Ontario family physicians are now taught to prescribe income-based solutions to the health problems of low income patients.[2] As well, the University of Toronto undergraduate medical program includes seven mandatory hours of teaching focused specifically on this issue. As one of us has written:

> *The link between health and income is solid and consistent—almost every major health condition, including heart disease, cancer, diabetes, and mental illness, occurs more often and has worse outcomes among people who live at lower income. As people improve their income, their health improves. It follows that improving my patients' income should improve their health.*[3]

We appreciate how the government is trying to improve the well-being of lower income Ontarians. Progress has been made but great strides are still needed, as evidenced by a child poverty rate of 19.9% for Ontario in 2012[4], representing 550,000 children.[5] Research has clearly shown that the experience of poverty in early childhood can lead to

what is termed "toxic stress", with profound implications for physical and mental health from childhood through to adulthood.[6] This evidence alone suggests the imperative of a BIG for Ontario's children and their families.

More is needed to improve social security for Ontarians. In this context we note that the 2014 Mandate Letter given to you by Premier Wynne asks "that you explore long-term options for a sustainable program that provides health benefits to lower-income Ontarians."[7] In our view, this directive provides an opening for the government to explore the idea of establishing a BIG trial program or demonstration project, a move which could eventually lead to significant health and social improvements for all Ontarians, and especially those living at or vulnerable to low income. Surely this is one of the most upstream and sustainable of health interventions.

As defined by Basic Income Canada Network (BICN), a BIG "ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status." As BICN further explains, a BIG for all:

> *"ensures that everyone can meet their needs, participate in society and live with dignity. It reduces steep income inequalities and contributes to better health and fewer societal problems, opening the door to long-term savings in health care and other public services. It enables people to manage transitions and setbacks, supports creativity and entrepreneurship, and keeps money moving and producing in our economy."*[8]

As Barry Ward, Chair of the Simcoe Muskoka District Health Unit, wrote in the Unit's recent letter to you et al.[9]:

> *Basic income is a concept that has been examined and debated for decades, including through pilot projects in the United States, Canada, and other countries more recently.*[10,11] [The Dutch city of Utrecht is currently embarking on its own test of basic income.[12]] *As you may be aware, Mincome, in particular, was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in the 1970s, which demonstrated several improved health and educational outcomes.*[13] *Basic income also resembles income guarantees currently provided in Canada for seniors and children, which have contributed to health and social improvements in those age groups.*[14,15]

We anticipate that policy makers will continue to place great emphasis on job creation and employment readiness as central to combating poverty. Of course, everything that

can practically be done to create and maintain employment should be pursued. The reality, however, is that labour is undergoing profound change due globalization, outsourcing and automation. This change is giving rise to a swelling "precariat"—those whose participation in the labour market is precarious. Twenty-two percent of jobs in Ontario are in this category[16] and in Canada's urban heartland in and around Toronto, "[t]his type of employment has increased by nearly 50% in the last 20 years. Another 20% are in employment relationships that share at least some of the characteristics of precarious employment."[17]

As BICN states, a BIG "safeguards the future as automation transforms the way people work and live together."[18] And as Barry Ward wrote (in his recent letter to you et al.):

> *"*[i]*n addition to providing an effective policy response to poverty and inequality, a basic income guarantee would be a key societal support in the face of rising precarious employment in Canada. Given the trend towards fewer opportunities for secure, permanent jobs, providing living wages and benefits, a basic income guarantee could help buffer the effects of precarious employment by providing a form of 'disaster insurance' that protects people from slipping into poverty during challenging times."*[19]

We recognize that, optimally, the federal government would be involved in establishing a BIG for all in Canada, in cooperation with the provinces and territories. While we are hopeful that a future federal government will demonstrate leadership for a BIG, we believe that Ontario could act on its own (as analysis by Toronto-based social policy expert John Stapleton suggests[20])—at the very least moving forward with a focused, well-designed and evaluated trial program or demonstration project.

Indeed, an initial trial or project would help to inform program design considerations in the phase of full implementation. It would help identify how a BIG could best intersect with other parts of health and social systems. It would also help evaluate the cost savings in health and elsewhere to make the case for a larger national shift.

