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ALGOMA PUBLIC HEALTH

BOARD OF HEALTH GOVERNANCE STANDING COMMITTEE

April 13, 2016

4:30 - 6:00pm

Sault Ste. Marie

Prince Meeting Room. 3rd Floor

www.algomapublichealth.com

April 13, 2016 - Governance Standing Committee

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10. **Items Identified to be brought forth to the Board**

11. **Next Meeting**

    a. Wednesday, May 11, 2016 @ 5:30pm

12. **Adjournment**

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH GOVERNANCE STANDING COMMITTEE
APRIL 13, 2016 @ 4:30-6:00 PM
PRINCE MEETING ROOM 3RD FLOOR
A*G*E*N*D*A

1) Meeting Called to Order — Mr. Ian Frazier, Committee Chair

2) Declaration of Conflict of Interest — Mr. Ian Frazier, Committee Chair

3) Adoption of Agenda Items — Mr. Ian Frazier, Committee Chair

RESOLUTION:
THAT the agenda items for the Governance Standing Committee meeting dated April 13, 2016 be adopted as circulated.

4) Adoption of Minutes — Mr. Ian Frazier, Committee Chair

RESOLUTION:
THAT the minutes for the Governance Standing Committee meeting dated February 10, 2016 be adopted as circulated.

5) Business Arising from Minutes — Mr. Ian Frazier, Committee Chair

No business arising from minutes

6) New Business/General Business — Mr. Ian Frazier, Committee Chair

a. Institute of Governance – March 30-31, 2016 — Dr. Tony Hanlon, CEO

b. Elliot Lake Grand Opening Celebration — Dr. Tony Hanlon, CEO

c. Marketing to Children — Dr. Tony Hanlon, CEO
   i. Briefing Note
   ii. Board Resolution

RESOLUTION:
That the Governance Standing Committee recommends the briefing note and resolution "Marketing to Children" and puts forth to the Board of Health for approval.

d. Basic Income Guarantee — Dr. Tony Hanlon, CEO
   i. Briefing Note
   ii. Board Resolution

RESOLUTION:
That the Governance Standing Committee recommends the briefing note and resolution "Basic Income Guarantee" and puts forth to the Board of Health for approval.

e. Meeting Evaluations – Results for February 2016 — Mr. Ian Frazier, Committee Chair

f. 2016 alPHa Annual Conference June 5-7, 2016 - Novotel Toronto Centre Hotel — Mr. Ian Frazier, Committee Chair

g. Accountability Agreement Review — Mr. Ian Frazier, Committee Chair

h. Governance Training — Mr. Ian Frazier, Committee Chair

i. APH Communication with Municipalities and the Public — Mr. Ian Frazier, Committee Chair

j. Communication with Board of Health Members — Mr. Ian Frazier, Committee Chair

k. 2015 APH Program Performance Quantitative Report — Dr. Tony Hanlon, CEO

7) Addendum — Mr. Ian Frazier, Committee Chair

8) In-Committee — Mr. Ian Frazier, Committee Chair

RESOLUTION:
THAT the Governance Standing Committee goes in-committee.
Agenda Items
a. Adoption of In-Committee minutes dated February 10, 2016
b. Personal matters about an identifiable individual, including municipal employees

9) Open Meeting — Mr. Ian Frazier, Committee Chair

RESOLUTION:
THAT the Governance Standing Committee goes into open meeting.

10) Items Identified to be brought forth to the Board — Mr. Ian Frazier, Committee Chair

11) Next Meeting: Wednesday, May 11, 2016 @ 5:30pm — Mr. Ian Frazier, Committee Chair

12) That The Meeting Adjourn — Mr. Ian Frazier, Committee Chair

RESOLUTION:
THAT the meeting of the Governance Standing Committee adjourns.

UNAPPROVED

ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE MEETING
FEBRUARY 10, 2016
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

UNAPPROVED

COMMITTEE MEMBERS PRESENT:	Ian Frazier	Candace Martin (Teleconference)	Lee Mason
COMMITTEE MEMBERS REGRETS:	Sue Jensen		
APH STAFF PRESENT:	Tony Hanlon, Ph.D.	Chief Executive Officer (Teleconference)	
	Christina Luukkonen	Recording Secretary	

1) CALL TO ORDER:

Mrs. Luukkonen called the meeting to order at 5:35pm.

2) ELECTION OF OFFICERS

a. Election of Committee Chair

Mrs. Luukkonen called for nominations for the position of Chair for the Governance Standing Committee. Nominations were received for Mr. Frasier and Ms. Martin

Mrs. Luukkonen called for any further nominations; no further nominations were received.

Ms. Martin declined the nomination at this time. Mr. Frazier accepted the nomination and was acclaimed Chair for the Governance Standing Committee.

GC2016-08 Moved: L. Mason
Seconded: C. Martin

THAT the Governance Standing Committee appoints Ian Frazier as Chair of the committee for the year 2016.
CARRIED.

b. Election of Committee Vice-Chair

Mrs. Luukkonen called for nominations for the position of Vice-Chair for the Governance Standing Committee. Nominations were received for Ms. Martin

Mrs. Luukkonen called for any further nominations; no further nominations were received.

Ms. Martin accepted the nomination and was acclaimed Vice-Chair for the Governance Standing Committee.

GC2016-09 Moved: L. Mason
Seconded: I. Frazier

THAT the Governance Standing Committee appoints Candace Martin as Vice-Chair of the committee for the year 2016.
CARRIED.

3) DECLARATION OF CONFLICT OF INTEREST

UNAPPROVED

Mr. Frazier called for any conflict of interests; none were reported.

4) ADOPTION OF AGENDA ITEMS

Approved with the addition of 7d) March Committee Meeting

GC2016-10 Moved: C. Martin
Seconded: L. Mason

THAT the agenda items for the Governance Standing Committee dated February 10, 2016 be adopted as amended; and
THAT the Committee accepts the items on the addendum.
CARRIED.

5) ADOPTION OF MINUTES

GC2016-11 Moved: L. Mason
Seconded: C. Martin

THAT the minutes for the Governance Standing Committee dated January 13, 2016 be adopted as circulated.
CARRIED.

6) BUSINESS ARISING FROM MINUTES

a. Governance Standing Committee Activities Report for 2015
No further feedback was received the report to be presented to the Board at the meeting on February 24, 2016.

7) NEW BUSINESS/GENERAL BUSINESS

a. Institute of Governance
Mr. Frazier opened the floor to discuss the meeting(s) with the governance consultants that occurred at the end of January. The committee requested someone to contact the consultants to see if there is any follow-up required. Mrs. Luukkonen to discuss with Mr. Pino.

b. 2015 Board Attendance Summary
Mrs. Luukkonen shared a summary of the 2015 Board meeting attendance. The Board requested that all special meetings be included in the summary and that a similar report be done for the committees as well.

c. Meeting Evaluations
The meeting evaluations for November 2015 and January 2016 were shared with the committee. It was noted that not all Board members are completed all the evaluations consistently in a timely fashion. The new BoardEffect will have the functionality for surveys built in. This will make the evaluation process more streamlined.

d. **March Committee Meeting**
Dr. Hanlon requested that the committee meeting scheduled for March 9, 2016 be cancelled. The next meeting will be April 13, 2016 unless there is pressing action items that need to addressed.

8) ADDENDUM

a. Basic Income Guarantee

The committee discussed a recent article in the Globe and Mail about the Federal government looking at ways to tackle poverty with initiatives such as basic income supplement (B.I.G.). Dr. Hanlon was directed to prepare a report for the April meeting on poverty levels in the Algoma District and how B.I.G might directly benefit our communities.

9) IN COMMITTEE at 6:20pm

GC2016-12 Moved: L. Mason
Seconded: C. Martin

THAT the Governance Standing Committee goes in-committee at 6:20pm.

Agenda items:

a. Adoption of Minutes dated January 13, 2016
b. Personal matters about an identifiable individual, including municipal employees

CARRIED.

10) OPEN MEETING at 623pm

GC2016-14 Moved: L. Mason
Seconded: C. Martin

THAT the Governance Standing Committee goes into open meeting at 6:23pm.

CARRIED.

11) NEXT MEETING: April 13, 2016 @ 5:30pm

12) THAT THE MEETING ADJOURN: 6:24pm

GC2016-15 Moved: C. Martin.
Seconded: L. Mason

THAT the Governance Standing Committee meeting adjourns.

CARRIED.

UNAPPROVED

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Briefing Note

To: The Board of Health

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

Date: April 27, 2016

Re: Marketing to Children

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Children lack adequate cognition to understand the effects of advertising, so their right to grow and develop without being advertising targets must be protected. Eliminating advertising targeted at children creates environments supportive of healthy choices being easier choices.

RECOMMENDED ACTION:

1. That the Board of Health for Algoma support the Association of Local Public Health Agencies, the Ontario Public Health Association, the Ontario Society of Nutrition Professionals in Public Health and other organizations in advocating for a comprehensive ban on all advertising to children under 16 years.
2. That the Board of Health for Algoma endorses The Ottawa Principles.

BACKGROUND:

- Children are exposed to a greater intensity and frequency of marketing than any previous generation.
- Younger children lack the cognitive abilities to understand marketing messages.
- There is strong evidence that food advertising has a direct influence on what children choose to eat and indirectly exerts pressure on parents to choose those things.
- The dominant focus of commercial ads targeted to kids for products that undermine parents' and public health professionals' efforts to promote healthy diets and physical activity.
- Industry initiatives promising to change advertising to children have proven to be ineffective.

The Stop Marketing to Kids (Stop M2K!) Coalition was founded by the Heart and Stroke Foundation in collaboration with the Childhood Obesity Foundation in 2014. Their goal is to restrict all food and beverage marketing to Canadian children age 16 and younger. The Ottawa Principles were developed to help achieve this goal.

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The Ottawa Principles

Context
The World Health Organization and health organizations worldwide are leading efforts to ensure children everywhere are protected against food and beverage marketing. Children are exposed to multiple forms of marketing as food and beverage companies spend billions of dollars targeting this group. Voluntary measures such as the Canadian Children's Food and Beverage Advertising Initiative have proven to be ineffective in changing the overall marketing environment. As such, policies need to be put in place to protect children from food and beverage marketing.

In Canada, many non-governmental organizations have developed policy recommendations to address the negative health impacts of marketing food and beverages to children. A summary of the policy recommendations, which demonstrates the great deal of convergence amongst them, can be found here.

In 2014, nationally-recognized health opinion leaders, health professional and researchers from across Canada came together to develop a consensus position on a set of definitions, scope and principles meant to guide "Marketing to Kids" (M2K) policy-making in Canada as follows:

Definitions and Scope
1. Marketing refers to any form of commercial communication or message that is designed to, or has the effect of, increasing the recognition, appeal and/or consumption of particular products and services. It comprises anything that acts to advertise or otherwise promote a product or service.
2. Restrictions would apply to all food and beverages.
3. Restrictions do not relate to non-commercial marketing for valid public health education or public awareness campaigns.
4. The age at which restrictions in marketing to children would apply should be 16 years and younger.

Policy Recommendation
Restrict the commercial marketing of all food and beverages to children and youth age 16 years and younger. Restrictions would include all forms of marketing with the exception of non-commercial marketing for public education. In addition, the regulations should fulfill the nine Ottawa principles:

The Ottawa Principles:
In Canada, policies and regulations to effectively protect children from commercial food and beverage marketing should:

1. **AFFORD SUBSTANTIAL PROTECTION TO CHILDREN.** Children are particularly vulnerable to commercial marketing. Policies and regulations need to be sufficiently powerful to provide them with a high level of protection. Child

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protection is the responsibility of every sector of society – parents and guardians, non-governmental organizations, the private sector, and government.

2. **BE STATUTORY IN NATURE.** Only legally enforceable regulations have sufficient authority and power to ensure high-level protection of children from marketing and its persuasive influence over food preference and consumption. Industry self-regulation is not designed to achieve this goal and has proven insufficient.

3. **TAKE A WIDE DEFINITION OF COMMERCIAL MARKETING.** Policies and regulations need to encompass a broad range of commercial targeting of children (e.g. television advertising, print, competitions, loyalty schemes, product placements, celebrity endorsements, financial inducements and incentives, relationship marketing, games, packaging, Internet) and be sufficiently flexible to include new marketing methods as they evolve.

4. **RESTRICT THE COMMERCIAL MARKETING TO CHILDREN IN CHILD-FOCUSED SETTINGS.** Policies and regulations need to ensure that the commercial marketing to children (*the specific types to be determined*) is restricted in child-focused settings such as schools, childcare, early childhood education facilities, and sports and recreation centres.

5. **TAKE ACTION TO MANAGE CROSS BORDER MEDIA.** Cross-border media or communication channels, such as Internet, satellite and cable television, and free-to-air television broadcast from neighbouring countries, should be managed wherever possible. This is not a pre-requisite for restrictions to be implemented.

6. **BE EVALUATED, MONITORED, RESOURCED AND ENFORCED.** Policies and regulations need to be independently evaluated to ensure the expected effects are achieved, independently monitored to ensure compliance, and fully resourced and enforced.

7. **BE IDENTIFIED AND ENACTED QUICKLY THROUGH A MULTI-GOVERNMENT APPROACH.** All levels of government are urged to take action, with a view to have full compliance, as soon as possible.

