Board of Health Meeting Package

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MONTHLY BOARD PACKAGE

Algoma Public Health with Maamwesying North Shore Community Health Services at the first launch site for Doodooshaaboo, it takes a community to breastfeed.

FOR THE MEETING DATED:

October 28, 2015

TIME & PLACE:

5:00 P.M.
Algoma Public Health, Sault Ste. Marie,
3rd Floor, Prince Meeting Room

ALGOMA PUBLIC HEALTH BOARD MEETING
October 28, 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** October 28 , 2015
   Resolution
   THAT the agenda items dated October 28, 2015 be adopted as circulated; and
   THAT the Board accepts the items on the addendum.
3) **Adoption of Minutes of Previous Meeting Dated**
   Resolution
   THAT the minutes of the meeting dated September 22, 2015 be adopted as circulated; and
4) **Delegations/Presentations.**
   a) Accountability Agreements Indicators – Jonathon Bouma, Program Manager Environmental Health and Communicable Disease Control and Jordan Robson, Epidemiologist
5) **Business Arising from Minutes**
   All items arising from previous minutes are reported under the Governance Standing Committee report.
6) **Reports to the Board**
   a) Acting Medical Officer of Health and Acting Chief Executive Officer
      Resolution
      THAT the report of the Acting Medical Officer of Health and CEO for the month of October 2015 be adopted as presented.

   b) Finance and Audit Committee
      i) Financial Statements for the Period Ending: September 30, 2015
      Resolution
      THAT the financial reporting for the period ending September 30, 2015 be adopted as presented.

      ii) 02-04-030 – Procurement Policy
      Resolution
      THAT the Board approves changes to policy 02-04-030 Procurement Policy as presented.

   c) Governance Standing Committee
      i) 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.

      ii) 02-05-015 – Conflict of Interest
      Resolution
      THAT the Board approves changes to policy 02-05-015 Conflict of Interest as presented.

      iii) 02-05-030 – Board Member Code of Conduct
      Resolution
      THAT the Board approves changes to policy 02-05-030 Board Member Code of Conduct as presented.

iv) 02-05-060 – Meetings and Access to Information – New

Resolution

THAT the Board approves the new policy 02-05-060 Meetings and Access to Information as presented.

7) New Business/General Business

a) Letter of Support for the Evacuation of First Nations Communities

b) External Audit Services

Resolution

WHEREAS the Municipal Act, 2001 states that:
Joint boards
(10) If a local board is a local board of more than one municipality, only the auditor of the municipality that is responsible for the largest share of the expenses of the local board in the year is required to audit the local board in that year. 2009, c. 18, Sched. 18, s. 5.; and

WHEREAS the City of Sault Ste. Marie being the largest municipality in the Algoma District: and

WHEREAS The City of Sault Ste. Marie passed Bylaw 2015-168 being a by-law to appoint the firm of KPMG LLP as municipal auditor to provide External Audit Services as required by the City of Sault Ste. Marie be passed in open Council this 28th day of September, 2015;

THEREFORE be it resolved that the Board of Health for Algoma Public Health appoints KPMG LLP as their External Audit Service provider for the same period of time as the City of Sault Ste. Marie.

8) Correspondence Items

a) Basic Income Guarantee - Letter to Ministers from Peterborough County-City Health Unit
b) Evacuation of First Nations Communities - Letter to Premier Wynne from Peterborough County-City Health Unit
c) Energy Drinks - Letter to Minister Hoskins from Peterborough County-City Health Unit
d) Enforcement of the Immunization of School Pupils' Act (ISPA)
   - Letter to Minister Hoskins from Peterborough County-City Health Unit
   - Letter to Premier Wynne from Durham Region
e) Public Health Funding Model
   - Letter to Minister Hoskins from Grey Bruce Health Unit
   - Letter to Minister Hoskins from Porcupine Health Unit
   - Email from alPHa
f) Healthy Babies Healthy Children - Letter to Premier Wynne from Durham Region

9) Items for Information

a) alPHa Meeting November 5, 2015
   Managing Uncertainty: Risk Management Workshop for Ontario Boards of Health
b) Finance and Audit Committee Minutes - July 22, 2015 and September 17, 2015
c) Governance Standing Committee Minutes - August 26, 2015

10) Addendum

11) That The Board Go Into Committee

Agenda Items:

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

12) That The Board Go Into Open Meeting

13) Resolution Resulting From In-Committee Session

14) Announcements:

Next Board Meeting:
November 25, 2015
Sault Ste. Marie Room A&B, 1st Floor, Algoma Public Health, Sault Ste. Marie

15) That The Meeting Adjourn

ALGOMA PUBLIC HEALTH BOARD MEETING
SEPTEMBER 22, 2015
SAULT STE MARIE ROOM A&B 1ST FLOOR, APH SAULT STE. MARIE
MINUTES

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

OFFICIALS PRESENT:	Acting Medical Officer of Health	Dr. Penny Sutcliffe
	Chief Executive Officer	Tony Hanlon, Ph.D.
	Chief Financial Officer	Justin Pino
	Director of Human Resources and Corporate Services	Antoniette Tomie
	Director of Community Services	Laurie Zeppa
	Director of Clinical Services	Sherri Cleaves
	Board Secretary	Christina Luukkonen

1) **CALL TO ORDER**

Mr. Mason called the meeting to order at 5:01 pm.

DECLARATION OF CONFLICT OF INTEREST

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

2) **ADOPTION OF AGENDA** dated September 22, 2015

2015-118 Moved: I. Frazier
Seconded: C. Martin
THAT the agenda items dated September 22, 2015 be adopted as circulated.
CARRIED.

3) **ADOPTION OF THE MINUTES**

2015-119 Moved: C. Martin
Seconded: D. Thompson
THAT the minutes of the Board of Health meeting dated June 17, 2015, be adopted as circulated; and

THAT the minutes of the Special Meeting of the Board of Health dated June 29, 2015, be adopted as circulated; and

THAT the minutes of the Special Meeting of the Board of Health dated August 6, 2015, be adopted as circulated.
CARRIED.

4) **DELEGATIONS/PRESENTATIONS**

a) No presentations were presented.

5) BUSINESS ARISING FROM MINUTES

a) Governance Standing Committee Terms of Reference

Final copy of the Governance Standing Committee Terms of Reference was presented to the Board for approval. A few minor changes were suggested.

2015-120 Moved: I. Frazier
Seconded: C. Martin
THAT the Board of Health approves the Terms of Reference for the Governance Standing Committee as amended.
CARRIED.

b) Algoma Public Health Performance Monitoring Plan

Final copy of the Algoma Public Health Performance Monitoring Plan was presented to the Board for approval.

2015-121 Moved: S. Jensen
Seconded: C. Martin
THAT the Board of Health approves the Algoma Public Health Performance Monitoring Plan as presented.
CARRIED.

6) REPORTS OF COMMITTEES

a) Finance and Audit Committee

Mr. Frazier, Chair of the Finance and Audit Committee, provided a verbal report to the Board of Health. Budget completion is set for November 2015. On September 18, 2015 the Ministry held a teleconference with all health units, executive teams and board of health chairs to outline the changes in the new funding model. The new funding model will be population based. Based on the new funding formula only 8 health units in the province were approved for a 2% increase to their base budgets. The remaining 28 health units received a 0% increase to their base budgets. Algoma Public Health was among the 28 health units. There will be opportunities for one-time funding that we will are planning to apply for. Base funding for the next three years have been flat lined while our budget realigns with the new model. The complete report from the ministry was included in the addendum and was distributed to Board members prior to the start of the meeting. The Ministry will be conducting one-on-one teleconferences with each health units to discuss these changes.

Dr. Sutcliffe informed the Board that this has not been well favoured by the 28 health units that have been flat lined. There is a need to advice on the needs of the community as well.

b) Governance Standing Committee

Mr. Frazier, Chair of the Governance Standing Committee, provided a verbal report to the Board of Health. The Committee met once over the summer. Going forward the Committee will be looking at the board matrix and what if any training is needed or available. There is an opportunity for the Board to participate in a community governance training hosted by the Children's Rehabilitation Centre Algoma in October. More information on the workshop was provided to the Board members in the addendum its 11c).

A survey to the Board members will be sent out to identify what they feel are the priority professional development needs.

The province is in the process of hiring a consultant to assist in identifying what skill based board governance model they may be adopting and the related professional development needs for all public health boards.

7) REPORTS OF OFFICERS/PROGRAM MANAGERS:

a) Medical Officer of Health/Chief Executive Officer:

Dr. Hanlon updated the Board on how things have been going since he started in the position on August 31, 2015. Dr. Hanlon and Dr. Sutcliffe had the opportunity to meet with the City of Sault Ste. Marie Mayor Christian Provenzano and MPP David Orazietti. Dr. Hanlon also advised the Board members that he will be visiting each of the district offices in the next couple of weeks to meet with staff and will be arranging meetings with other mayors from the municipalities.

Dr. Sutcliffe highlighted from the report the tobacco cessation initiative to reduce smoking rates by 5% in 5 years in the district of Algoma that APH is developing. As well as the Healthy Kids Challenge the City of Sault Ste. Marie and Thessalon were awarded.

Dr. Hanlon thanked the staff and the Board for their support during this transition period.

Questions were answered to the satisfactory of the Board

2015-122 Moved: D. Thompson
Seconded: I. Frazier
THAT the report of the Acting Medical Officer of Health and Chief Executive Officer for the month of September 2015 be adopted as presented.
CARRIED.

b) Chief Financial Officer/Director of Operations:

i) Financial Statements for the Period Ending: August 31, 2015

Mr. Pino highlighted his report that was included in the Board package. The Finance and Audit committee reviewed the report at their meeting on September 18, 2015 and recommend it for approval.

2015-123 Moved: C. Martin
Seconded: I. Frazier
THAT the financial reporting for the period ending August 31, 2015 be adopted as presented.
CARRIED.

2015-124 Moved: I. Frazier
Seconded: D. Thompson
THAT the Board accepts the Algoma Public Health Financial Statements for the period ending August 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.

2015-125 Moved: C. Martin
Seconded: D. Thompson
THAT the Board of Health approves the annual reconciliation for the Infant Development Program for the year ending March 31, 2015 as presented.
CARRIED.

8) **New Business/General Business**

a) Ontario Public Health Organizational Standards Compliance Checklist/Attestation

The compliance checklist was shared with Board members that Algoma Public Health was required to complete for the Ministry. There are five items that we are not incompliance with but APH is currently working corrective actions.

The Board requested the information that was submitted to the Ministry evidence for these incomplete items. This information will be made available for Board members via email before the next board meeting.

b) Board Evaluation Summary

A Summary of the monthly Board evaluations was provided to the Board in their Board package for their review. The yearly evaluation summary was emailed to Board members as it was missing in the Board packages. Copies will be provided for Board members at the next meeting in October.

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

Copies of the revised policy were provided in the Board package and changes were highlighted.

2015-126 Moved: I. Frazier
Seconded: D. Thompson
THAT the Board of Health approves the changes to policy 02-05-010 Board Minutes and Packages – Posting/Circulation/Retention as presented.
CARRIED.

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

Copies of the new policy were provided in the Board packages. Policy identifies our current practice.

2015-127 Moved: C. Martin
Seconded: D. Thompson
THAT the Board accepts the changes to as presented.
CARRIED.

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

Board members were asked to review and send your comments or suggestions to Ms. Luukkonen. Feedback will be compiled and the Governance Committee will review at their next meeting and present the revised bylaw to the Board.

Ms. Luukkonen will let everyone know once the date is set for the next Governance Meeting.

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

Ms. Martin moved to defer the approval of the policy 02-05-060 – Freedom of Information. A briefing note will be provided at the October Board meeting explaining the purpose of the policy.

2015-128 Moved: C. Martin
Seconded: D. Thompson
THAT the Board of Health defers the approval of Policy 02-05-060 Freedom of Information until the October 2015 Board meeting.
CARRIED.

g) 02-05-030 – Board Member Code of Conduct

The Governance Committee will be reviewing our current code of conduct policy. The Board is being asked to forward any suggestions to the Ms. Luukkonen. Ms. Luukkonen will compile the feedback for the Governance Committee to review and a final draft will be presented to the Board for approval in October.

h) Healthy Babies Health Children Program

Dr. Hanlon spoke to the briefing note provided in the Board package. A resolution is being presented to the Board to support a letter to the minister to advocate for improved funding for the program.

2015-129 Moved: I. Frazier
Seconded: D. Thompson
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 through 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. **CARRIED.**

i) Public Health Support for a Basic Income Guarantee

Dr. Hanlon spoke to the briefing note provided in the Board Package. A resolution is being presented to the Board to endorse the concept of a basic income guarantee.

Questions were raised by Board members and the Board inquired if there are any reports or resources that could be reviewed that support this strategy.

Dr. Sutcliffe informed the Board that there is support from the Association of Local Public Health Agencies and the Canadian Medical Association.

Ms. Zeppa spoke to the work that the Health Equity nurses have been working on.

There was no mover for a resolution.

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

Dr. Hanlon and Ms. Zeppa spoke to the briefing note provided in the Board package.

2015-130 Moved: C. Martin
Seconded: D. Thompson

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.
CARRIED.

k) Prenatal Postnatal Nurse Practitioner Program

A revised briefing note was distributed to the Board members at the beginning of the meeting. Dr. Hanlon and Ms. Zeppa spoke to this briefing note. At one time there was a need for the Nurse Practitioner Program at Algoma Public Health. The position has been vacant for over a year now and the community need has declined.

Questions were raised on the impact to Algoma Public Health with the loss of position. Dr. Hanlon explained that the position is currently vacant so there is not staffing impact.

2015-131 Moved: D. Thompson
Seconded: I. Frazier

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.
CARRIED.

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

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:**

2015-132 Moved: I. Frazier
Seconded: C. Martin

THAT the Board accepts the items on the addendum.

11) Addendum

a) Provincial Public Health Funding
b) Electronic Means of Participation of Local Boards
c) Board Development Workshop – October 24, 2015
d) d) Board of Health Orientation Manual Updates – Items for replacement in Orientation Binder

CARRIED.

a) Provincial Public Health Funding

Documents were distributed to Board members for their review. This is an ongoing discussion with the ministry.

- Letter from the Minister of Health and Long-Term Care to Algoma Public Health Board of Health Chair dated September 4, 2015
- Memo: Update on Public Health Funding Review dated September 4, 2015
- Final Report of the Funding Review Working Group dated December 2013
- Appendix 1 – Funding Review Working Group Field Input Responses

b) Electronic Means of Participation of Local Boards

Dr. Sutcliffe spoke to the letter received from Wellington-Dufferin-Guelph Public Health to the Ministry regarding participating by electronic means at local board meetings. Being shared as information there is no change in our practice. There is a difference in interpretation of the Act.

- Letter to the Ministry of Municipal Affairs and Housing from Wellington-Dufferin-Guelph Public Health dated September 10, 2015.
- Letter to Wellington-Dufferin-Guelph Medical Officer of Health from the Interim Chief Medical Officer of Health dated June 30, 2015
- Resolution from Wellington-Dufferin-Guelph BoH Meeting September 9, 2015

c) Board Development Workshop – October 24, 2015
Hosted by The Children's Rehabilitation Centre Algoma Board of Directors

Background was provided to the Board on the upcoming Board workshop in October. If any Board members are interested in attending please let Ms. Luukkonen know by Thursday, September 24, 2015.

d) Board of Health Orientation Manual Updates – *For replacement in Orientation Binder*.

- 02-05-065 – Algoma Board of Health Reserve Fund
- Bylaw 95-2 – To Provide for Banking and Finance
- Bylaw 95-3 – To Provide for the Duties of the Auditor of the Board of Health
- Bylaw 2015-1 – To Provide for the Management of Property
- 2015 alPHa Orientation Manual for Board of Health

Copies of revised policies and bylaws that were previously approved were provided to Board members to replace in their Board Orientation and Reference Manual.

12) **THAT THE BOARD GO INTO COMMITTEE: 6:30pm**

Agenda items:

a) Adoption of In-Committee minutes dated September 22, 2015

2015-33 Moved: I. Frazier
Seconded: C. Martin
THAT the Board goes into committee.
CARRIED.

13) **THAT THE BOARD GO INTO OPEN MEETING @ 6:51pm**

2015-135 Moved: I. Frazier
Seconded: D. Thompson
THAT the Board goes into open meeting.
CARRIED.

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

There were no resolutions resulting from In-Committee Session to be passed in open meeting.

15) **ANNOUNCEMENTS:**

Next Board Meeting: To be Announced

16) **THAT THE MEETING ADJOURN: 6:56 pm**

2015-136 Moved: I. Frazier
Seconded: S. Jensen
THAT the meeting adjourns.
CARRIED.

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

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Accountability Agreement Indicators

Overview and look at most recent performance

Performance Measurement

- Performance management principles and techniques are widely accepted as management best practice.
- Performance management involves establishing goals, monitoring progress, and making adjustments to achieve desired outcomes.
- Intended to capture, report on, and respond to the performance of boards of health and health units and the public health system

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What is an Indicator?

- Indicators are **succinct** measures that aim to **describe** as much about a **system** as possible in as few points as possible.
- Indicators help us **understand** a system, **compare** it and **improve** it.

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Use of Indicators

- **Currently used by health units to:**
  To support local program management and manage service delivery; determined at the BOH level.
  To inform surveillance activities and policy development;

- **Provincial uses within performance management system:**
  Public reporting
  Accountability agreements
  Monitoring/risk assessment

- **The same indicators may be used for multiple purposes.**

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Accountability Agreements

- The Public Health Accountability Agreement (AA) is built on performance management principles accepted as management best practice
- Accountability Agreements between BOH and the MOHLTC were introduced in 2011
- Was initially set for a 3 year term from 2011-2013, renewed for 2014-2016
- Set of indicators are common across all BOH in the province

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Structure

- Indicators in place from 2014-2016 after which new indicators may be added or considered.
- In the 1st year of an indicator, baselines are established for each for each board of health.
- In the subsequent years, targets for performance improvement will be established in consultation with each board of health, relative to its baseline level of achievement.
- Health units, for each indicator, can either propose a target, respond to a ministry proposed target or confirm a previously established target, depending on the indicator.

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Indicator Types

- **Performance indicators**: annual targets for achievement.
- **Monitoring indicators**: do not have targets and performance is reviewed internally by the ministry to ensure expectations are met.
- **Long-term indicators**: measure population level outcomes when data becomes available.

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Recent Indicator Performance

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Indicators we are meeting

- 1.4 % of tobacco vendors in compliance with youth access legislation at the time of the last inspection
- 1.6 % tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA) - Seasonal
- 1.9 Implementation of NutriSTEP Preschool Screen
- 1.10 Baby-Friendly Initiative (BFI) Status
- 2.3 % of Class A pools inspected while in operation
- 4.2 % of influenza vaccine wasted that is stored/administered by the public health unit
- 4.3 % of refrigerators storing publically funded vaccines that have received a completed routine annual cold chain inspection.

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Indicators we are working towards meeting

- 1.6 % tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA) – Non-seasonal
- 1.8 Oral health Assessment and Surveillance: % of schools screened and % of all JK, SK *and* Grade 2 students screened in all publically funded schools
- 2.1 % of high-risk food premises inspected once every 4 months while in operation (2015 monitoring)
- 2.2 % of moderate-risk food premises inspected once every 6 months while in operation (2015 monitoring)
- 2.4 % of high-risk Small Drinking Water Systems (SWDS) inspections completed for those that are due for re-inspection
- 3.1 % of personal services settings inspected annually (2015 monitoring)
- 4.1 % of HPV vaccine wasted that is stored/administered by the public health unit

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Common challenges for meeting targets

- Business owner availability
- Weather for travel to some inspection sites
- Staffing shortages – short and long term
- Data entry issues
- Cooperation of external agencies/partners
- Unrealistic targets given nature of APH's region

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Indicators being monitoring

- 2.5 % of public spas inspected while in operation *(2015 monitoring)*
- 3.2 % of suspected rabies exposures reported with investigation initiated within one day of public health unit notification *(2015 100% target)*
- 3.3 % of confirmed gonorrhea cases where initiation of follow-up occurred within two business days *(2015 monitoring)*
- 3.4 % of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case *(2015 monitoring)*
- 3.5 % of salmonellosis cases where one or more risk factor(s) other than "Unknown" was entered into iPHIS *(2015 90% target)*
- 4.4 % of school-aged children who have completed immunizations for hepatitis B *(2015 monitoring)*
- 4.5 % of school-aged children who have completed immunizations for HPV *(2015 monitoring)*
- 4.6 % of school-aged children who have completed immunizations for meningococcus *(2015 monitoring)*

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Thank You

- Additional details can be found on the MOHLTC website at http://www.health.gov.on.ca/en/pro/programs/publichealth/performance/
- Attached Appendix A lists all the Accountability Agreements for your reference.