The establishment of a BIG for Ontarians would be a magnificent legacy for those with the vision to act, and the Ontario government has an opportunity to be the provincial groundbreaker and innovator for this policy. We would be pleased to help you and your colleagues in thinking about how to move this forward. Please advise if a delegation from our ranks can meet with you soon to discuss this idea. Thank you for your consideration and we look forward to hearing from you: please direct your response to Philip Berger, MD (bergerp@smh.ca) and Lisa Simon, MD (lisa.simon@smdhu.org).

Sincerely,

On behalf of the 194 physician signatories listed on the attached pages

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Cc. Hon. Kathleen Wynne, Premier
Hon. Deb Matthews, Deputy Premier, President of the Treasury Board, Minister Responsible for the Poverty Reduction Strategy

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References

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[20] http://vibrantcanada.ca/blogs/john-stapleton/they-cant-we-can#segal

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Ontario

9i) Attachment

AUG 10 2015

(1) BOH correspondence SL

Mr. Robert P. MacLean
Clerk-Treasurer
The Corporation of the Town of Thessalon
187 Main Street
P.O. Box 220
Thessalon ON P0R 1L0

Dear Mr. MacLean:

Thank you for your letter dated November 13, 2014, in support of Algoma Public Health Unit's resolution to maintain preventive oral health services in the *Ontario Public Health Standards* (OPHS), and regarding the Low Income Dental Integration (LIDI) commitment through which six publicly funded provincial dental programs will be integrated into one program for low income children and youth. I value your input and the time you have taken to express your concerns. I do apologize for the delay in responding.

As you know, in December 2013, the government of Ontario announced that it would streamline six oral health programs and/or benefits for children and youth from low-income families into a single 100 per cent provincially-funded program. A number of concerns related to this commitment were raised with respect to eligibility once the programs were integrated and the aggressiveness of the implementation time lines.

I want to reassure you that I have heard your concerns and they have been addressed. The advice of the public health and other sectors has been invaluable as work proceeds.

On May 29, 2015, my ministry announced that to successfully implement the new integrated dental program, the full implementation date will be extended to January 2016. The decision was made after thorough consultation and collaboration with our valued delivery partners, including the public health units (PHUs) to best inform and guide implementation of this streamlined program. While I feel it is important for children and families to benefit from this initiative as soon as possible, I share your commitment to getting it right.

As such, I am pleased to reassure you that this new date does not impact those children currently enrolled in existing dental programs. Also, children who are currently eligible for free dental services will continue to be eligible in the new integrated program. The announcement is available on my ministry's website at:
http://www.health.gov.on.ca/en/news/bulletin/2015/hb_20150529_1.aspx.

...2

Mr. Robert P. MacLean

I understand that the shift in implementation date, at this point, may have implications for PHU budgets for the 2015 fiscal year. My ministry staff will work closely with each health unit to mitigate these potential impacts and ensure that all health units are able to continue to meet the needs of the current programs until the launch of the integrated program, taking place in January 2016.

The new integrated program will provide a simplified enrolment and renewal process and access to a full range of oral health services, from preventive care, such as cleanings and fluoride treatments to basic care such as fillings, extractions and x-rays. The integration of these six oral health programs will also help build community capacity to deliver oral health prevention and treatment services to children and youth from low-income families in Ontario. Providing more children and youth with access to free dental care is part of Patients First: Action Plan for Health Care, and Ontario's Poverty Reduction Strategy.

The new integrated program will also ensure that currently eligible children will continue to be eligible in the future state integrated program. This will include ensuring that they have access to preventive services as well as emergency and essential care.

With respect to preventive services, PHUs will be asked to assess eligibility for preventive services which will be available to clinically eligible children whose families attest to financial hardship. The services that will be included in this component of the program have been considered by the Dental Services Schedule Review Expert Panel (DSSREP) based on the three services currently in the Preventive Services Protocol of the OPHS. This approach will, in fact, make more children eligible than in the current state under the Protocol which currently defines financial eligibility as one of the following: enrollment in the Children in Need of Treatment Program (CINOT) program; the child is a dependent of a recipient of the Ontario Child Benefit, or the family's income is below the financial eligibility cut-off (the cut-off is set at 20 per cent above Statistic Canada's low income cut-offs).