8. **ENSURE GOVERNMENT IS A KEY STAKEHOLDER IN DEVELOPING POLICY.** Governments should provide leadership in setting the policy framework, while protecting the public interest and avoiding conflict of interest.

9. **ENSURE GOVERNMENT SETS CLEAR POLICY DEFINITIONS.** The setting of clear definitions would facilitate uniform implementation and consistency, irrespective of the implementing body.

ASSESSMENT OF RISKS AND MITIGATION:

No conceivable risks are identified at this time.

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FINANCIAL IMPLICATIONS:
No conceivable financial implications are identified at this time.

OPHS STANDARD:
Ontario Public Health Standards (2014):
- Chronic Disease Prevention Program – Healthy Eating and Healthy Weights
- Child Health Program – Healthy Eating and Healthy Weights

STRATEGIC DIRECTION:
Collaborate Effectively, Improve Health Equity

CONTACT:
Laurie Zeppa, CNO/Director of Community Services

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Algoma PUBLIC HEALTH Santé publique Algoma

Board of Health

Date:	RESOLUTION NO.: 2016 -
MOVED:	SECONDED:
SUBJECT: Marketing to Children	

Resolution:

Whereas Algoma Public Health is committed to prevent disease and promote the health of individuals and communities in the Algoma District; and

Whereas children today are exposed to a greater intensity and frequency of marketing than any previous generation; and

Whereas there is strong evidence that younger children lack the cognitive abilities to understand marketing messages; and

Whereas there is strong evidence that food advertising has a direct influence on what children choose to eat and indirectly exerts pressure on parents to choose those things; and

Whereas the dominant focus of commercial advertising targeted to children is for products that undermine parents' and public health professionals' efforts to promote healthy diets and physical activity; and

Whereas recent industry initiatives promising to change advertising to children have proven to be ineffective; and

Whereas the Association of Local Public Health Agencies, the Ontario Public Health Association and numerous other organizations have called for a ban on all commercial advertising targeted to children; and

Whereas The Ottawa Principles provide a set of definitions, scope and principles to guide policy-making decisions on commercial food and beverage marketing to children;

Now Therefore Be It Resolved That:

The Board of Health of Algoma:

1. Supports the Association of Local Public Health Agencies, the Ontario Public Health Association, the Ontario Society of Nutrition Professionals in Public Health and other organizations in advocating for a comprehensive ban on all advertising to children under 16 years.
2. Endorses The Ottawa Principles.

CARRIED: Chair's Signature ______________________________

- ☐ **Lee Mason - Chair**
- ☐ **Ian Frazier – Vice Chair**
- ☐ **Sue Jensen**
- ☐ **Candace Martin**
- ☐ **Dennis Thompson**

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Briefing Note

www.algomapublichealth.com

To: The Board of Health

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

Date: April 27, 2016

Re: Basic Income Guarantee

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

People who have fewer resources are less healthy than those with more money or social status (Let's Talk Health Equity, NCCDH, 2013). Furthermore, income determines the *quality* of other social determinants of health, such as food security, housing and basic necessities of life (SDOH, Canadian Perspectives, Dennis Raphael, 2009, p.12).

Income insecurity continues to rise in Ontario and Canada as labour force trends such as part-time, contractual and minimum-wage precarious employment opportunities increase. Existing income security programs have not proved sufficient to ensure that all Canadians have equitable access to the social determinants of health. Currently, 13.9 % of Ontarians and **14.4 % of Algoma residents live in low income circumstances**–that's approximately 16,000 people.

One poverty reduction strategy with the potential to address income insecurity is a basic income guarantee. **BIG or Basic Income Guarantee is a regular, reliable distribution of money to families to help ensure they have an income sufficient to meet their basic needs**.

RECOMMENDED ACTION:

1. That the Board of Health of Algoma endorses the concept of basic income guarantee as a poverty reduction strategy.

2. That the Board of Health of Algoma join OPHA, alPHa, CMA, CPHA etc. in supporting the Federal government's plan to pursue a pilot study of basic income guarantee as a viable means of alleviating poverty.

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BACKGROUND:

Poverty is the single largest determinant of health. Low income has a well-established link to adverse health outcomes and is associated with shorter life expectancy. Canadians with the lowest incomes are more likely to suffer from chronic conditions such as diabetes, arthritis and heart disease, have mental illness or live with a disability. The lower an individual's income, the more likely that person is to experience multiple chronic conditions and the less likely they are to have health or dental coverage. Research has shown us that countries with high income inequality have not only higher levels of health problems but also social problems such as violence and crime.

Low Income Families in Algoma

Too many individuals and families live in poverty in the district of Algoma.

- Currently, 13.9 % of Ontarians and **14.4 % of Algoma residents live in low income circumstances**–that's approximately 16,000 people.
- Of these Algoma residents living in poverty, **25% are children under age 6** and **20% are youth under age 18**.
- Single parent families are consistently over-represented as living below the poverty line. **Lone parent families make up 17.4 % of Algoma households.**
- Spending over 30% of your income on shelter is a well-established indicator of poverty. **Twenty percent, or almost 10,000 households in Algoma, spend over 30% of their total income on shelter.** This translates into at least 22,000 Algoma men, women and children who may live in precarious housing conditions and possibly are only one paycheck away from being homeless.
- Employment opportunities and earning capacity are linked to educational attainment. **Only 17.4 % of Algoma adults have a university degree** compared to 28.9% of Ontarians.

A BIG Solution for Public Health Impact

BIG or Basic Income Guarantee is a regular, reliable distribution of money to families to help ensure they have an income sufficient to meet their basic needs. Also known as a guaranteed annual income, it is usually a cash transfer from the government to individuals or families and is not tied to labour force participation.

There are a number of social, fiscal and economic reasons behind the basic income movement. Socially, it is seen as a dignified, non-stigmatizing option that doesn't further marginalize vulnerable individuals and families. Fiscally, it would avoid the disincentives to work currently enmeshed in our welfare system and provide strong incentive for recipients to work to earn additional income. Finally, economically it can help close the income gap that has resulted in the prevalence of poverty and the associated poor health outcomes and potentially reduce health care spending.

Who Benefits from a Basic Income Guarantee?

Basic income is not seen as a replacement for all social programs. Primarily it is seen as impacting three populations:

- Adults receiving Ontario Works
- Adults in the Ontario Disability Support Program
- The working poor

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It is estimated that 45-70% of those currently living in poverty are the working poor. It is a common misunderstanding that those living in poverty are either not working or unwilling to work. A number of circumstances contribute to why individuals who are working are living in low income. These include the changing job market, lack of education and training, lack of opportunity, and a significant increase in precarious employment in the last 20 years. **In Algoma, almost 16,000 people are living in low income.**

The Health Care Sector Supports BIG

Basic Income is a movement that has been around for decades but has had a resurgence of support in the last few years. Many key players in the health care sector have publically endorsed BIG as a strategy to explore as part of multipronged approach to poverty. These include the Alberta Public Health Association, Association of Local Public Health Agencies (Ontario), Canadian Medical Association, Canadian Public Health Association, Ontario Public Health Association, the Canadian Association of Social workers, to name a few. Recently Ontario announced it is considering a B.I.G. pilot project. The research is very clear **poverty is the single largest contributor to poor health outcomes** and with Canadian healthcare costs well over 200 billion dollars annually it is not only ethically but economically sound to consider supporting poverty reduction strategies such as a Basic Income Guarantee.

ASSESSMENT OF RISKS AND MITIGATION:

None

FINANCIAL IMPLICATIONS:

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

OPHS STANDARD:

The Ontario Public Health Standards (OPHS) clearly articulates that “Addressing determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. Effective public health programs and services consider the impact of the determinants of health on the achievement of intended health outcomes” (p.4, OPHS)

STRATEGIC DIRECTION:

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

CONTACT:

Laurie Zeppa, CNO/Director of Community Services

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Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health

Date:	RESOLUTION NO.: 2016 -
MOVED:	SECONDED:
SUBJECT: Public Health Support for Basic Income Guarantee	

Resolution:

Whereas addressing determinants of health and reducing health inequities are fundamental to the work of public health; and

Whereas effective public health programs and services consider the impact of the determinants of health on the achievement of intended health outcomes; and

Whereas income is the single largest determinant of health and low income has a well-established link to adverse health outcomes and is associated with shorter life expectancy; and

Whereas income or lack thereof determines the *quality* of other social determinants of health, such as food security, housing and basic necessities of life; and

Whereas currently, 13.9 % of Ontarians and **14.4 % of Algoma residents** live in low income circumstances; and

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

Whereas a basic income guarantee can reduce poverty and income security, and enable people to pursue educational, occupational, social and health opportunities relevant to them and their
families; and

Whereas there has also been growing public and political sector backing for basic income guarantee including the announcement of an Ontario pilot.

Now Therefore Be It Resolved That: the Board of Health of Algoma endorses the concept of basic income guarantee as a poverty reduction strategy;

And Further in keeping with Algoma Public Health's endorsement of basic income guarantee, we join with other health care sector members in supporting the Federal government's plan to pursue a pilot study of basic income guarantee as a viable means of alleviating poverty.

CARRIED: Chair's Signature ______________________________

- ☐ **Lee Mason - Chair**
- ☐ **Ian Frazier – Vice Chair**
- ☐ **Sue Jensen**
- ☐ **Candace Martin**
- ☐ **Dennis Thompson**

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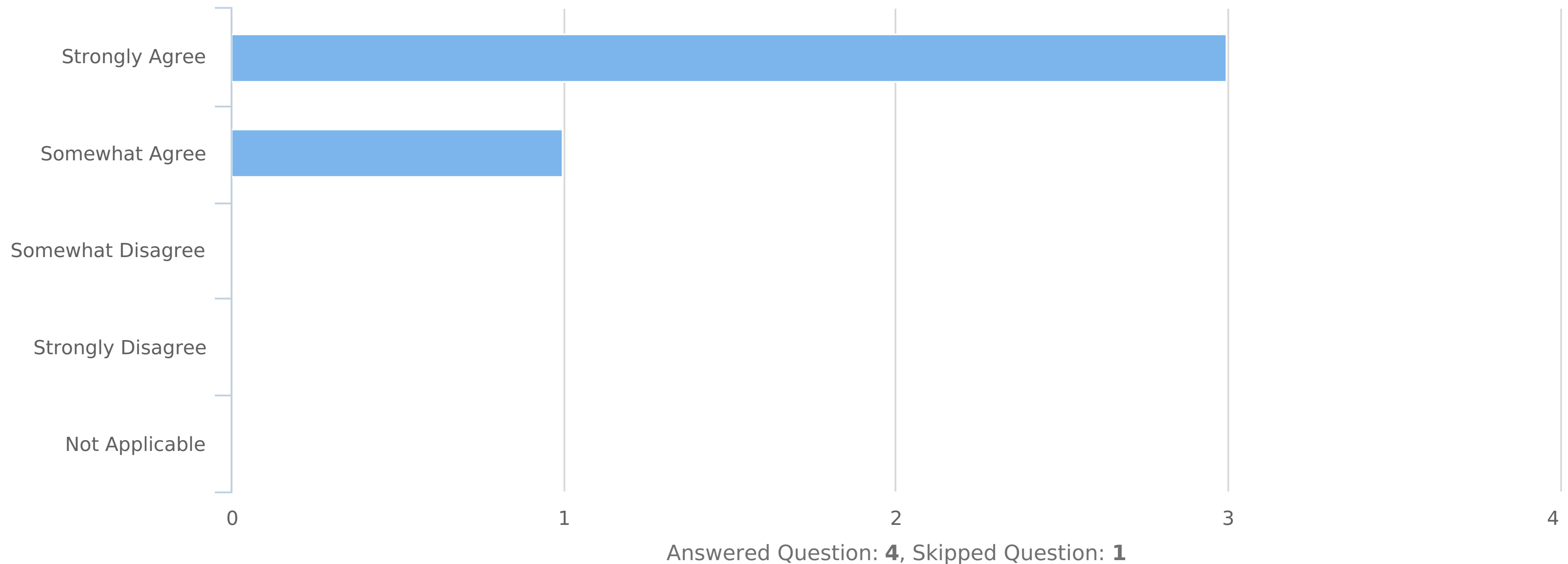
February 24, 2016 - BoH Monthly Meeting Evaluation