Questions?

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Appendix A – Indicator List with Performance

1.1 % of population (19+) that exceeds the Low-Risk Alcohol Drinking Guidelines
- Not currently monitored; considered as long term indicators

1.2 Fall-related emergency visits in older adults aged 65+
- Not currently monitored; considered as long-term indicators

1.3 % of youth (ages 12-18) who have never smoked a whole cigarette
- Not currently monitored; considered as long term indicators

1.4 % of tobacco vendors in compliance with youth access legislation at the time of last inspection
- 2015 Mid-Year 93/96 – 96.9%
- Target >=90%

1.5 % of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act (SFOA)
- 2015 year-end target = 100%

1.6 % tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA)
- 2014 Year End
  - Non-seasonal 96.2% Target 100%
  - Seasonal 100% Target 100%
- 2015 Year End Targets 100%

1.7 % tobacco retailers inspected for compliance with display, handling and promotion sections of the Smoke-Free Ontario Act (SFOA)
- 2014 Year End 100% Target 100%
- 2015 Year End Target 100%

1.8 Oral health Assessment and Surveillance
- % of schools screened
  - July 1 2014 – June 30 2015 49/50 98% Target 100%
- % of all JK, SK and Grade 2 students screened in all publically funded schools
  - July 1 2014 – June 30 2015 2675/2809 95.2% Target 100%

1.9 Implementation status of NutriSTEP Preschool Screen
- 2015 Mid-Year – Preliminary stage
- 2015 Year End Target – Intermediate stage

1.10 Baby-Friendly Initiative (BFI) Status
- 2015 Mid-Year – Designated
- 2015 Year End - Designated

2.1 % of high-risk food premises inspected once every 4 months while in operation
- 2014 Year End (Target 100%)
  - 168/183 91.8%
  - Performance Report
- 2015 Year End Monitoring

2.2 % of moderate-risk food premises inspected once every 6 months while in operation

- 2014 Year End (Target 98.4%)
  - 160/180 88.9%
  - Performance Report
- 2015 Year End Monitoring

2.3 % of Class A pools inspected while in operation

- 2014 Year End (Target 100%)
  - 7/7 100%
- 2015 Year End Target 100%

2.4 % of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection

- 2014 Year End (Target 85%)
  - 29/35 82.9%
  - Performance Report
- 2015 Year End Target 90%

2.5 % public spas inspected while in operation

- 2014 Year End (Target 100%)
  - 15/15 100%
- 2015 Year End Monitoring

3.1 % of personal services settings inspected annually

- 2014 Year End (Target 86.1%)
  - 113/141 80.1%
  - Performance Report
- 2015 Year End Monitoring

3.2 % of suspected rabies exposures reported with investigation initiated within one day of public health unit notification

- 2014 Year End (Target 100%)
  - 193/193 100%
- 2015 Year End Target 100%

3.3 % of confirmed gonorrhea cases where initiation of follow-up occurred within two business days

- 2014 Year End (No Target)
  - 27/28 96.4%
- 2015 Year End Monitoring

3.4 % of confirmed IGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case

- 2014 Year End (Target 100%)
  - 168/183 91.8%
  - Performance Report
- 2015 Year End Monitoring

3.5 % of salmonellosis cases where one or more risk factor(s) other than “Unknown” was entered into iPHIS

- 2014 Year End
  - 10/15 66.7% Baseline
- 2015 Year End 90% Target

3.6 % of confirmed gonorrhea cases treated according to the recommended Ontario treatment guidelines

- 2015 Year End Baseline

4.1 % of HPV vaccine wasted that is stored/administered by the public health unit

- September 1st 2014 – August 31st 2015 (Target 0.3%)
  - 0.6%

4.2 % of influenza vaccine wasted that is stored/administered by the public health unit

- September 1st 2014 – August 31st 2015 (Target 2.3%)
  - 2.0%

4.3 % of refrigerators storing publically funded vaccines that have received a completed routine annual cold chain inspection

- 2014 Year End (Target 100%)
  - 115/115 100%
- 2015 Year End Target 100%

4.4 % of school-aged children who have completed immunizations for hepatitis B

- 2013-2014
  - 795/1044 76.1%
  - Monitoring
- 2014-2015
  - 724/980 73.9%
  - Monitoring

4.5 % of school-aged children who have completed immunizations for HPV

- 2013-2014
  - 283/498 56.8%
  - Monitoring
- 2014-2015
  - 285/493 57.8%
  - Monitoring

4.6 % of school-aged children who have completed immunizations for meningococcus

- 2013-2014
  - 868/1041 83.4%
  - Monitoring
- 2014-2015
  - 820/980 83.7%
  - Monitoring

Algoma
PUBLIC HEALTH
Santé publique Algoma

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

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

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SUMMARY/INTRODUCTION

T.Hanlon along with Directors Cleaves and Zeppa visited the Elliott Lake office September 25, Wawa office September 28 and Blind River office October 15. He chaired an introductory session at each office to get to know staff and hear directly from them about program and service delivery in the Elliott Lake, Blind River & Wawa catchment areas.

The Elliott Lake staff were updated on plans for the new office location and are looking forward to relocation in the new year.

The staff at all three offices were also given a high level overview of the new MOHLTC funding model for PHUs.

T. Hanlon also held separate meetings with Mayor Dan Marchisella and MPP Michael Mantha on September 25. Both gentlemen made positive remarks about APH programs and services. He updated both on MOHLTC new funding model. He also met with Mayor Rody in Wawa who was also very appreciative of the work of APH staff.

Flu clinics started in Sault Ste. Marie on October 13 and on October 19. In the first week of flu clinic operations (October 13-19th) in SSM and district offices, APH provided 1320 flu immunizations at onsite and outreach clinics. Our Wawa office scheduled their first flu clinic at the Community Centre on Election Day (October 19th). This model of clinic delivery was successful as it was convenient for clients that were at the Community Centre to vote, and also for families that were bringing their children to various activities.

PROGRAM HIGHLIGHTS

COMMUNITY MENTAL HEALTH

Topic: Program Update

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables: NELHIN & MOHLTC Mental Health &Addiction Accountability Agreement(s) 2014-17: Deliverables.

This report addresses the following Strategic Directions: Accountability

Accountability
The Community Mental Health Program provides Psychiatric Case Management Programing (Intensive Case Management; Community Treatment Order Case Management and Transitional Case Management) throughout the Algoma District for individuals living with serious mental illness through a NELHIN funding agreement.

The NELHIN Accountability Agreement: Targets 2014/15

Deliverable	LHIN Target	Q2 Report
Individuals served by Functional Center:	1040	575
Total Visits:	12,830	5,594

Program data for these targets are reported quarterly. This data indicates we are on track to meet our yearly LHIN target of accountability.

The program has extended the CMHP hours of operation in SSM until 8pm- Monday-Friday & 10am - 6pm weekend(s) through expansion of our "Transitional Case Management Program". This new initiative has added to our local continuum of available case management resources.

In addition, the program delivers a Rent Supplement Administration and Supports within Housing Program, through a MOHLTC corporate funding agreement.

The MOHLTC Funding Agreement 2014/15: Administration of $286,000 in mental health and addiction rent supplement(s).
Apr. 1/15 – October 1/15

Mental Health	Addiction
116	14

The Program also continues to work with other Algoma Public Health programs and many community partners on broader social housing initiatives throughout the district. In April of this year, CMHP entered into partnership with Sault Ste. Marie Housing Corporation, one CMHP case manager has been aligned

full time for up to one year to provide mental health and addiction supports within the corporations many housing initiatives including emergency shelters.

HEALTHY BABIES HEALTHY CHILDREN

Topic: Doodooshaaboo

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables: Family Health Program Standards, Child Health; Health Promotion and Policy Development; Breastfeeding

This report addresses the following Strategic Directions: Health Equity and Collaboration

Algoma Public Health and Maamwesying North Shore Community Health Services Incorporated were successful applicants to a grant offered by Best Start Health Nexus. The purpose of the grant was to fund a project that would support "Populations with Lower Breastfeeding Rates."

Algoma Public Health with Maamwesying North Shore Community Health Services developed a breastfeeding awareness campaign, Doodooshaaboo, it takes a community to breastfeed. Doodooshaaboo is an Anishinaabe word meaning breast milk. The goal of the Doodooshaaboo campaign is to ensure that mothers and their families have access to the best supports and resources in their communities.

The campaign includes 14 life-sized photographs of local mother's breastfeeding to encourage and promote community support. A local directory and magnets for families to have easy access to contact information was developed. The directory includes contact information for cultural workers and traditional health.

The campaign will be featured at the Sault Ste. Marie Indian Friendship Centre, the Baawaating Family Health Team, Batchewana First Nation, Garden River First Nation, Thessalon First Nation, Mississauga First Nation, Serpent River First Nation, Sagamok First Nation and Atikameksheng First Nation.

The campaign launch dates were October 1, 2015 at Garden River Wellness Centre, October 6, 2015 at Non Dway Gamig 'Healing Place,' Batchewana First Nation, and October 7, 2015 at Sault Ste. Marie Indian Friendship Centre. This launch coincided with National Breastfeeding Week October 1-7 2015. Algoma Public Health has since been invited to showcase this partnership project at the preconference event during the Best Start Annual Conference in Toronto in 2016.

The Doodooshaaboo project embraces our strategic directions, values and guiding principles, and is in alignment with the resolution passed on June 17th, 2015 to continue conversation and dialogue with the Indigenous Communities in the Algoma District to support further relationship building.

RISK MANAGEMENT

COMMUNICABLE DISEASE CONTROL

Topic: Infectious Diseases/Environmental Health

This report addresses the following requirements of the Ontario Public Health Standards (2014) Requirement #8 The board of health shall provide public health management of cases and outbreaks to minimize the public health risk in accordance with the Infectious Diseases Protocol, 2008(or as current); the Institutional/Facility Outbreak Prevention and Control Protocol, 2008(or as current); and provincial and national protocols on best practices.

This report addresses the following strategic directions: Collaborate Effectively

Risk	Although to date the outbreaks have been colonizations rather than infections, there is always a risk of this balance changing within the hospital. Community-wide there is a significant amount of transfer within and without of the SAH. Several Long Term Care Homes now have substantial MRSA cases attributable to the SAH therefore efforts at minimizing spread of both community and hospital transmissions are worthwhile. This outbreak along with many others within a year adds extra workload on the Infection Prevention and Control inspection team.
Recommendations	Algoma Public Health (APH) shall continue to support Sault Area Hospital (SAH) and by extension its community healthcare partners and public with outbreak management of antibiotic resistant organisms such as Methicillin-Resistant Staph Aureus (MRSA). The SAH and APH work jointly to lessen the transmission of such organisms and are exploring strategies with the outbreak team to improve environmental cleaning.
Key Points	A MRSA outbreak was declared at SAH on Aug 21, and a second declared on Sept 9. A public health inspector and manager have been meeting regularly with the OB team to provide guidance and support the control efforts.
Analysis	Antibiotic-resistant organisms are difficult to control in a highly variable hospital environment. A dedicated focus on hand hygiene and environmental cleaning is crucial in MRSA outbreak control.
Action	APH's inspection team will continue to support the efforts of the greater outbreak team at the SAH and provide advice, consultation and support to reduce transmission of the bacteria and lessen the opportunity of an infection occurring due to MRSA.
Financial Implications	None, Time for inspections is decreased during the outbreak seasons and even more during antibiotic resistant strains of microorganisms are involved.
Staffing Implications	Increased focus on outbreak management necessitates re-distribution of workload in other areas which affects other program standards and MOHLTC Accountability Agreements.

ENVIRONMENTAL HEALTH

Topic: Memorandum of Understanding (MOU) regarding Boil Water Advisories (BWO)/ Drinking Water Advisories (DWA) & Municipalities

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables: Requirement # 10.
The board of health shall ensure that the medical officer of health or designate is available on a 24/7 basis to receive reports of and respond to: Adverse events related to safe water, such as reports of adverse drinking water on drinking-water systems governed under the Health Protection and Promotion Act or the Safe Drinking Water Act;

This report addresses the following strategic directions: Collaborate Effectively

Risk	Municipalities deal with broken water lines and repairs regularly. APH works with the municipalities to ensure the safety of the patrons during these repairs. This is addressed by issuing a BWA or DWA to the affected houses/ businesses during this time. Due to chain of command notification process, it can range in the response time when notifying the patrons of the potential risks associated with these repairs (i.e. chemical / bacteriological in nature).
Recommendations	APH & municipalities have a MOU in place that provides the BWA and DWA templates to the municipalities to expedite the notification process which will reduce the risk of the patrons drinking potentially contaminated water. These MOU have been in place for most municipalities for several years for issuing of BWA for these events and we recommend maintaining this process with all municipalities and Small Drinking Water Operators.
Key Points	Water line breaks & repairs, loss of pressure and leaks are common within municipalities.
Analysis	Chain of command notification is important.
Action	Notifying patrons of risks associated with repairs is vital.
Financial Implications	MOU in place and templates provided to municipalities will speed the notification process up and reduce the potential risks associated with patrons consuming contaminated water during breaks and repairs.
Staffing Implications	Although a process is already in place to deal with water main breaks and repairs, this tool will speed the notification process up and reduce the risks associated with patrons drinking potentially contaminated water. This will save time, which will save money.

PARTNERSHIPS

Public Health Ontario

APH has teamed with Public Health Ontario (PHO) to submit a joint application to The Ontario Public Health Convention (TOPHC) in April 2016 to present and discuss the work we have done with them and the Ministry of the Environment and Energy around the Soil and Air Studies surrounding Essar Steel. Over several years APH has been working with assessing public health threats from Benzo-a-Pyrene in soil samples and particulates –Polyareomatic Hydrocarbons (PAHs) in air near the Essar Steel Plant in the Bayview Area. APH also sits on the Community Advisory council of Essar Steel to aid in the continuing monitoring and decreasing of emissions from the plant.

St. Joseph's Hospital in Elliot Lake

On September 24, 2015 the Health Equity Public Health Nurses (PHN's) delivered a presentation to the Senior Management Team at the Elliot Lake St. Joseph's hospital, entitled "Advancing Health Equity in the Health Care System". The presentation covered the social determinants of health and introduced the concept of health equity, with the intention of supporting the hospital in applying a health equity lens to decision making and planning patient care. Relevant local data related to the social determinants of health and the impacts on health was shared to enhance the understanding about "what makes people ill and what keeps people well". Providing consultation and support to community partners regarding health equity is one of the objectives in the PHN's health equity work plan. Follow-up with St Joseph's hospital is planned to review the presentation evaluation results and determine need for further consultation.

NEXT STEPS

T. Hanlon and J. Pino will be presenting at the upcoming alPHa workshop on November 5, 2015 in Toronto. This year's topic is Managing Uncertainty.

The new office location in Elliot Lake is progressing. Tenders for the interior construction have been received and the Finance and Audit Committee will be awarding the contract soon.

Respectfully submitted,

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

Algoma Public Health
Financial Statements
For the period ending: September 30, 2015

Algoma Public Health
Statement of Operations and Fund Balances
For the period ending: **September 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	$ 3,280,533	$ 2,440,042	$ 840,492	$ 3,253,389	134%
Provincial Grants -public health	7,379,339	$ 7,353,450	$ 25,889	$ 9,804,600	100%
Grants/Levies - Capital	$ -	-	$ -	-	
Provincial Grants - community health	4,505,681	4,069,007	$ 436,674	7,463,339	111%
Fees, other grants and recovery of expenditures	466,410	618,153	$ (151,743)	824,204	75%
	$ 15,631,964	$ 14,480,652	$ 1,151,312	$ 21,345,532	108%
Expenditures					
Public Health Programs					
Public Health	$ 10,032,902	$ 10,411,644	$ 378,742	$ 13,882,192	96%
Public Health (Capital)	0	-	-	-	
Community Health Programs					
Healthy Babies and Children	803,811	$ 801,008	(2,803)	1,068,011	100%
HBHC Screening Liais(Combined with HBHC for 2015)	0	$ -	-	-	
Child Benefits Ontario Works	13,333	$ 15,000	1,667	20,000	89%
Dental Benefits Ontario Works	238,276	$ -	-	-	
Early Years Development (NPClinic II)	1,000	$ 104,250	103,250	139,000	1%
Misc Calendar	1,556	$ -	(1,556)	-	
		$ -		-	
Healthy Community Partnership	2,480	$ -	(2,480)	-	
Northern Ontario Fruit & Vegetable Program	52,916	$ 57,554	4,637	117,400	92%
Brighter Futures for Children	48,389	$ 56,722	8,333	113,448	85%
Infant Development	326,296	$ 337,993	11,697	675,986	97%
Preschool Speech and Languages	294,163	$ 307,128	12,965	614,256	96%
Nurse Practitioner	59,892	$ 61,427	1,535	122,853	98%
Genetics Counseling	149,823	$ 183,903	34,080	367,806	81%
Community Mental Health	1,464,312	$ 1,586,999	122,687	3,173,998	92%
Community Alcohol and Drug Assessment	345,262	$ 339,135	(6,127)	678,260	102%
Remedial Measures	97,362	$ 91,740	(5,622)	122,320	
Diabetes	56,687	$ 75,000	18,313	150,000	76%
Misc Fiscal	72,688	$ 50,000	(22,689)	100,000	145%
	$ 14,061,148	$ 14,479,502	$ 656,630	$ 21,345,531	97%
Excess of revenues over expenses - CH	477,435	1,149		1	
Excess of revenues over exp. - Public Health	1,093,380	0		-	
Operating fund balance, beginning of year	3,009,266				
Operating fund & capital, end of month (Note 1)	$ 4,606,873				4,606,873