In terms of urgent, or emergency and essential, treatment, access to this stream of the program will continue to be based on clinical need and attestation of financial hardship. The DSSREP has been asked to provide advice regarding a definition of urgent need as well as a related basket of services. The DSSREP has provided its advice to government which includes advising that children should be provided with access to an appropriate course of treatment to fully address the urgent need. Providers will also have the discretion to be able to provide additional treatment to children where other clinical needs would soon become urgent if not addressed. Further operational details related to this component of the program will continue to be developed once advice from the DSSREP is received. My ministry will also provide further direction to PHUs on a common approach to be employed to assess financial hardship for preventive and urgent treatment.

Ongoing engagement and dialogue with key stakeholders will continue through the LIDI Implementation Technical Advisory Committee and the Service Schedule Review Expert Panel. My ministry will also provide updates to PHUs through regularly scheduled Chief Medical Officer of Health teleconferences.

...3

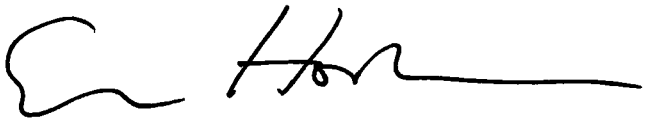
Mr. Robert P. MacLean

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

Providing free dental care and helping to break down barriers for low-income children and youth is part of Ontario's Poverty Reduction Strategy. To date, more than 47,000 children and their families have been lifted out of poverty, and between 2008 and 2011, 61,000 were prevented from falling into poverty. In fact, the child poverty rate in Ontario fell from 15.2 per cent in 2008 to 13.6 per cent in 2011. Ensuring that children have the ability to escape the cycle of poverty is a priority for this government.

Again, thank you for writing to me. Your level of commitment to Ontario's children and advocacy is appreciated. I look forward to your continued advice and collaboration as this work continues.

Yours sincerely,



Dr. Eric Hoskins
Minister

c: Dr. Kimberly Barker, Medical Officer of Health, Algoma Public Health

August 6, 2015

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

Dear Dr. Hoskins:

Re. Smoke-Free Multi-Unit Housing

On June 26, 2015 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached resolution from Perth District Health Unit regarding smoke-free multi-unit housing. The following motion was passed:

Motion No: 2015-49

Moved by: Mitch Twolan **Seconded by: John Bell**

"That the Board of Health for the Grey Bruce Health Unit support the resolution from Perth District Health Unit regarding smoke-free multi-unit housing."

Carried

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: Minister of Municipal Affairs and Housing
All Ontario Boards of Health

Encl.

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
519-271-7600 Fax 519-271-2195
www.pdhu.on.ca

May 19, 2015

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

Dear Minister Hoskins,

The Perth District Health Unit Board recently considered a request for action for Smoke-free Multi-unit Housing. The following resolution was passed at the March 18, 2015 meeting:

That the Board endorse the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

- **encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties;**
- **advocate that all future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;**
- **encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties;**
- **advocate that all future public/social housing developments in Ontario should be smoke-free from the onset.**
- **encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.**

Carried

Yours truly,

Dr. Miriam Klassen
Medical Officer of Health

c. Minister of Housing and Municipal Affairs (minister.mah@ontario.ca)
alPHa (by email)
Ontario Health Units (by email)
Perth County Municipalities (by email)

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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

Providing leadership in public health management

NEWS RELEASE

June 19, 2015 **For Immediate Release**

alPHa Passes New Slate of Resolutions

TORONTO – At its Annual General Meeting in Ottawa last week, the members of the Association of Local Public Health Agencies passed resolutions calling for:

- development and implementation of a provincial Naloxone Strategy that would expand access to Naloxone in support of reducing deaths from opioid overdoses;
- development and implementation of a national, universal pharmacare program to enable all Canadians access to quality, safe and cost effective medications, improve health outcomes and generate cost savings;
- joint federal-provincial consideration and investigation into a basic income guarantee, as a policy option for reducing poverty and income insecurity, give the well-established, strong relationship between low income and a range of adverse health outcomes; and
- increasing the minimum legal age for access to tobacco products in Ontario to 21 as a measure to deter smoking initiation.