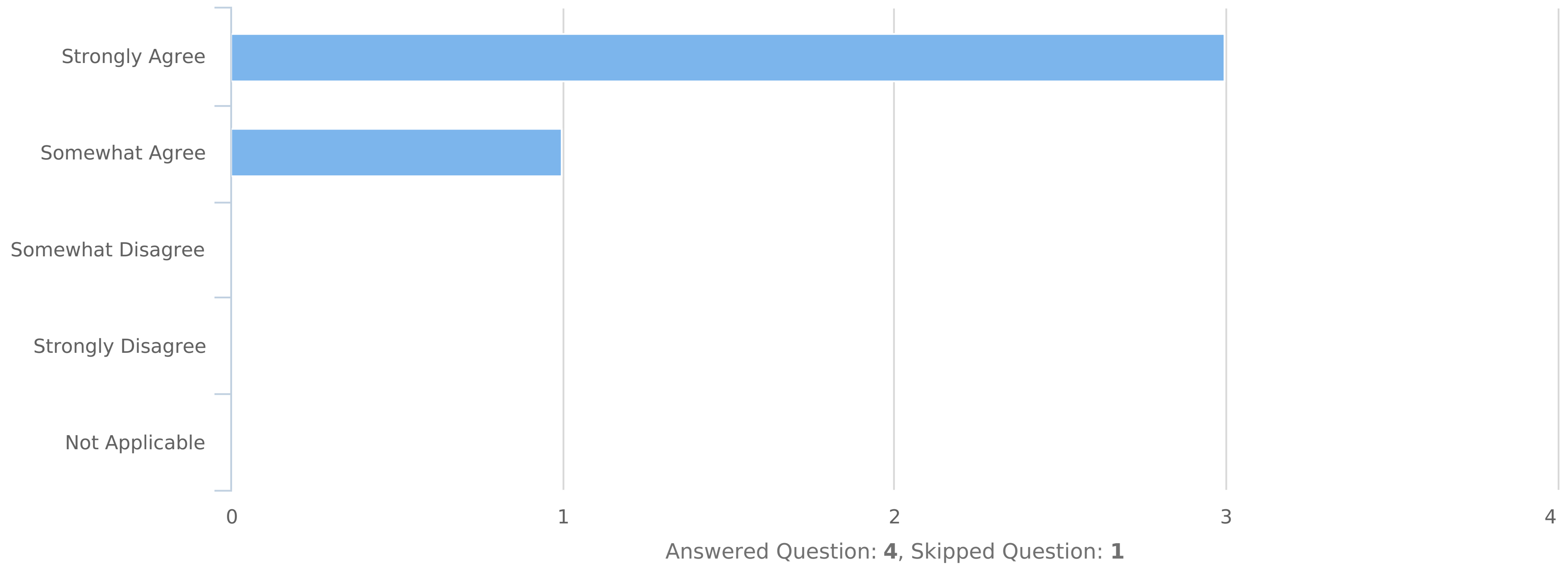
Please complete the following confidential/anonymous evaluation after each regularly scheduled Board of Health meeting. Your ongoing feedback is important in ensuring Board of Health meetings are effective, informative and enjoyable.

Total Invited to Survey: 5
Total Finished Survey: 4

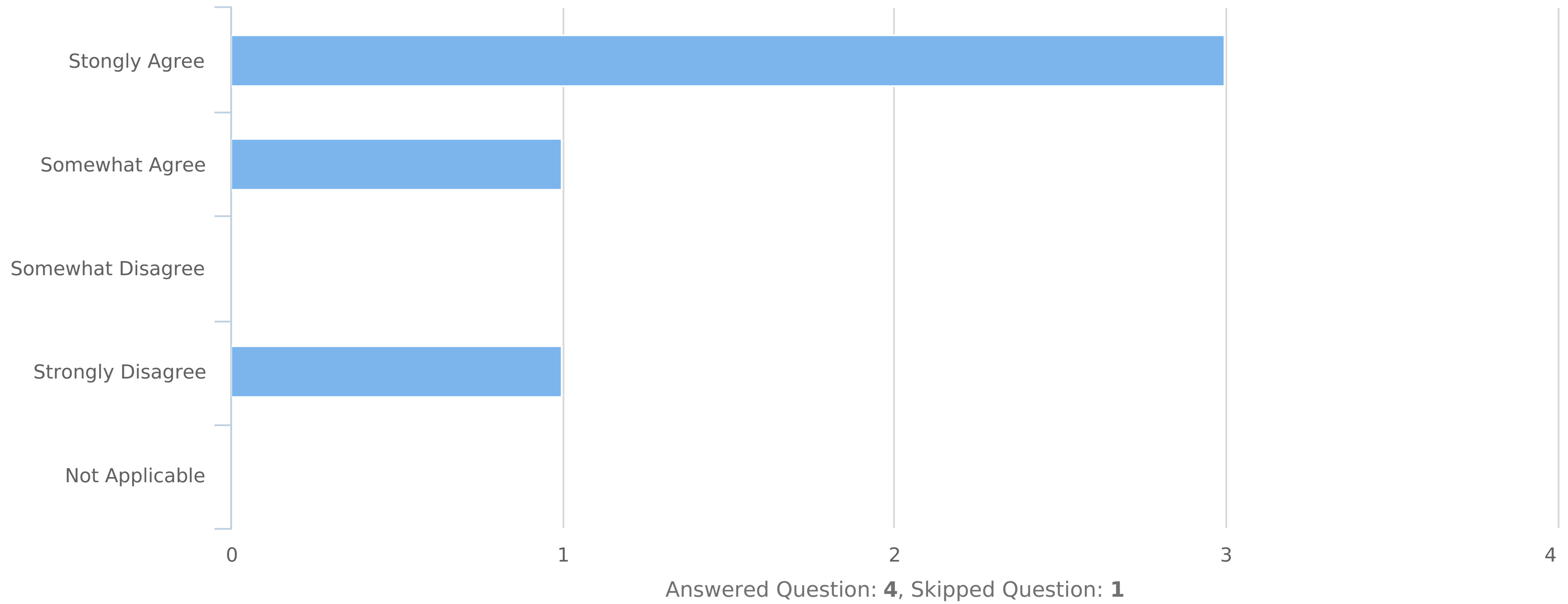
The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.



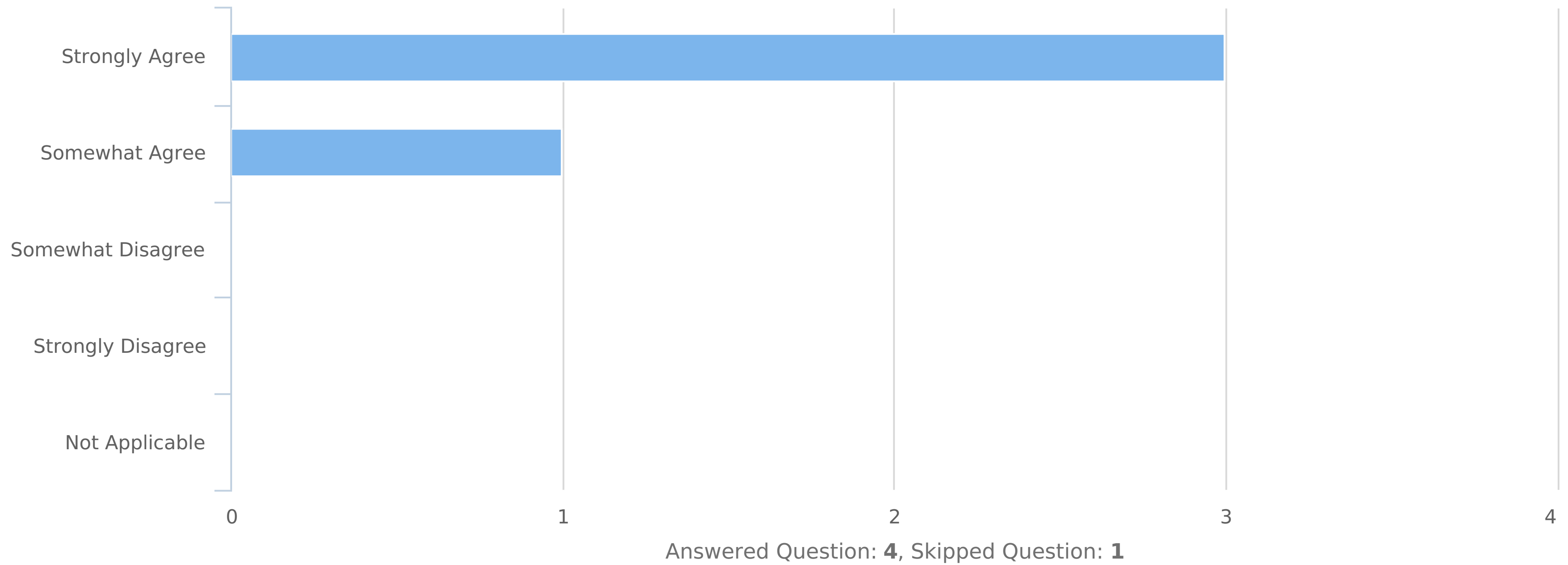
The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.



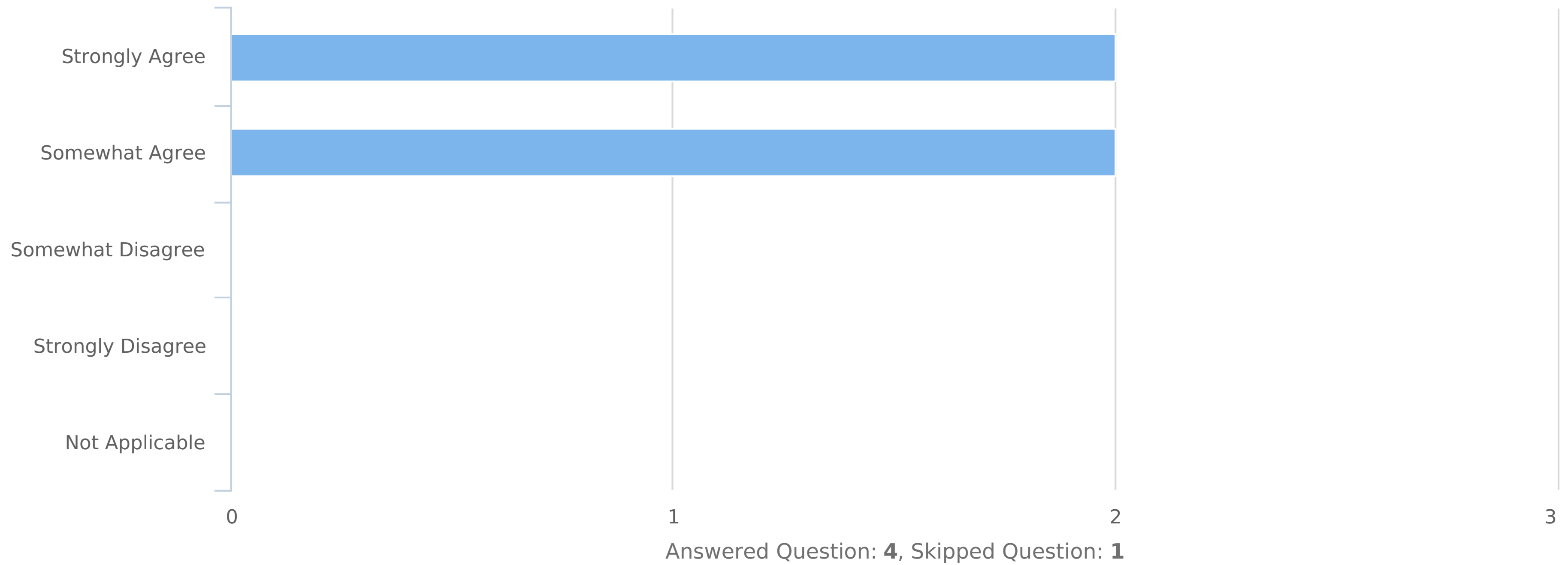
The MOH/CEO report was informative, timely and relevant to my governance role.



Overall, the Board meeting was conducted in an active, informative, and responsible manner with decisions made that advance the APH vision and mission

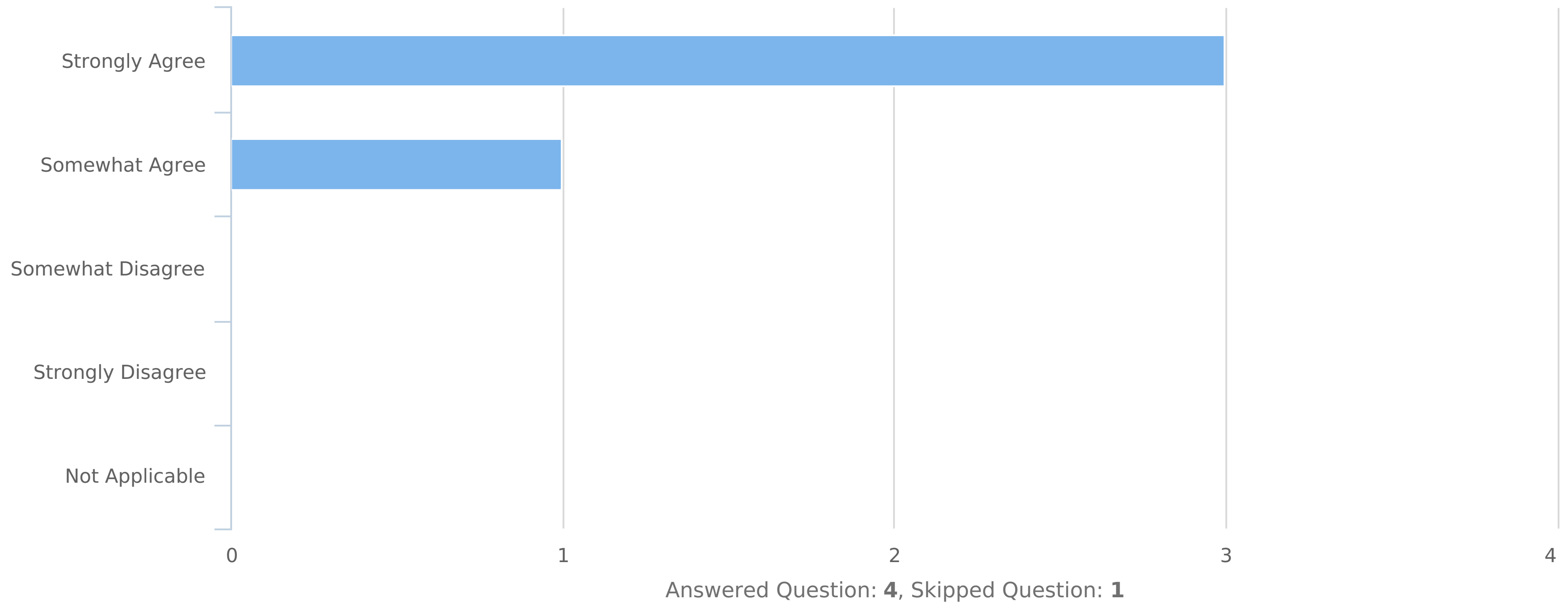


There is alignment with items that were included in the Board agenda package and the APH’s 2015-2020 Strategic Plan.



