Algoma
PUBLIC HEALTH
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Board of Health Meeting

September 25, 2019

SSM Community Room A

www.algomapublichealth.com

Meeting Book - September 25, 2019 Board of Health

Algoma Public Health Board of Health Meeting Table of Contents

Board of Health Meeting
AGENDA
September 25, 2019 at 5:00 pm
Sault Ste. Marie - Community Room A

BOARD MEMBERS
Lee Mason - Chair
Ed Pearce - 1st Vice Chair
Deborah Graystone - 2nd Vice Chair
Dr. Patricia Avery
Louise Caicco Tett
Randi Condie
Micheline Hatfield
Adrienne Kappes
Dr. Heather O'Brien
Brent Rankin
Karen Raybould
Matthew Scott

APH EXECUTIVE
Dr. Marlene Spruyt - MOH/CEO
Dr. Jennifer Loo - AMOH & Director of Health Protection
Justin Pino - CFO /Director of Operations
Antoniette Tomie - Director of Human Resources
Laurie Zeppa - Director of Health Promotion & Prevention
Tania Caputo - Board Secretary

1.0 Meeting Called to Order *E. Pearce*

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda *E. Pearce*

RESOLUTION

THAT the Board of Health agenda dated September 25, 2019 be approved as presented.

3.0 Adoption of Minutes of Previous Meeting *E. Pearce*

RESOLUTION

THAT the Board of Health minutes dated June 26, 2019 be approved as presented.

4.0 Delegations / Presentations

a. Climate Change Presentation *C. Spooney*

5.0 Business Arising from Minutes *E. Pearce*

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports *M. Spruyt*

i. MOH Report - September 2019

RESOLUTION

THAT the report of the Medical Officer of Health and CEO for September 2019 be adopted as presented.

ii. Q2 Program Activity Indicators *M. Spruyt*

b. Finance and Audit Committee *E. Pearce*

i. Financial Statements *M. Spruyt*

RESOLUTION

THAT the Draft Financial Statements for the period ending July 31, 2019 be approved as presented.

ii. Infant Development Annual Reconciliation *M. Spruyt*

RESOLUTION

THAT the Board of Health receives and approves the Transfer Payment Annual Reconciliation for the Infant Development program as presented.

c. Governance Committee *D. Graystone*

i. Governance Committee Chair Report

RESOLUTION

THAT the Governance Committee Chair Report for September 2019 be adopted as presented.

7.0 New Business/General Business *E. Pearce*

a. Annual BOH Meeting Evaluation Results

b. APH Public Health Champion

i. Call for volunteer BOH members for panel

8.0 Correspondence *E. Pearce*

a. Letter to the Minister of Children, Community and Social Services, the Minister of Education, the Minister of Health and Long-Term Care from Peterborough Public Health regarding Support for Children Count Task Force Recommendations dated June 25, 2019.

b. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Simcoe Muskoka District Health Unit regarding Public Health Modernization mandate and funding dated June 27, 2019.

c. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Windsor-Essex Health Unit regarding Health Promotion as a Core Function of Public Health dated July 2, 2019.

d. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Windsor-Essex Health Unit regarding Immunization for School Children – Seamless Immunization Registry dated July 2, 2019.

e. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Windsor-Essex Health Unit regarding Smoke-Free – Smoke/Vape Free Outdoor Spaces dated July 2, 2019.

f. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Southwestern Public HealthConcerns about the future delivery of health promotion programs and services in Ontario by public health units dated July 8, 2019.

g. Letter to the Premier of Ontario from North Bay Parry Sound District Health Unit regarding a resolution related to the public health transformation initiative in northeastern Ontario dated July 5, 2019.

h. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Middlesex-London Health Unit regarding Essential Components for Strong Local Public Health dated July 19, 2019.

i. Communication regarding Climate Change Resolutions from alPHa dated July 24, 2019.

j. Communication to all Boards of Health from Regional Council of Niagara Region regarding Respecting Proposed Restructuring of Local Public Health Agencies dated July 19, 2019.

k. Communication from City of Hamilton to all Boards of Health endorsing support for increased actions to the opioid crisis and support for managed opioid programs dated July 26, 2019.

l. Communication from City of Hamilton to all Boards of Health endorsing support for correspondence from Sudbury & Districts Public Health, respecting Support for Bill S-228, the Child Health Protection Act and correspondence from the Simcoe Muskoka District Health Unit, respecting Urgent Provincial Action to Address the Potential Health and Social Harms from the Ongoing Modernization of Alcohol Retail Sales in Ontario dated July 26, 2019.

m. Communication from City of Hamilton to all Boards of Health endorsing support for Correspondence from Kingston, Frontenac and Lennox & Addington Public Health respecting Health Promotion as a Core Function of Public Health dated July 26, 2019.

n. Communication from City of Hamilton to all Boards of Health endorsing support for Correspondence from Sudbury & Districts Public Health respecting Parity of Esteem Position Statement, Correspondence from Peterborough Public Health respecting Support for Children Count Task Force Recommendations, Correspondence from the Windsor-Essex County Board of Health respecting Smoke-Free Multi-Unit Dwellings dated July 26, 2019.

o. Letter to the Deputy Premier and Minister of Health and Long-Term Care from KFL&A Public Health regarding Restructuring Local Public Health in Ontario dated August 6, 2019.

p. Communication to all Boards of Health from Grey Bruce Health Unit regarding Smoke-Free multi-unit Dwelling and Protecting Children through Immunization and Smoke and Vape Free Outdoor Space dated August 27, 2019.

q. Communication to all alPHa members from regarding Update on Public Health Modernization dated September 11, 2019.

r. Letter to the Premier of Ontario from Public Health Sudbury & Districts regarding North East Public Health Transformation dated September 16, 2019.

9.0 Items for Information *M. Spruyt*

a. Response regarding cancer study

b. alPHa Fall Symposium & Section Meetings November 6-7, 2019

10.0 Addendum *E. Pearce*

11.0 In Camera *E. Pearce*

For discussion of **labour relations and employee negotiations,** matters about identifiable individuals**, adoption of in camera minutes, security of the property of the board,** litigation or potential litigation.

RESOLUTION

THAT the Board of Health go in camera.

12.0 Open Meeting *E. Pearce*

a. Resolutions resulting from the in camera meeting.

13.0 Announcements / Next Committee Meetings: *E. Pearce*

Finance & Audit Committee Meeting

October 9, 2019 @ 4:00 pm

Prince Meeting Room, 3rd Floor

Board of Health Meeting:

October 23, 2019 @ 5:00 pm

Sault Ste. Marie, Room A

14.0 Evaluation *E. Pearce*

15.0 Adjournment *E. Pearce*

RESOLUTION

THAT the Board of Health meeting adjourns.

Algoma PUBLIC HEALTH
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Board of Health Meeting
MINUTES
June 26, 2019 at 5:00 pm
Sault Ste. Marie - Community Room A

PRESENT :

BOARD MEMBERS
Lee Mason - Chair
Ed Pearce - 1st Vice Chair
Deborah Graystone - 2nd Vice Chair
Dr. Patricia Avery
Louise Caicco Tett
Micheline Hatfield
Adrienne Kappes
Brent Rankin
Matthew Scott

APH EXECUTIVE
Dr. Marlene Spruyt - MOH/CEO
Justin Pino - CFO /Director of Operations
Antoniette Tomie - Director of Human Resources
Tania Caputo - Board Secretary

REGRETS: Randi Condie, Dr. Heather O'Brien, Karen Raybould, Dr. Jennifer Loo - AMOH & Director of Health Protection, Laurie Zeppa - Director of Health Promotion & Prevention

1.0 Meeting Called to Order

a. Declaration of Conflict of Interest

None declared

2.0 Adoption of Agenda

RESOLUTION 2019-52

Moved: E. Pearce
Seconded: A. Kappes

THAT the Board of Health agenda dated June 26, 2019 be approved as presented.

CARRIED

3.0 Adoption of Minutes of Previous Meeting

RESOLUTION 2019-53

Moved: M. Hatfield
Seconded: B. Rankin

THAT the Board of Health minutes dated May 22, 2019 be approved as presented.

CARRIED

4.0 Delegations / Presentations

a. APH Addiction and Mental Health Programs

Kaytee Iachetta, Case Manager for Community Mental Health spoke on behalf of the Mental Health and Addiction Program requesting a deferral of a resolution to transfer the Multi Sector Service Agreement (MSSA) from APH to CMHA Sault Ste. Marie Branch. The delegation provided a document for consideration and due to it containing unverified information about another agency the Board requested to view and discuss it in camera and a motion to change the order of the agenda followed.

5.0 Change the order of agenda items

RESOLUTION 2019-54

Moved: E. Pearce

Seconded: M. Scott

That the Board of Health change the order of agenda items to accommodate the in camera session to follow item **4 a.** on the agenda

CARRIED

6.0 In Camera - 5:11 pm

For discussion of labour relations and employee negotiations, matters about identifiable individuals**, adoption of in camera minutes, security of the property of the board, litigation or potential litigation.**

RESOLUTION 2019-55

Moved: D. Graystone

Seconded: L. Caicco Tett

THAT the Board of Health go in camera.

CARRIED

7.0 Open Meeting - 6:05 pm

On return to open meeting L. Mason addressed the delegation, thanking them for the information provided and stating the Board decision to move forward with the Notice of Intended Integration.

The Board requested that the staff provide facts that will assist management to determine important factors and how we address and incorporate them into the process moving forward.

A resolution is being drafted and will be brought forward before the end of the meeting.