alPHa also installed a new President for 2015-16, Lorne Coe, Regional Councillor, Town of Whitby, who is also the Chair of Durham Region's Health & Social Services Committee. Says Coe: *"I am very proud of the dedication to the overall health of the population shown by Boards of Health through the resolutions passed at this years' annual general meeting. We look forward to working on these issues with government in order to ensure that investments in keeping people healthy remain a cornerstone of its pledge to change and improve Ontario's health system."*

The full slate of resolutions passed on June 8 can be found at http://www.alphaweb.org/?Resolutions_2015
The complete alPHa Board of Directors can be found at http://www.alphaweb.org/?page=BOD_2015

About alPHa

The Association of Local Public Health Agencies (alPHa) is a non-profit organization that provides leadership to Ontario's boards of health and public health units. The Association works with governments and other health organizations, to advocate for a strong and effective public health system in the province, as well as public health policies, programs and services that benefit all Ontarians.

- 30 -

For more information regarding this news release, please contact:

Linda Stewart
Executive Director
(416) 595-0006 ext. 22
linda@alphaweb.org

Ministry of Health and Long-Term Care

Chief Medical Officer of Health

Public Health Division
21st Floor, 393 University Avenue
Toronto ON M7A 2S1

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

Ministère de la Santé et des Soins de longue durée

Médecin hygiéniste en chef

Division de la santé publique
393 avenue University, 21e étage
Toronto ON M7A 2S1

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

August 10, 2015

MEMORANDUM

To: Board of Health Chairs
Medical Officers of Health and Associate Medical Officers of Health

Re: Amendments to the Protocol under the Ontario Public Health Standards – *Food Safety Protocol, 2015*

I am writing to inform you of the following changes to the Ontario Public Health Standards (OPHS):

- The *Food Safety Protocol, 2013* has been replaced with the *Food Safety Protocol, 2015.*

The changes to the Protocol were made by the Ministry of Health and Long-Term Care (the ministry) based on input from public health units.

Amendments in the *Food Safety Protocol, 2015* include:

- Revisions to the annual risk categorization process for food premises. The protocol has been updated to mandate boards of health to conduct risk categorization in accordance with the *Guidance Document for the Risk Categorization of Food Premises*, *2015*. As such, the *Guidance Document for the Risk Categorization of Food Premises*, *2015* is legally binding and must be followed during the risk categorization process; and
- Clarification regarding routine inspection frequency of seasonal fixed premises. These premises, if in operation for six months or less, are to be inspected at least once per calendar year.

The new *Food Safety Protocol, 2015* is attached for your reference and will come into effect immediately. It will be available in English and French, respectively, through the OPHS website at the following links:

http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/food_safety.pdf

http://www.health.gov.on.ca/fr/pro/programs/publichealth/oph_standards/docs/food_safetyf.pdf

The ministry will communicate further details regarding the changes to the *Food Safety Protocol, 2015* to public health units via regular communications to ensure continued compliance with the *Health Protection and Promotion Act* and the OPHS.

…/2

I would like to express my thanks to you and your staff for your ongoing work in upholding the OPHS and Protocols to ensure the continued strength of the public health system in Ontario.

Yours truly,

Original signed by

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

Attachments:
Food Safety Protocol, *2015*

c: Roselle Martino, Executive Director, Public Health Division
Nina Arron, Director, Public Health Policy and Programs Branch, Public Health Division
Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Public Health Division
Dr. Peter Donnelly, President and Chief Executive Officer, Public Health Ontario
Dr. George Pasut, Vice-President, Science and Public Health, Public Health Ontario
Dr. Ray Copes, Chief, Environmental and Occupational Health, Public Health Ontario

Ministry of Health and Long-Term Care

Chief Medical Officer of Health

Public Health Division
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August 19, 2015

MEMORANDUM

To: Board of Health Chairs
Medical Officers of Health and Associate Medical Officers of Health

Re: Amendment to the Protocol under the Ontario Public Health Standards – Public Health Emergency Preparedness Protocol, 2015

I am writing to inform you of the following changes to the Ontario Public Health Standards (OPHS):

- The *Public Health Emergency Preparedness Protocol, 2008* has been replaced with the *Public Health Emergency Preparedness Protocol, 2015.*

The changes to the Protocol were made by the Ministry of Health and Long-Term Care (the ministry) based on input from Public Health Ontario (PHO) and Public Health Units.