Answered Question: **4**, Skipped Question: **1**

Board members' conduct was professional, cordial and respectful.



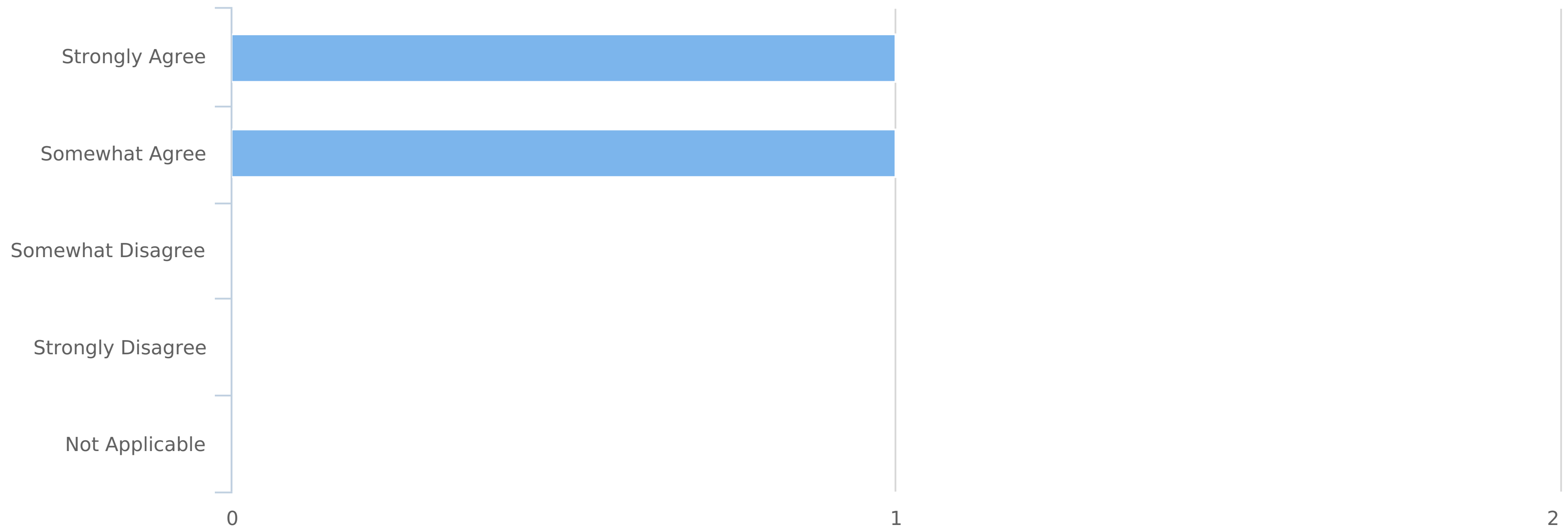
1. Comments: (For example: what did you like/dislike about the meeting, what are your suggestions to improve future meetings, etc.)

March 30, 2016 - BoH Monthly Meeting Evaluation

Please complete the following confidential/anonymous evaluation after each regularly scheduled Board of Health meeting. Your ongoing feedback is important in ensuring Board of Health meetings are effective, informative and enjoyable.

Total Invited to Survey: 5
Total Finished Survey: 2

The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.



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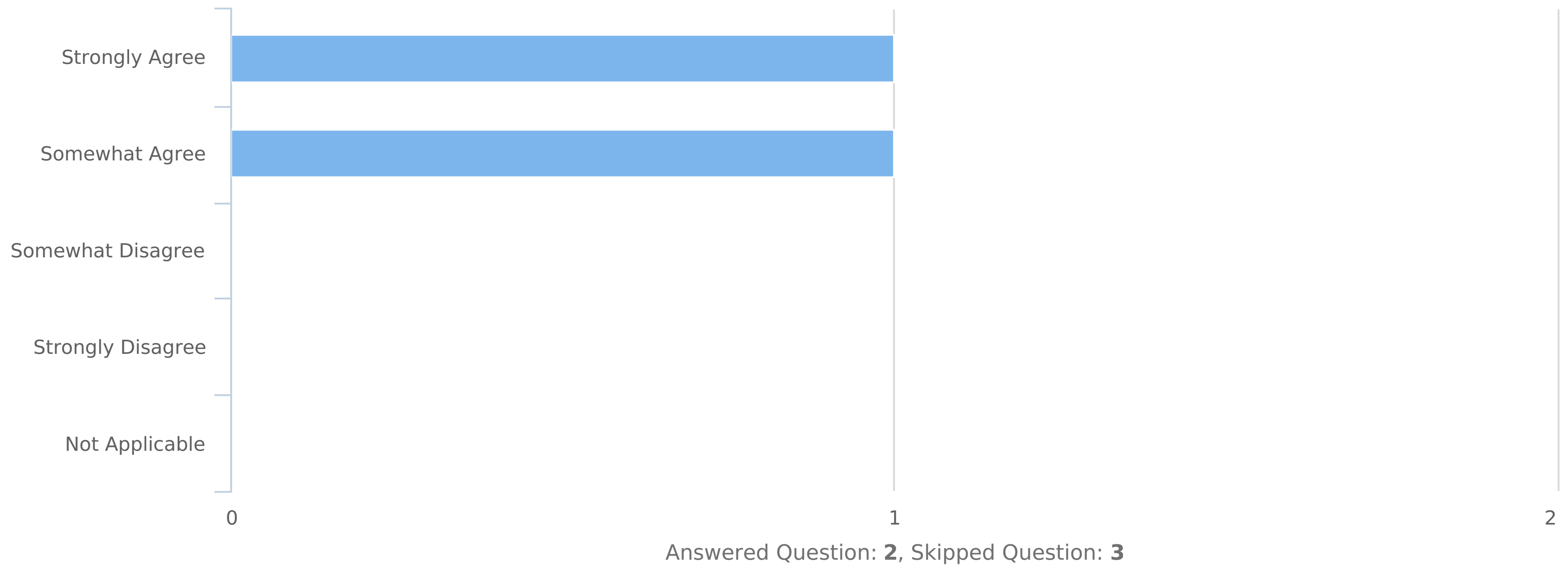

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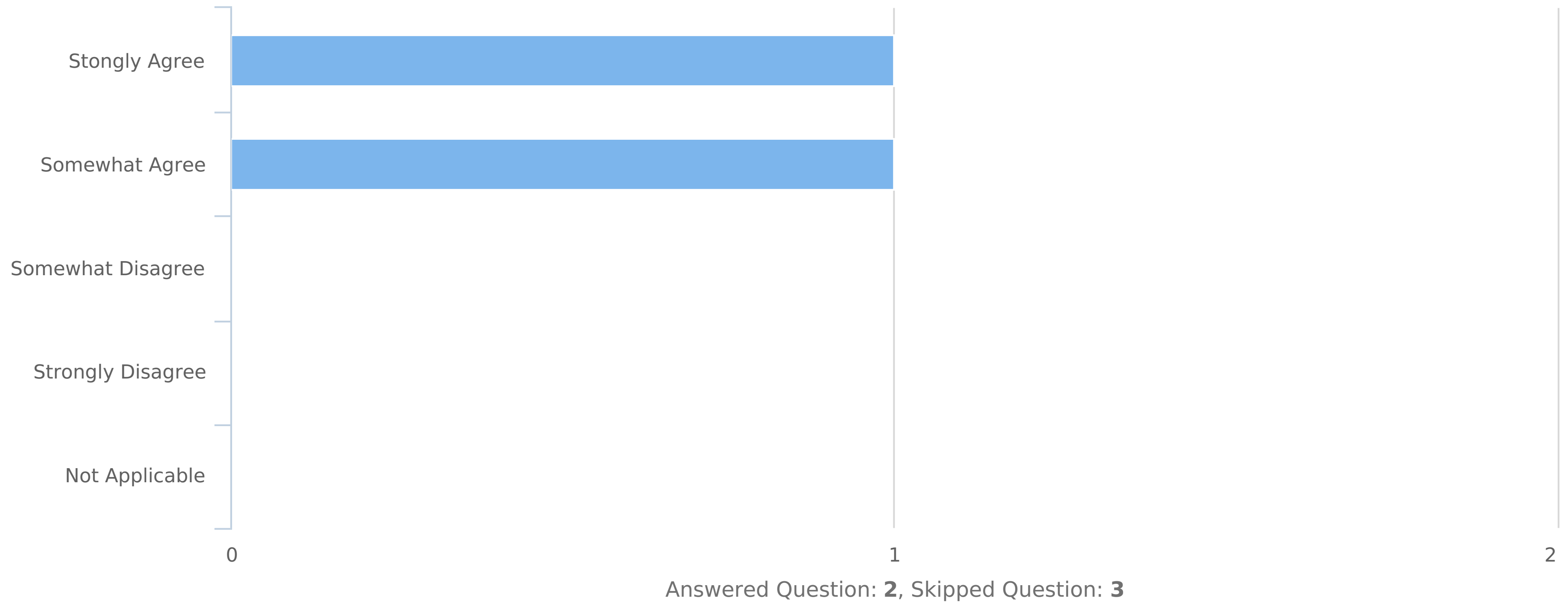
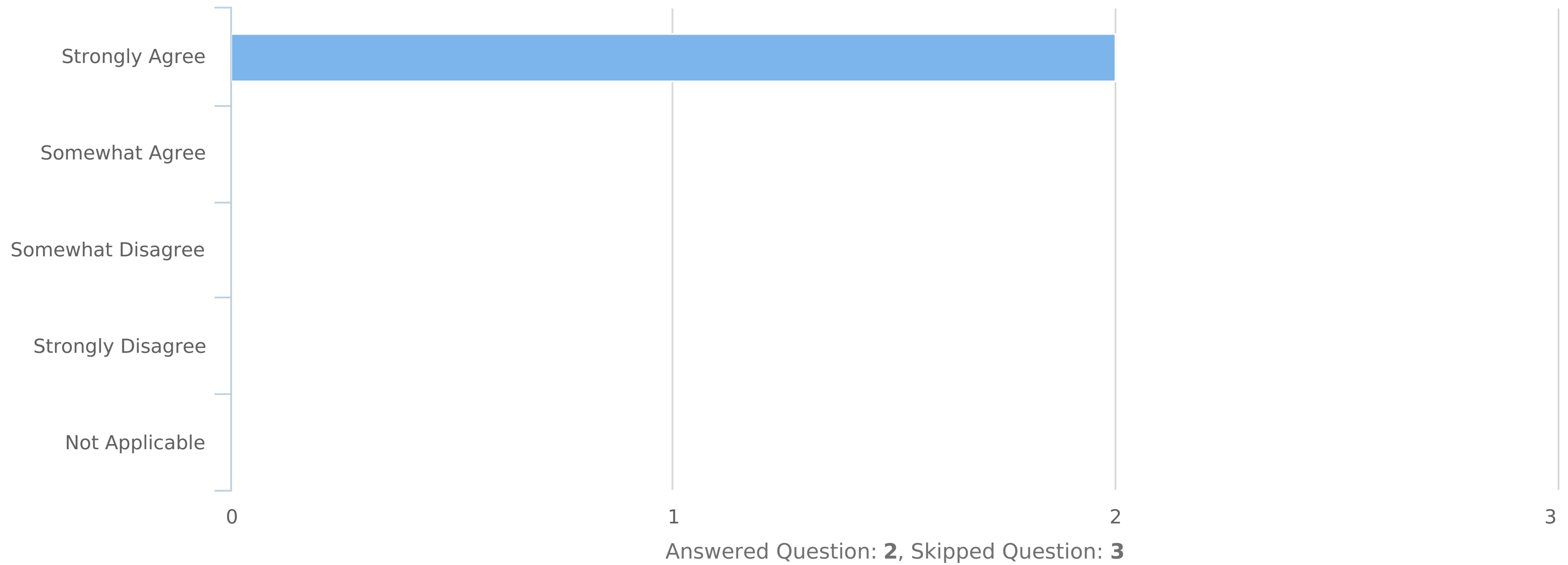
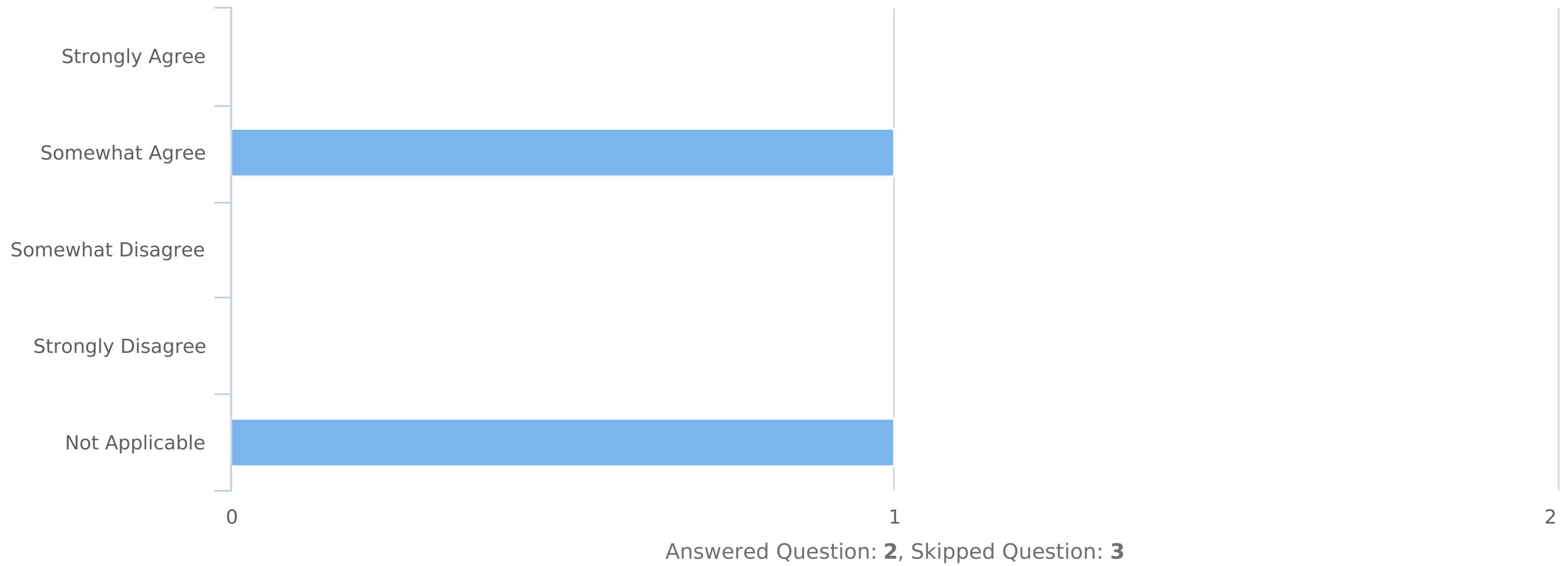