8.0 Delegations / Presentations - continued after item 4a.

b. North East Public Health Transformation Update

M. Spruyt provided a Transformation update on work underway and answered questions although there is a lack of information available at this time. The timeline for transformation is not clear with all of the work required, however historically it is recognized that changes that happen quickly have a poor outcome. Discussion about the budgets in each area of the Northeast and potential end-state structure.

c. Accountability Indicators Presentation

M. Spruyt presented the 2018 indicators answering questions related to immunization, heat and cold warnings, the Mennonite community interaction and smoking rates. There was a question about a refuted report of high cancer results in SSM and Dr. Spruyt provided some clarity regarding the validity of the data.

9.0 Business Arising from Minutes

Not applicable.

10.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Reports

i. MOH Report - June 2019

ii. Annual Compliance Reporting

M. Spruyt's report provided information on the recent cyber-attack, recovery, and assessment of the external Cyber Audit. News on the base funding for Seniors Low Income Dental for 2019-20 was delivered. The Program Highlights included this month were Corporate Services, Profile & Cisco as well as the Q1 Program Indicators for 2019.

RESOLUTION 2019-58	**Moved:** P. Avery **Seconded:** M. Scott

THAT the report of the Medical Officer of Health and CEO for June 2019 be adopted as presented.

b. Finance and Audit Committee

i. Finance and Audit Committee Chair Report

E. Pearce provided commentary on the June 2019 meeting.

RESOLUTION 2019-59	**Moved:** B. Rankin **Seconded:** P. Avery

THAT the Finance and Audit Committee Chair Report for June 2019 be adopted as presented.

ii. Financial Statements

E. Pearce provided an overview of the key points in the statements.

RESOLUTION 2019-60	**Moved:** E. Pearce **Seconded:** A. Kappes

THAT the Draft Financial Statements for the period ending April 30, 2019 be approved as presented.

iii Finance and Audit Committee Terms of Reference

E. Pearce noted that the Terms of Reference had been reviewed with no changes at this time.

RESOLUTION 2019-61

Moved: E. Pearce

Seconded: D. Graystone

THAT the Finance and Audit Committee has reviewed and recommend to the Board of Health that the Terms of Reference be approved as presented.

c. Governance Committee

i. Governance Committee Chair Report

D. Graystone provided an overview of the work underway at Governance Committee, including review and changes to policies.

RESOLUTION 2019-62

Moved: D. Graystone

Seconded: L. Caicco Tett

THAT the Governance Committee Chair Report for May 2019 be adopted as presented.

ii Governance Committee Terms of Reference

Reviewed with no changes made at Governance Committee.

RESOLUTION 2019-63

Moved: D. Graystone

Seconded: A. Kappes

THAT the Governance Committee has reviewed and recommend to the Board of Health that the Terms of Reference be approved as presented.

iii. 02-05-087 Board Member Terms of Office

New policy from Governance Committee.

RESOLUTION 2019-64

Moved: D. Graystone

Seconded: P. Avery

THAT the Governance Committee recommend to the Board of Health for approval the policy for Terms for Municipal and Provincial Appointees be adopted as presented

iv. 02-04-030 Procurement Policy

Reviewed and revised at Governance Committee.

RESOLUTION 2019-65

Moved: D. Graystone

Seconded: A. Kappes

THAT the Governance Committee recommend to the Board of Health for approval the Procurement Policy 02-04-030 as amended.

v. 02-05-040 Employee Retirement - Board Recognition

Reviewed at Governance Committee and recommended to archive.

RESOLUTION 2019-66

Moved: D. Graystone

Seconded: A. Kappes

THAT the Governance Committee recommend to the Board of Health that policy 02-05-040 Employee Retirement - Board Recognition be archived as of Jan 1, 2020.

11.0 New Business/General Business

a. Collaboration of Northern Public Health Units

L. Mason discussed that this came about as a result of meeting of the Board of Health Chairs of NE Public Health Units.

RESOLUTION 2019-67

Moved: E. Pearce

Seconded: D. Graystone

WHEREAS since November 2017, the boards of health in Northeastern Ontario, namely the Boards for Algoma Public Health, Public Health Sudbury & Districts, Porcupine Health Unit, North Bay Parry Sound District Health Unit, and Timiskaming Health Unit, have proactively and strategically engaged in the Northeast Public Health Collaboration Project to identify opportunities for collaboration and potential shared services; and

WHEREAS the Northeast Public Health Collaboration Project work to date has been supported by two one-time funding grants from the Ministry of Health and Long-Term Care (MOHLTC); and

WHEREAS subsequent to the proposed transformation of public health announced in the April 11, 2019 provincial budget, the work of the Collaboration has been accelerated and reoriented as the Northeast Public Health Transformation Initiative with the vision of a healthy northeastern Ontario enabled by a coordinated, efficient, effective, and collaborative public health entity; and

WHEREAS the Board understands there will be opportunities for consultation with the MOHLTC on the regional implementation of public health transformation;
Now THEREFORE be it resolved that the Board of Health for Algoma Public Health is committed to the continued collaboration of the boards of health in Northeastern Ontario and looks forward to ongoing MOHLTC support for this work;

AND FURTHER that the Board, having engaged in this work since 2017, anticipates sharing with the MOHLTC its experiences so that other regions may benefit and further anticipates providing to the Ministry its expert advice on public health functions and structures for the North East;

AND FURTHER that this motion be shared with Members of parliament of northeastern Ontario, the leader of the official opposition, the health critic of both provincial parties, The Chief Medical Officer of Health of Ontario, the Boards of Health throughout Ontario, the councils of Algoma municipalities, and the North East LHIN CEO

12.0 Correspondence

a. Letter to the Prime Minister of Canada from Windsor-Essex County Health Unit regarding Smoke-Free Multi Unit Dwelling dated May 21, 2019.

b. Letter to the Minister of Health and Long-Term Card from Windsor-Essex County Health Unit regarding Alcohol Retail Sales in Ontario dated May 21, 2019.

c. Letter to the Deputy Premier and Minister of Health and Long-Term Care from North Bay Parry Sound District regarding Support for Simcoe Muskoka district Health Unit - Proposed Boundaries dated May 23, 2019.

d. Letter to the Premier of Ontario and the Deputy Premier and Minister of Health and Long-Term Care from Brant County Health Unit regarding implications of the 2019 budget dated May 27, 2019.

e. Letter to the Premier of Ontario from Sudbury Public Health regarding North East Public Health Regional Boundaries - Modernization of the Ontario Public Health System dated May 28, 2019.

f. Letter to the Premier of Ontario from Grey Bruce Health Unit regarding Modernization of alcohol sales in Ontario dated June 4, 2019.

g. Letter to the Premier of Ontario from Grey Bruce Health Unit regarding Endorsement of the Children Count Task Force Recommendations dated June 4, 2019.

h. Letter to the Premier of Ontario from Grey Bruce Health Unit regarding Minimizing Harm Alcohol Retail Sales in Ontario dated June 4, 2019.

i. Letter to the Premier of Ontario from Grey Bruce Health Unit regarding Modernization of Alcohol Sales in Ontario dated June 4, 2019.

j. Letter to the Ministry of Health and Long-Term Care from Timiskaming Health Unit regarding Northeastern Regional Public Health Boundaries dated June 4, 2019.

k. Letter to the Premier of Ontario from KFL&A Public Health regarding Retroactive Funding Cuts to Municipal funding dated June 4, 2019.

l. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Algoma Public Health regarding Proposed Changes to Public Health in Ontario dated June 5, 2019.

m. Letter to the Ministry of Health and Long-Term Care from Timiskaming Health Unit regarding North East Public Health Collaboration Project dated June 6, 2019.

n. Letter to the Premier of Ontario from Hastings Prince Edward Public Health regarding concerns with announced expansion of the sale of alcohol beverage in Ontario dated June 6, 2019.

o. Letter to the Minister of Health and Long -Term Care from Sudbury and Districts Public Health regarding Public Mental Health - Parity of Esteem Position Statement dated June 7, 2019

p. Letter to the Deputy Premier and Minister of Health and Long-Term Care from the Mayor of Hamilton regarding proposed changes to Public Health in Ontario dated June 14, 2019.

q. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Porcupine Health Unit regarding Support for Simcoe-Muskoka District Health Unit and Proposed Boundaries dated June 19, 2019.

r. Resolution from the Porcupine Health Unit regarding Northeast Public Health Collaboration Project dated June 19, 2019.

s. Letter to the Deputy Premier and Minister of Health and Long-Term Care from Haliburton, Kawartha, Pine Ridge District Health Unit regarding Health Promotion as a Core Function of Public Health dated June 20, 2019.

13.0 Items for Information

a. Disposition of 2019 alPHa Resolutions

b. alPHa Resolution A19-9 (corrected)

14.0 Addendum

15.0 Announcements / Next Committee Meetings:

Governance Committee Meeting

September (tbd), 2019 @ 5:00 pm

Prince Meeting Room, 3rd Floor

Board of Health Meeting:

September 25, 2019 @ 5:00 pm

Sault Ste. Marie, Room A

Finance & Audit Committee Meeting

October 9, 2019 @ 4:00 pm

Prince Meeting Room, 3rd Floor

At this time a resolution resulting from the in camera meeting was brought forward

RESOLUTION 2019-68	**Moved:** M. Hatfield **Seconded:** A. Kappes

THAT the Board of Health directs management to proceed with the Notice of Integration under Section 27 of the LHSIA: Heath Service Integration Business Plan and to continue to work with current APH employees to make transition as smooth as possible.

16.0 Evaluation

L. Mason reminded the Board to complete the monthly and annual evaluations.

17.0 Adjournment

RESOLUTION 2019-69

Moved: P. Avery

Seconded: L. Caicco Tett

THAT the Board of Health meeting adjourns.