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 Nine Months Ending September 30, 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	5,614,937	5,639,325	(24,388)	75%	7,519,100	5,615,102	5,623,350	(8,248)
MOH Funding- Needle Exchange	33,592	38,025	(4,433)	66%	50,700	33,592	33,601	(9)
MOH Funding Haines Food Safety	18,397	18,450	(53)	75%	24,600	18,397	18,400	(3)
MOH Funding CINOT/Healthy Smiles	320,654	307,950	12,704	78%	410,600	320,652	320,657	(5)
MOH Funding - Social Determinants of Health	135,328	135,375	(47)	75%	180,500	132,679	132,683	(4)
MOH Funding Vector Bourne Disease	81,453	81,525	(72)	75%	108,700	81,453	81,458	(5)
MOH Funding Chief Nursing Officer	91,050	91,125	(75)	75%	121,500	89,267	89,275	(8)
MOH Funding Safe Water	52,167	52,200	(33)	75%	69,600	52,167	52,172	(5)
MOH Enhanced Funding Safe Water	11,615	11,625	(10)	75%	15,500	11,615	11,625	(10)
MOH Funding Unorganized	326,917	375,225	(48,308)	65%	500,300	320,508	320,508	0
IC Prevention & Control Week	0	0	-	0%	0	0	0	0
CINOT Expanded Funding	25,632	25,500	132	75%	34,000	10,458	16,875	(6,417)
MOH Funding Infection Control	234,207	234,300	(93)	75%	312,400	232,889	232,900	(11)
Levies Sault Ste Marie	2,031,795	1,477,094	554,702	103%	1,969,458	1,937,114	1,387,421	549,693
Levies Sault Ste Marie Capital	220,215	220,215	-	75%	293,620	217,113	217,113	(0)
Levies Vector/ SDWS	49,466	49,466	-	75%	65,955	44,544	44,544	0
Levies District	889,110	603,320	285,790	111%	804,427	818,122	589,025	229,097
Levies District Capital	89,947	89,947	-	75%	119,929	93,049	93,049	0
Recoveries from Programs	5,030	7,546	(2,515)	50%	10,061	8,517	7,546	971
Program Fees	162,420	185,357	(22,937)	66%	247,143	119,380	185,357	(65,977)
Land Control Fees	123,720	120,000	3,720	77%	160,000	118,231	120,000	(1,769)
Program Fees Immunization	144,986	120,000	24,986	91%	160,000	127,000	120,000	7,000
HPV Vaccine Program	867	7,500	(6,633)	9%	10,000	1,292	7,500	(6,208)
Influenza Program	760	45,000	(44,240)	1%	60,000	7,190	45,000	(37,810)
Meningococcal C Program	255	7,500	(7,245)	3%	10,000	298	7,500	(7,202)
Interest Revenue	8,390	1,500	6,890	420%	2,000	3,039	1,500	1,539
Other Revenues	19,982	123,750	(103,768)	12%	165,000	26,183	56,250	(30,067)
Funding Holding	0	0	0	100%	0	0	0	0
Funding Ontario Tobacco Strategy	321,176	342,825	(21,649)	70%	457,100	315,326	319,200	(3,874)
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	562,500	(562,500)
First Nations Inititative -One Time	112,214	0	112,214	100%	0	0	112,500	(112,500)
	$ 11,126,283	$ 10,411,645	$ 714,638		$ 13,882,193	$ 10,825,570	$ 10,809,507	$ 16,063
Summary								
Levies	3,280,533	2,440,042	840,492	134%	3,253,389	3,109,942	2,331,151	778,791
Funding Grants	7,379,339	7,353,450	25,889	100%	9,804,600	7,304,497	7,927,703	(623,206)
Fees & Recoveries	466,410	618,153	(151,743)	75%	824,204	411,130	550,653	(139,523)
	$ 11,126,283	$ 10,411,645	714,638	107%	$ 13,882,193	$ 10,825,570	$ 10,809,507	$ 16,063

Algoma Public Health

Expense Statement- Public Health

For the Nine Months Ending September 30, 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	$ 5,811,106	$ 6,097,472	286,366	71%	$ 8,129,963	$ 5,961,327	$ 6,209,502	$ 248,175	1
Benefits	1,427,327	1,522,496	95,169	70%	2,029,995	1,506,578	1,552,374	45,796	2
Travel - Car Allowances	39,767	46,470	6,703	64%	61,960	78,528	111,513	32,984	3
Travel - Mileage	101,273	94,085	(7,188)	81%	125,447	82,775	105,809	23,034	3
Travel - Other	49,525	94,731	45,206	39%	126,308	91,151	99,231	8,080	3
Program	724,162	543,187	(180,975)	100%	724,249	594,079	644,053	49,974	4
Program Equipment Purchased			-	0%		307	375	68	
Office	52,486	98,962	46,477	40%	131,950	77,376	127,650	50,274	4
Computer Services	543,525	577,297	33,771	71%	769,729	446,488	612,937	166,450	4
Telephone Charges	23,757	36,197	12,440	49%	48,263	34,897	80,072	45,176	5
Telecommunications	126,910	128,221	1,311	74%	170,961	136,380	107,250	(29,130)	5
Program Promotion	91,495	158,687	67,192	43%	211,583	62,945	151,676	88,731	4
Facilities Expenses	523,663	569,326	45,664	69%	759,102	599,915	563,326	(36,588)	6
Renovations			-	0%		116,013	48,750	(67,263)	
Fees & Insurance	243,358	209,618	(33,740)	87%	279,490	185,474	163,500	(21,974)	7
Special Projects	113	0	(113)	100%	0	0	0	0	
Debt Management	342,000	342,000	-	75%	456,000	(44,916)	(110,512)	(65,596)	
Recoveries	(67,565)	(107,106)	(39,541)	47%	(142,808)	79,827	0	(79,827)	8
Elliot Lake Relocation	0		-	0%		341,892	342,000	108	
	$ 10,032,902	$ 10,411,644	$ 378,742		$ 13,882,192	$ 10,351,035	$ 10,809,507	$ 458,472	

Notes to Financial Statements – September 2015

Reporting Period

The September 2015 financial reports include nine 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 six month results from operations year ended March 2016.

Public Health – Statement of Operations (see page 1)

General Comments

As of September 30th, 2015, Public Health programs are reporting a surplus of approximately $1M. On the Revenue side, $840k 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 $25k variance associated with Provincial Grants. Offsetting these positive variances is a $151k negative variance related to the timing of the collection of Program Fees & Recoveries.

There is a positive variance of $378k 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. APH was notified on September 4th, 2015 that it will receive a 0% increase in mandatory program funding from the Ministry. The inherent time lag in filling positions within the agency is also contributing to this variance.

Community Health programs are reporting a surplus of $477k. $103k of the variance noted is attributable to a vacant position within APH's Nurse Practitioner Clinic. In addition, there is a $122k 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. There is a positive $18k variance related to the Diabetes program. Purchases related to the Diabetes Program typically occur within the last quarter of the year.

Notes Continued…

Revenue (see page 2 for details)

Public Health funding revenues are indicating a positive variance of $714k. Driving this is an $840k 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. 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 $103k variance related to Other Revenues. The negative $44k variance related to the Influenza Program should reduce as flu season begins. Collection of Land Control fees have improved since last month and are now showing a positive $3k variance.

Public Health Expenses Budget (see page 3)

Note 1/2– Salaries/Benefits

The positive variance of $286k is a result of two vacant positions which have been gapped as a means of mitigating uncertainty surrounding the Board of Health request to the Ministry of a 2.5% funding increase for mandatory programs. In addition, the vacant permanent Medical Officer of Health (MOH) position is impacting the noted positive variance. 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 $95k with regards to benefits. In addition, the vacant permanent MOH role is contributing to this positive variance.

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

Car allowance is showing a positive $6k variance. This is a result of the elimination of car allowance as collectively bargained.

Mileage is showing a negative $7k variance. This is a result of staff now being reimbursement at or near CRA rates as collectively bargained.

Travel - Other is showing a positive $45k variance. Staff travel has been less than in previous years.

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

Program expenses are indicating a negative variance of $180k. The purchased services for the Acting CEO and MOH role are driving the noted variance.

Office expense is showing a positive $46k variance as a result of timing of office supply expenditures not yet incurred.

Notes Continued…

Computer Services is showing a positive variance of $33k. This is a result of planned equipment purchases not yet incurred (laptop/desktop replacements). These purchases will be taking place before the end of the calendar year.

Program Promotion is showing a positive variance of $67k. Program Promotion expenses have been less than anticipated.

Note 5 – Telephone Charges/Telecommunications

Telephone Charges are indicating a positive variance of $12k. This is due to timing of expenditures not yet incurred.

Telecommunications is operating within budget.

Note 6 – Facilities Expenses/Renovations

Facilities Expenses is showing a positive variance of $45k. 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 $33k. 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 $39k. 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 August 2015. Cash includes $.698 million in short-term investments. A portion of the short-term investments relates to insurance settlement funds associated with the Elliot Lake mall collapse and will be used to help finance renovations for the new Elliot Lake offices.

There are no collection concerns for accounts receivable.
Long term debt of $5.872 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 September 2015		September 2015		December 2014
Assets				
Current				
Cash & Investments	$	**2,343,144**	$	2,289,828
Accounts receivable		**447,073.45**		413,625
Receivable from municipalities		**779,085**		12,840
Receivable from Province of Ontario		**-**		
Subtotal Current Assets		***3,569,303***		*2,716,292*
Financial Liabilities:				
Accounts Payable & Accrued Liabilities		**1,624,541**		1,698,086
Payable to Gov't of Ont/Municipalities		**272,598**		701,964
Deferred Revenue		**638,238**		555,359
Employee Future Benefit Obligations		**2,417,999**		2,417,999
Capital Lease Obligation		**213,730**		539,027
Term Loan		**6,114,240**		6,114,240
Subtotal Current Liabilities		**11,281,346**		12,026,675
Net Debt		**(7,712,044)**		(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		**14,767,514**		13,169,175

Algoma Public Health – GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**REFERENCE #:**	02-04-030
DATE:	O: February 13, 1996 Revised: May 28, 2015 Revised: October 28, 2015	**SECTION:**	Board Policy
PAGE:	1 of 13	**SUBJECT:**	Procurement Policy

1.0 PURPOSE

The purpose of this policy is:

a) To ensure that the Board of Health for the District of Algoma Health Unit (the Board) utilizes fair, reasonable and efficient methods to procure quality goods and services required to execute the Board's programs and services.

b) To ensure Algoma Public Health (APH) aims to be accountable and transparent when procuring goods and services while safeguarding the assets of the agency.

c) To protect the financial interest of APH while meeting the needs of its programs and services it offers within the District of Algoma.

d) To promote and ensure the integrity of the procurement process and to ensure the necessary controls are present for a public institution.

2.0 POLICY ACCOUNTABILITY AND RESPONSIBILITIES

The Board of Health for the District of Algoma Health Unit is accountable to ensure that Algoma Public Health uses fair, reasonable and efficient methods to procure quality goods and services required to execute the Board's programs and services. The Board delegates responsibility to Algoma Public Health staff as outlined below:

Medical Officer of Health/CEO

a) Ensures the Executive Team is aware of and follows the Procurement policy

b) Ensures that an adequate system of internal controls is in place related to APH Procurement policy

c) Ensures changes to the Procurement Policy are implemented

d) Report to the Board on any liability incurred as a result of the policy not being followed

The Leadership Team

a) Ensures all staff know and follow policy directions for procurement of goods and services

b) Considers price, quality and timely delivery of the product or service being procured rather than only the lowest invoice price

c) Considers the total acquisition cost

d) Monitors expenses on a regular basis to ensure that they are within the approved budget

Staff

a) Ensure they understand the Procurement Policy

b) Ensure they are accountable for the decision and actions they take pursuant to this policy

c) Continually seek to purchase goods and services in an efficient and cost effective manner

For the purposes of this policy, “Administration” includes the MOH/CEO, Executive Team, Manager of Accounting & Budgeting and the Manager of Records, Storage, and Facilities.

3.0 SCOPE OF APH PROCUREMENT POLICY

This policy applies to the procurement of goods and services for Algoma Public Health. Exemptions of this policy include:

a) Training and Education
   i. Registration for conferences, conventions, courses and seminars
   ii. Magazines, subscriptions, books and periodicals
   iii. Memberships

b) Refundable Employee Expenses
   i. Meal allowances
   ii. Travel expenses

c) Employer’s General Expenses
   i. Payroll deduction remittances
   ii. Government license fees
   iii. Insurance premiums/employee benefits
   iv. Damage and insurance deductible claims
   v. Petty cash replenishment
   vi. Tax remittances

vii. Loan payments
viii. Bank fees and charges
ix. Grants to agencies and partners
x. Payments pursuant to agreements approved by the Board of Health

d) Professional and Special Services
   i. Special tax, accounting and audit services and advice from the Board-approved auditor
   ii. Legal fees and other professional services related to litigation or legal matters
   iii. Witness fees
   iv. Medical, Clinical and Laboratory Services
   v. Honoraria
   vi. Warranty work resulting from contractual obligations

e) Utilities

f) Advertising services required by APH on or in but not limited to radio, television, online, newspaper and magazines

g) Bailiff or collection agencies

h) Software licensing renewals

i) Real Property Interests
   i. All real estate transactions

j) A situation where a competitive process could interfere with the APH's ability to maintain security or order or to protect human, animal or plant life or health

k) Emergency Goods & Services where an unforeseen situation or urgency exists, and the goods or services cannot be obtained through a competitive process. Purchase of these emergency items must be authorized by the CFO or the Medical Officer of Health/CEO. An unforeseen situation of emergency does not occur where APH has failed to allow sufficient time to conduct a competitive process.

l) Goods & services where there is only one supplier available and no alternative or substitute exists

4.0 PROCUREMENT PROCEDURES

The purchasing cycle includes the following steps:

a) Authority to purchase goods and services through budget approval and delegation of duties by the Board of Health

b) A purchase requisition/ purchase order approval

c) Receipt of goods/services and invoice

d) Payment made to vendor

All goods and services necessary to support Algoma Public Health programs and services must be authorized and follow the appropriate purchasing procedures.

4.1 Signing Authority and forms of Commitment by Role

Expenditure $ Amount	Required Approval
0-$500	Executive Assistant to CEO or MOH/Board Secretary or Executive Assistant to Executive Team
$0-2,500	Program Manager
$0 - $10,000	Any Director or Manager of Accounting & Budgeting
$0 - $50,000	CEO or MOH or CFO
Greater than $50,000	Board of Health

4.2 General Guidelines

a) The spending authorization limits noted above and throughout this policy are before applicable taxes

b) The goods or services purchased must be taken in their entirety (and not broken down into component parts)

4.3 Purchase Requisition/Purchase Order.

For the purposes of this Policy, an APH Purchase Order will serve as the request to purchase a good or service (purchase requisition) by staff. Requisitions may be initiated at any level, but only the above named positions can bind a Purchase Order through the authorization levels as defined by the dollar amounts noted above. A Purchase Order serves as the legal offer to buy products or services from a vendor. Once a vendor accepts a P.O from APH, a contract now exists to purchase the goods or services.

a) The Purchase Requisition/Purchase Order is used to request a vendor or administration to acquire materials, parts, supplies, equipment, or services.

b) The Purchase Requisition/Purchase Order is a three (3) part form with a pre-printed number. The white copy is to be forwarded to the vendor via mail or electronic means, the yellow copy is to be forwarded to APH Accounts Payable. APH Accounts Payable will use the Purchase order number to match with the vendor invoice in addition to the receipt documentation such as a packing slip in order to execute payment. Once payment is completed, documentation is filed by APH Accounts Payable. The pink copy along with copies of all documentation should be retained by the requisitioning department for future inquiry,

c) The requisitioning program is responsible for providing the complete account number, and appropriate signature(s) as indicated by Signing Authority established in this policy.

d) All quotations and correspondence from the vendor and supporting documentation (e.g., written bids, letters of justification and/or Sole Source Justification) must be attached by the requisitioning department to the Purchase Order when submitted to APH Accounts Payable.

e) Administration reserves the right to seek additional bids from other qualified sources as it deems appropriate.

f) Departments should anticipate their requirements to allow adequate lead time for order processing and product delivery. Item descriptions should be complete and accurate to allow buyers to bid the requirements expeditiously.

g) Petty Cash purchases are not required to provide a purchase order.

4.4 Change Order – Cancellation or Modification of a Purchase Order

Only Administration is authorized to change a purchase order. Changes in a previously issued purchase order can be made only by a new purchase order marked “Change Order”. The changes may refer to price, quantities ordered, terms and conditions, delivery point, etc. Please contact Administration for assistance with Change Orders.

4.5 Blanket Purchase Orders

A Blanket Purchase Order is a purchase order APH makes with a supplier which contains multiple delivery dates over a period of time, often negotiated to take advantage of predetermined pricing. It is normally used when there is a recurring need for expendable goods (i.e. birth control pills, vaccines, etc.). Blanket Purchase Orders are often used when APH buys large quantities of a particular good and has obtained special discounts as a result of bulk purchasing.

Request to enter into a blanket Purchase Order must be approved by the CFO or Manager of Accounting and Budgeting. A blanket Purchase Order generally should not exceed 1year. The associated Program Manager and their reporting Director must approve the Blanket Purchase Order. As a need for the product is recognized within the program, an order form template must be completed and approved by staff.

4.6 Cheque Requisition

For miscellaneous or non-competitive purchases, payment for goods and services may be initiated by completing a Cheque Requisition. A Cheque Requisition is completed by the department making the request and is authorized and signed by the employee’s Manager. Cheque Requisitions require the approval of the CFO or Manager of Accounting and Budgeting.

4.7 Petty Cash

Petty cash **may be used for immediate needs such as** stationery, or miscellaneous program material supply purchases of $200 and under. Petty cash **may not be used** for travel expenses, business meetings, meals, personal loans, registration fees, equipment purchases, consultant fees or any other type of personal service payments, salary advances or the cashing of personal cheques.

Disbursements from the Petty Cash Fund must be properly documented with original itemized receipts approved by the employees Manager or a Director and include the appropriate cost center as to where the charges should be expensed to. Receipts should include a description of the business purpose of the transaction, goods, or services purchased and the date. (See petty cash policy).

4.8 Use of Corporate Credit Card

Corporate credit cards are authorized by the Board of Health to permit staff to carry out approved business transactions. Purchases made via a corporate credit card must follow the guidelines as set out in this policy.

5.0 VENDOR SELECTION AND QUOTATION PROCEDURE

5.1 Requests for Bids/Quotations/Proposals/Tenders and Dollar Thresholds

Requests for bids, quotations and proposals are **mandated** for the purchase of all goods and services according to the following guidelines:

- $1 – $5,000: Bids, quotations and/or proposals are **recommended but not required**.
- $5,000 – $15,000: Two (2) written or faxed bids, quotations, and/or proposals **are required**.
- $15,000 to $50,000: Three (3) written bids, quotations, and/or proposals **are required**.
- For purchases greater than $50,000 a formal Request for Quotation (Tender) must be adhered to. Board approval is required once the successful bidder is chosen.

The time frames for soliciting this information are generally ten (10) business days. **The submission of split requisitions in an attempt to circumvent the bidding policy is not allowed**.

Faxed or written bids, quotations and/or proposals must go through APH Administration.

Vendors submitting an RFQ should be in good standing with APH. Administration may, at their discretion, secure other competitive bids regardless of the dollar thresholds listed at any time. Furthermore, Administration may, at their discretion, conduct negotiations with more than the apparent low bidder when it is deemed to be in APH's best interest to do so.

As APH strives to provide the best quality of program offerings and services, the lowest price received in the bid and RFQ process may not always be accepted. In such cases, justification for choosing an alternative bid or RFQ must accompany the package of bids or RFQs. In some

cases, the required number of formal bids may not be possible (i.e. potential vendors decides not to bid). In such cases, evidence of solicitation of the required number of bids as outlined in this policy must be maintained.

Bids and RFQs should be filed for a minimum of 2 years. Purchasing decisions are based on price, quality, availability and suitability.

5.2 Confidentiality of Bids/Quotations/Proposals

In accordance with fair and best business practice, all information supplied by vendors in their bid, quotation or proposal must be held in strict confidence by the employee evaluating the bid, quotation or proposal and may not be revealed to any other vendor or unauthorized individual. Failure to do so may result in termination.

5.3 Late Bids/Quotations/Proposals

a) All bids, quotations and proposals are to be date and time stamped to assure that they are received prior to the deadline for submission. It is the responsibility of the vendor to ensure that their bids are received by the responsible person no later than the appointed hour of the bid opening date as specified on the request for bid.

b) **Late submissions will not be considered**.

5.4 Errors in Bids/Quotations/Proposals

a) Vendors are responsible for the accuracy of their quoted prices. In the event of an error between a unit price and its extension, the unit price will govern. Quotations may be amended or withdrawn by the bidder up to the bid opening date and time, after which, in the event of an error, bids may not be amended but may be withdrawn prior to the acceptance of the bid.

b) After an order has been issued, no bid may be withdrawn or amended unless the Administration considers the change to be in APH's best interests.