Overall, the Board meeting was conducted in an active, informative, and responsible manner with decisions made that advance the APH vision and mission

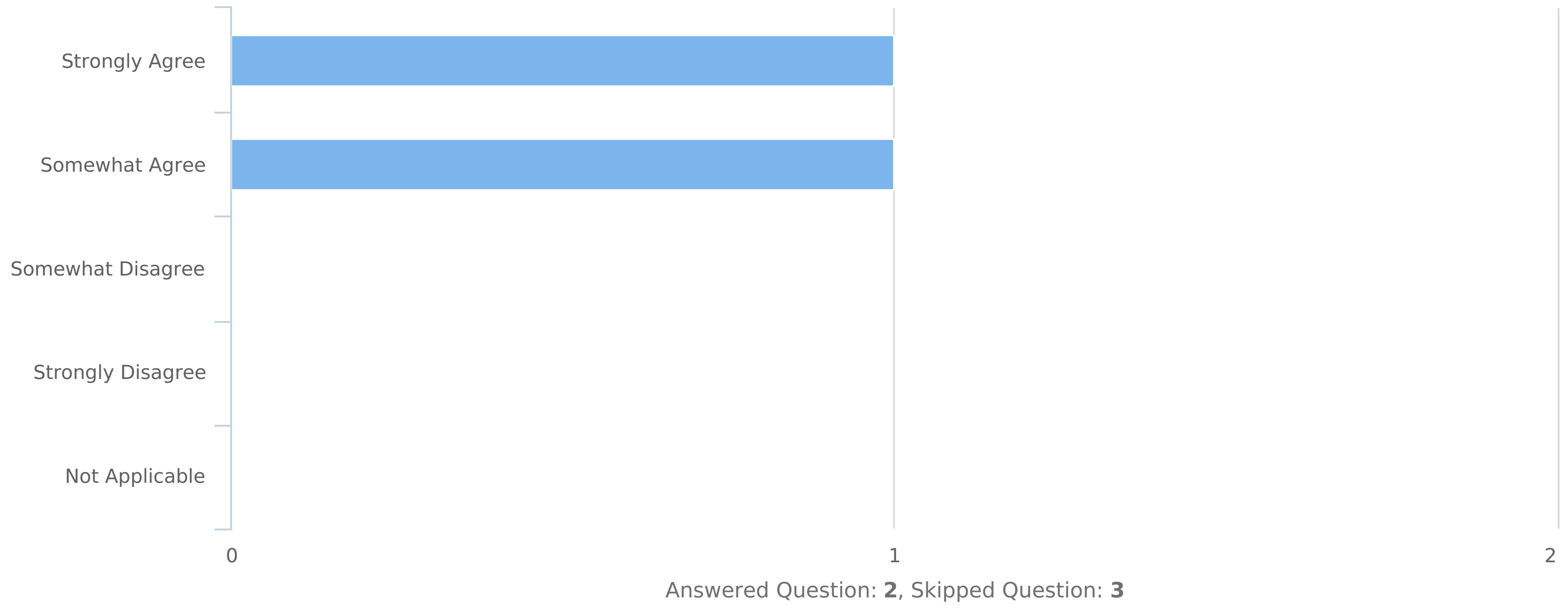


Answered Question: **2**, Skipped Question: **3**

There is alignment with items that were included in the Board agenda package and the APH's 2015-2020 Strategic Plan.



Board members' conduct was professional, cordial and respectful.



Answered Question: **2**, Skipped Question: **3**

2015 APH PROGRAM PERFORMANCE

A Quantitative Report to the Board

Abstract

An overview of key performance measures associated with select programs from Algoma Public Health for the most recent reporting period

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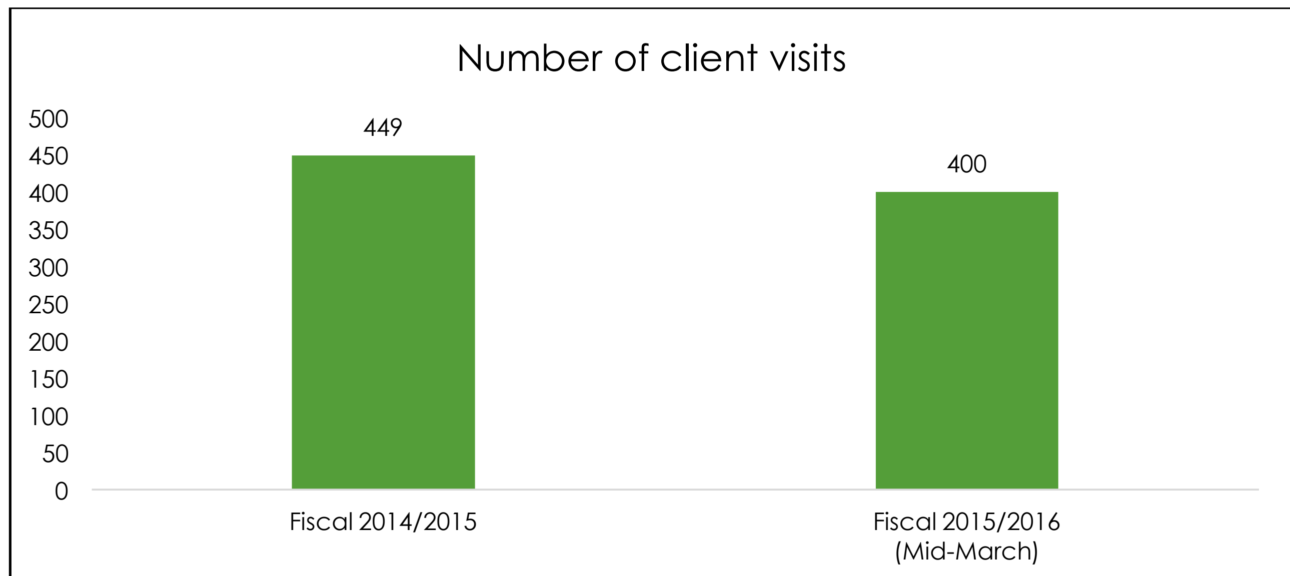
Introduction

The following report provides an update about select programs and their performance by comparing the two most recent reporting periods available, typically calendar 2014 and 2015. Each program manager was asked to provide statistics for two performance measures to represent programs they are responsible for. In addition, a brief summary to help provide context to accompany the measures and offer explanations for any trends is also included.

Addiction Supportive Housing

Number of client visits in Addiction Supportive Housing

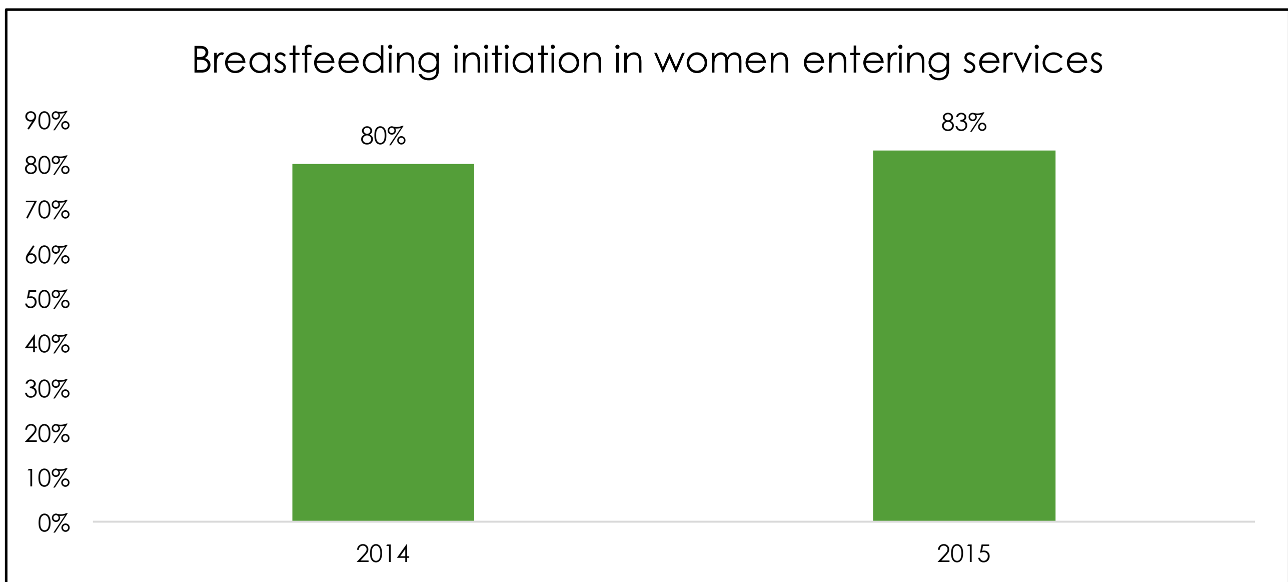
The number of client visits in the Addiction Supportive Housing program decreased approximately 10.9% to 400 in fiscal 2015/2016 from 449 in fiscal 2014/2015. However, since fiscal 2015/2016 was not complete at the time of reporting, the final percent decrease will be slightly less than 10.9%. The observed decrease between fiscal 2014/2015 and fiscal 2015/2016 can be partially attributed to the passing away of some clients receiving subsidies and transition to new clients. Additionally, staffing challenges in fiscal 2015/2016 limited the capacity of the program to conduct visits. Despite the decline in fiscal 2015/2016, the program is still on pace to meet its target.