CARRIED

Lee Mason, Chair	**Tania Caputo, Secretary**
Date	**Date**

Climate Change, Public Health, and Impacts

Chris Spooney, Environmental Health Manager

September 25, 2019

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Overview

- Climate vs Weather
- Ontario Public Health Standard / Mandate
- Algoma, Canada, International Perspective
- Health Impacts Associated with Climate Change
- Adaptation and Mitigation
- Current Public Health Initiatives
- Climate Change – Summary
- Questions

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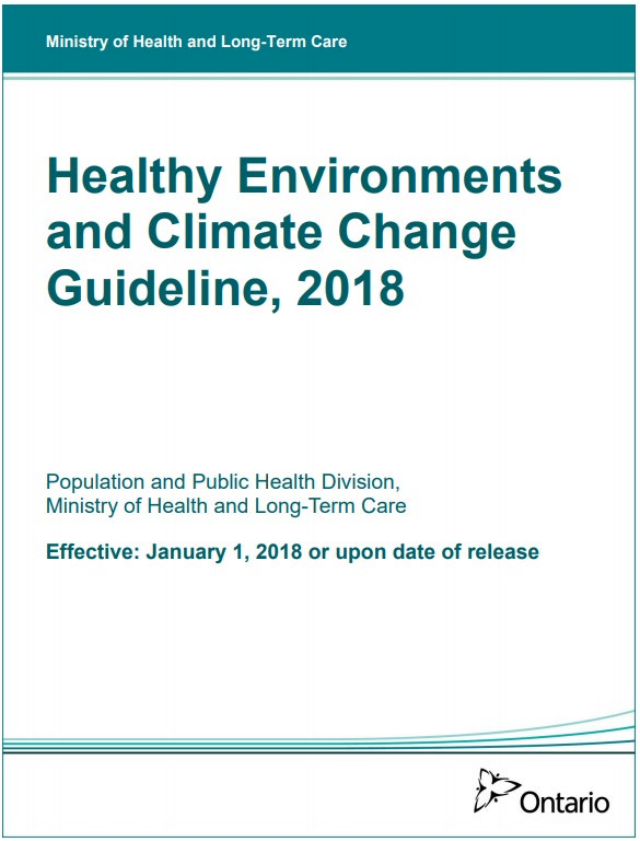
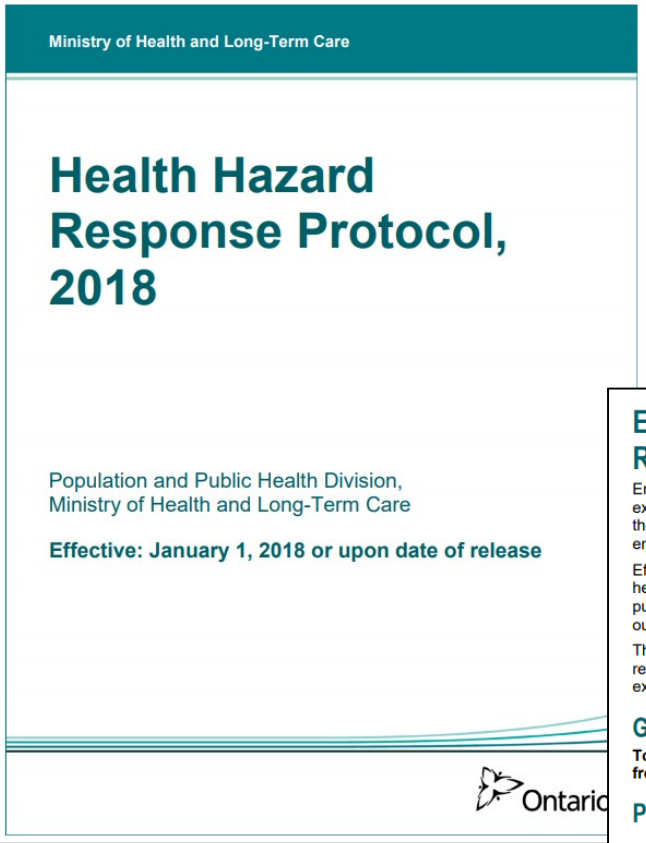
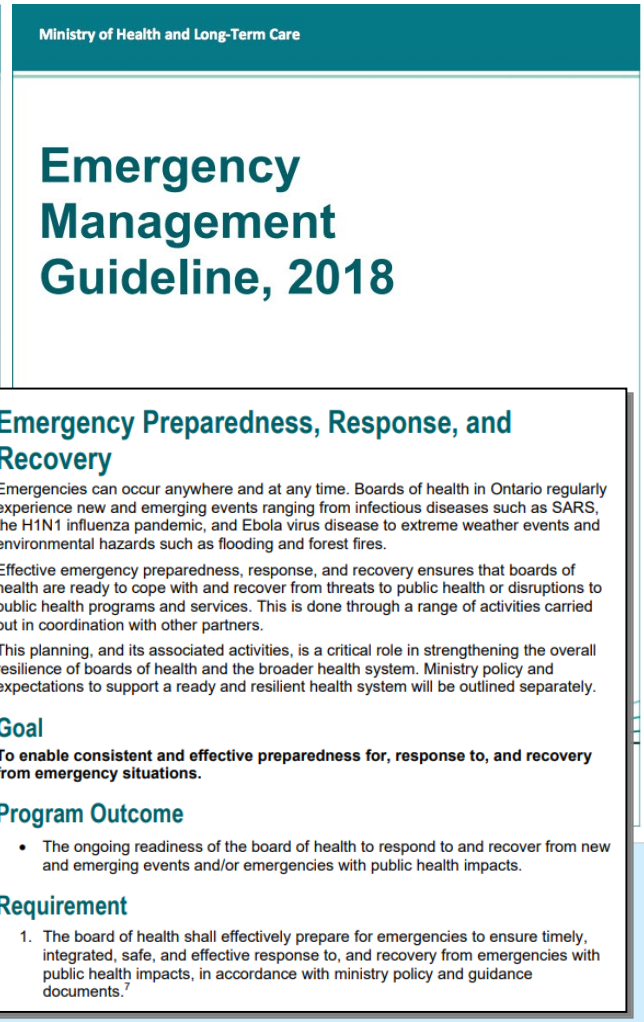
Ontario Public Health Standards (OPHS)







OPHS & how it relates to us

Health Hazard Response Protocol 2018

APH shall collaborate with community partners to develop effective strategies to reduce exposure to health hazards and promote healthy built and natural environments.

Healthy Environments and Climate Change Guideline, 2018

APH shall enhance public health capacity to address risk factors in the environment, including the impacts of climate change, using population-based activities (Vulnerability assessments).

Emergency Management Guideline, 2018

To enable consistent and effective preparedness for, response to, and recovery from emergency situations

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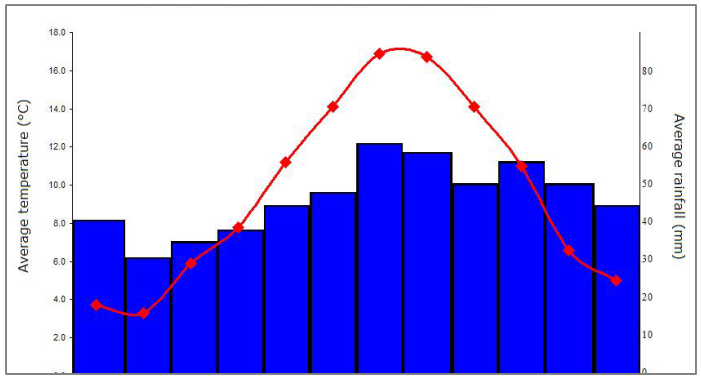
Climate vs. Weather

Knowing the difference

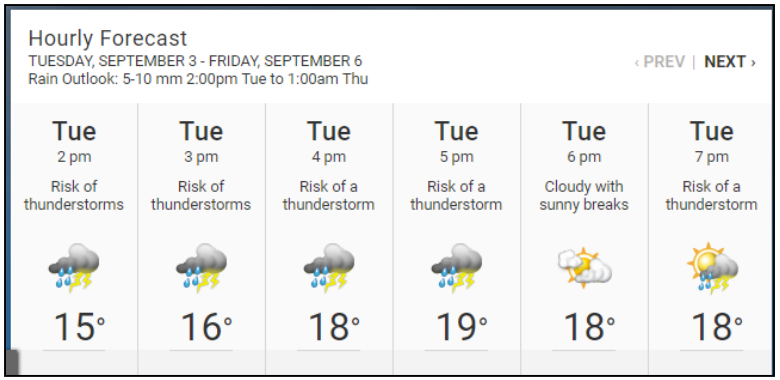
CLIMATE

Refers to the average atmospheric conditions that occur over long periods of time.



WEATHER

Refers to the atmospheric conditions – the sunshine, cloud cover, winds, rain, snow and excessive heat – of a specific place over a short period of time.



Source(s):
World Health Organization. (2003). *Climate change and human health - risks and responses.* (Malta: World Health Organization).
Health Canada. (2008). *Human Health in a Changing Climate: A Canadian Assessment of Vulnerabilities and Adaptive Capacity.* (Ottawa: Health Canada)

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What is Climate Change?

DEFINITION (IPCC, 2007)

Long-term shift or trend from the usual climate and weather patterns towards…

Global warming

Climate instability

Extreme heat/cold alerts

Catastrophic weather events (heat waves, floods, hurricanes, tornadoes, etc.)