5.5 Sole Source Procurement and Justification

The Director, in consultation with the applicable Manager, shall initiate sole source purchases provided that any of the following conditions apply:

a) where there is only one known source

b) where the compatibility of a purchase with existing equipment, facilities, or services is a paramount consideration

c) when competition is precluded because of the existence of patent rights, copyrights, trade secrets

d) where the procurement is for electric power or energy, gas, water or other utility services

e) where it would not be practical to allow a contractor other than the utility company itself to work upon the system

f) where a good is purchased for testing or trial use

g) where it is most cost effective or beneficial to APH

h) when the procurement is for technical services in connection with the assembly, installation or servicing of equipment of a highly technical or specialized nature

i) when the procurement is for parts or components to be used as replacements in support of equipment specifically designed by the manufacturer

j) when a contractor is already at work on the site (based on an existing Purchase Order) and it would not be practical to engage another contractor

6.0 SPECIAL PROCUREMENT POLICIES

6.1 CONTRACTS/LEASES

Signing authority to enter into a contract/lease will follow the limits as set out in section 4.1 of this policy. In addition;

The Board of Health must approve contracts where:

a) Irregularities preclude the award of a contract to the lowest bidder in the Tending and Request for Quotation process **and** the 'total acquisition cost' exceeds $50,000,

b) A bid solicitation has been restricted to a single source supply and the 'total acquisition cost' of such goods or services exceeds $50,000

c) The contract/lease is for multiple years and exceeds $50,000 per year

6.2 Consulting Services

Consulting Services are provided by an individual or company with expertise or strategic advice. The individual is working under a contract relationship rather than an employee relationship.

The acquisition of **all** consulting services **must** be sought through a competitive process. The limits for the competitive process for consulting services are as follows:

- $1 – $50,000: Three (3) written or faxed bids, quotations, and/or proposals **are required**.

- For purchases greater than $50,000 a formal Request for Quotation must be adhered.

All contractual agreements with consultants up to $50,000 must be approved by the Medical Officer of Health/CEO **and** CFO. Consulting Contracts for more than $50,000 requires the approval of the Medical Officer of Health/CEO **and** the Board of Health.

If an emergency consulting services situation arises where a competitive process is not practical or feasible, the Chair **or** Vice Chair of the Board of Health must be notified by the MOH/CEO. Allowable exceptions for a non-competitive procurement of consulting services include:

a) Situations of urgency where the consulting services cannot be obtained by means of a competitive process. An urgent situation does not include the failure to plan ahead leaving insufficient time.

b) Where consulting services regarding maters of a confidential or privileged nature are being purchased and disclosure of those maters would be contrary to public interest.

c) Where a competitive process could interfere with APH's ability to protect human, animal or plant life or health.

d) Where there is an absence of the required number of bids in response to a competitive procurement process based on this policy

Consulting Services do not include services in which the physical component of an activity would be prevailing. For example, services for the operation and maintenance of a facility or plant;

Consulting services do not include any licensed professional services such as medical doctors, dentists, nurses, pharmacists, engineers, chartered accountants, lawyers, actuaries, land surveyors, etc. engaged to work on behalf of APH.

All consultants working on behalf of APH who will have direct access to APH financial records, bank accounts, or employee records as per the terms of their contract are required to provide a current police information check (PIC). This includes but is not limited to any consultant or licensed professional who will serve in the capacity of APH's Chief Financial Officer/Business Administrator, Manager of Accounting and Budgeting, Payroll Administrator, Information Technology support, or Director of Human Resources.

All consultants or service providers working on behalf of APH who will interact with children, youth or vulnerable persons as per the terms of their contract are required to provide a current police vulnerable sector check (PV5C). If the service provider is required to provide a criminal reference check to their Regulatory College as part of the annual licensure process, an attestation from the service provider along with the copy of their current licensure will be accepted.

Provision of the required criminal record search is required prior to commencement of any consulting work with APH. All offers for consulting services are conditional on receipt of satisfactory criminal reference checks.

References

All consultants are required to provide the names and contact information of at least two (2) references for which similar services were recently provided. This includes, but is not limited to any consultant or licensed service provider who is a nurse.

Positive references are required prior to commencement of any consulting work with APH. All offers for consulting services are conditional on receipt of satisfactory reference checks.

6.3 Approvals for Construction and Alterations to Physical Space

a) All requisitions for construction, renovation, or alteration to physical space at Algoma Public Health under $50,000 require the review and prior written approval of the CFO **and** the Medical Officer of Health/CEO**.** Over $50,000, they require authorization of the Board of Health.

b) Detailed specifications, drawings, and/or blue prints, if appropriate, should accompany the Purchase Requisition. Requisitions submitted to Accounts Payable without the prior written approval will not be processed.

6.4 Equipment and Equipment Screening

a) Algoma Public Health has established a policy governing the acquisition, control, and disposition of Algoma Public Health equipment.

b) It is the policy of Algoma Public Health to ensure that every effort is made to avoid the purchase of unnecessary or duplicate equipment.

c) The purchasing authorization levels by role defined in the policy will govern equipment purchases.

7.0 PROHIBITIONS

7.1 Conflicts of Interest

a) Employee shall not place themselves into positions where they could be tempted to prefer their own interests or the interest of another, over the interest of the public that they are employed to serve. Whenever employees, during the discharge of their duties, become exposed to or involved in actual/or potential Conflicts of Interest, they must disclose the situation to their Manager/ Director/MOH/CEO/Board of Health (as may be appropriate) and shall abide by the advice given.

7.2 Gifts, Gratuities, and Kickbacks

Algoma Public Health policy prohibits all employees from accepting gifts, gratuities or kickbacks of any value from vendors or service providers to Algoma Public Health**.** Items of a very minimal value which are of an advertising nature only, and available to other customers may be accepted (e.g. pens, hats, coffee cups, etc.). Any questions an APH employee may have as the appropriateness of the value of the item must be communicated to the employee's Manager/ Director/ MOH/CEO/Board of Health (as may be appropriate).

7.3 Personal Purchases

The purchase of any goods or services for personal use by or on behalf of any APH employee, for purposes other than the bona fide requirements of APH is strictly prohibited.

7.4 Disposal of Surplus Goods

The Disposal of surplus and obsolete equipment shall be evaluated on a case by case basis.

The CFO in conjunction with the MOH/CEO shall have the authority to sell, exchange, or otherwise dispose of Goods declared as surplus needs of APH, and where it is cost effective and in the best interest of APH to do so. Items or groups of items may:

a) Be offered for sale to other Health Units, affiliates or other government agencies or public authorities; or
b) Be sold by external advertisement, formal request, auction or public sale (where it is deemed appropriate, a reserve price may be established); or
c) Be donated to a not-for-profit agency; or
d) Be recycled; or
e) In the event all efforts to dispose of Goods by sale are unsuccessful, these items may be scrapped or destroyed if recycling is unavailable

No disposition of such Good(s) shall be made to employees, elected officials, or their family members.

7.5 Purchase of Surplus Goods

As appropriate, the Manager of Accounting and Budgeting and/or the CFO shall record the disposition of Tangible Capital Assets.

7.6 Division of Contracts

The division of a contract to avoid the requirements of this policy is prohibited.

8.0 Review and Evaluation

The effectiveness of this policy will be evaluated and reviewed every five years by the Board of Health, or more frequently as required. This review will include both legislative requirements and best practices.

Glossary of Roles Noted within Algoma Public Health Procurement Policy

Administration – consist of the Medical Officer of Health/CEO, the Executive Team, the Manager of Accounting & Budgeting and the Manager of Records, Storage and Facilities.

Board of Health for the District of Algoma Health Unit - is the governing body of Algoma Public Health and is established by the provincial public health legislation, the Health Protection and Promotion Act, RSO 1990, (HPPA) and regulations.

Chair of the Board – is the highest officer of Algoma Public Health. The individual holding this position is elected by members of the Board of Health for the District of Algoma Health Unit.

Consultant – is an individual or company that provides expertise or strategic advice to Algoma Public Health. The individual is working under a contract relationship rather than an employee relationship and is paid through submission of invoices. Consulting services do not include any licensed professional services engaged to work on behalf of Algoma Public Health.

Executive Team – consists of the Medical Officer of Health/CEO, the Chief Financial Officer, Director of Human Resources, Program Directors.

Leadership Team – consists of the Executive Team plus Program Managers, the Manager of Accounting and Budgeting and the Manager of Records, Storage and Facilities.

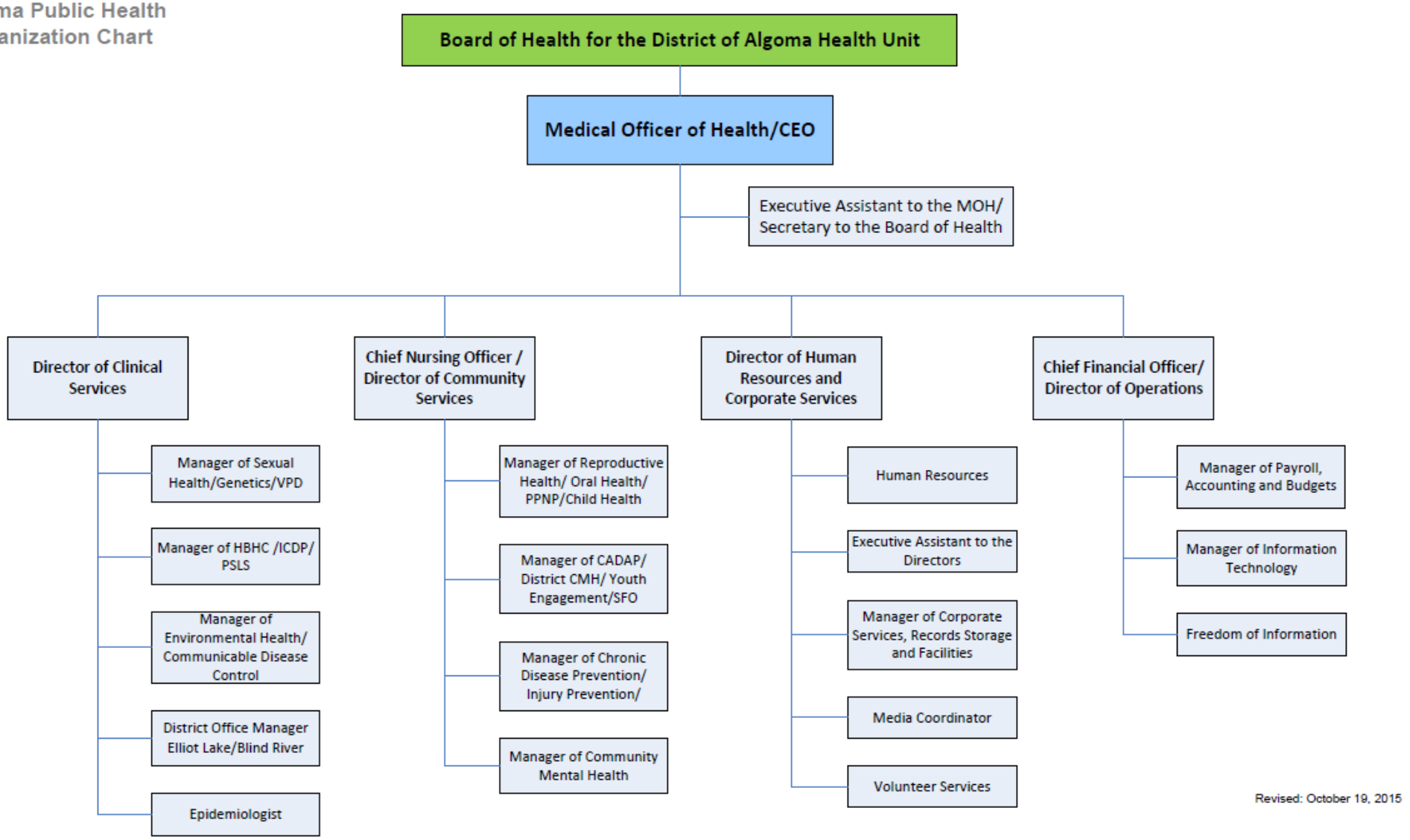
Staff/Employee – a person who is hired to provide services to a company on a regular basis in exchange for compensation and who does not provide these services as part of an independent business.

Vendor – the party in the supply chain that makes the goods or services available or sells something to Algoma Public Health.

Vice Chair of the Board - is the second highest officer of Algoma Public Health behind the Chair of the Board. The individual holding this position is elected by members of the Board of Health for the District of Algoma Health Unit.

Original: February 13, 1996
Revised: March 2006
Revised: February 24, 2009
Revised: March 18, 2015
Revised: May 20, 2015
Revised: October 28, 2015

Algoma Public Health Organization Chart



Revised: October 19, 2015

Algoma Public Health - GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**BY-LAW #:**	95-1
DATE:	O: December 13, 1995 Revised: February 2011 Revised: October 28, 2015	**SECTION:**	Board
PAGE:	1 of 9	**SUBJECT:**	To Regulate the Proceedings of the Board of Health

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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. The Vice-chair shall chair at least one of the standing committees of the Board.

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, *Robert's Rules of Order* 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 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.

Meetings

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, council or the province.

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.

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 electronic means 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.

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.

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

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.

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.

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.

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

17. When two or more members ask to speak, the Chair shall name the member who, in his opinion, first asked to speak. The Chair shall develop a speakers list when more than one member wishes to address each item.

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.

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.

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

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.

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.

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.

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.

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

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

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

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

Conduct of Business in Committees

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

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

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

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 Chief Financial Officer.

Short Name

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

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.

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/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/CEO and by the appropriate program Director.

    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

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/CEO using input from the Medical Officer of Health/CEO as well as 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.

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

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/CEO

39. A decision by the Board of Health to dismiss a Medical Officer of Health/CEO 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) in situations where the Medical Officer of Health is a separate position from the CEO position the Minister consents in writing to the dismissal of the MOH.

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

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/CEO; 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/CEO

1. The Medical Officer of Health/CEO 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/CEO of a board of health is entitled to notice of and to attend each meeting of the Board and every committee of the Board, but the Board may require the Medical Officer of Health/CEO to withdraw from any part of a meeting at which the Board or 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 28th day of October 2015

Algoma Public Health – GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-015
DATE:	O: January 18, 1995 Reviewed: June 17, 2014 Revised: October 28, 2015	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	Conflict of Interest

POLICY:

Each member of the Board of Health has the obligation to avoid ethical, legal, financial or other conflicts of interest and to ensure that their activities and interests do not conflict with their obligations to the Board of Health of the Algoma District Health Unit (operating as Algoma Public Health) or its welfare.

The basic concept underlying the development of guidelines on conflict of interest is to prevent conflict of interest from arising by placing responsibility on the member for disclosing any conflicts of interest to the meeting or for removing oneself from the Board if employment with the Board is being sought by the member.

A board member should not use information that is not public knowledge, obtained as a result of his or her appointment, for personal benefit.

No board member should divulge confidential information obtained as a result of his or her appointment unless legally required to do so.

The purpose of the Conflict of Interest Policy is to:

i) assist individual board members in determining when his or her participation on a board decision/discussion has the potential to be used for personal or private benefit, financial or otherwise;
ii) protect the integrity of the Board as a whole and its members by following the conflict of Interest Policy and Procedures

Definitions: A conflict of interest situation arises where a member either on his/her own behalf or while acting for, by, with or through another, has any direct or indirect non-pecuniary or pecuniary interest in any contract or transaction with the Board or in any contract or transaction that is reasonably likely to be affected by a decision of the Board.

Actual conflict of interest: a situation where a board member has a private or personal interest that is sufficiently connected to his or her duties and responsibilities as a board member that it influences the exercise of these duties and responsibilities

Perceived conflict of interest: a situation where reasonably well-informed persons could properly have a reasonable belief that a board member may have an actual conflict even where that is not the case in fact

Procedure:

1) At the beginning of every Board meeting, the Board Chair shall ask and have recorded in the minutes whether any board member has a conflict to declare in respect to any agenda item.

2) A Board member shall declare a conflict of interest at the earliest opportunity. In an open session of a Board meeting the member may remain in the room. Should the Board be in an in-camera session the board member shall leave the room until the agenda item has been decided.

3) In situations where a board member declares a perceived conflict of interest the Board will determine by majority vote whether the member(s) participate in the discussion and vote on the item. The minutes should reflect the discussion and the Board decision on the matter. Alternately the board member may decide on his or her own accord to not participate in the discussion and to not vote on the agenda item in question.

4) Resignation in writing from the Board prior to seeking employment with programs administered by the Board; however, the member may seek re-appointment if not successful in the job competition.

Where a conflict of interest is discovered during or after consideration of a matter it is to be declared to the Board at the earliest opportunity and recorded in the minutes. If the board determines that the involvement of the member declaring the conflict influenced the decision on the matter, the Board shall re-examine the matter and may rescind, vary, or confirm its decision. Any action taken by the Board shall be recorded in the minutes

Where there has been a failure on the part of a Board member to comply with this policy, unless the failure is the result of a bona fide error in judgement as determined by the Board, the Board shall request that the Chair, :

i) Issue a verbal; or
ii) Issue a written reprimand; or
iii) Request that the Board member resign or
iv) Seek dismissal of the Board member based on regulations relevant as to how the board member \ was appointed.

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Algoma Public Health – GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-030
DATE:	O: June 20, 2007 Reviewed; June 17, 2014 Revised October 28, 2015	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	Board Member Code of Conduct

The Algoma Public Health Board believes that its members must adhere to a high standard of ethical behavior in all aspects of their conduct at all times and that all members shall fulfill their duties in a manner that maintains and enhances confidence in the APH Board.

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).

CODE OF CONDUCT:

Board Members shall:

1) Adhere to all Board of Health bylaws, policies, and rules of procedure and perform their duties with integrity, transparency and accountability.

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

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

4) Keep in confidence any confidential information acquired by virtue of their position as a Board member

5) Preserve a state of neutrality by referring via email all questions or requests related to APH programs and services whether of a personal nature or on behalf of others to the MoH /CEO who will be responsible for initiating a course of action appropriate to the circumstances including advising the Chair of the request via email and advising the board member and the Chair of the outcome.

6) Review board package materials in advance of the meeting and participate productively in the meeting .

7) Recognize that only the Board of Health Chair speaks for the Board on public disclosures unless the Chair delegates that responsibility on a specific topic.

8) Interact with each other, staff and members of the public with respect, diplomacy and dignity.

9) Support one another and the MOH/CEO. If a Board member has a performance concern regarding the MOH/CEO or a fellow Board member, that concern shall be brought to the Board through the Chair.

10) Agree that the Board of Health Chair will mediate any disputes between Board members and/or the MOH/CEO in situations where the parties were unable to resolve the issue.

Where there has been a failure on the part of a Board member to comply with this policy, unless the failure is the result of a bona fide error in judgement as determined by the Board, the Board shall request that the Chair, :

i) Issue a verbal; or
ii) Issue a written reprimand; or
iii) Request that the Board member resign or
iv) Seek dismissal of the Board member based on regulations relevant as to how the board member \ was appointed.

Algoma Public Health – GENERAL ADMINISTRATIVE – Policies and Procedures Manual

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-060
DATE:	O: October 28, 2015	**SECTION:**	Board of Health
PAGE:	1 of 2	**SUBJECT:**	Meetings and Access to Information

PREAMBLE:

As reflected in the Algoma Public Health Strategic Plan the Board of Health strongly supports the principles of accountability and transparency. This policy regarding Meetings and Access to Information instructs the Board and informs the public as to:

i) how meetings of the Board will be held
ii) how the public can access information from Board meetings
iii) how information from Board meetings will be disseminated
iv) the terms under which a meeting or part of a meeting may be closed to the public in accordance with Section 239 of the *Municipal Act.*

POLICY:

Board of Health meetings are open to the public and the Board will conduct its meetings subject to Section 239 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.

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.

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.*

Algoma
PUBLIC HEALTH
Santé publique Algoma

www.algomapublichealth.com

October 28, 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

At its meeting on September 22, 2015 the Board of Health for the District of Algoma Health Unit considered the correspondence forwarded by the Sudbury and District Health Unit in regards to the evacuations of First Nations communities in Northern Ontario.

This Board supports their recommendations as outlined in their attached letter and hopes that you will consider the need for a proactive, planned and adequately resourced evacuation system to ensure the safety of all First Nations Communities affected.