Amendments in the *Public Health Emergency Preparedness Protocol, 2015* include:

- Clarification of requirements throughout the protocol including requirements for:
  - Engagement and collaboration with relevant local government bodies and community partners;
  - Reviewing and updating the hazard-identification and risk-assessment;
  - Updating the continuity of operations plan and the emergency response plan;
  - Conducting annual exercises of the continuity of operations plan, emergency response plan, and 24/7 notification protocol;
  - Identifying high-risk populations in the community relevant to specific hazards or threats and assessing potential for disproportionate health impacts to high-risk populations;
  - Evaluating the use of the continuity of operations plan after each use; and
  - Reviewing and updating contacts for 24/7 notifications.
- Minor wording changes to clarify language.

The new *Public Health Emergency Preparedness Protocol, 2015* is attached for your reference and will come into effect immediately.

It will be available in English and French, respectively, through the OPHS website at the following links:
http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/emergency_preparedness.pdf
http://www.health.gov.on.ca/fr/pro/programs/publichealth/oph_standards/docs/emergency_preparednessf.pdf

…/2

The ministry will communicate further details regarding these changes to public health units via regular communications to ensure continued compliance with the *Health Protection and Promotion Act* and the OPHS.

I would like to express my thanks to you and your staff for your ongoing work in upholding the OPHS and Protocols to ensure the continued strength of the public health system in Ontario.

Yours truly,

Original signed by

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

Attachment

c: Roselle Martino, Executive Director, Public Health Division
Clint Shingler, A/Director, Emergency Management Branch, Public Health Division
Paulina Salamo, A/Director, Public Health Standards, Practice and Accountability Branch, Public Health Division
Dr. Peter Donnelly, President and Chief Executive Officer, Public Health Ontario
Dr. George Pasut, Vice-President, Science and Public Health, Public Health Ontario
Dr. Brian Schwartz, Chief, Communicable Diseases, Emergency Preparedness and Response, Public Health Ontario
Lisa Fortuna, Director, Communicable Diseases, Emergency Preparedness and Response, Public Health Ontario

August 11, 2015

Kelley Coulter, CAO
The County of Bruce
30 Park Street
Walkerton ON N0G 2V0

Re. Endorsement of the Bruce Grey Food Charter

On June 26, 2015, the Board of Health for the Grey Bruce Health Unit passed the following resolution.

Resolution #2015-54

Moved by: David Shearman Seconded by: David Inglis

"WHEREAS a diverse, sustainable, and just food system is integral to the overall health of any community; and

WHEREAS leaders representing all aspects of food across our community engaged in an extensive process to develop the guiding document; and

WHEREAS the Bruce Grey Food Charter recognizes the impacts of food on health, social justice, culture, education, economic development and the environment; and

WHEREAS involving people and local governments in building healthy, strong, safe and clean communities is identified as vital to the Grey Bruce Health Unit strategic plan;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Grey Bruce Health Unit endorse the Bruce Grey Food Charter;

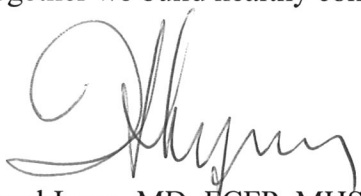
AND FURTHER THAT the Grey Bruce Health Unit identify the role it can play in creating a just, sustainable, and secure food system for Bruce Grey;

AND FURTHER THAT the Grey Bruce Health Unit ask the question, in any applicable decision making process, "What impact will this have on Bruce Grey's food system?" before decisions are finalized;

AND FURTHER THAT the Grey Bruce Health Unit agrees to the use of its logo for endorsement purposes."

Carried

Together we build healthy communities,



Hazel Lynn, MD, FCFP, MHSc
Medical Officer of Health
Grey Bruce Health Unit

Copies to: Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Municipalities in Grey & Bruce Counties
Ontario Boards of Health

Encl.