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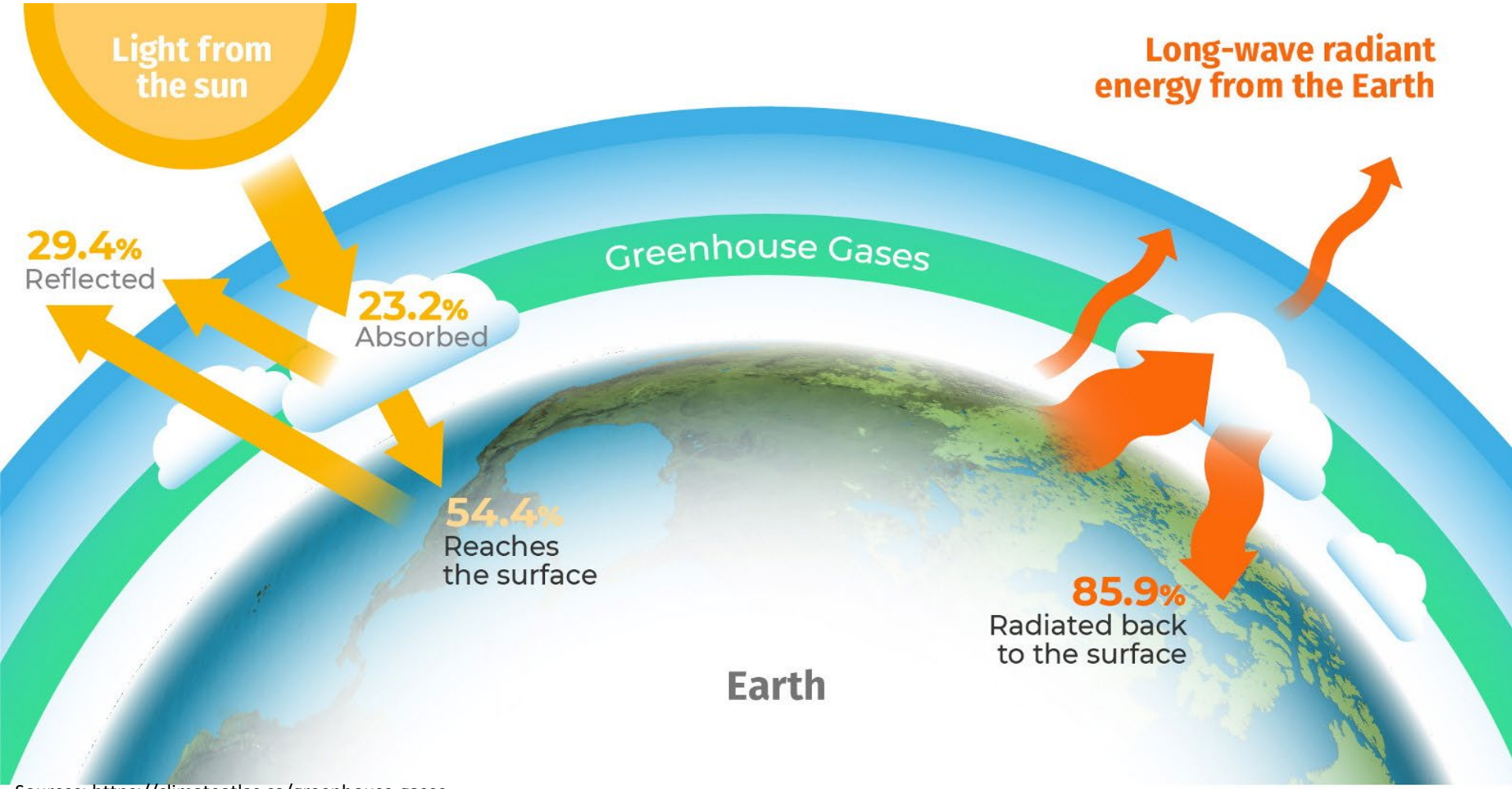
How Climate Change happens

Evidence shows that only increased concentrations of greenhouse gases in the atmosphere—specifically carbon dioxide concentrations—can explain Earth's observed warming trend.

Greenhouse gases are called that because they effectively act like a greenhouse or a layer of insulation for the Earth: they trap heat and warm the planet.

Sources: https://climateatlas.ca/greenhouse-gases

How Climate Change happens



Sources: https://climateatlas.ca/greenhouse-gases

Climate Change in the news

Wawa

(Huffington Post Canada)

(Huffington Post Canada)

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Climate Change in the news

Wawa

(CTVNews.ca)

(CTVNews.ca)

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Climate Change in the news

Fort McMurray

(CBC.ca)

(Scott Olson/Getty Images)

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Glacier Melt

WHAT WE KNOW …

97%

of climate change scientists agree: [IPCC, 2007]

- Climate is changing
- Temperatures are rising
- Green house gasses are continuing to increase
- If we continue to operate as ‘business as usual’ we may see a 4-6°C increase by the year 2100

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Increased Temperatures

Observed changes in annual and seasonal mean temperature between 1948 and 2016 for six regions and for all Canadian land area

REGION	CHANGE IN TEMPERATURE, °C				
	Annual	Winter	Spring	Summer	Autumn
British Columbia	1.9	3.7	1.9	1.4	0.7
Prairies	1.9	3.1	2.0	1.8	1.1
Ontario	1.3	2.0	1.5	1.1	1.0
Quebec	1.1	1.4	0.7	1.5	1.5
Atlantic	0.7	0.5	0.8	1.3	1.1
Northern Canada	2.3	4.3	2.0	1.6	2.3
Canada	1.7	3.3	1.7	1.5	1.7

Source: Canada's Changing Climate Report – Chapter 4: Changes in Temperature and Precipitation Across Canada
https://www.nrcan.gc.ca/sites/www.nrcan.gc.ca/files/energy/Climate-change/pdf/CCCR-Chapter4-TemperatureAndPrecipitationAcrossCanada.pdf

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Increased Temperatures

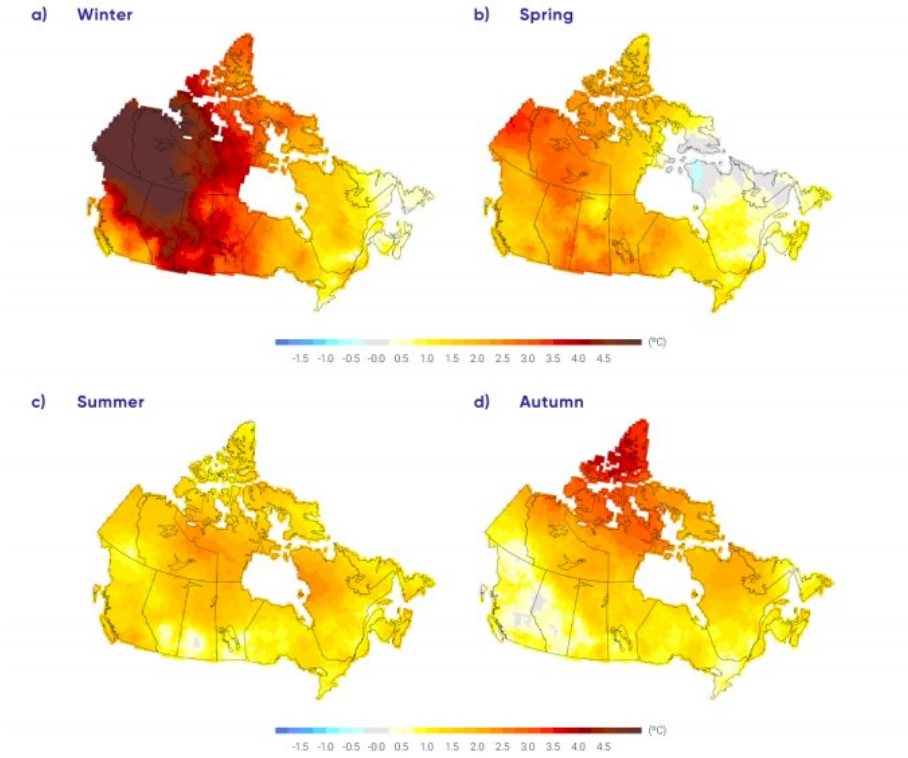

Figure 4.4: Trends in seasonal temperatures across Canada

Figure caption: Observed changes (°C) in seasonal mean temperatures between 1948 and 2016 for the four seasons. Estimates are derived based on linear trends in the gridded station data.

"… the most substantial changes are projected in temperature extremes. There will be more hot and fewer cold temperature extremes."