Child Health

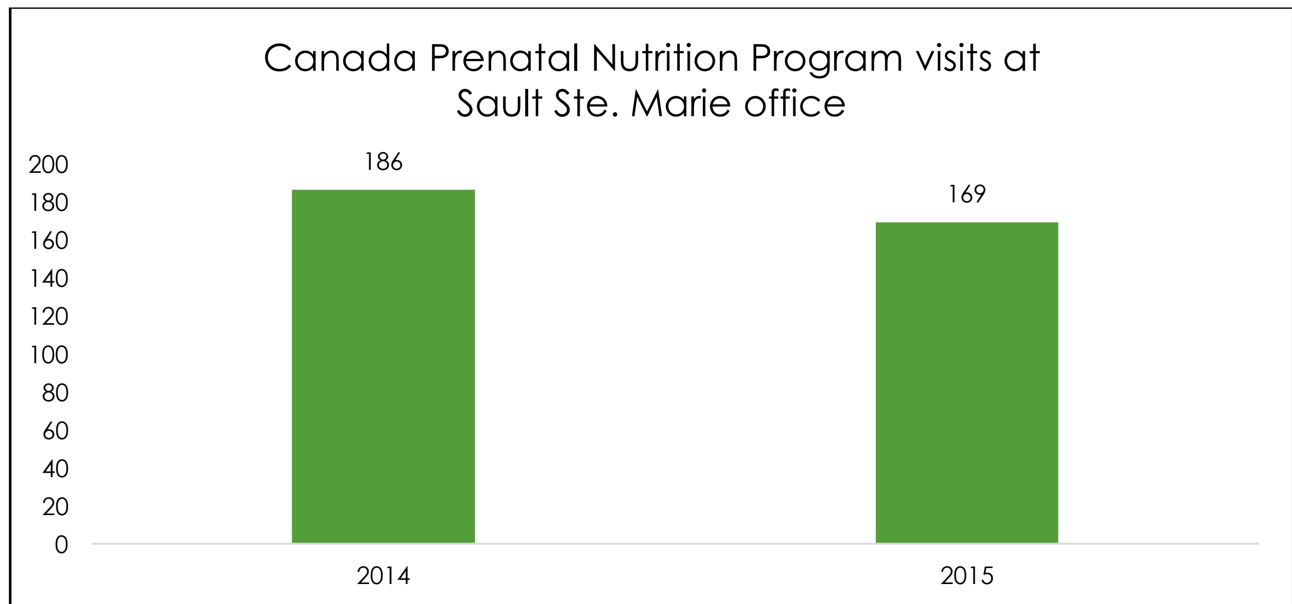
Mothers initiating breastfeeding

Breastfeeding initiation in women entering services at Algoma Public Health increased from 80% in 2014 to 83% in 2015. As a reference, in 2014 and 2015 respectively, 64.6% and 66.9% of the women who gave birth in the district of Algoma entered services at Algoma Public Health. Factors that may have accounted for this slight increase in breastfeeding initiation rates include support received from the Parent Child Information Line, the Parent Child Information Centre and lactation consultant appointments available at Algoma Public Health. Other contributing factors include ongoing district wide health promotion initiatives and bedside breastfeeding support from public health nurses for new mothers at the Sault Area Hospital.



Canada Prenatal Nutrition Program usage for Sault Ste. Marie

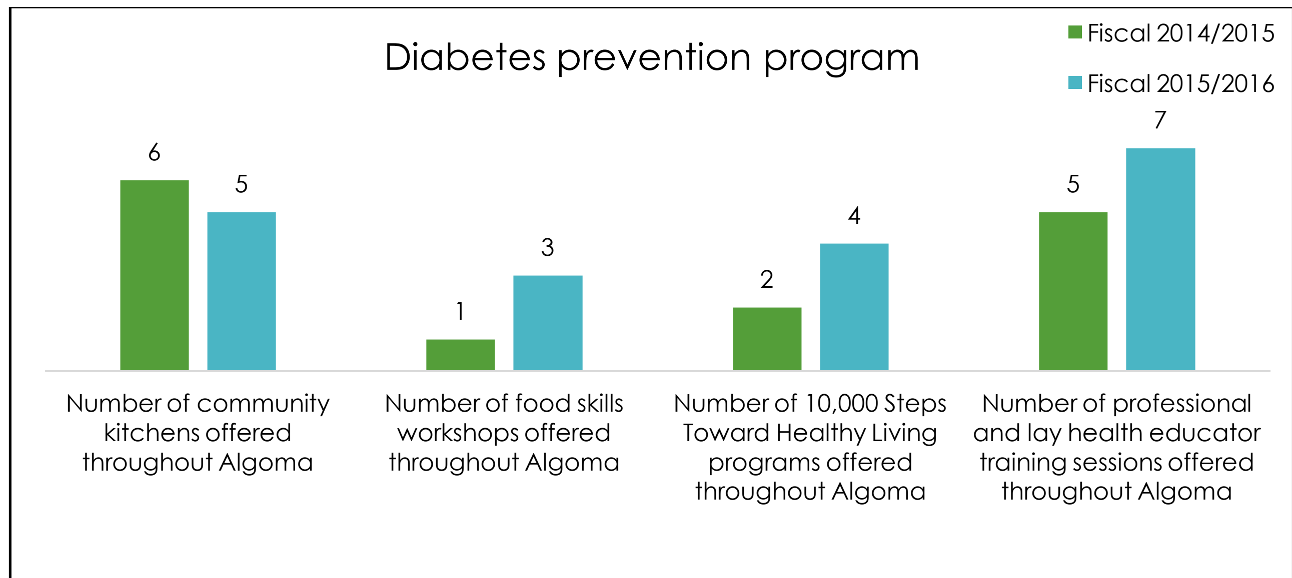
Visits for the Canada Prenatal Nutrition Program, which provides food, vitamins and support to pregnant women in financial need, decreased 9.1% to 169 in 2015 from 186 in 2014. This decrease is in line with the trend observed since 2010 when the Canada Prenatal Nutrition Program in Sault Ste. Marie moved from 126 Queen Street East, adjacent to the city bus terminal, to 294 Willow Avenue. Since this move, there has been a decline in visits for the program, from 265 in 2010 to 169 in 2015 as clients have indicated to staff that they find it difficult to get to the Willow Avenue location. Efforts are being made on several fronts to improve participation, including: offering monthly participation instead of the traditional biweekly participation, offering bus passes worth 20 rides when need is expressed, delivering milk coupons and food bags to Healthy Babies Healthy Children clients at home visits and promotion of the program to improve awareness for community partners and pregnant women.



Chronic Disease Prevention

Diabetes prevention program offerings

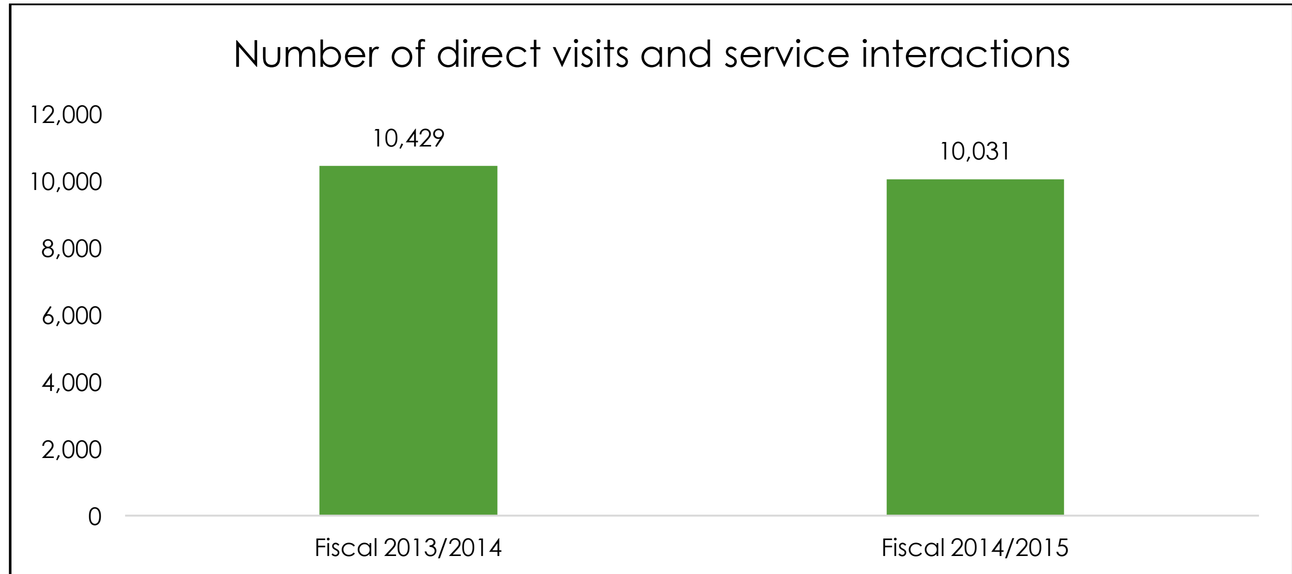
Overall in 2015, the number of workshops, programs and training sessions related to diabetes prevention has increased since 2014. Algoma Public Health works with community partners to increase awareness and provide skill building opportunities to groups and individuals related to diabetes prevention and modifiable health behaviours. Over the past three years, we have been able to continue to build on the successes and partnerships to extend programming and the reach in the district of Algoma.



Community Mental Health

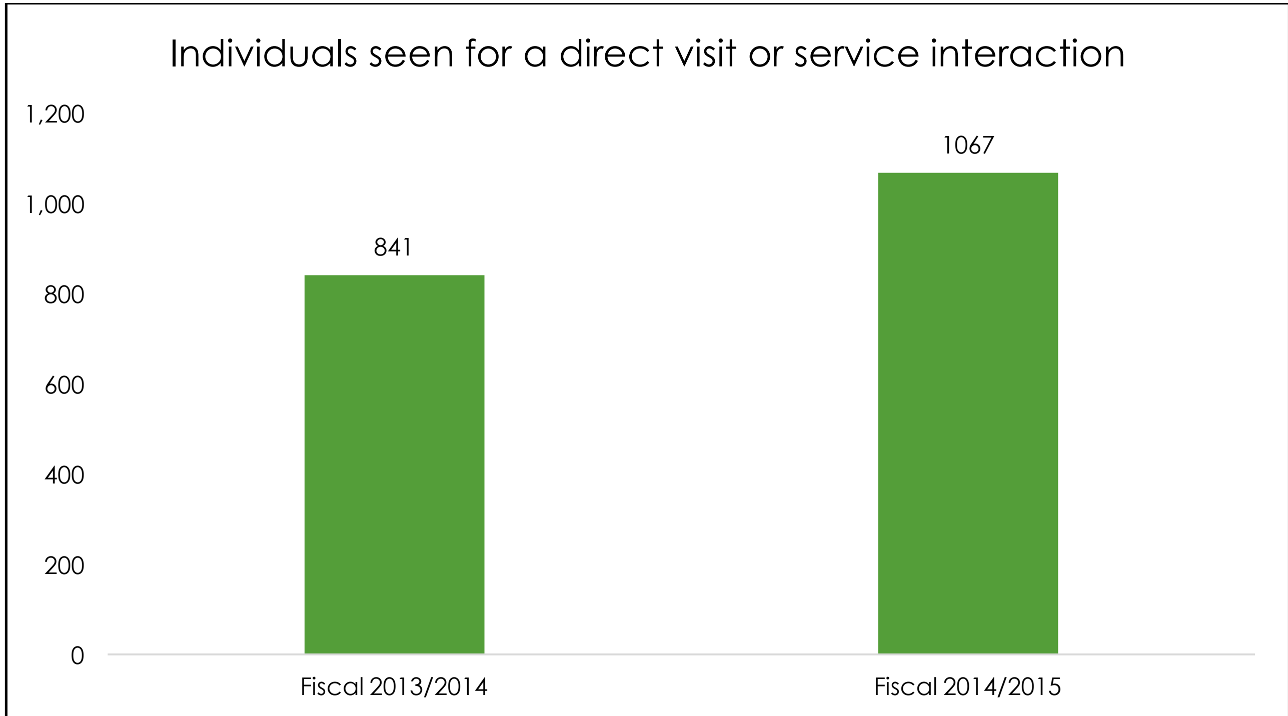
Direct case management and brief service contact visits

Direct visits from case managers declined 3.8% to 10,031 in fiscal 2014/2015 from 10,429 in fiscal 2013/2014. This decline is representative of a shift towards offering more group interactions where possible instead of multiple individual visits. Group interactions are only counted as one direct case management visit which lowers the number of visits and service interactions, but provides the benefit of an environment for mutual support between clients.



Individuals served by case management and brief service contact

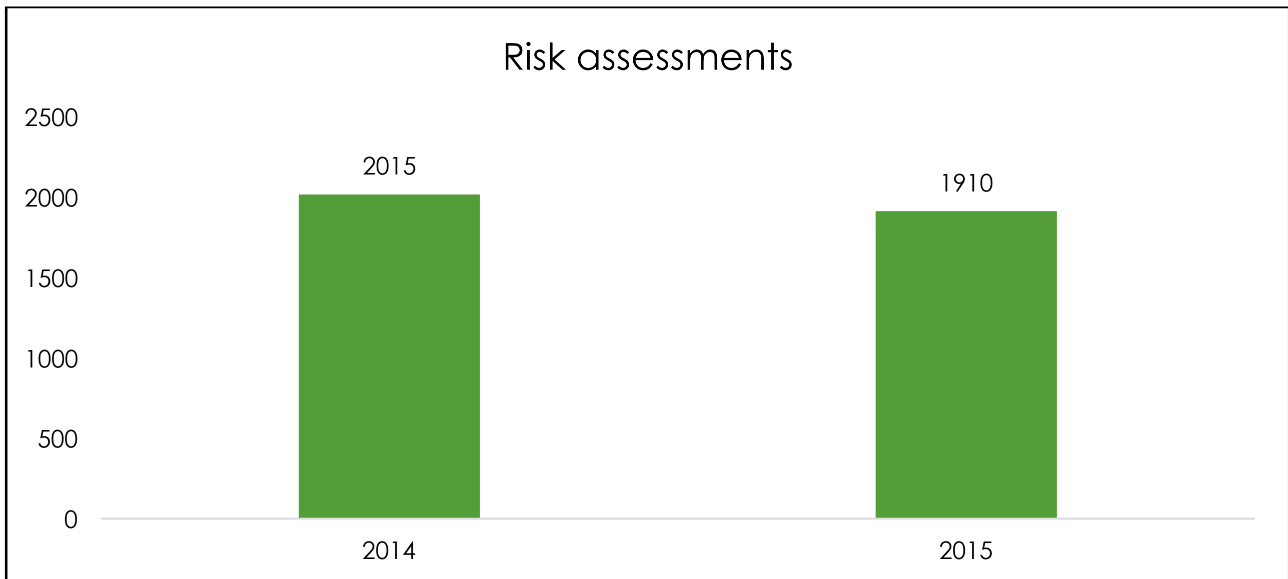
The number of individuals served by case management and brief service contact increased 26.9% from 841 in fiscal 2013/2014 to 1,067 in fiscal 2014/2015. This substantial increase is likely attributable to the alignment of one additional staff person at Sault Area Hospital and improved outreach at the Neighbourhood Resource Centre.