August 11, 2015

Sharon Vokes, Acting CAO
Corporation of the County of Grey
595 9th Avenue East
Owen Sound ON N4K 3E3

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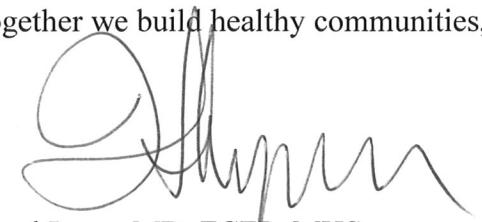

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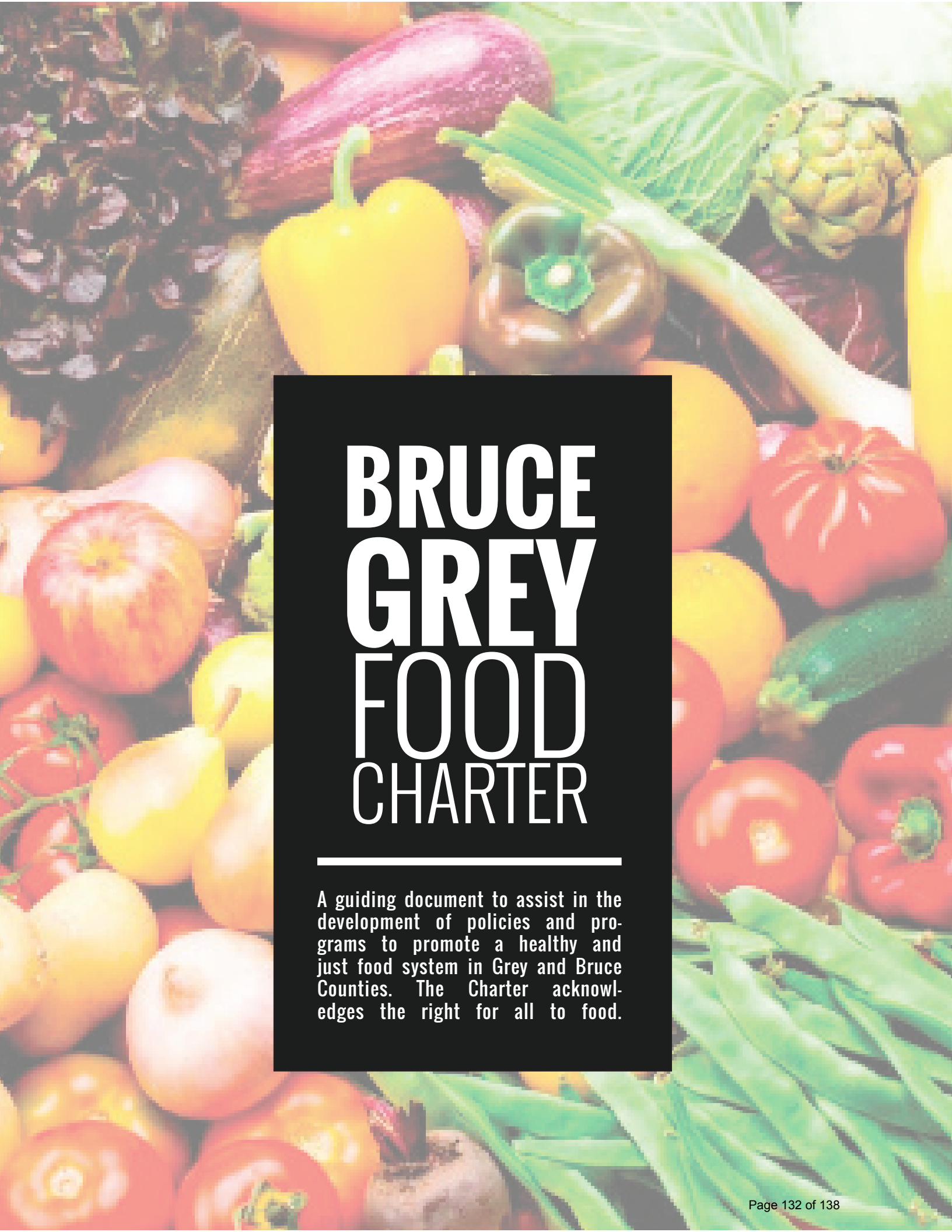

BRUCE GREY FOOD CHARTER

A guiding document to assist in the development of policies and programs to promote a healthy and just food system in Grey and Bruce Counties. The Charter acknowledges the right for all to food.