Source: Canada's Changing Climate Report – Chapter 4: Changes in Temperature and Precipitation Across Canada
https://www.nrcan.gc.ca/sites/www.nrcan.gc.ca/files/energy/Climate-change/pdf/CCCR-Chapter4-TemperatureAndPrecipitationAcrossCanada.pdf

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Flooding

Increased precipitation can lead to:

- Injuries and deaths
- Increased risk of infectious disease
- Mold
- Contaminated water supplies

Vector-Borne Diseases

- New and emerging diseases
- Geographical boundaries
- Transmission cycles
- Lyme Disease, WNV, Rabies

Wildfires

- Cause and result of climate change
- Reduced precipitation and drought
- Increase air pollutants and particulate matter

Poor Air Quality

- Increased risk of asthma
- Increased risk of emergency visits and possible admissions

Pollen

- Rising temperatures can affect plant metabolism and pollen production
- Earlier and longer pollen seasons
- Asthma, chronic obstructive pulmonary disease

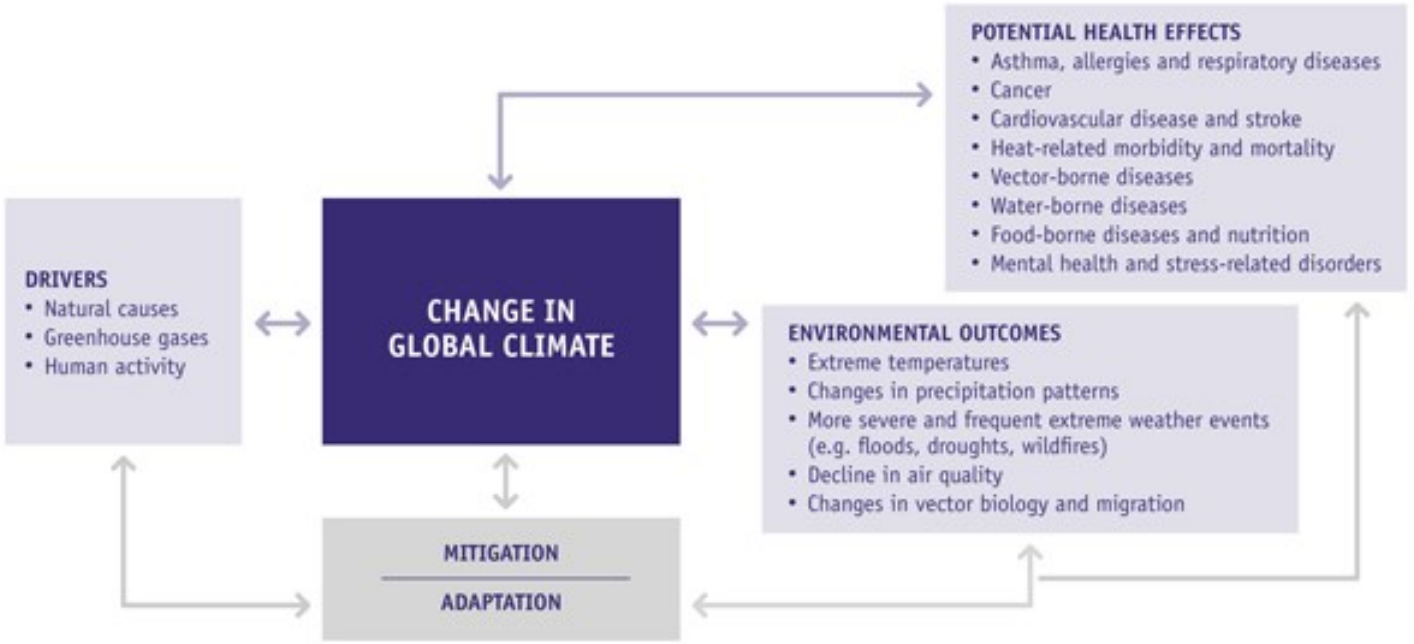
Why is this a Public Health concern?

- Ontario Public Health Standards Healthy Environments goal: to reduce exposure to health hazards and **promote the development of healthy built and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate**.

- Public Health Units are on the front line of their communities

Why is this a Public Health concern?

Pathways by which changes in climate can increase risks to health



Source(s):

Environmental Health Perspectives and National Institute of Environmental Health Sciences. (2010). *A Human Health Perspective on Climate Change. A Report Outlining the Research Needs on the Human Health Effects of Climate Change.* (Environmental Health Perspectives and National Institute of Environmental Health Sciences).

Health Canada. (2008). *Human Health in a Changing Climate: A Canadian Assessment of Vulnerabilities and Adaptive Capacity.* (Ottawa: Health Canada).

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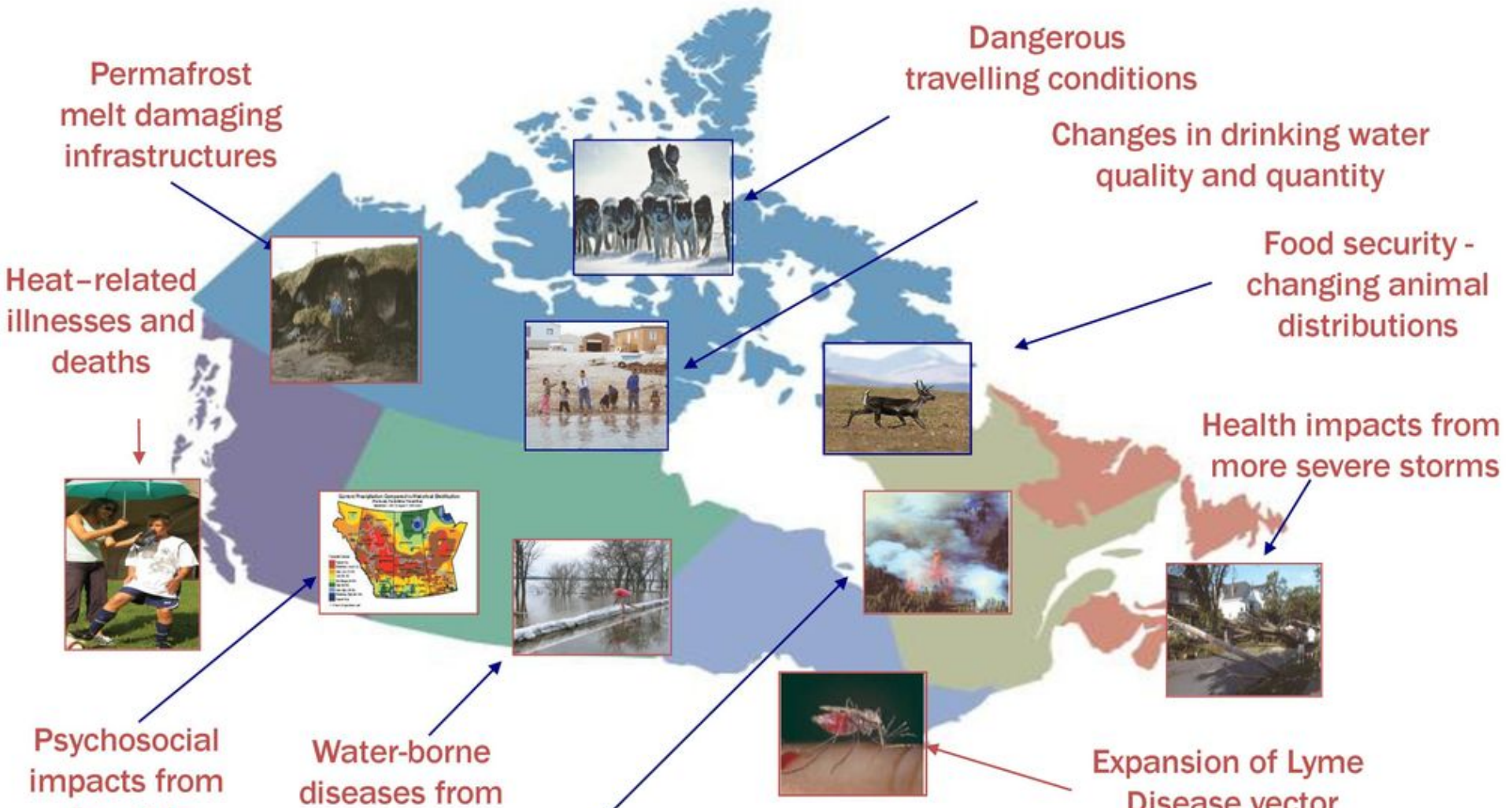
Health Risks in Canada from Climate Change



http://publications.gc.ca/collections/collection_2008/hc-sc/H128-1-08-528E.pdf

alPHa
Association of Local
PUBLIC HEALTH
Agencies

…the current environmental health harms borne by the people of Ontario are significant, and include:

Source: alPHA resolution - 2019 Annual General Meeting , Monday, June 10, 2019 - Ballroom, Four Points by Sheraton, 285 King Street East, Kingston, Ontario

https://cdn.ymaws.com/www.alphaweb.org/resource/collection/A91B962A-D10D-4264-9A46-AA6FB806E3C6/Disposition_of_alPHa_June_2019_Resolutions.pdf

Algoma
PUBLIC HEALTH
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Air Pollution

560

cancer cases per year attributable exposure to fine particulate matter air pollution

Source: Cancer Care Ontario, Ontario Agency for Health Protection and Promotion (Public Health Ontario). *Environmental Burden of Cancer in Ontario.* Toronto2016.

Algoma PUBLIC HEALTH Santé publique Algoma

Foodborne Illness

Deaths	Hospitalizations	Emergency Dept. visits
67	6,600	41,000

Source: Drudge C, Greco S, Kim J, Copes R. Estimated Annual Deaths, Hospitalizations, and Emergency Department and Physician Office Visits from Foodborne Illness in Ontario. *Foodborne pathogens and disease.* 2019;16:173-9.

Algoma PUBLIC HEALTH
Santé publique Algoma

Waterborne Disease

Deaths	Hospitalizations	Emergency Dept. visits
73	2,000	11,000

Source: Drudge C, Fernandes R, Greco S, Kim J, Copes R. Estimating the Health Impact of Waterborne Disease in Ontario: A Key Role for Pathogens Inhaled from Plumbing Systems. *The Ontario Public Health Convention (TOPHC)*. Toronto 2019.

Algoma PUBLIC HEALTH
Santé publique Algoma

Vector borne diseases

West Nile virus	Lyme disease
138	612

Source: Cancer Care Ontario, Ontario Agency for Health Protection and Promotion (Public Health Ontario). *Environmental Burden of Cancer in Ontario.* Toronto2016.