Food Safety

Food premise risk assessments and inspection frequency

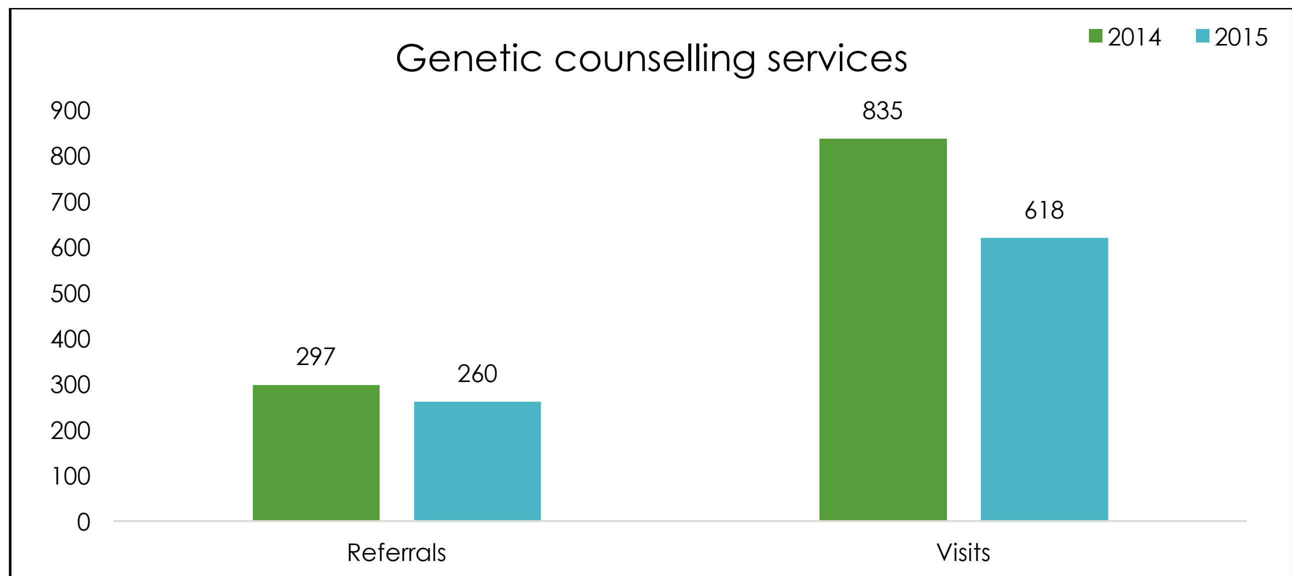
Annually, food premise risk assessments are completed by public health inspectors to determine the frequency that an establishment is inspected. The required number of inspections decreased 5.2% from 2,015 in 2014 to 1,910 in 2015. This decrease in frequency can be attributed in part to the implementation of a new food risk assessment tool for assessing the annual frequency of food premise inspections. The new food risk assessment tool has allowed for a reduction in inspections at premises with multiple processing locations, such as a hot handling food section, a deli, and a grocery store.



Genetics

Genetic counselling program usage

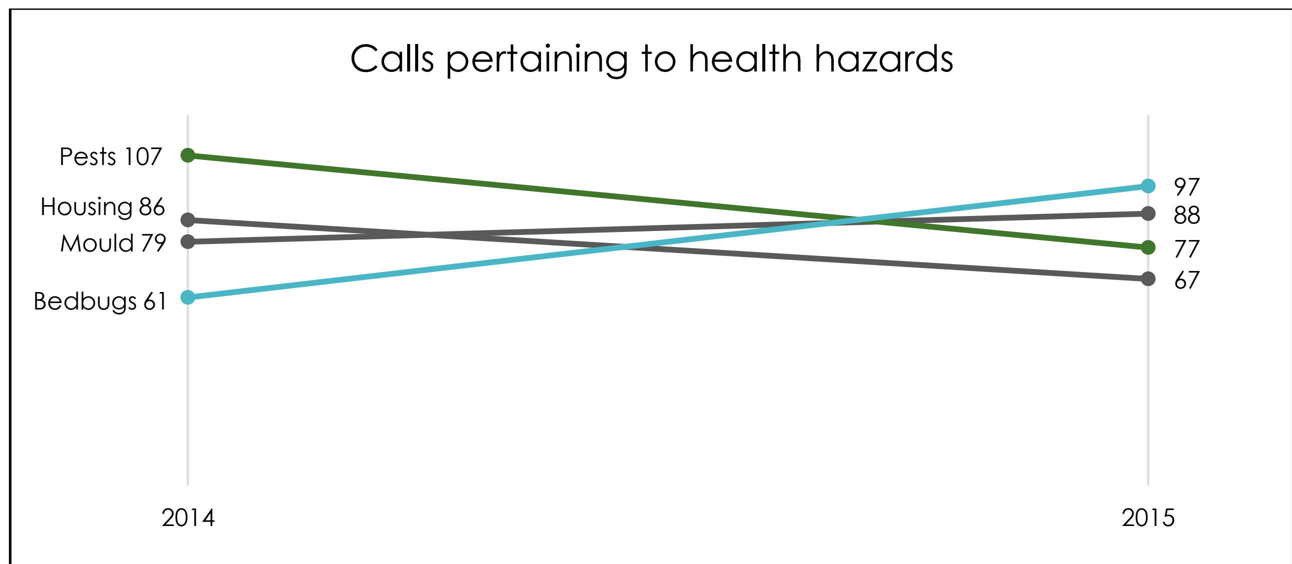
The number of physician referrals processed by the Algoma Public Health genetics program decreased 12.5% to 260 in 2015 from 297 in 2014. Additionally, the number of client visits decreased 26% to 618 in 2015 from 835 in 2014. This decrease in processing is attributable to program staffing changes and vacancies, which due to the small number of staff working in the program had a large impact on capacity. While a new public health nurse was hired, due to the significant orientation period of program they were limited in their ability to conduct genetic counselling sessions independently. By fall 2016, the program should return to a full complement of trained staff through the continued development of the new public health nurse.



Health Hazards

Complaints and requests for service

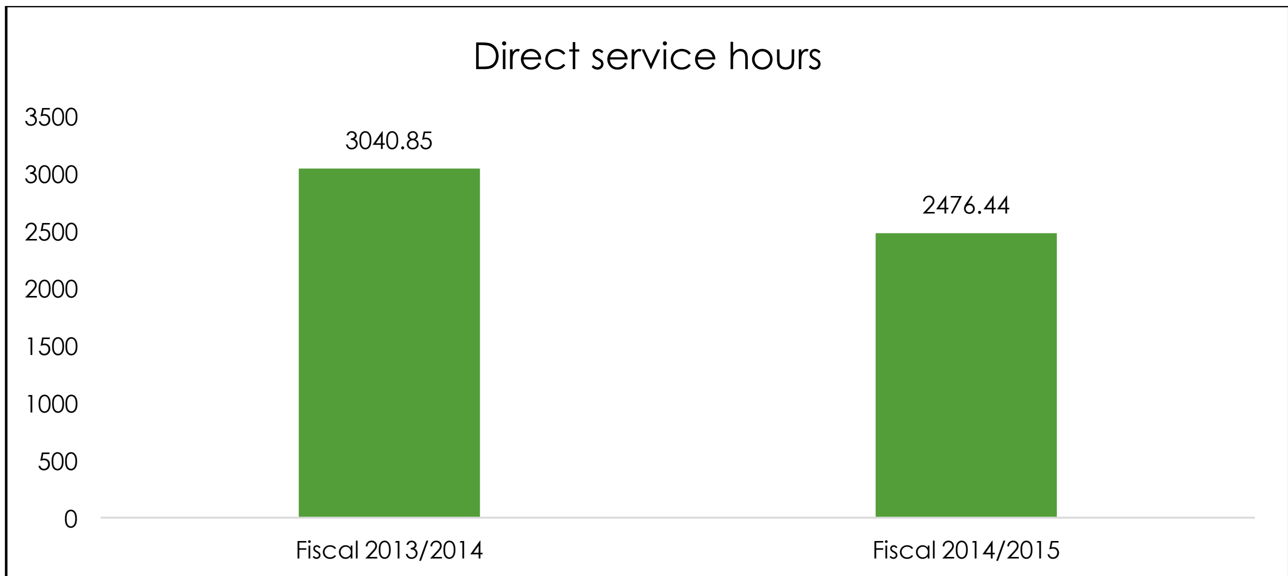
The total number of calls related to health hazard complaints were almost identical in 2014 and 2015 with 333 and 329 respectively. Differences were observed however when comparing call types. Most notably, calls related to bedbugs increased 59.0% to 97 in 2015 from 61 in 2014, while calls related to pests dropped 37.4% from 107 in 2014 to 67 in 2015. It is hard to attribute differences in call volume year-over-year to any singular cause; however, one major factor is the degree to which any given topic receives media attention. As an example, one national news story about bedbugs can prompt a noticeable increase in the amount of calls received.



Infant Child Development Program

Service hours provided

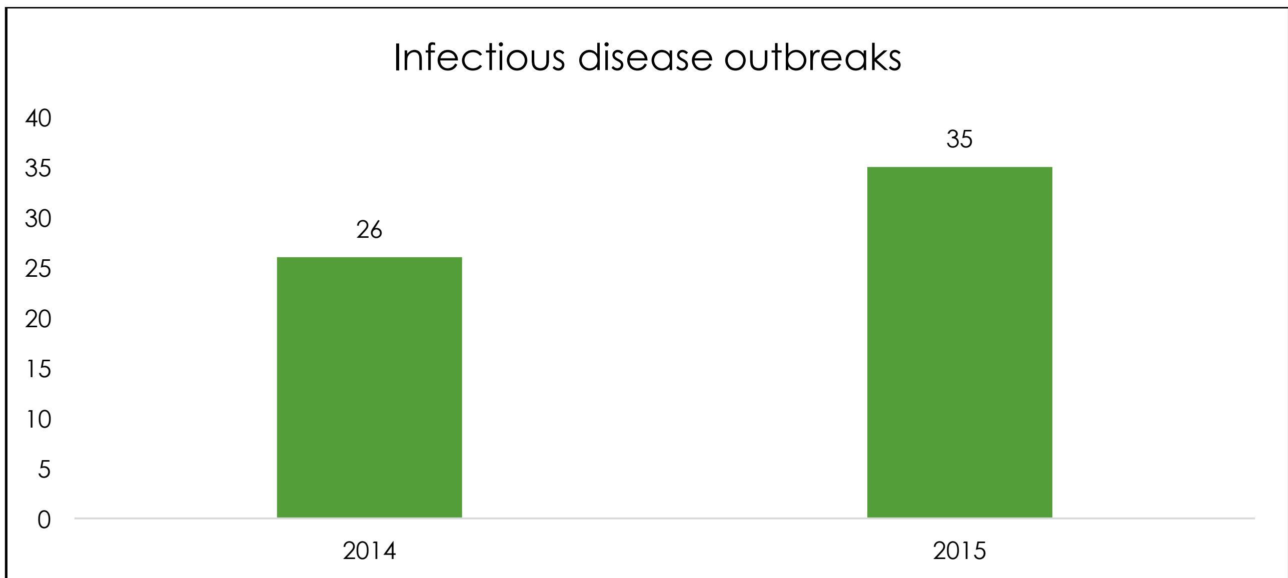
The Infant Child Development Program works with children who have or are at risk of developmental delays that may result from a large range of causes (i.e. low birth weight, genetic conditions, prenatal drug or alcohol exposure and autism). The number of service hours provided by the Infant Child Development Program decreased 18.6% from 3,040.85 in fiscal 2013/2014 to 2,476.44 in fiscal 2014/2015. While the internal target (3000) for hours was met in fiscal 2013/2014, the target for fiscal 2014/2015 (3220) was not. The observed decrease can be attributed in large part due to staffing challenges and turnover. As newly hired staff have recently completed their orientation and are now taking on a full case load, the number of service hours should rise.