Thank you for your consideration.

Sincerely,

Lee Mason
Chair, Board of Health

Attachment

Cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. David Orazietti, MPP for Sault Ste. Marie
Michael Mantha, MPP for Algoma-Manitoulin
Association of Local Public Health Agencies
Ontario Boards of Health

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

Elliot Lake
50 Roman Avenue
Elliot Lake, ON P5A 1R9
Tel: 705-848-2314
TF: 1 (877) 748-2314
Fax: 705-848-1911

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

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

COUNCIL REPORT

September 28, 2015

TO: **Mayor Christian Provenzano and Members of City Council**

AUTHOR: **Jacob Bruzas, Manager of Audits and Capital Planning**

DEPARTMENT: **Finance Department**

RE: **RFP for External Audit Services (2015TA02P)**

PURPOSE

Attached hereto for your information and conside ation is a report prepared on behalf of the Evaluation Committee concerning proposals received for the provision of External Audit Services for the five (5) year period commencing with the 2015 year end audit.

BACKGROUND

The Request for Proposal was publicly advertised and RFP documents forwarded to all firms on our bidders list. Proposals were required to be submitted for consideration no later than 4:00 p.m. on August 14, 2015.

ANALYSIS

Proposals from two (2) proponents were received prior to the closing date.

BDO Canada LLP

KPMG LLP

The proposals received have been evaluated by a committee comprised of staff from the Finance Administration Division – Finance Department; the Accounting Division – Finance Department; and the Sault Ste. Marie District Social Services Administration Board.

It is the consensus of the evaluation committee that the proponent scoring the highest in the evaluation process was KPMG LLP. KPMG LLP is presently providing External Audit Services for the City of Sault Ste. Marie.

The City's Finance Committee passed the following resolution at its September 11, 2015 meeting supporting the recommendation of the Evaluation Committee.

Resolved that the Finance Committee supports the recommendation of the RFP Evaluation Committee which recommends that City Council approve the appointment of KPMG LLP, to provide External Audit Services for the City of Sault Ste. Marie for a five (5) year period commencing with the 2015 year end audit with the option for an additional two (2) years.

IMPACT
Fees of approximately $120,910 plus H.S.T. will be billed in the first year for these services; with adjustments for each subsequent year. The City will be responsible for fees of approximately $62,250 plus H.S.T. for the 2015 year end audit; with its Boards and Agencies responsible for the balance.

STRATEGIC PLAN
Provision of External Audit Services is not an activity listed in the Corporate Strategic Plan.

RECOMMENDATION
Resolved that the report of the Manager of Audits and Capital Planning dated 2015 09 28 be received, and the recommendation that the proposal submitted by KPMG LLP to provide External Audit Services as required by the City of Sault Ste. Marie, be approved. The appointment as municipal auditor will be for a five (5) year period commencing with the 2015 year end audit; allowing for an additional two (2) year extension by mutual agreement. By-law 2015-168 appointing KPMG LLP as the municipal auditor, pursuant to Section 296 of the Municipal Act, 2001, appears elsewhere on this Council Agenda.

Respectfully submitted,

Jacob Bruzas, CPA, CA
Manager of Audits & Capital Planning

JB/

Lettie Della-Savia

From: eAGENDA Notification <DoNotReply@cityssm.on.ca>
Sent: Thursday, October 01, 2015 9:59 AM
To: Kathleen Lavergne
Subject: Agenda Notification for Regular Council Meeting_Sep28_2015

This is an automated message from eSCRIBE.

Agenda Item: By-law 2015-168 (Finance) Appoint Municipal Auditor
Description: A report from the Manager of Audits and Capital Planning is on the Agenda.
Minutes:
Resolution(s):

Resolution:	Resolved that all By-laws under item 11 of the Agenda under date 2015 09 18 be approved, save and except 2015-166, 2015-167 and 2015-171.
Moved By:	Councillor J. Hupponen
Seconded By:	Councillor R. Niro
Vote Type:	Majority
Result:	Carried

:

Resolution:	Resolved that By-law 2015-168 being a by-law to appoint the firm of KPMG LLP as municipal auditor to provide External Audit Services as required by the City of Sault Ste. Marie be passed in open Council this 28th day of September, 2015.
Moved By:	Councillor J. Hupponen
Seconded By:	Councillor R. Niro
Vote Type:	Majority
Result:	Carried

Task(s):

Lettie Della-Savia

From: eAGENDA Notification <DoNotReply@cityssm.on.ca>
Sent: Thursday, October 01, 2015 9:59 AM
To: Kathleen Lavergne
Subject: Agenda Notification for Regular Council Meeting_Sep28_2015

This is an automated message from eSCRIBE.

Agenda Item: RFP for External Audit Services (2015TA02P)

Description: A report of the Manager of Audits and Capital Planning is attached for the consideration of Council.

The relevant By-law 2015-168 is listed under item 11 of the Agenda and will be read with all by-laws under that item.

Minutes: The report of the Manager of Audits and Capital Planning was received by Council.

The relevant By-law 2015-168 is listed under item 11 of the Minutes.

Resolution(s):

Resolution:	Resolved that all the items listed under date 2015 09 28 – Part One – Consent Agenda be approved as recommended.
Moved By:	Councillor M. Shoemaker
Seconded By:	Councillor R. Niro
Vote Type:	Majority
Result:	Carried

Task(s):

Audit ✓

KPMG LLP
111 Elgin Street, Suite 200
Sault Ste. Marie Ontario P6A 6L6
Canada

Telephone (705) 949-5811
Fax (705) 949-0911
Internet www.kpmg.ca

PRIVATE & CONFIDENTIAL

Mr. Justin Pino, CPA, CMA
Business Administrator
Algoma Public Health
294 Willow Avenue
Sault Ste. Marie, ON P6B 0A9

October 13, 2015

Dear Sir:

The purpose of this letter is to outline the terms of our engagement to audit the financial statements of Algoma Public Health (the "Entity"), commencing for the period ending December 31, 2015.

This letter supersedes our previous letter to the Entity dated February 19, 2014. The terms of the engagement outlined in this letter will continue in effect from period to period, unless amended or terminated in writing. The attached Terms and Conditions form an integral part of the terms of this engagement and are incorporated herein by reference (collectively the "Engagement Letter").

FINANCIAL REPORTING FRAMEWORK FOR THE FINANCIAL STATEMENTS

The financial statements will be prepared and presented in accordance with Canadian public sector accounting standards (hereinafter referred to as the "financial reporting framework").

The financial statements will include an adequate description of the financial reporting framework.

MANAGEMENT'S RESPONSIBILITIES FOR THE FINANCIAL STATEMENTS

Management acknowledges and understands that they are responsible for:

(a) the preparation and fair presentation of the financial statements in accordance with the financial reporting framework referred to above
(b) ensuring that all transactions have been recorded and are reflected in the financial statements
(c) such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. Management also acknowledges and understands that they are responsible for the design, implementation and maintenance of internal control to prevent and detect fraud
(d) providing us with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters
(e) providing us with additional information that we may request from management for the purpose of the audit

(f) providing us with unrestricted access to persons within the Entity from whom we determine it necessary to obtain audit evidence

(g) providing us with written representations required to be obtained under professional standards and written representations that we determine are necessary. Management also acknowledges and understands that professional standards require that we disclaim an audit opinion when management does not provide certain written representations required

An audit does not relieve management or those charged with governance of their responsibilities.

AUDITORS' RESPONSIBILITIES REGARDING THE AUDIT OF THE FINANCIAL STATEMENTS

Our function as auditors of the Entity is:

- to express an opinion on whether the Entity's financial statements, prepared by management with the oversight of those charged with governance, are, in all material respects, in accordance with the financial reporting framework referred to above

- to report on the financial statements

We will conduct the audit of the Entity's financial statements in accordance with Canadian generally accepted auditing standards and relevant ethical requirements, including those pertaining to independence (hereinafter referred to as applicable "professional standards").

We will plan and perform the audit to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error. Accordingly, we will, among other things:

- identify and assess risks of material misstatement, whether due to fraud or error, based on an understanding of the Entity and its environment, including the Entity's internal control. In making those risk assessments, we consider internal control relevant to the Entity's preparation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control

- obtain sufficient appropriate audit evidence about whether material misstatements exist, through designing and implementing appropriate responses to the assessed risks

- form an opinion on the Entity's financial statements based on conclusions drawn from the audit evidence obtained

- communicate matters required by professional standards, to the extent that such matters come to our attention, to the appropriate level of management, those charged with governance and/or the board of directors. The form (oral or in writing) and the timing will depend on the importance of the matter and the requirements under professional standards

AUDITORS' DELIVERABLES

The expected form and content of our audit report(s) is provided in Appendix - Expected Form of Report. However, there may be circumstances in which a report may differ from its expected form and content.

In addition, if we become aware of information that relates to the financial statements after we have issued our audit report, but which was not known to us at the date of our audit report, and which is of such a nature and from such a source that we would have investigated that information had it come to our attention during the course of our audit, we will, as soon as practicable: (1) communicate such an occurrence to the audit committee; and (2) undertake an investigation to determine whether the information is reliable and whether the facts existed at the date of our audit report. Further, management agrees that in conducting that investigation, we will have the full cooperation of the Entity's personnel. If the subsequently discovered information is found to be of such a nature that: (a) our audit report would have been affected if the information had been known as of the date of our audit report; and (b) we believe that the audit report is currently being relied upon or is likely to be relied upon by someone who would attach importance to the information, appropriate steps will be taken by KPMG and expected by the Entity to prevent further reliance on our audit report. Such steps include, but may not be limited to, appropriate disclosures by the Entity of the newly discovered facts and the impact to the financial statements.

INCOME TAX COMPLIANCE AND ADVISORY SERVICES

Tax compliance and advisory services are outside the scope of this letter. These services will be subject to the terms and conditions of a separate engagement letter.

ADDITIONAL SERVICES

- Selected accounting assistance.
- Financial statements presentation and disclosure.
- Attendance at the Board of Health and other management meetings.

FEES

We estimate that our fees for the services described in this letter are $16,500. Circumstances encountered during the performance of these services that warrant additional time or expense could cause us to be unable to deliver them within the above estimates. We will endeavor to notify you of any such circumstances as they are assessed.

Routine administration expenses, such as long distance telephone calls, photocopies, fax charges, printing, postage, delivery, and secretarial time will be charged on the basis of 5% of our professional costs. Out-of-pocket costs such as travel will be charged as incurred.

* * * * * * * * * *

We are available to provide a wide range of services beyond those outlined above. Additional services are subject to separate terms and arrangements.

We are proud to provide you with the services outlined above and we appreciate your confidence in our work. We shall be pleased to discuss this letter with you at any time. If the arrangements and terms are acceptable to the Entity, please sign the duplicate of this letter in the space provided and return it to us.

Yours very truly,

KPMG LLP

Michael Marinovich, CPA, CA, LPA
Partner responsible for the engagement and its performance, and for the report that is issued on behalf of KPMG LLP, and who, where required, has the appropriate authority from a professional, legal or regulatory body.

Enclosure

The terms of the engagement for Algoma Public Health set out are as agreed:

_____
Justin Pino, CPA, CMA, Business Administrator

_____
Date (DD/MM/YY)

APPENDIX - EXPECTED FORM OF REPORT

INDEPENDENT AUDITORS' REPORT

To the Board of Health for the District of Algoma

We have audited the accompanying financial statements of Algoma Public Health, which comprise the statement of financial position as at December 31, 2015, the statements of operations, changes in net debt and cash flows for the year then ended, and notes, comprising a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of Algoma Public Health as at December 31, 2015, and its results of operations and the changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

The Terms and Conditions are an integral part of the accompanying engagement letter from KPMG that identifies the engagement to which they relate (and collectively form the "Engagement Letter"). The Engagement Letter supersedes all written or oral representations on this matter.

1. SEVERABILITY.

If any of the provisions of this Engagement Letter are determined to be invalid or unenforceable, the remaining provisions shall remain in effect and be binding on the parties to the fullest extent permitted by law.

2. GOVERNING LAW.

This Engagement Letter shall be subject to and governed by the laws of the province where KPMG's principal office performing this engagement is located (without regard to such province's rules on conflicts of law) and all disputes arising hereunder or related thereto shall be subject to the exclusive jurisdiction of the courts of such province of Canada.

3. LLP STATUS.

KPMG LLP is a registered limited liability Partnership ("LLP") established under the laws of the Province of Ontario and, where applicable, has been registered extra-provincially under provincial legislation. KPMG is a partnership, but its partners have a degree of limited liability. A partner is not personally liable for any debts, obligations or liabilities of the LLP that arise from a negligent act or omission by another partner or by any other person under that other partner's direct supervision or control. The legislation relating to limited liability partnerships does not, however, reduce or limit the liability of the firm. The firm's insurance exceeds the mandatory professional indemnity insurance requirements established by the relevant professional bodies. Subject to the other provisions hereof, all partners of the LLP remain personally liable for their own actions and/or actions of those they directly supervise or control.

4. DOCUMENTS AND INFORMATION.

Management's cooperation in providing us with documents and related information and agreed-upon assistance on a timely basis is an important factor in being able to issue our report. KPMG shall be entitled to share all information provided by the Entity with all other member firms of KPMG International Cooperative ("KPMG International") performing services hereunder. All work papers, files and other internal materials created or produced by KPMG during the engagement and all copyright and intellectual property rights in our work papers are the property of KPMG.

5. USE OF MEMBER FIRMS AND THIRD PARTY SERVICE PROVIDERS.

Personal and/or confidential information (e.g. entries into KPMG's time and billing system and into KPMG's conflicts database) collected by KPMG during the course of this engagement may be used, processed and stored outside of Canada by KPMG, KPMG International member firms performing services hereunder or third party service providers. KPMG represents to the Entity that each KPMG International member firm and third party service provider providing services hereunder has agreed or shall agree to conditions of confidentiality with respect to the Entity's information. Further, KPMG is responsible to the Entity for causing third party service providers to comply with such conditions of confidentiality, and KPMG shall be responsible to the Entity for their failure to comply and failure of each KPMG International member firm providing services hereunder to comply with its obligations of confidentiality owed to KPMG. Any services performed by third party service providers shall be performed in accordance with the terms of this Engagement Letter, but KPMG shall remain responsible to the Entity for the performance of such services and services performed by each KPMG International member firm providing services hereunder. Such personal and/or confidential information may be subject to disclosure in accordance with the laws applicable in the jurisdiction in which the information is processed or stored, which laws may not provide the same level of protection for such information as will Canadian laws.

6. PERSONAL INFORMATION CONSENTS AND NOTICES.

Any collection, use or disclosure of personal information is subject to KPMG's Privacy Policy available at www.kpmg.ca. KPMG may be required to collect, use and disclose personal information about individuals during the course of this engagement.

The Entity represents and warrants that: (i) it will obtain any consents reasonably required to allow KPMG to collect, use and disclose personal information in the course of the engagement, and (ii) it has provided notice of the potential processing of such personal information outside of Canada (as described in paragraph 5 above). KPMG's Privacy Officer noted in KPMG's Privacy Policy is able to answer any individual's questions about the collection of personal information required for KPMG to deliver services hereunder.

The Entity consents to KPMG sending to the Entity, its officers, directors and employees, as applicable, electronic messages (including emails) relating to KPMG products and services and other matters of interest to the Entity. The Entity, its officers, directors or employees may withdraw such consent by contacting KPMG's National Office located at Bay Adelaide Centre, 333 Bay Street, Suite 4600, Toronto, Ontario M5H 2S5, Attention: Unsubscribe; or info@kpmg.ca.

7. OFFERS OF EMPLOYMENT.

In order to allow issues of independence to be addressed, management agrees that prior to extending an offer of employment to any KPMG partner, employee or contractor, the matter is communicated to the engagement partner or associate partner.

8. OFFERING DOCUMENTS.

If the Entity wishes to include or incorporate by reference the financial statements and our report thereon in an offering document, we will consider consenting to the use of our report and the terms thereof at that time. Nothing in this Engagement Letter shall be construed as consent and KPMG expressly does not consent to the use of our audit report(s) in offering documents. If the Entity wishes to obtain KPMG's written consent to the use of our audit report(s) in an offering document, or wishes us to provide a comfort or advice letter, we will be required to perform procedures as required by professional standards; any agreement to perform such procedures will be documented in a separate engagement letter. Management agrees to provide us with adequate notice of the preparation of such documents.

9. FEE AND OTHER ARRANGEMENTS.

KPMG's estimated fee is based on the quality of the Entity's accounting records, the agreed-upon level of preparation and assistance from the Entity's personnel, and adherence to the agreed-upon timetable. KPMG's estimated fee also assumes that the Entity's financial statements are in accordance with the applicable financial reporting framework and that there are no significant new or changed accounting policies or issues, or financial reporting, internal control over financial reporting or other reporting issues. KPMG will inform the Entity on a timely basis if these factors are not in place.

Additional time may be incurred for such matters as significant issues, significant unusual and/or complex transactions, informing management about new professional standards, and any related accounting advice. Where these matters arise and require research, consultation and work beyond that included in the estimated fee, the Entity and KPMG agree to revise the estimated fee. No significant additional work will proceed without management's concurrence, and, if applicable, without the concurrence of those charged with governance. Upon completion of these services KPMG will review with the Entity any fees and expenses incurred in excess of KPMG's estimate, following which KPMG will render the final billing. Routine administrative expenses such as long distance telephone calls, photocopies, fax charges, printing of statements and reports, postage and delivery and secretarial and report department assistance

will be charged on the basis of a percentage of KPMG's professional costs. Other disbursements for items such as travel, accommodation and meals will be charged based on KPMG's actual disbursements.
KPMG's invoices are due and payable upon receipt. Amounts overdue are subject to interest. In order to avoid the possible implication that unpaid fees might be viewed as creating a threat to KPMG's independence, it is important that KPMG's bills be paid promptly when rendered. If a situation arises in which it may appear that KPMG's independence is threatened because of significant unpaid bills, KPMG may be prohibited from signing the report and, if applicable, any consent.
Fees for any other services will be billed separately from the services described in this engagement letter and may be subject to written terms and conditions supplemental to those in this letter.
Canadian Public Accountability Board (CPAB) participation fees, when applicable, are charged to the Entity based on the annual fees levied by CPAB.
To the extent that KPMG partners and employees are on the Entity's premises, the Entity will take all reasonable precautions for the safety of KPMG partners and employees at the Entity's premises.

10. LEGAL PROCESSES.

The Entity on its own behalf hereby acknowledges and agrees to cause its subsidiaries and affiliates to hereby acknowledge that KPMG may from time to time receive requests or orders from the Canadian Public Accountability Board or from professional, securities or other regulatory, judicial or governmental authorities (both in Canada and abroad) to provide them with information and copies of documents in KPMG's files including working papers and other work-product relating to the affairs of the Entity, its subsidiaries and affiliates. Except where prohibited by law, if a request or order is directly related to an inspection or investigation of KPMG's audit of the Entity, KPMG will advise the Entity of the request or order. The Entity hereby acknowledges that KPMG will provide these documents and information without further reference to, or authority from, the Entity, its subsidiaries and affiliates.
When such an authority requests access to KPMG's working papers and other work-product relating to the Entity's affairs, KPMG will, on a reasonable efforts basis, refuse access to any document over which the Entity has expressly informed KPMG at the time of delivery that the Entity asserts privilege, except where disclosure of documents is required by law. The Entity must mark any document over which it asserts privilege as "privileged". If and only if the authority requires such access to privileged documents pursuant to the laws of a jurisdiction in which express consent is required for such disclosure, then the Entity hereby provides its consent.
Where privileged Entity documents are disclosed, KPMG is directed to advise the authority that the Entity is permitting disclosure only to the extent required by law and for the limited purpose of the authority's exercise of statutory authority. KPMG is directed to advise the authority that the Entity does not intend to waive privilege for any other purpose and that the Entity expects its documents to be held by the authority as privileged and confidential material (held securely, limited distribution, etc.). For greater certainty, the Entity and KPMG hereby agree that this acknowledgement (and, if required, consent) does not negate or constitute a waiver of privilege for any purpose and the Entity expressly relies upon the privilege protections afforded under statute and otherwise under law.
The Entity agrees to reimburse KPMG, upon request, at standard billing rates for KPMG's professional time and expenses, including reasonable legal fees, incurred in dealing with the matters described above.