Algoma PUBLIC HEALTH Santé publique Algoma

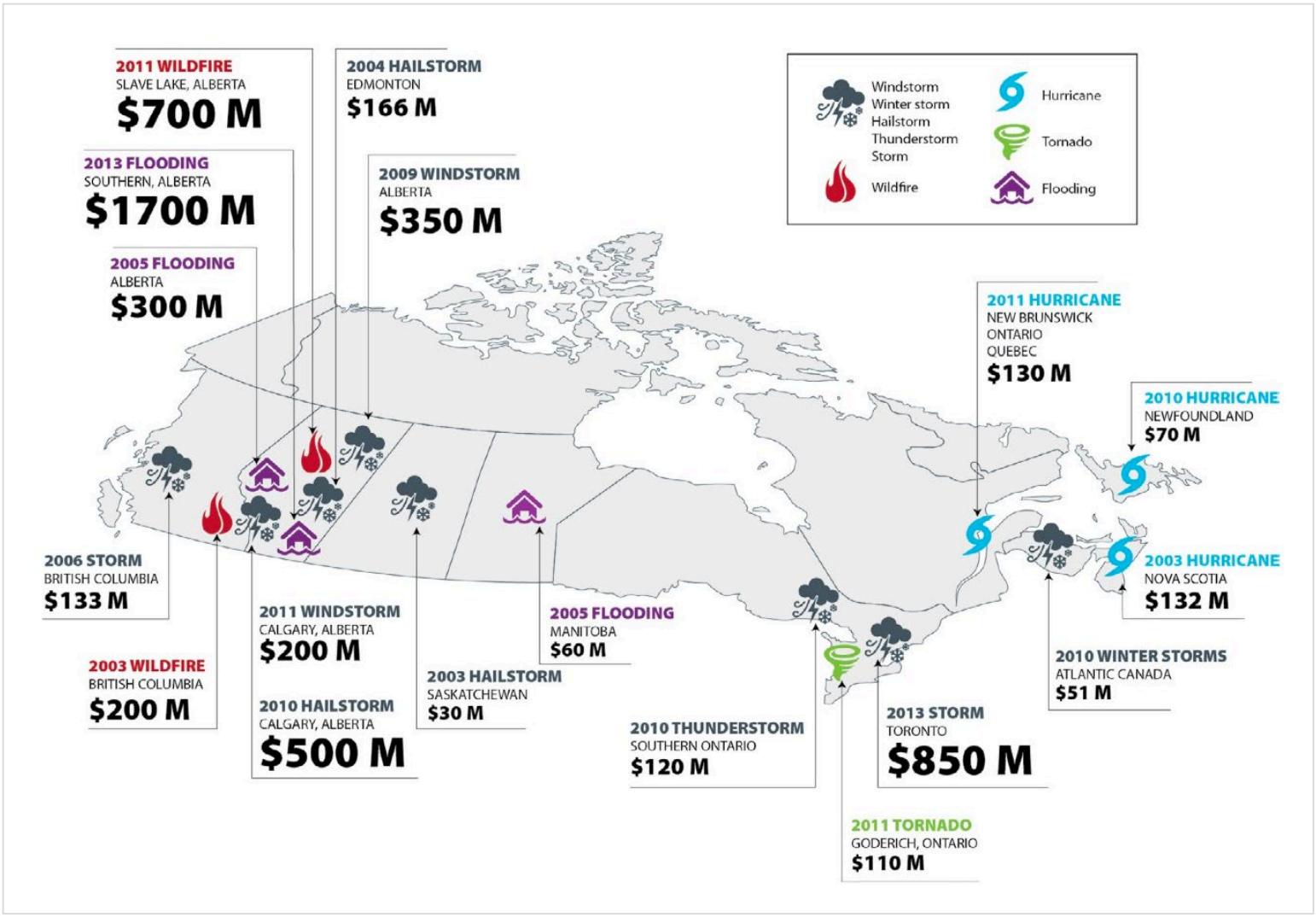
Warmer temperature

Four excess deaths per day for each **5°C change in daily** temperature in warm seasons

Source: Chen H, Wang J, Li Q, et al. Assessment of the effect of cold and hot temperatures on mortality in Ontario, Canada: a population-based study. *CMAJ open.* 2016;4:E48.

Algoma PUBLIC HEALTH Santé publique Algoma

Costs of Climate Change



Source: https://www.wcel.org/blog/how-not-dealing-climate-change-killing-our-economy

Adaptation

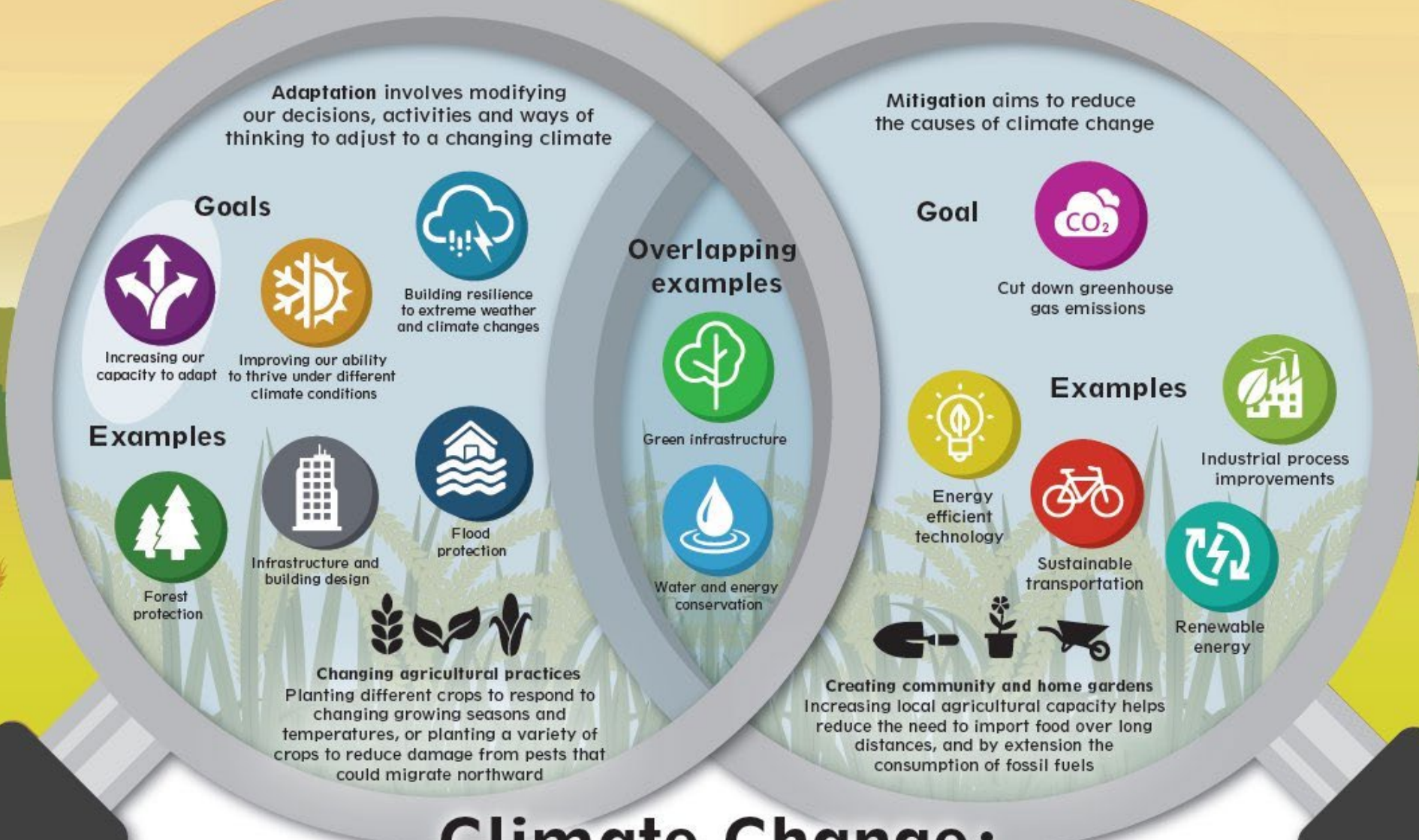
Involves modifying our decisions, activities and ways of thinking to adjust to a changing climate.

Source: Adaptation.NRCan.gc.ca

Adaptation

The Environmental Health Climate Change Framework for Action was developed by The Population and Public Health Division of MOHLTC. The framework was created to improve the overall effectiveness and efficiency of public health and its ability to:

- Reduce incidence of adverse health outcomes from impacts of climate change
- Reduce public exposure to health hazards related to changing climate
- Identify interventions that reduce exposure to climate change impacts
- Enhance capacity to address the risks associated with climate change



Climate Change:
Adaptation and Mitigation

For the whole Canada in a Changing Climate report, visit **Adaptation.NRCan.gc.ca**

Let's Talk Energy

Canadian Geographic

Canada

Extreme Weather Events

Infectious Diseases

Healthy Environments

Mitigation

Aims to reduce the causes of climate change.