Infectious Disease Control

Number of outbreaks

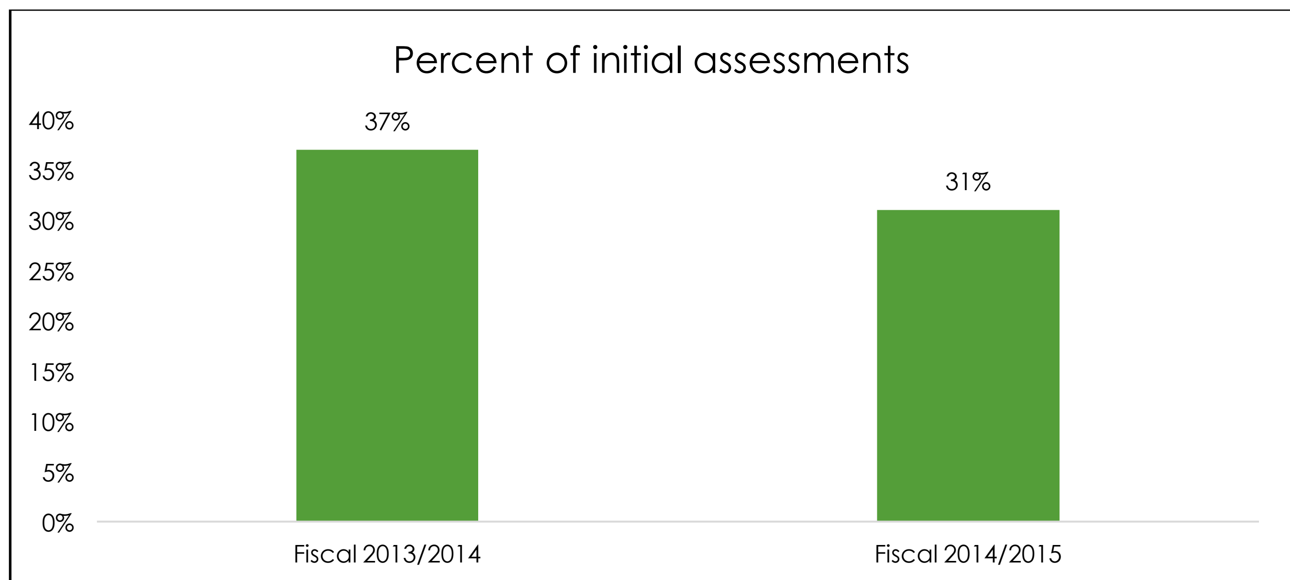
The number of infectious disease outbreaks that Algoma Public Health has investigated increased from 26 in 2014 to 35 in 2015. Infectious disease outbreaks are most commonly due to respiratory illnesses; however, outbreaks related to antimicrobial resistant organisms, enteric illnesses, and vaccine preventable diseases, such as mumps or measles are also investigated. The number of outbreaks year-over-year is highly variable, and affected by many causes including: flu strain type and vaccine effectiveness, vaccination prevalence, efficacy of antivirals, weather season severity and variable reporting by health care institutions. Algoma Public Health works closely with community partners for Infection Prevention and Control at the institutional level to effectively lead outbreak response plan and provide guidance for implementing infection control measures.



Preschool Speech and Language

Percent of initial assessments provided to children under 30-months old

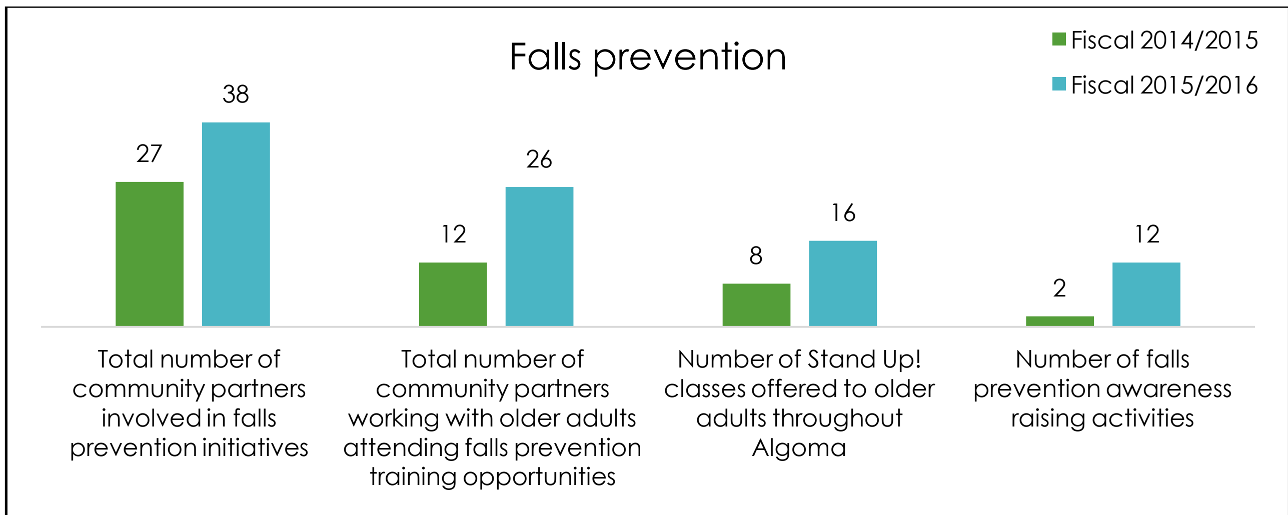
The percent of initial assessments provided to children under 30-months old has decreased from 37% in fiscal 2013/2014, to 31% in fiscal 2014/2015. During these last two fiscal years, the average age for a child being assessed was 32 and 33 months respectively, indicating that it has been a struggle to complete the assessments before the 30-month age time designated by the ministry. The difference between the last two periods may be the result of staffing changes at Algoma Public Health and an important partner agency as well as changes in how the reporting system works. As staff hired in 2015 are now at or approaching a full case load after their orientation, progress towards assessing more children under 30-months old should be seen.



Prevention of Injury and Substance Misuse

Falls across the lifespan prevention efforts

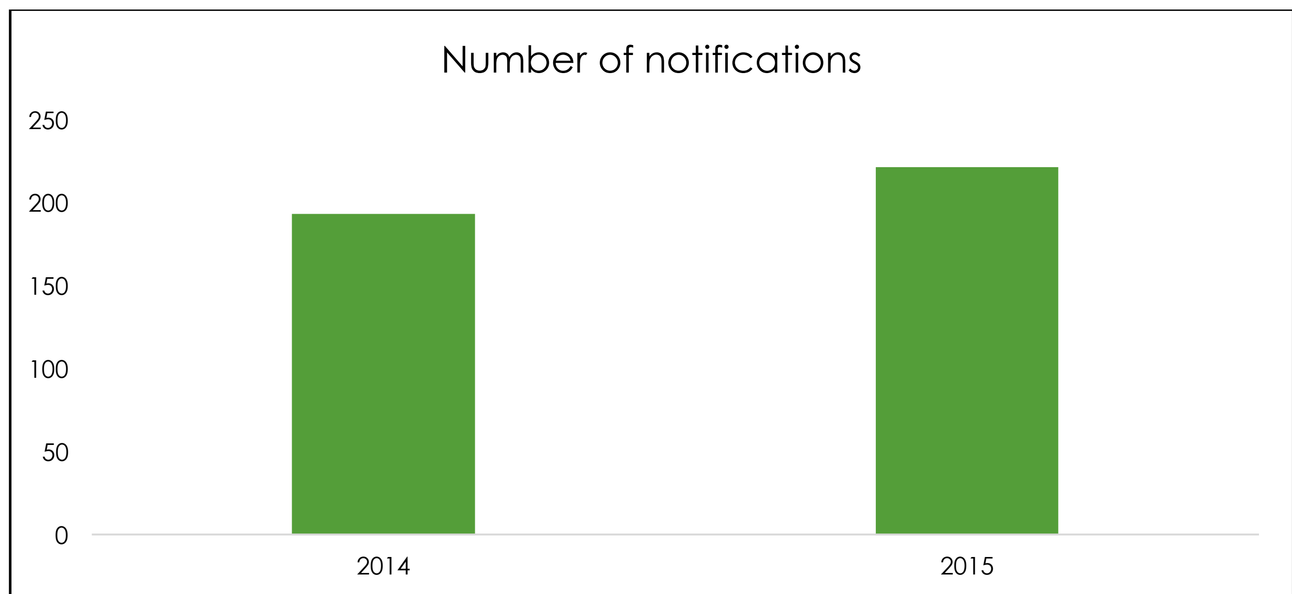
In the fall of 2014, APH became involved with a regional falls prevention strategy: Stay On Your Feet. Stay On Your Feet is a multi-faceted, collaborative strategy between the North East Local Health Integration Network and five public health units in Northeastern Ontario. The goal of the strategy is to improve the quality of life for older adults by reducing the rate and severity of falls. Overall in 2015, there was an increase in the number of community partners engaged and fall prevention/awareness activities offered in the district of Algoma compared to 2014. In order to influence this goal, multiple approaches have been included in the strategy and has provided opportunities for Algoma Public Health to greatly enhance efforts in the area of falls prevention.



Rabies

Number of notifications of potential rabies exposure

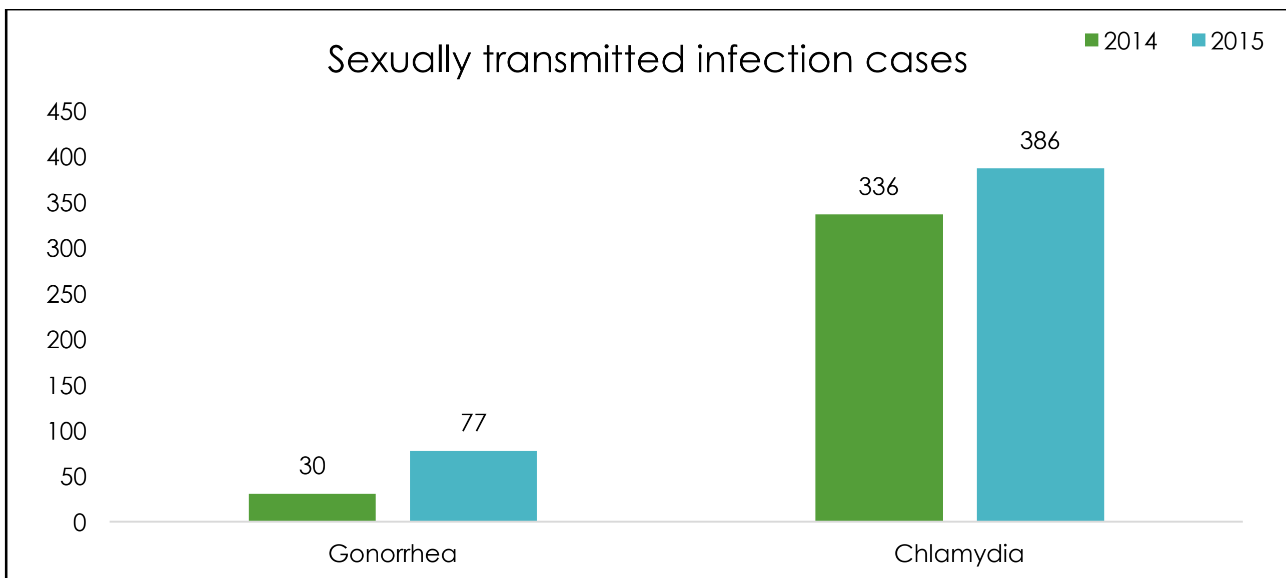
The number of notifications of potential exposure to animals carrying rabies increased 14.5% to 221 in 2015 from 193 in 2014. This is not a reflection of the number of human cases of rabies, which is extremely rare, but of the exposure of people to an animal that may or may not have rabies. The majority of notifications received have pertained to exposures from canines, accounting for 77.2% and 77.4% of the notifications in 2014 and 2015 respectively. The observed increase in potential exposures to rabies represents common fluctuation that is influenced heavily by the frequency of self-reporting from citizens and required reporting from agencies (i.e. hospitals and veterinarians) to Algoma Public Health.



Sexual Health

Sexually transmitted infections

The number of sexually transmitted infections has increased between 2014 and 2015. Most notably, cases of gonorrhea have increased by 157% to 77 in 2015 from 30 in 2014, and cases of chlamydia by 14.9% to 386 in 2015 from 336 in 2014. Reasons for the observed rise for these two sexually transmitted infections are complex and not attributable to any single cause. The Sexual Health program continues to diligently conduct case management work to identify and treat cases and contacts of those infected. Additionally, efforts are being made to deliver outreach services to increase the availability of testing for high risk populations. Lastly, health promotion work continues. Most recently was a messaging campaign during Sexual and Reproductive Health Awareness Week in February 2016 that generated significant media attention and interest.



Smoke Free Ontario

Number of clients provided intensive smoking cessation counselling

The number of clients provided intensive smoking cessation counselling in scheduled clinics or as part of their existing home supports increased by 59.6% from 57 in 2014 to 91 in 2015. The observed increase is reflective of more staff from additional Algoma Public Health programs receiving specialized training and delivering the counseling. This increase is also a result of enhancements to the nicotine replacement therapy discount voucher supports and the expanded option of direct dispensing for clients in need. This positive expansion in quitting smoking support services were possible due to the receipt of Ministry one-time funding.