11. KPMG INTERNATIONAL MEMBER FIRMS.

The Entity agrees that any claims that may arise out of this engagement will be brought solely against KPMG, the contracting party, and not against any other KPMG International Cooperative ("KPMG International") member firms participating in this engagement or such third party service providers referred to in Section 5 above.

12. CONNECTING TO THE ENTITY'S IT NETWORK.

KPMG personnel are authorized to connect their computers to the Entity's IT Network, subject to any restrictions communicated to KPMG from time to time. Connection to the Entity's IT Network or the Internet via the Network, while at the Entity's premises, will be for the express purpose of conducting normal business activities, primarily relating to facilitating the completion of work referred to in this letter.

13. DELIVERABLES OR COMMUNICATIONS.

KPMG may issue other deliverables or communications as part of the services described in this Engagement Letter. Such deliverables or communications may not to be included in, summarized in, quoted from or otherwise used or referred to, in whole or in part, in any documents or public oral statement.
KPMG expressly does not consent to the use of any communication, report, statement or opinion prepared by us on the interim financial statements and such communication, report, statement or opinion may not be included in, summarized in, quoted from or otherwise used in any document or public oral statement.

14. ALTERNATIVE DISPUTE RESOLUTION.

The parties hereby agree that they will first attempt to settle any dispute arising out of or relating to this Engagement Letter or the services provided hereunder through good faith negotiations in the spirit of mutual cooperation between representatives of each of the parties with authority to resolve the dispute. In the event that the parties are unable to settle or resolve their dispute through negotiation within 30 days of the dispute first arising or such longer period as the parties may mutually agree upon, such dispute shall, as promptly as is reasonably practicable, be subject to mediation pursuant to the National Mediation Rules of the ADR Institute of Canada, Inc. All disputes remaining unsettled for more than 60 days following the parties first meeting with a mediator or such longer period as the parties may mutually agree upon shall, as promptly as is reasonably practicable, be subject to arbitration pursuant to the National Arbitration Rules of the ADR Institute of Canada, Inc. (the "Arbitration Rules"). Such arbitration shall be final, conclusive and binding upon the parties, and the parties shall have no right of appeal or judicial review of the decision. The parties hereby waive any such right of appeal which may otherwise be provided for in any provincial arbitration statute made applicable under the Arbitration Rules. The place of mediation and arbitration shall be the city in Canada in which the principal KPMG office that performed the engagement is located. The language of the mediation and arbitration shall be English.

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

September 30, 2015

The Honourable Pierre Poilievre
Minister of Employment and
Social Development
House of Commons
Ottawa, ON K1A 0A6
pierre.poilievre@parl.gc.ca

The Honourable Kellie K. Leitch
Minister of Labour
Ministry of Labour
House of Commons
Ottawa, ON K1A 0A6
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The Honourable Rona Ambrose
Minister of Health
Ministry of Health
House of Commons
Ottawa, ON K1A 0A6
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The Honourable Kevin Daniel Flynn
Minister of Labour
Ministry of Labour
400 University Avenue, 14th Floor
Toronto, ON M7A 1T7
kflynn.mpp@liberal.ola.org

The Honourable Eric Hoskins
Minister of Health and Long-Term Care
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
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ehoskins.mpp@liberal.ola.org

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
56 Wellesley Street West, 14th Floor
Toronto, ON M5S 2S3
tmaccharles.mpp.co@liberal.ola.org

The Honourable Deborah Matthews
Minister Responsible for the
Poverty Reduction Strategy
Room 4320, 4th Floor, Whitney Block
99 Wellesley Street West
Toronto, ON M7A 1W3
dmatthews.mpp.co@liberal.ola.org

Dear Ministers:

Re: Public health support for a basic income guarantee

At its meeting held on September 9, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence forwarded and supported by the Windsor-Essex County Health Unit regarding joint federal-provincial consideration for a basic income guarantee for Ontarians and all Canadians.

The Board echoes the recommendations originally outlined by the Simcoe Muskoka District Health Unit (letter attached) urging you to undertake this initiative in order to address the extensive health inequities in our province, and across the country.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

cc: The Right Honourable Steven Harper, Prime Minister of Canada
The Honourable Kathleen Wynne, Premier of Ontario
Dr. David Williams, Ontario Interim Chief Medical Officer of Health
Association of Local Public Health Agencies
Ontario Public Health Association
Office of the Peterborough Member of Parliament
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Ontario Boards of Health

simcoe muskoka
DISTRICT HEALTH UNIT

May 28, 2015

The Honourable Pierre Poilievre
Minister of Employment and
Social Development
House of Commons
Ottawa, Ontario K1A 0A6

The Honourable Kellie K. Leitch
Minister of Labour
Ministry of Labour
House of Commons
Ottawa, ON K1A 0A6

The Honourable Rona Ambrose
Minister of Health
Ministry of Health
House of Commons
Ottawa, ON
K1A 0A6

The Honourable Kevin Daniel Flynn
Minister of Labour
Ministry of Labour
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The Honourable Eric Hoskins
Minister of Health and Long-Term Care
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

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

The Honourable Deborah Matthews
Minister Responsible for the
Poverty Reduction Strategy
Room 4320, 4th Floor, Whitney Block
99 Wellesley Street West
Toronto, ON M7A 1W3

Dear Minister Poilievre, Minister Leitch, Minister Ambrose, Minister Flynn, Minister Hoskins, Minister MacCharles, and Minister Matthews:

Re: Public health support for a basic income guarantee

On behalf of the Simcoe Muskoka District Health Unit's Board of Health, I am writing today to express our strong support for joint federal-provincial (Ontario) consideration for and investigation into a basic income guarantee for Ontarians and all Canadians.

Several reports in recent years have described the extent of poverty and growing income inequality in Ontario and Canada.[1,2] From a public health perspective, there is a strong literature base demonstrating the relationship between both low absolute income, and the extent of income inequality in a society, and a range of adverse health and social outcomes. This includes morbidity and/or mortality from chronic and infectious disease, mental illness, and infant mortality, amongst others.[3] Given that 56 000 people (or more than 11% of the population) in Simcoe and Muskoka live in low income situations based on the after-tax low-income (2011 National Household Survey, Statistics Canada), the avoidable burden of disease from low income and income inequalities is substantial.

In response to these key social and public health challenges, a growing number of individuals and organizations in the health, economics, social, and political sectors have proposed the introduction of a basic income guarantee for all Canadians, also known as guaranteed annual income. A basic income guarantee ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status. It can be achieved through a range of policy approaches.

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.[4,5] 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.[4] 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. [6,7]

In 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.[6]

There has been recent support for a basic income guarantee from the Canadian Medical Association, the Alberta Public Health Association, and the Canadian Association of Social Workers. The Canadian Public Health Association is also examining the issue. Beyond the health and social sectors, a non-governmental organization by the name of Basic Income Canada Network is now dedicated to achieving a basic income guarantee in Canada, and several citizen groups are forming across Ontario and Canada in support of this issue.

Advocating for improved income security policies is supportive of the Simcoe Muskoka District Health Unit's strategic direction on the Determinants of Health, which requires the health unit to 'Address the factors that create inequities in overall health and improve the quality of life for populations at risk of poor health outcomes'.

We urge you to undertake a joint federal-provincial investigation into a basic income guarantee in order to address the extensive health inequities in Canada, which are both highly concerning and largely preventable.

Sincerely,

Barry Ward
Chair, Board of Health

c. The Right Honourable Steven Harper, Prime Minister of Canada
The Honourable Kathleen Wynne, Premier of Ontario
Dr. David Mowat, Ontario Chief Medical Officer of Health
Linda Stewart, Association of Local Public Health Agencies
Pegeen Walsh, Ontario Public Health Association
Ontario Boards of Health
Simcoe Muskoka Members of Parliament
Simcoe Muskoka Members of Provincial Parliament
North Simcoe Muskoka and Central Local Health Integration Network
Gary McNamara, President, Association of Municipalities Ontario
Brock Carlton, Chief Executive Officer, Federation of Canadian Municipalities
Simcoe Muskoka Municipalities

References

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2. Conference Board of Canada. How Canada Performs: A Report Card on Canada. 2013. Accessed April 27, 2015. http://www.conferenceboard.ca/hcp/details/society/income-inequality.aspx
3. Auger, N and Alix, C. Income, Income Distribution, and Health in Canada. In: Raphael, D (Ed). Social Determinants of Health, 2nd edition. Toronto: Canadian Scholars Press Inc, 2009.
4. Forget, E. The Town with No Poverty: The Health Effects of a Canadian Guaranteed Annual Income Field Experiment. Canadian Public Policy xxxvii(3) 283-306, 2011. http://utpjournals.metapress.com/content/xj02804571g71382/fulltext.pdf
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6. Emery, J.C.H., Fleisch, V.C., and McIntyre, L. How a Basic income guarantee Could Put Food Banks Out of Business. University of Calgary School of Public Policy Research Papers 6 (37), 2013. http://www.policyschool.ucalgary.ca/sites/default/files/research/emery-foodbankfinal.pdf
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Peterborough County-City HEALTH UNIT
...because health matters!

September 30, 2015

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

Dear Premier Wynne,

Re: Northern Ontario Evacuations of First Nations Communities

At its meeting held on September 9, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence forwarded and supported by the Sudbury District Health Unit regarding evacuations of First Nations communities in Northern Ontario.

The Board echoes the recommendations outlined in their letter (attached) and it is our hope that you will address the needs of these vulnerable communities and ensure their safe, efficient and effective temporary relocation when faced with environmental and weather-related threats.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Yasir Naqvi, Minister of 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
MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Sudbury & District
Health Unit
Service de santé publique

Make it a Healthy Day!

Visez Santé dès aujourd'hui!

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
☎ :705.522.9200
🖷 : 705.522.5182

Rainbow Centre
40 rue Elm Street
Unit / Unité 109
Sudbury ON P3C 1S8
☎ : 705.522.9200
🖷 : 705.677.9611

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

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

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

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

Toll-free / Sans frais
1.866.522.9200

www.sdhu.com

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;

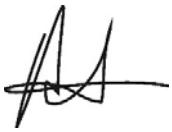
THEREFORE BE IT RESOLVED THAT the Sudbury and District Board of Health support the Thunder Bay District Board of Health's resolution 50-2015 dated March 18, 2015; and

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

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

September 30, 2015

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

Dear Minister Hoskins:

Re: Energy drinks

At its meeting held on September 9, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence forwarded and supported by the Windsor-Essex County Health Unit regarding energy drinks.

The Board echoes the recommendations originally outlined by the Wellington-Dufferin-Guelph Public Health (letter attached) and urges you to take action to protect the health of our children.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

cc: MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Association of Local Public Health Agencies
Ontario Boards of Health

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

February 4, 2015

DELIVERED VIA REGULAR MAIL & E-MAIL

Ministry of Health and Long-Term Care
Office of the Minister
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Attention: Hon. Dr. Eric Hoskins,
Minister

Dear Honourable Dr. Hoskins:

RE: Energy Drinks

Wellington-Dufferin-Guelph Public Health (WDGPH) supports the recent report *Patients First: Action Plan for Health Care*, released by the Ministry of Health and Long-Term Care. In this report, the *Healthy Kids Strategy* is highlighted as a framework to support healthy habits from childhood. As part of this strategy, two recommendations were listed that referred to banning the marketing and promotion of unhealthy foods and beverages to children. A review of health data and literature by WDGPH suggests that energy drinks meet this recommendation.

Energy drinks are a rapidly growing component of the beverage market and current research demonstrates that children and youth are consuming energy drinks. The main concern about rising rates of energy drink use is caffeine and sugar content. Overuse of caffeine can contribute to acute physical and mental health conditions, and increasing levels of sugar among the diets of children and youth have already been linked to obesity and higher numbers of dental carries.

Health Canada has set Recommended Daily Maximum Intake (RDMI) limits for caffeine, based upon age. However, the average 8oz energy drink contains 80 mg of caffeine, which exceeds the RDMI for children 4-9 years of age. Moreover, energy drinks are often sold in sizes double that amount, which would also exceed the RDMI for children 10-12 years of age. It is therefore concerning that children and youth can readily access energy drinks.

.../2

160 Chancellors Way, Guelph, ON N1G 0E1
Telephone: 519-822-2715 | **Fax:** 519-836-7215 | **www.wdgpublichealth.ca**

The *No Time to Wait: Healthy Kids Strategy (2013)* made recommendations regarding unhealthy foods and beverages for children. These included:

- Ban the marketing of high calorie, low-nutrient foods, beverages and snacks to children under the age of 12; and
- Ban point-of-sale promotions and displays of high-calorie, low-nutrient foods and beverages in retail settings, beginning with sugar-sweetened beverages.

In 2011, Health Canada enacted labeling requirements on energy drinks to include "High source of caffeine" and "Not recommended for children, pregnant or breastfeeding women and individuals sensitive to caffeine". Since Health Canada has acknowledged that this product it not to be consumed by children, it further supports the *Healthy Kids Strategy (2013)* to ban the marketing and point-of-sale displays and promotions to children of such beverages.

On behalf of the Board of Health for WDGPH, I would like to urge you to consider a timely implementation of the above-noted recommendations from the *Healthy Kids Strategy (2013)* beginning with sugar-sweetened beverages to reduce the consumption of high-calorie, low-nutrient beverages and, in particular, energy drinks by children.

Sincerely,

Doug Auld
Chair, WDGPH Board of Health

c.c. Wellington-Dufferin-Guelph MPPs – via e-mail
c.c. Ontario Public Health Units – via e-mail
c.c. Rita Sethi, Director, Community Health & Wellness (WDGPH) – via e-mail.

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

Report to:	**Board of Health**
Submitted by:	**Dr. Nicola Mercer, Medical Officer of Health & CEO**
Prepared by:	**Jennifer McCorriston, Manager, Chronic Disease, Injury Prevention & Substance Misuse**
Approved by:	**Rita Sethi, Director, Community Health & Wellness**
Subject:	**ENERGY DRINKS**

RECOMMENDATION(S)

(a) That the Board of Health receives this report for information.

(b) That the Board of Health send a letter to Toronto Public Health applauding their efforts to explore a municipal ban on the sale and promotion of energy drinks.

(c) That the Board of Health send a letter to the Minister of Health and local MPP's to support recommendations 2.1 and 2.2 in the *No Time to Wait: The Healthy Kids Strategy*, and that the letter specifically include 1) language to identify energy drinks as a high-calorie, low-nutrient beverage of health concern and 2) that Health Canada has already identified energy drinks as "High source of caffeine" and "not recommended for children, pregnant or breastfeeding women, and individuals sensitive to caffeine" and 3) that this letter along with a copy of this report be sent to all Public Health units within the province

Nicola J. Mercer, MD, MBA, MPH, FRCPC
Medical Officer of Health & CEO

EXECUTIVE SUMMARY

In recent years, an increasing number of caffeinated beverages have been introduced into the Canadian marketplace. These products, known as energy drinks, are generally marketed to improve energy and concentration. Most energy drinks contain 70 to 80 mg caffeine per 8 oz (237 ml) serving.[1,2] The sugar content is typically similar to the amount of sugar in soft drinks.[2]

There are a number of health and safety concerns with regard to consumption, labelling and marketing. Among adolescents and young adults, research suggests that 30-50% consume energy drinks. [3] This raises public health concerns of caffeine consumption and possible caffeine toxicity, which is known to cause headaches[2-6], agitation/anxiety[2-7], irregular heart rate[3,6-8] and insomnia[4,7,9]. Beyond the potential side-effects of caffeine, increased energy drink consumption among children and youth could contribute to the obesity epidemic.[3,8,10]

In light of these concerns there is strong interest to reduce access and marketing of energy drinks in the province. Recently, Toronto Public Health was given direction to conduct a feasibility study on reducing access to energy drinks for persons under the age of 19 in the City of Toronto. Although these efforts should be applauded, a provincial approach would have a greater benefit to the health and well-being of the population and therefore it is urged that the provincial government take immediate action in light of the increasing evidence.

BACKGROUND

In recent years, an increasing number of caffeinated beverages have been introduced into the Canadian marketplace. These products, known as energy drinks, are generally marketed to improve energy and concentration. These beverages typically contain caffeine, taurine (an amino acid), vitamins, herbal ingredients and sugar or artificial sweeteners. Some ingredients such as guarana and yerba mate, commonly found in energy drinks are natural sources of caffeine. Most energy drinks contain 70 to 80 mg caffeine per 8 oz (237 ml) serving.[1,2] This is similar to the amount of caffeine in coffee and approximately 3 times the amount of caffeine in cola drinks.[1] The sugar content is typically similar to the amount of sugar in soft drinks (approximately 21 to 34 grams per 8 oz serving).[2]

Energy drinks are a rapidly growing component of the beverage market. In 2006, the Canadian energy drink market was valued at $287.2 million and is expected to reach $375.2 million by 2011.[1] Energy drinks are popular with children, youth and young adults. Among adolescents and young adults, 30-50% consume energy drinks.[3]

There are a number of health and safety concerns with regard to consumption, labelling and marketing of energy drinks. A 2013 assessment of the potential health risks in Canada reported that as of July 2010, 61 adverse reactions were associated with consumption of energy drinks. Of these, 32 were considered serious with 15 of these involving the cardiac system (6 of these 15 cardiac events occurred in 13-17 year olds).[2]

With increasing concerns of caffeine consumption by Canadians, particularly among adolescents, Health Canada conducted a scientific assessment of the potential hazards and exposure associated with caffeinated energy drinks. The common amounts consumed of similar beverages (e.g. soft drinks) were used to help assess risks for various populations. This assessment revealed that children and youth are most at risk of exceeding Health Canada's Recommended Daily Intake (RMDI) of caffeine because of the volumes consumed and lower RMDI for these age groups. As such, Health Canada released labeling requirements in 2011, which included statements on the label such as:

- The amount of caffeine from all sources in mg per container or serving size
- "High source of caffeine" and "not recommended for children, pregnant or breastfeeding women, and individuals sensitive to caffeine"
- "Do not mix with alcohol"[11]

In response to Health Canada's approach, several public health units in Ontario, including WDGPH, formed an Energy Drink Joint Advocacy Work Group to organize a coordinated public health response to encourage Health Canada to strengthen its actions. On February 1, 2012, WDGPH Board of Health passed a resolution to send letters to Health Canada, the Ministry of Health and Long-Term Care (MOHLTC) and the Chief Medical Officer of Health to adopt the recommendations of the working group.[12]

In June 2012, the Association of Local Public Health Agencies (alPHa) took the issue one step further to pass a resolution (A12-6) on energy drink regulation that supported recommendations from the Ontario Society of Nutrition Professionals in Public Health (OSNPPH).[13] These recommendations stated that:

- Health Canada and the Province of Ontario should prohibit the advertising and sale of energy drinks to children and adolescents.
- Health Canada should require the addition of a warning label to energy drink packaging that states: "*Energy drinks are not recommended for use during exercise or to rehydrate following exercise.*" The space allocated for warning labels should be at least 25% of the total packaging.
- Province of Ontario should prohibit the sale of all pre-mixed caffeinated-alcoholic beverages at Provincial Liquor Outlets or at a minimum require the addition of a warning label to all pre-mixed caffeinated-alcoholic beverages packaging that states: "*This product contains alcohol and caffeine. Consuming alcohol and caffeine together may increase your risk of injury.*"
- Province of Ontario should prohibit the sale of energy drinks at all locations where alcohol is sold and served.