Source: Adaptation.NRCan.gc.ca

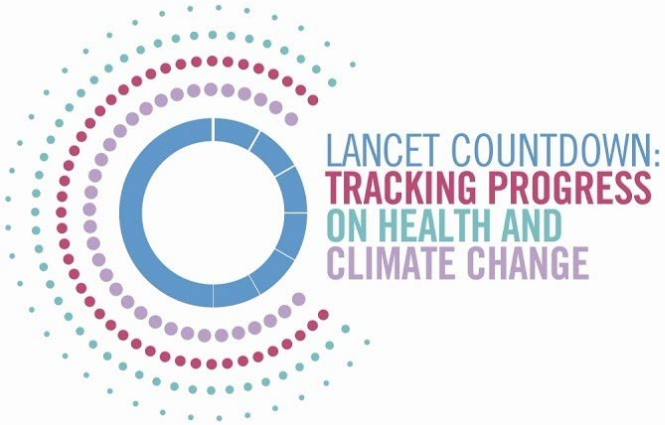
Mitigation

alPHa Association of local Public Health Agencies resolution:
(A19-1) – Climate change & health in Ontario: adaptation and mitigation

"climate change is the greatest health threat of the 21st century"

Algoma PUBLIC HEALTH
Santé publique Algoma

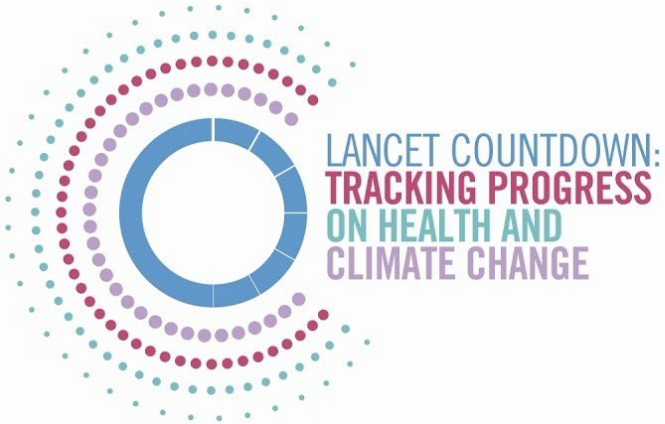
Lancet Countdown Report 2018



The Lancet Countdown: tracking progress on health and climate change was established to provide an independent, global monitoring system dedicated to tracking the health dimensions of the impacts of, and the response to, climate change.

Source: https://www.thelancet.com/climate-and-health

Lancet Countdown Report 2018



27 academic institutions & intergovernmental organizations

Briefing for Canadian Policy makers

7 Recommendations

Source: https://www.thelancet.com/climate-and-health

7 Recommendations

1. Coordinate federal government departments, local governments, and national institutions to standardize surveillance and reporting of heat-related illness.

2. Rapidly integrate CC and health into the curriculum of all medical and health science facilities.

3. Reduce Greenhouse gas emissions and air pollution in Canada.

4. Phase out coal-powered electricity in Canada by 2030 or sooner

Source: https://www.thelancet.com/climate-and-health

7 Recommendations (cont'd)

5. Integrate air pollution related health and healthcare impacts into ongoing policy.

6. Be pro-active in external communications by health related organizations in pointing out the links between CC and health impacts in real time as scenarios (Heat wave, wildfires, extreme weather).

7. Fund further research into the mental health impacts of CC and the opportunity for psychosocial adaptation opportunities.

Source: https://www.thelancet.com/climate-and-health

Summary - Public Health's Role

As health professionals, we have the opportunity to:

- Inform, educate, and engage with the public
- Be a leader both personally and professionally
- Advocate local, provincial, and federal climate policies
- Engage decision makers
- Disseminate information to colleagues and networks
- Collaborate with professionals outside of the health sector

Conclusion

- Increasing evidence to suggest change has already begun locally and is accelerating
- Adaptation measures are needed to reduce adverse impacts to climate change.
- Mitigation measures at all levels and through a multitude of partners can make a difference locally.

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Questions?

Algoma
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September 2019

Medical Officer of Health / CEO

Welcoming Signs
MOH Dr. Marlene Spruyt joined the inaugural Ride of the Lake Huron North Channel expansion of the Great Lakes Waterfront Trail. Photos show the cyclists greeted by Huron Shores Councilors at a water stop in Iron Bridge (top right) and lunch served to cyclists at Desbarats Farmers Market (bottom right)

Prepared by:
Dr. Marlene Spruyt and the Leadership Team

Presented to:
Algoma Public Health Board of Health
09/25/2019

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APH AT-A-GLANCE

Greetings, and welcome back. I hope everyone had a relaxing summer. It was a busy summer with lots of activity in the health system from our government.

Seniors Low Income Dental:

This program is still in the early implementation phase. We have submitted a capital request for some alterations to our existing dental clinic in SSM to allow for the expanded service delivery. We anticipate that we may begin to provide some service by late fall pending recruitment of professional staff.

North East Public Health Collaborative and Public Health Transformation:

This work continued at quite a hectic pace during June and the first three weeks of July, culminating in a document that was submitted to the Ministry. This work was then placed on pause pending further information from the Province. At the Association of Municipalities (AMO) meeting in Ottawa in August it was communicated that the timelines for public health regionalization would be extended and that further consultation would take place with respect to new health unit boundaries and governance structures. We have also been advised that all health units will move to a 70:30 funding split (province: municipalities) for the 2020 budget year and that we should budget for the entire year. This suggests that any significant financial merging of health units will not occur until 2021.

PARTNERSHIPS

Over the summer we continued our cycle of presentations to our municipal councils and travelled to Blind River on July 8, Huron Shores July 10th, North Shores July 17th, Dubreuiville August 28 and Spanish September 18.

Ontario Health Teams:

The SSM and area health care providers group that submitted an Expression of Interest to be an Ontario Health Team received an invitation to proceed to a full application. They have been meeting regularly since mid-June. I have been representing APH on the Leadership Council to support the integration of a population health perspective throughout the process. Our role in the Ontario health team is mostly supportive at this time. I continue to share population health data and identify health issues within our community. The initial focus of integrated care for this Algoma Health Team will be on assisting navigation through the healthcare system for individuals with complex/multiple medical problems and consequently, the role of public health is minimal. For those of you who would like to know more I urge you to attend the All Boards meeting on Tuesday Sept 24 in SSM (invitation previously sent).

Community Engagement:

One of the highlights of my summer was the invitation I received to participate as a Public Health Champion in the "Cycle the North" Event organized by the Waterfront Regeneration Trust. https://waterfronttrail.org/great-waterfront-trail-adventure/gwta/

Cycle trails provide safe routes for individuals in our communities to engage in active transportation. We have learned that people are more likely to walk or cycle to work or for recreation if safe, accessible opportunities exist. The associated increase in physical activity provides a wide range of health benefits. Cycle routes that span larger distances such as the SSM to Sudbury route also encourage cycle tourism with a resultant economic benefit to all communities along the way.

The level of engagement from our Algoma municipalities was amazing. A morning send-off from the SSM starting point with well wishes from municipal and provincial politicians; a healthy locally-sourced luncheon in Desbarats; community breakfasts and dinners in Bruce Mines and Blind River; representatives from the Municipality of Huron Shores, Township of North Shore and Spanish greeting us at the water and rest stops in Iron Bridge Bootlegger Bay and the Spanish Marina respectively. As well many of them supported additional signage and wayfinding to minimize any wrong turns. Other riders commented very positively on the municipal and community involvement and the peaceful and beautiful Northern scenery.

PROGRAM HIGHLIGHTS

Topic: Health Equity Collaboration and Partnerships
From: Laurie Zeppa – Director of Health Prevention and Promotion

Public Health Goal:

Public health practice results in decreased health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances.

Program Standard Requirements addressed in this report:

Health Equity, Requirement 3

The board of health shall engage in multi-sectoral collaboration with municipalities, LHINs, and other relevant stakeholders in decreasing health inequities in accordance with the *Health Equity guideline, 2018* (or as current). Engagement with Indigenous communities and organizations, as well as with First Nation communities striving to reconcile jurisdictional issues, shall include the fostering and creation of meaningful relationships, starting with engagement through to collaborative partnerships, in accordance with the Relationship with Indigenous Communities Guideline, 2018 (or as current).

Health Equity, Requirement 4

The board of health shall lead, support, and participate with other stakeholders in health equity analysis, policy development, and advancing healthy public policies that decrease health inequities in accordance with the Health Equity Guideline, 2018 (or as current).