THE CHARTER

In acknowledgement of the basic right to food, the Charter is a commitment to work together to build a vibrant, sustainable, food secure community. Based on community participation, a sustainable local food system will prioritize health, social justice, education, economic development, the environment, and culture.

BECAUSE WE VALUE **HEALTH** WE SUPPORT

- Public policy that recognizes food's contribution to physical, mental, spiritual, and emotional well-being
- Making food readily accessible for our rural and urban residents, including adequate transportation links, neighbourhoods that encourage walkable and bikeable access to healthy food
- Strategies to prevent and manage chronic diseases through access to affordable, healthy, safe, adequate, and culturally appropriate food
- Baby friendly policies that protect, promote, and support breastfeeding through informed decision making

BECAUSE WE VALUE **SOCIAL JUSTICE** WE SUPPORT

- Making sure everyone has access to healthy food
- A fair wage for the production of food, and a safe and respectful environment for all farmers and food workers
- Allowing land access for people interested in growing and/or processing food
- Income, education, employment, housing, and transportation policies and practices that support access to healthy, sustainable food

BECAUSE WE VALUE **CULTURE** WE SUPPORT

- Celebrating and promoting respect for and inclusion of traditional, cultural, and spriritual food diversity
- Enhancing the dignity and joy of growing, preparing, and eating food
- Strengthening links between rural and urban communities
- Opportunities for all community members to be included and to make connections through the experience and sharing food.

BECAUSE WE VALUE **EDUCATION** WE SUPPORT

- Food literacy and skill building initiatives that engage youth and students integrated in school curricula
- Programs that train current and future farmers, home gardeners, food producers, and others involved in the food value chain
- Integrating food literacy, community gardening and seed saving into communities
- Developing community gardens at schools and other public settings
- Public education about the connections between our health, the environment, and our food choices
- Public awareness of the role of agriculture in our lives

BECAUSE WE VALUE

SUSTAINABLE ECONOMIC DEVELOPMENT

WE SUPPORT

- Increasing the production, processing, distribution, and consumption of foods from Grey and Bruce
- Promoting our region as a food, agricultural, and culinary destination
- Food and agricultural research that is innovative, sustainable, and includes alternative food systems
- Services and infrastructure that support local farms and the development of local food related programs and businesses
- Practices that recognize the detrimental impact of food transportation and strive to minimize environmental burden

BECAUSE WE VALUE

ENVIRONMENT

WE SUPPORT

- Farming practices, protect, and enhance watersheds, wildlife habitat, soil and bio-diversity
- Food production methods that sustain the natural environment in rural and urban settings
- Sustainable development of agriculture, water, land use policies and practices that support the production of healthy food

Bruce Grey

POVERTY TASK FORCE

OUR VISION

REDUCE AND ELIMINATE POVERTY IN OUR COMMUNITY

OUR PURPOSE

FACILITATE COMMUNITY PARTNERSHIPS TO ADVOCATE FOR POVERTY REDUCTON AND ELIMINATION

JOIN THE BRUCE GREY POVERTY TASK FORCE

The Bruce Grey Poverty Task Force focuses on building partnerships with key community stakeholders and networks; working together to eliminate poverty, enhancing our common understanding of poverty issues through solution-based research, knowledge development, and information sharing.

CONNECT

Jill Umbach
Planning Network Coordinator
Bruce Grey Poverty Task Force
519-377-9406
jill.umbach@gmail.com

United Way of Bruce Grey
380 9th Street East, Owen Sound
N4K 1P1

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E-MAIL PRINT

Improving Access to Free Dental Care for Children and Youth

New Integrated Dental Program to Begin January 2016

May 29, 2015

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

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

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

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

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

In April 2014, the government expanded the Healthy Smiles Ontario program so that more kids from low-income families without dental coverage could access free dental care. More than 70,000 additional children are now eligible for services under the Healthy Smiles Ontario program as a result of this expansion, for a total of over 460,000 children.

Providing more children and youth with access to free dental care is part of Patients First: Action Plan for Health Care and Ontario's Poverty Reduction Strategy.

For More Information

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

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

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