ANALYSIS/RATIONALE

The literature is showing that children and youth are using energy drinks and the amount of data is steadily growing. According to the Ontario Drug Use Survey (2013), 39.7% reported drinking energy drinks in the past year.[14] Similar results were found in the Student Drug Use Survey of the Atlantic Provinces (2012), where 62% of junior and senior high school students used energy drinks at least once in the past year and 20% used energy drinks once or more

per month.[9]

In 2011, the Canadian Pediatric Surveillance Program survey on energy drinks revealed that more than 30% of youth reported using energy drinks, and among the 741 respondents, 9% reported some sort of caffeine-related complication.[6] That same year, the European Food Safety Authority gathered energy drink consumption data among 16 European countries and found that 68% of youth aged 10-18 years consumed energy drinks. This was greater than adults where 30% of this population reported use.[15] To specifically look at children, researchers in Italy studied energy drink consumption among 916 students. They revealed that 17.8% of sixth graders and 56.2% of eight graders consumed energy drinks less than once a week, and 16.5 and 6.2% did so at least once per week.[16] Locally, WDG is collecting energy drink consumption data among grade 7 and grade 10 students through the Youth Report Card, which will be analyzed in late 2015.

The main concern about rising rates of energy drink use is caffeine. Caffeine consumption in one's diet can come from a variety of sources, however literature suggests that the vast majority of caffeine consumed in one's diet comes from beverages.[5] In low to moderate amounts, caffeine may have some short-term benefits including improvements in certain aspects of cognition (e.g. reaction time) and athletic performance.[2-5] Health Canada has produced recommendations for caffeine consumption across all age groups. For children aged 4-6, 7-9 and 10-12 the recommendations are no more than 45 mg/day, 62.5 mg/day and 85 mg/day, respectively. For youth, the recommendation is no more than 2.5 mg/kg of body weight.[17]

Although these guidelines are helpful to direct parental and health care decisions, potential caffeine side effects are influenced by a variety of factors including pre-existing health conditions, current medications and individual tolerance levels.[7,18] Thus, when considering the typical energy drink caffeine content is 80 mg, this is already above the recommendations set for children under ten years of age. Even for older children, if they are already consuming caffeine from other sources in their daily diet (e.g. soft drinks, chocolate milk), one energy drink would put them beyond their recommended limit. This also assumes that children and youth are buying an 8 oz (237 ml) serving, when in fact, many energy drinks are sold in sizes double that amount ranging in caffeine content from 160-180 mg.[2]

The overuse and side effects from caffeine, particularly among children and youth, is an emerging public health concern. Caffeine toxicity is defined as "specific symptoms that emerge as a direct result of caffeine consumption".[7] Caffeine toxicity can result in adverse effects such as headaches[2-6], agitation/anxiety[2-7], irregular heart rate[3,6-8] and insomnia[4,7,9]. In overdoses, "caffeine toxicity can mimic amphetamine poisoning and lead to seizures, psychosis, cardiac arrhythmias, and potentially, but rarely death".[10] In 2014, the American Association of Poison Control Centers received 2,808 reports of exposure to energy drinks, of which 1673 were for children aged 18 and younger.[19]

In the American Pediatric Association paper on energy drinks, they cite concerns regarding the use of caffeine in children because of its "potential effects on the developing neurological and cardiovascular systems and risk of physical dependence and addiction."[8] Consequently, children and youth who do not use caffeine daily are at greater risk for caffeine toxicity because they may be inexperienced and less tolerant to the effects of caffeine.[7]

Beyond the caffeine risks of energy drinks, they also have the potential to contribute to childhood obesity.[3,8,10] Studies report that energy drinks typically range from 21 to 34 grams of sugar per 8 oz serving[2], although there are some types that are artificially sweetened. This high sugar content is similar to that of soft drinks, which has already been shown to play a role in the rising rates of overweight and obesity, and increased risk for dental caries.[2,8,20] Additionally, a review of commonly sold energy drinks shows that the carbohydrates contained in energy drinks range from 3 to 31 grams per 8 oz serving.[8] For average children and youth, carbohydrate-containing beverages are not needed within the diet, beyond the recommended daily intake of lower fat milk.[8] Hence, the American Pediatric Association has stated that "excessive regular consumption of carbohydrate-containing beverages increases overall daily caloric intake without significant additional nutritional value".[8]

The rising rates of energy drink consumption among children and youth suggests the energy drink industry is targeting this segment of the population. Several research papers propose that energy drinks are largely promoted and advertised to younger generations[7,10,16,18,20] Specifically, it has been noted that the industry focuses on appealing to young males with claims of performance enhancement.[7,15]

In 2010, approximately $164 million was spent by the energy drink industry on television, sports sponsorship, event marketing and social media.[18] For example, youth in the United States watched an average of 124 energy drink television ads, which equals about 1 ad every 3 days (this is similar to those viewed on soft drinks).[20] Moreover, youth were approximately twice as likely to visit energy drink websites compared to adults.[20]

Local jurisdictions have taken it upon themselves to set some regulations for marketing and sale. In August 2014, the City of Toronto, as directed by their Board of Health, banned the sale of energy drinks at all City properties. Furthermore, November 17, 2014, the "Toronto Board of Health Requested the Medical Officer of Health, in consultation with other appropriate staff, to report to the Board of Health on ways and means of preventing children and youth under the age of majority from buying energy drinks, and on the feasibility of:

- banning energy drink marketing, distribution (sampling) and advertising on City properties;
- banning the sale of energy drinks to youth and children in all Toronto affiliated agencies, boards, and commissions including the Canadian National Exhibition in compliance with the ban at City properties;
- banning the sale of energy drinks to youth and children in Toronto retail outlets; and
- requiring point-of-sale warning signage to be posted in retail outlets to assist in awareness to the potential dangers that these drinks pose."[21]

WDGPH applauds Toronto's action and supports this feasibility study. Nevertheless, since Health Canada has recognized that energy drinks are "not recommended for children", the next logical step would be to examine provincial regulatory approaches to decrease access and marketing to children. In the words of the American Pediatric Association "stimulant containing energy drinks have no place in the diets of children and adolescents".[8]

In 2013, the Healthy Kids Panel released *No Time to Wait: The Healthy Kids Strategy.*[22] This report was produced by a panel of experts appointed by the Minister of Health to make recommendations for the health and well-being of children and youth. On September 4,

2013, WDGPH Board of Health passed a resolution to send a letter to the MOHLTC requesting all of the strategies in the report be endorsed.[23] It is timely to re-examine recommendations 2.1 and 2.2 in the Healthy Kids Strategy report:

- Ban the marketing of high calorie, low-nutrient foods, beverages and snacks to children under the age of 12.
- Ban point-of-sale promotions and displays of high-calorie, low-nutrient foods and beverages in retail settings, beginning with sugar-sweetened beverages.

We propose that WDGPH sends a letter to the Minister of Health and local MPP's asking them to endorse these recommendations and explicitly state the inclusion of energy drinks.

In summary, recent research indicates that energy drinks are emerging as a public health threat to children and youth. Additional research on consumption patterns, long-term health effects and regulatory approaches is appropriate and may result in future policy recommendations.

ONTARIO PUBLIC HEALTH STANDARD

Board of Health Outcomes

- The Board of Health is aware of and uses epidemiology to influence the development of healthy public policy and its programs and services for chronic disease prevention.
- There is increased awareness among community partners about the factors associated with chronic diseases that are required to inform program planning and policy development, including the following:
  - Community health status;
  - Risk, protective, and resiliency factors; and
  - The importance of creating healthy environments.
- Policy-makers have the information required to enable them to amend current policies or develop new policies that would have an impact on the prevention of chronic diseases.
- The public is aware of the importance of healthy eating, healthy weights, comprehensive tobacco control, physical activity, reduced alcohol use, and reduced exposure to ultraviolet radiation.

WDGPH STRATEGIC COMMITMENT

Community and Partner Relationships
We will work with our communities and key stakeholders, and consider their perspectives in our decision-making processes. We will identify important partnerships and collaborate to improve the health of our community.

Evidence-Informed Practices
We will use the best available information to guide our decisions regarding which programs and services to provide, the manner in which we provide them, and the allocation of our resources in support of these decisions.

HEALTH EQUITY

Health equity is the differences in the quality of health and health care across diverse populations. It can refer to the equal treatment of individuals or groups in the same circumstances, or conversely "the principle that individuals who are unequal should be treated differently according to their level of need".[24]

Children and youth are a priority population for health. Many health behaviours are developed in childhood, therefore certain restrictions for harmful products may be beneficial until a young person reaches an age where they can access and process all the relevant health information to make an informed choice. For example, lessons gained from tobacco efforts show that private industry will target youth using deceptive marketing practices to hook young people on their products to become life-long users.[25] Youth may not always be able to discern that they are being targeted and may fall victim to this these aggressive marketing tactics, which may ultimately have an impact on their long-term health.

APPENDICES

NONE.

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

September 30, 2015

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

Dear Minister Hoskins:

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

At its meeting held on September 9, 2015, the Board of Health for the Peterborough County-City Health Unit considered correspondence forwarded and supported by the Sudbury District Health Unit regarding enforcement of the Immunization of School Pupils' Act

The Board echoes the recommendations outlined in their letter (attached) and urges you to consider amending the Act to require all healthcare providers to electronically report immunizations for all children attending school in Ontario in a timely and accurate manner.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

cc: MPP Jeff Leal, Peterborough
MPP Laurie Scott, Haliburton-Kawartha Lakes Brock
Association of Local Public Health Agencies
Ontario Boards of Health

Sudbury & District
Health Unit
Service de santé publique

Make it a Healthy Day!

Visez Santé dès aujourd'hui!

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🖷 : 705.522.5182

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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:

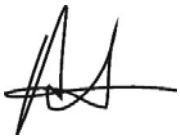
> *WHEREAS each public health unit in Ontario is required to enforce the Immunization of School Pupils Act by assessing and maintaining immunization records of school pupils (students) each year; and*
>
> *WHEREAS parents/guardians whose child(ren) receive vaccine at a health care provider other than 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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The Regional Municipality of Durham

Corporate Services Department - Legislative Services

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Matthew L. Gaskell
Commissioner of Corporate Services

September 29, 2015

COPY

The Honourable Kathleen Wynne
Premier
Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

RE: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated September 8, 2015 re: *Immunization of School Pupils Act (ISPA)* (Our File No. P00)

Honourable Premier, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on September 23, 2015 Council adopted the following recommendations of the Committee:

"A) That the correspondence dated June 30, 2015 from the Sudbury & District's Medical Officer of Health to the Ministry of Health and Long-Term Care, urging the Ontario government to require health care providers to report to the local Medical Officer of Health all immunizations administered to patients under 18 years of age through a common electronic database be endorsed; and

B) That the Premier of Ontario, Minister Health and Long-Term Care, Durham's MPPs, Interim Chief Medical Officer of Health, alPHa, and all Ontario Boards of Health be so advised."

Attached is a copy of the correspondence dated June 30, 2015 from the Sudbury & District's Medical Officer of Health to the Ministry of Health and Long-Term Care.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

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"

c: The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
The Honourable Tracy MacCharles, MPP (Pickering/ Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Interim Chief Medical Officer of Health
L. Stewart, Executive Director, Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
R.J. Kyle, Commissioner & Medical Officer of Health

Sudbury & District

Health Unit

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: 705.522.9200
: 705.677.9611

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

Espanola
800 rue Centre Street
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: 705.867.0474

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1.866.522.9200

www.sdhu.com

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

PUBLIC HEALTH
GREY BRUCE HEALTH UNIT

September 25, 2015

Hon Eric Hoskins
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4
ehoskins.mpp@liberal.ola.org

Re: Public Health Funding

On September 25, 2015, the Board of Health for the Grey Bruce Health Unit considered the attached resolution from Porcupine Health Unit and passed the following resolution, #2015-88.

Moved by: Mitch Twolan Seconded by: David Shearman

WHEREAS, the Ministry of Health and Long-Term Care has, on September 4, 2015, released the 2013 report of the Funding Review Working Group with respect to a public health funding model for Mandatory Programs, which it has accepted for the 2015 budget year and beyond; and

WHEREAS, based upon current information, the model indicates that approximately 80% of Public Health Units in the Province of Ontario are overfunded, which in and of itself calls into question, the validity of said model; and

WHEREAS, in some large centres there is a possibility that these extra public health funds could effectively be consumed by larger municipal budgets and not utilized for additional public health services; and

WHEREAS, under this model, health units who have been identified as being overfunded, may have many years of shrinking public health services, in the face of higher costs, due to having to deal with a flatlined budget allocation;

NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for the Grey Bruce Health Unit support the resolution from the Porcupine Health Unit and opposes this new funding model and the radical long-term shifting of public health resources to wealthier urban centres of the Province, at the direct expense of Northern and Rural Health Units in the Province, who are much less able to replace those lost funds than our growing urban centered health units, and

FURTHER THAT, the Board of Health for the Grey Bruce Health Unit calls for the Ministry of Health and Long-Term Care to reverse their decision to support this report, and revise the funding formula which appears biased against smaller, Northern and Rural Health Units; and

FURTHER THAT, this resolution be forwarded to the Premier of Ontario, the Minister of Health and Long-Term Care, AMO, ROMA, alPHa, Local MP's and MPP's, All Municipalities in Grey and Bruce Counties and All Ontario Boards of Health.

Carried

Together we build healthy communities,

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

Porcupine
Health Unit • Bureau de santé

September 21, 2015

Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

email: info4you@porcupinehu.on.ca
Website: www.porcupinehu.on.ca

Dear Public Health Stakeholder,

Please find attached, a copy of Resolution #2015.39 adopted by the Board of Health for the Porcupine Health Unit, at its meeting held September 18, 2015.

The Board of Health for the Porcupine Health Unit strongly objects to the radical change in public health funding, in the Province of Ontario, which the Province has begun implementing in 2015.

It is the Board of Health's position that this drastic change will effectively transfer scarce public health financial resources to areas of the Province of relative health and wealth, and away from those areas of the Province such as Northern and rural areas, which have the greatest public health needs.

We would request your support in opposing this massive redistribution of public health funding in Ontario.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

Encl.

pc: Federation of Northern Ontario Municipalities (FONOM)
Northeastern Ontario Municipal Association (NEOMA)
Northern Ontario Municipal Association (NOMA)
Association of Local Public Health Agencies (alPHa)
Local Member Municipalities
Dr. Eric Hoskins, Minister of Health & Long-Term Care (MOHLTC)
Kathleen Wynne, Premier of Ontario
Provincial Party Leaders
Northern Members of Provincial Parliament
Ontario Nurses Association (ONA)
Canadian Union of Public Employees (CUPE)
Ontario Boards of Health

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

Date: 15 / 09 / 18
y m d

Porcupine
Health Unit • Bureau de santé

R-2015.39

MOVED BY: Gilles Chartrand

SECONDED BY: Claude Bourassa

Head Office:
169 Pine Street South
Postal Bag 2012
Timmins, ON P4N 8B7

Phone: 705 267 1181
Fax: 705 264 3980
Toll Free: 800 461 1818

email: info4you@porcupinehu.on.ca
Website: www.porcupinehu.on.ca

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WHEREAS, based upon current information, the model indicates that approximately 80% of Public Health Units in the Province of Ontario are overfunded, which in and of itself calls into question, the validity of said model; and

WHEREAS, this funding model will result in an inevitable significant long-term transfer of public health resources to relatively wealthier, and healthier, large urban settings, and will cause reductions in public health services in Northern and rural areas of the Province; and

WHEREAS, in some large centres there is a possibility that these extra public health funds could effectively be consumed by larger municipal budgets and not utilized for additional public health services; and

WHEREAS, under this model, health units who have been identified as being overfunded, may have many years of shrinking public health services, in the face of higher costs, due to having to deal with a flatlined budget allocation; and

WHEREAS, Unorganized Territories funding for public health services will not be allocated in the same manner as the Mandatory Programs funding, it appears that equitable access to public health resources depend on where you live in this Province, and since only Northern health units have Unorganized Territories funding, and the Ministry of Health and Long-Term Care has indicated that there will only be a one-time adjustment to that funding, this model, with its implementation inconsistencies, is particularly detrimental to those health units in Northern Ontario;

NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for the Porcupine Health Unit opposes this new funding model and the radical long-term shifting of public health resources to wealthier urban centres of the Province, at the direct expense of Northern and rural health units in the Province, who are much less able to replace those lost funds than our growing urban centred health units; and

FURTHERMORE THAT, the Ministry of Health and Long-Term Care reverse their decision to support this report, which appears biased against smaller, Northern, and rural health units; and

FURTHERMORE THAT, this resolution be forwarded to FONOM, NEOMA, NOMA, alPHa, local member municipalities, the Minister of Health and Long-Term Care, the Premier of Ontario, Provincial Party leaders, Northern members of Provincial Parliament, ONA, CUPE, and Ontario Boards of Health.

(circle as appropriate)
CARRIED **DEFEATED**

Stan Black
Chair - Board of Health

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

Porcupine
Health Unit • Bureau de santé

September 21, 2015

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email: info4you@porcupinehu.on.ca
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We would request your support in opposing this massive redistribution of public health funding in Ontario.

Yours very truly,

Donald W West BMath, CPA, CA
Chief Administrative Officer

DW:mc

Encl.

pc: Federation of Northern Ontario Municipalities (FONOM)
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Ontario Boards of Health

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

Date: 15 / 09 / 18
y m d

Porcupine
Health Unit • Bureau de santé

R-2015.39

MOVED BY: Gilles Chartrand

SECONDED BY: Claude Bourassa

Head Office:
169 Pine Street South
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NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for the Porcupine Health Unit opposes this new funding model and the radical long-term shifting of public health resources to wealthier urban centres of the Province, at the direct expense of Northern and rural health units in the Province, who are much less able to replace those lost funds than our growing urban centred health units; and

FURTHERMORE THAT, the Ministry of Health and Long-Term Care reverse their decision to support this report, which appears biased against smaller, Northern, and rural health units; and

FURTHERMORE THAT, this resolution be forwarded to FONOM, NEOMA, NOMA, alPHa, local member municipalities, the Minister of Health and Long-Term Care, the Premier of Ontario, Provincial Party leaders, Northern members of Provincial Parliament, ONA, CUPE, and Ontario Boards of Health.

(circle as appropriate)
CARRIED **DEFEATED**

Stan Black
Chair - Board of Health

Branch Offices: Cochrane, Hearst, Hornepayne, Iroquois Falls, Kapuskasing, Matheson, Moosonee, Smooth Rock Falls

From: allhealthunits-bounces@lists.alphaweb.org [mailto:allhealthunits-bounces@lists.alphaweb.org]
On Behalf Of Linda Stewart
Sent: October-08-15 12:33 PM
To: 'All Health Units' <allhealthunits@lists.alphaweb.org>
Subject: [allhealthunits] Member Update re Public Health Funding

Please forward to the Chair of your Board of Health. Thank you.

Dear Public Health Colleague,

This is to provide you with an update on the actions alPHa is taking regarding the new funding formula in use by the MOHLTC for program-based grants to boards of health. alPHa's Board of Directors met with representatives from the Ministry at its meeting on October 2 and had the opportunity to clarify and provide comment on the road ahead.

The Ministry clarified that in order to apply an increase to program-based grants this year, they were required to use a funding formula. They made the decision to apply the formula recommended in the report of the Funding Review Working Group to the funds that were available to provide 2 percent growth. This resulted in 8 boards of health receiving increases while the remaining 28 were held to 2014 funding levels. At the meeting on October 2, the ministry communicated to alPHa's Board that they are open to reviewing the impacts of the funding formula and to possible alterations. They were also clear that there is no guarantee of any further funds being available in future years for increases and they have recommended to business administrators to plan for zero percent increases into the future.

As next steps, alPHa is undertaking the following:

1. Developing a resolution outlining action steps for alPHa Board endorsement that will be shared with boards of health for their consideration
2. A letter is being prepared to the Minister to provide a formal response to the application of the funding formula
3. alPHa will be collecting some key pieces of information through a short survey to assist with assessing the financial impact on public health units and municipalities of the funding formula
4. alPHa will be meeting with representatives of the Association of Municipalities of Ontario (AMO) to discuss areas of mutual concern
5. alPHa will be meeting with representatives from other parts of the health system that have already experienced funding changes to determine possible strategies forward
6. alPHa will continue to discuss member concerns with government decision makers
7. alPHa's Executive Committee and Board of Directors will continue to strategize and communicate with alPHa members on this issue

Please do not hesitate to contact me with any questions, comments or suggestions.

Linda

Linda Stewart
Executive Director
Association of Local Public Health Agencies (alPHa)

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The Regional Municipality of Durham

Corporate Services Department - Legislative Services

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Matthew L. Gaskell
Commissioner of Corporate Services

September 29, 2015

COPY

The Honourable Kathleen Wynne
Premier
Minister of Intergovernmental Affairs
Room 281
Main Legislative Building
Queen's Park
Toronto ON M7A 1A1

RE: Memorandum from Dr. Robert Kyle, Commissioner & Medical Officer of Health, dated September 8, 2015 re: Healthy Babies Healthy Children (HBHC) Program (Our File No. P00)

Honourable Premier, please be advised the Health & Social Services Committee of Regional Council considered the above matter and at a meeting held on September 23, 2015 Council adopted the following recommendations of the Committee:

"A) That the correspondence dated June 30, 2015 from the Sudbury & District's Medical Officer of Health to the Minister of Children and Youth Services, urging the Ontario government to fully fund all program costs related to the Healthy Babies Healthy Children (HBHC) program, including all staffing, operating and administrative costs be endorsed; and

B) That the Premier of Ontario, Ministers of Children and Youth Services, Finance, and Health and Long-Term Care, Durham's MPPs, Interim Chief Medical Officer of Health, alPHa, and all Ontario Boards of Health be so advised."

Attached is a copy of the correspondence dated June 30, 2015 from the Sudbury & District's Medical Officer of Health to the Minister of Children and Youth Services.

Debi A. Wilcox, MPA, CMO, CMM III
Regional Clerk/Director of Legislative Services

DW/np

Attach.

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"

c: The Honourable Tracy MacCharles, Minister of Children and Youth Services
The Honourable Charles Sousa, Minister of Finance
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
Joe Dickson, MPP (Ajax/Pickering)
The Honourable Tracy MacCharles, MPP, (Pickering/Scarborough East)
Granville Anderson, MPP (Durham)
Jennifer French, MPP (Oshawa)
Laurie Scott, MPP (Haliburton/Kawartha Lakes/Brock)
Dr. David Williams, Interim Chief Medical Officer of Health
L. Stewart, Executive Director, Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
R.J. Kyle, Commissioner & Medical Officer of Health

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Toll-free / Sans frais
1.866.522.9200

www.sdhu.com

June 30, 2015

PUBLIC PROMOTION

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 100% 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

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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

Providing leadership in public health management

FALL 2015 MEETINGS

COMOH Section General Meeting
(ONE DAY ONLY)

Wednesday, November 4, 2015
9 AM – 3:30 PM (tentative)
Toronto Ballroom
DoubleTree by Hilton Hotel Downtown Toronto
108 Chestnut Street, Toronto
(near University/Dundas)

Open to:

- Member Medical Officers of Health
- Member Associate Medical Officers of Health
- Public Health & Preventive Medicine Residents*

$295 + HST per person

To register for the COMOH Section Meeting, please click here

** Note: PHPMRs – alPHa regrets it is unable to reimburse expenses related to attendance of this meeting*

Managing Uncertainty: Risk Management Workshop for Ontario Boards of Health
(ONE DAY ONLY)

Thursday, November 5, 2015
8:30 AM – 4:30 PM
Toronto Ballroom
DoubleTree by Hilton Hotel Downtown Toronto
108 Chestnut Street, Toronto
(near University/Dundas)

Open to:

- All Board of Health Members
- All Medical/Associate Medical Officers of Health
- All Senior Public Health Managers

$295 + HST per person

To register for the Board of Health Risk Management Workshop, please click here

See workshop agenda attached

Hotel guestroom reservations and registration details coming soon!

alPHa Association of Local PUBLIC HEALTH Agencies

Managing Uncertainty. Risk Management for Boards of Health

- PROGRAM -

Thursday, November 5, 2015

Toronto Ballroom, DoubleTree by Hilton Hotel, 108 Chestnut Street, Toronto

8:30–9:00	**BOH Section Business Meeting**	*Mary Johnson*, alPHa Board of Health Section Chair
9:00-9:10	**Welcome and Introduction**	*Mary Johnson*, alPHa Board of Health Section Chair
9:10-10:10	**Introduction to Risk**	*Graham Scott*, Chair, Institute For Research in Public Policy, Canada Health Infoway / Algoma Public Health Assessor
10:10-10:30	**Individual Exercise**	Participant Self-Assessment – Part A
10:30-11:00	BREAK	
11:00–12:00	**Implementation of Risk Management**	*Corinne Berinstein*, Senior Audit Manager, Treasury Board Secretariat
12:00-12:30	**Exercise & Discussion**	Participant Self-Assessment – Part B
12:30-1:30	LUNCH	
1:30-2:30	**Case Studies**	*Tony Hanlon*, CEO & *Justin Pino*, CFO, Algoma Public Health *Hazel Gilchrist*, Director, Corporate Services, KFLA Public Health
2:30-3:00	**Exercise & Discussion**	Participant Self-Assessment- Part C
3:00-3:30	BREAK	
3:30-4:20	**Insights, Comments & Next Steps**	Group Discussion
4:20-4:30	**Wrap Up**	*Mary Johnson*, alPHa Board of Health Section Chair

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ALGOMA PUBLIC HEALTH FINANCE AND AUDIT COMMITTEE MEETING
JULY 22, 2015
SAULT STE MARIE ROOM B, 1ST FLOOR
MINUTES

BOARD MEMBERS PRESENT	Ian Frazier	Lee Mason	Candace Martin
	Dennis Thompson		

REGRETS:

ALGOMA PUBLIC HEALTH STAFF PRESENT:	Acting Chief Executive Officer	Sandra Laclé
	Chief Financial Officer	Justin Pino
	Recording Secretary	Christina Luukkonen

1) CALL TO ORDER:
I. Frazier called the meeting to order at 10:30AM

2) DECLARATION OF CONFLICT OF INTEREST
Ms. Martin declared a conflict of interest for item 7a) Opening RFP Submissions

3) ADOPTION OF AGENDA ITEMS dated July 22, 2015
FC2015-18 Moved: L. Mason
Seconded: C. Martin
THAT the agenda items dated July 22, 2015 be adopted as circulated.
CARRIED.

4) ADOPTION OF MINUTES dated June 11, 2015
FC2015-19 Moved: L. Mason
Seconded: D. Thompson
THAT the minutes for the Finance Committee dated June 11, 2015 be adopted as circulated.
CARRIED.

5) FINANCIAL STATEMENTS FOR THE PERIOD ENDING: JUNE 30, 2015
J. Pino presented the financial statements for the period ending June 30, 2015. The committee has informed that we still have not heard from the Ministry on the requested 2015 budget.
Questions were asked regarding noted variances in the report. J. Pino explained that municipal levy variance depends on the municipality payment cycle. J. Pino will investigate further and report back to Board members questioning the two noted variances that relate to the Northern Ontario Fruits & Vegetable Program and HPV Vaccine.

6) BUSINESS ARISING FROM MINUTES
None to report.

7) THAT THE BOARD GO INTO COMMITTEE 10:45am
a) Litigation
FC2015-20 Moved: L. Mason
Seconded: D. Thompson
THAT the Committee goes in-committee.
CARRIED.

8) THAT THE BOARD GO INTO OPEN MEETING 11:05am

FC2015-22 Moved: L. Mason
Seconded: C. Martin
THAT the Committee goes into open meeting.
CARRIED.

9) ADDITIONS TO AGENDA

No items to add to the agenda.

10) NEW BUSINESS/GENERAL BUSINESS

a) Opening RFP Submissions

Six RFP's were received in response to our Request for Architectural/Engineering/Project Management Services. C. Luukkonen opened each submissions received and read out the names. Three copies of each proposal were received.

RFPs were received from:

1. Ergo Office Plus
2. EPHO Inc.
3. David Ellis Architect Inc.
4. Mitchell Architects
5. Sawchuk Peach Associates and John R. Hamalainen Engineering Ltd.
6. MGP Architects Engineer Inc.

The Committee decided to review and score each proposal independently and then discuss and score as a group for final decision.

The Committee unanimously agreed to award the Request for Proposal to David Ellis Architect Inc. subject to reference check.

FC2015-23 Moved: L. Mason
Seconded: D. Thompson
THAT the Board of Health accepts David Ellis Architect Inc. subject to reference checks and other due diligent to serve as the Architectural Engineering/Project Management service provider for the Elliot Lake office – ELNOS Building Interior Renovations.
CARRIED.

11) ITEMS IDENTIFIED TO BE BROUGHT FORTH TO THE BOARD

None were identified.

12) NEXT MEETING: TBD

13) THAT THE MEETING ADJOURN: 1:15pm

FC2015-24 Moved: C. Martin
Seconded: L. Mason
THAT the meeting adjourns.
CARRIED.

ALGOMA PUBLIC HEALTH FINANCE AND AUDIT COMMITTEE MEETING
SEPTEMBER 17, 2015
SAULT STE. MARIE ROOM A, 1ST FLOOR, APH SSM
MINUTES

BOARD MEMBERS PRESENT	Ian Frazier	Lee Mason	Candace Martin (teleconference)
	Dennis Thompson		
REGRETS:			
ALGOMA PUBLIC HEALTH STAFF PRESENT:	Acting Chief Executive Officer		Tony Hanlon
	Chief Financial Officer		Justin Pino
	Recording Secretary		Trina Mount

1) CALL TO ORDER:
I. Frazier called the meeting to order at 4:17 pm.

2) DECLARATION OF CONFLICT OF INTEREST
None were reported.

3) ADOPTION OF AGENDA ITEMS dated September 17, 2015
Additions to the agenda were agreed to as follows:
8a) Public Health Funding Formula Review
8b) Reserves Definition and Usage

FC2015-25 Moved: L. Mason
Seconded: C. Martin
THAT the agenda items dated September 17, 2015, be adopted as amended.
CARRIED.

4) ADOPTION OF MINUTES dated July 22, 2015

FC2015-26 Moved: L. Mason
Seconded: D. Thompson
THAT the minutes as amended for the Finance Committee dated July 22, 2015, be adopted as amended.
CARRIED.

5) FINANCIAL STATEMENTS FOR THE PERIOD ENDING: August 31, 2015
This item was covered under 8a) Public Health Funding Review

6) BUSINESS ARISING FROM MINUTES

a) ELNOS Progress
APH is actively working with the architect, David Ellis, on the new Elliot Lake APH site. He distributed copies of a related email (reading aloud for the benefit of C. Martin who participated by teleconference). The final product, he said, is targeted to be ready by Wednesday, September 23; the tender closing date is September 30. J. Pino assured that the plan committed to in the RFP by David Ellis is within only a couple of days of being fully on schedule. The Committee instructed the

CEO/CFO to review the tender, following which it will go to the Board for analysis and input.

J. Pino relayed that staff have been engaged for input and through advice of the architect have addressed most concerns. J. Pino will ensure that the Board is provided with the final drawing plan at the September meeting.

7) NEW BUSINESS/GENERAL BUSINESS

a) Board Budget

L. Mason had requested information on the BOH budget citing concerns on how much has been spent as a result of the increased number of meetings. J. Pino responded that while expenditures are over what is typical to cover the cost of meetings, the Board budget remains in good position for the rest of the year.

b) Board Protocol

Board protocol was reviewed. Board members were reminded to funnel queries through the Board Chair and the CEO. If questions arise from Committee meetings (Finance or Governance) then the Chair of the Committee should also be copied. T. Hanlon and J. Pino to bring related policy, tightened to reflect the conversation and the procedures discussed at this table to the next Board meeting.
C. Martin added that the Board would benefit from a retreat to gain knowledge on these types of issues. It was acknowledged this would be valuable and I. Frazier agreed to bring forth to a Governance meeting to compile topics to be addressed at the retreat.

c) Meeting Schedule

J. Pino informed that a new schedule for Board meetings (to better accommodate Dr. Sutcliffe's schedule) will be proposed at the next Board of Health meeting. The Finance Committee was asked to consider whether these meetings should be moved ahead by a week to dovetail the Board meetings with the current one-week gap or to maintain as is. Discussion took place and it was decided that this would be addressed further at the BOH meeting. As well, the start time for meetings will be examined.

8) ADDITIONS TO AGENDA

a) Public Health Funding Review

J. Pino apprised the Board of the revised Public Health funding model set out by the Ministry – an equity adjusted population model. I. Frazier, T. Hanlon and J. Pino participated in a Ministry Teleconference this morning which spoke to this new funding. He described the drivers and related indicators as follows:
1. Service Cost: geography, language
2. Drivers of Need: aboriginal, Ontario marginalization index, preventable mortality rate
J. Pino relayed the funding by health unit indicating which have been historically underfunded and overfunded according to this new equitable formula. He described the impact to Algoma Public Health, saying that there will be no growth funding for the next 3 years. One-time funding requests will still be permitted to be submitted. J. Pino referenced the Notes to Financial Statements reviewing the piece related to Public Health expenses budget. It was raised that the sale/lease back is expiring next year and that this committee will need to consider options. It was also noted that the Ministry agreed that APH could apply for one-time funding for purchased services to fill the Acting CEO and MOH role. Discussion took place on the new funding formula impact to costs such as inflation, general wage increases and collective bargaining agreements. J. Pino responded that a budgeting process strategy has started. T. Hanlon added that APH is striving to substantiate what the plans will look like for the three

years and the potential effect on outlying communities. Further to a Board query, J. Pino affirmed that APH continues to examine the Genetics program (whether to maintain or divest) and T. Hanlon added that similar consideration is being given to the PPNP program. This will be brought forth at the September Board meeting. J. Pino responded to queries related to staffing of vacant positions, stating that some were deliberately on hold until the budget was announced.

b) Reserves Definition and Usage

Discussion took place around reserves – definition and usage. I. Frazier clarified the purpose as being to ensure proper protocols were being followed. It was noted that a policy was approved a few months back. The Committee was apprised of the amount in our GIC fund. J. Pino offered to consult auditors around appropriate usage for the funds; he will bring the finding back to this Committee, following which it will be brought to the Board of whole.

9) THAT THE BOARD GO INTO COMMITTEE 5:50 p.m.

Agenda items:

a) Adoption of Minutes from Previous In-Committee meeting dated July 22, 2015

10) THAT THE BOARD GO INTO OPEN MEETING 5:55 p.m.

FC2015-29 Moved: C. Martin
Seconded: L. Mason
THAT the Committee goes into open meeting.
CARRIED.

11) ITEMS IDENTIFIED TO BE BROUGHT FORTH TO THE BOARD

1. **New Ministry Funding Model**
2. **ELNOS: Floor Plan**
3. **Meeting Schedule**
4. **Board Budget Update FYI (typically provided in January–considering moving this to November)**

12) NEXT MEETING: TBD

13) THAT THE MEETING ADJOURN: 6:01 p.m.

FC2015-30 Moved: D. Thompson
Seconded: C. Martin
THAT the meeting adjourns.
CARRIED.

ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE MEETING
AUGUST 26TH , 2015
WHITE RIVER MEETING ROOM, 3RD FLOOR, APH SSM
MINUTES

BOARD MEMBERS PRESENT	Ian Frazier	Lee Mason	Candace Martin
ALGOMA PUBLIC HEALTH STAFF PRESENT:	Acting Chief Executive Officer		Sandra Laclé
	Chief Executive Officer		Tony Hanlon, Ph.D.
	Director of Human Resources and Corporate Services		Antoniette Tomie
	Recording Secretary		Christina Luukkonen

1) CALL TO ORDER:
Mr. Frazier called the meeting to order at 4:12 pm.

2) DECLARATION OF CONFLICT OF INTEREST
None were reported.

3) ADOPTION OF AGENDA ITEMS dated August 26, 2015

GC2015-11 Moved: L. Mason
Seconded: C. Martin

THAT the agenda items dated August 26, 2015 be adopted as circulated.
CARRIED.

4) ADOPTION OF MINUTES

GC2015-12 Moved: L. Mason
Seconded: C. Martin

THAT the minutes for the Governance Standing Committee dated July 22, 2015 be adopted as amended.
CARRIED.

5) BUSINESS ARISING FROM MINUTES

a) Terms of Reference

The Committee reviewed the Terms of Reference. Changes to membership and distribution to be made by C. Luukkonen and added to the September Board meeting agenda for Board approval.

GC2015-13 Moved: C. Martin
Seconded: L. Mason

THAT the Governance Standing Committee approves the Terms of Reference for the Governance Standing Committee as amended and put forth to the Board for approval
CARRIED.

b) APH Performance Monitoring Plan

The APH Performance Monitoring Plan was reviewed. Concern was raised with 2015 being the baseline year. The Committee approved the plan but will request the Board be flexible with the deadlines for this year.

Board evaluations were discussed. It was decided that the results for the monthly evaluations would be reviewed at the next month's Board meeting and the annual evaluation would be reviewed at the Committee meeting and presented to the Board with recommendations and a plan of action. The

comments submitted on the evaluation will be reviewed in-camera on quarterly bases.

GC2015-14 Moved: C. Martin
Seconded: L. Mason
THAT the Governance Standing Committee approves the Performance Monitoring Plan as amended and with flexibility with start date/baseline and put forth to the Board for approval.

c) MOH/CEO Recruitment

S. Laclé and A. Tomie updated the Committee on the recruitment efforts for a permanent MOH/CEO. Job posting has recently been advertised in the Montreal Gazette. We will continue to post on the various websites for the next few months and will start with a more aggressive approach again in the spring. Dr. Sutcliffe will continue in the acting role on a month-to-month basis.

6) NEW BUSINESS/GENERAL BUSINESS

None to report.

7) Additions to Agenda

a) Ministry Teleconference

Mr. Mason updated the Committee on the teleconference with the Ministry on August 26. The Ministry is focusing on governance as a whole for municipal and provincial appointees for all health units not just Algoma. They are in the process of hiring a consultant to create a report and develop a plan for skills base members. The process could take up to 6 months to complete. At this time they are not looking to fill any of the vacant positions on our Board.

The 2014 Audit is now complete. Final teleconference to be scheduled to discuss the final steps.

S. Laclé updated the Committee on the Ontario Public Health Organizational Standards Compliance Checklist/Attestation that Algoma Public Health was required to complete for the Ministry. Five outstanding items were identified and discussed. We are the first health unit to complete the checklist based on the organizational standards.

The Committee discussed the need to have an overview of the organizational standards again. To be discussed at the September Board meeting.

8) THAT THE BOARD GO INTO COMMITTEE 5:23 pm

GC2015-15 Moved: L. Mason
Seconded: C. Martin
THAT Governance Standing Committee goes in-committee at 5:23 for Labour Relations.
CARRIED.

9) THAT THE BOARD GO INTO OPEN MEETING 5:45 pm

GC2015-17 Moved: C. Martin
Seconded: L. Mason
THAT Governance Standing Committee goes into open meeting at 5:45pm.
CARRIED.

10) ITEMS IDENTIFIED TO BE BROUGHT FORTH TO THE BOARD

a) Terms of Reference for Committee
b) Performance Monitoring Plan

c) Organizational Standards
d) Board of Governance Community Event in October
e) Board Matrix

Mr. Frazier thanked Ms. Laclé for her leadership over the last five months and welcomed Tony Hanlon as the new Interim Chief Executive Assistant. Ms. Laclé expressed her thanks for their support during her time with Algoma Public Health.

11) NEXT MEETING: TBD

12) THAT THE MEETING ADJOURN: 5:53 pm

GC2015-18 Moved: L. Mason
Seconded: C. Martin

THAT the meeting adjourns at 5:53 pm.
CARRIED.