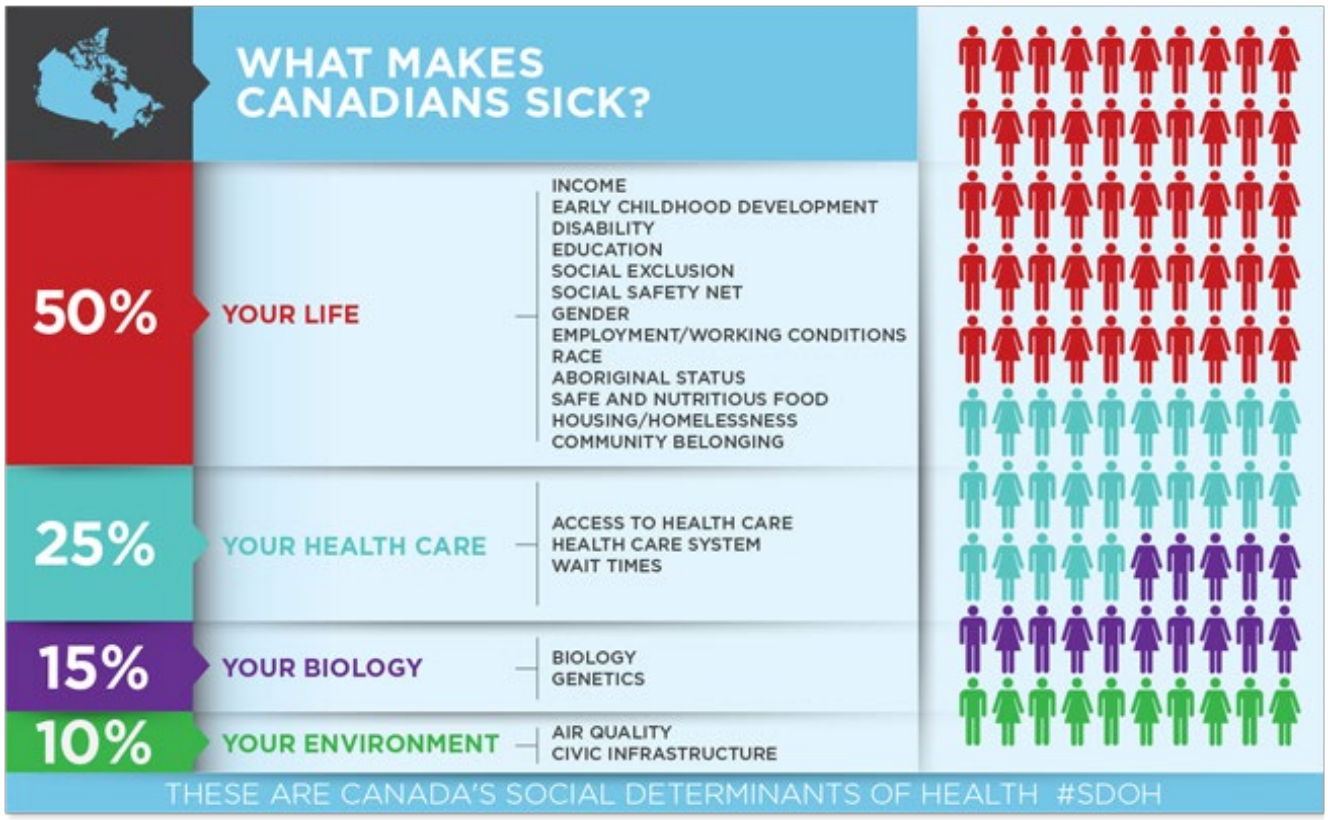
Key Messages

- Social determinants of health (SDOH), such as income, working environment/employment, education and social exclusion contribute to health inequities in Algoma; food insecurity, and poor health outcomes including increased rate of chronic diseases, mental illness and addictions which all place greater demands on our health care system
    - A higher proportion of Algoma adults and children live in low income and experience food insecurity, compared to Ontario.
- Algoma Public Health (APH) works collaboratively with health and non-health partners in an effort to decrease health inequities.
- APH will continue to conduct health equity analyses and help develop local, healthy public policies.

Health inequities and the importance of collaboration for advancing healthy public policy

Health is defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[1] However, not everyone has the same opportunities to be healthy. This is because health is greatly influenced by social, political, and economic factors that create the conditions in which people live, learn, work, and play; these conditions are known as the ***social determinants of health (SDOH).***[2] Some of the factors that impact one's health include level of income, education and employment status, physical and social environments, and identifying as being of Indigenous heritage or of another race, culture, or gender. Figure 1 depicts the relationship between health and the SDOH, illustrating that a great proportion of our health is determined beyond our individual biology and behaviours or access to health care services.[2,3]

Figure 1- The social determinants of health and their relationship with illness[3]



Individuals, communities, and populations may experience the SDOH factors differently, putting some at disadvantage and greater susceptibility to poor health outcomes.[2] These differences in health outcomes between population groups, such as living in high versus low-income situations, are known as ***health inequities***. Health inequities are related to disadvantage; they are unfair, avoidable, and beyond an individual's control.[4]

Because health inequities are socially produced, they require multi-sectoral collaboration (i.e. all of society) in order to improve them. For example:

> Imagine a community where many low-income families live in the downtown core. When the only grocery store is removed, and the transit schedule is infrequent and costly, these people, as a result of social policies and not their individual choices, are now at a higher risk for negative health outcomes (e.g. poor mental and physical well-being, social isolation, and food insecurity). Partnerships between the municipality, retailers, public health sector, and social services are needed in order to identify and implement evidence-based interventions for improving health and reducing health inequities by addressing the SDOH.

Although many factors and upstream interventions for addressing health inequities and the SDOH live outside the purview of public health (e.g. income and housing policies), a fundamental role of the public health sector is to remain connected and engaged with partners across multiple sectors, lead health equity policy analyses through research and knowledge exchange, and work with partners to plan and implement effective local policies that seek to improve the SDOH for the entire population (i.e. a population health approach).[2] There is no single agency nor approach that will reduce the burden of health inequities in Algoma- it is through multi-sectoral collaboration and efforts to develop local, healthy public policy, that APH and its partners can effectively decrease health inequities in the community.

Population Health Snapshot

A significant number of Algoma residents live in low income, particularly children and youth.[5] Income is a key SDOH and those living in low income are at a greater risk for experiencing poor health outcomes, such as chronic disease and lower life expectancy.[6] Table 1 presents data regarding the proportion of low income and food insecure residents in Algoma.

Table 1: Proportion of Algoma adults and children living in low income and experiencing food insecurity, compared to Ontario.[5]

	Ontario (%)	Algoma (%)
Adults (18-64 years) in low income*	13.7	16.1
Children (<18 years) in low income	18.4	22.0
Children (<5 years) in low income	19.8	25.5
People aged 12+ years experiencing food insecurity**	8.4	12.4

*measured as living in a low-income household after taxes which is approximately 50% of the median income when taking household needs into account.

**measured as a compromise in either food quality or food quantity of both [most likely due to low income].

Addressing health inequities in Algoma: Multi-sectoral collaboration and health equity policy analysis in action

APH works with community partners to collectively address the SDOH in an effort to decrease health inequities and improve health outcomes for Algoma residents. Through multi-sectoral collaboration with networks such as the Sault Ste. Marie (SSM) Poverty Round Table, Harvest Algoma, North Channel Poverty Network and the Algoma University Shingwauk Residential School, APH works to decrease the occurrence of poor health outcomes that result from social and economic disparities.

Poverty in Algoma

APH partners with the SSM Poverty Roundtable, North Channel Poverty Network, and Neighbourhood Resource Centre to address poverty in Algoma communities. Currently, APH is working with the SSM Poverty Roundtable to calculate a living wage in the City of Sault Ste. Marie, support food security initiatives (i.e. Harvest Algoma) and collect local poverty data.

As part of the North Channel Poverty Network, APH works with partners- including North Shore municipalities, First Nations communities, Social Services, Algoma Family Services, United Way, Rural Agri-Innovation Network (RAIN), Child Care Algoma, and community members that represent local food banks, community gardens, farmers, and agricultural societies- to improve access to nutritious food and advocate for improved transportation policies for North Shore residents.

In partnership with SSM Social Services, APH is leading the Bridges Out Of Poverty training in the community; a foundational workshop that addresses myths and misconceptions about people living in poverty, and brings to light the realities and multi-sectoral solutions necessary for alleviating poverty in our communities.

Food insecurity in Algoma

Rooted in poverty,[7] food insecurity is prevalent in Algoma. APH is a member of the United Way's Harvest Algoma initiative. While community approaches tend to focus on many factors that contribute to *food security* (e.g. access to nutritious food, community gardens), APH has recently taken an enhanced focus on local policy solutions for addressing *food insecurity*.

The internal work group is finalizing their scoping review and looking forward to sharing the findings with community organizations and partners while continuing to work together to discuss a whole-of-community approach. The final report will be used to help leverage community relationships for the purpose of healthy public policy development in Algoma. For example, a collaboration between social services, the transportation sector, and public health regarding evidence-informed interventions for reducing food insecurity at the local level, is an example of a health equity-informed, multi-sectoral policy approach.

Indigenous Engagement

13.8% of Algoma's population (compared to 2.8% in Ontario) identifies as being of Indigenous status; this includes First Nations, Inuit, and Metis Peoples.[5] The SDOH for Indigenous Peoples includes additional factors such as colonialism, racism, and social exclusion, which continue to have a profound effect on the health of communities, families, and individuals.[8] In a recent report detailing the mortality in communities served by Maamewsying North Shore Community Health Services, 53% of all deaths among band members occurred before the age of 65, compared to 22% in Ontario.[9] Furthermore, 4 out of every 10 deaths in this community could be avoided with timely health care or public health interventions.[9]

As part of engaging with Indigenous communities and organizations, APH has created an internal Indigenous Engagement Work Group, which includes consultation with the Shingwauk Residential School Project at Algoma University. By fostering and creating meaningful relationships with local Indigenous partners, APH is working collaboratively across sectors to address Indigenous-specific health inequities in Algoma.

Next Steps

APH will continue to collaborate with the valued partners and networks listed above, as well as other health and non-health partners to address the SDOH and reduce health inequities in Algoma.

As the internal food insecurity work group finalizes their report on effective local policy interventions for decreasing food insecurity at the local level, the next step will be stakeholder mapping to identify partners from multiple sectors, with a goal of collaborating to implement policies that help lift people out of poverty in Algoma.

APH plans to conduct more health equity analyses (i.e. research, situational assessments, stakeholder mapping) and continue to work towards advancing healthy public policy with new and future community partners (e.g., partners representing affordable housing, transportation, access to health care).

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Topic: School Health - Immunization

From: Roylene Bowden, Manager, School Health
Laurie Zeppa, Director, Prevention and Promotion

Public Health Goal: To achieve optimal health of school-aged children and youth through partnership and collaboration with school boards and schools.

Immunization Goal: Reduce or eliminate the burden of vaccine preventable disease through immunization.

Program Standard Requirements addressed in this report:

School Health, Requirement 8

Assess immunization status of children. Immunization for Children in Schools and Licensed Child Care Settings Protocol; Enforce Immunization of School Pupils Act (ISPA)
Requirement 9. Work with school boards and schools to identify opportunities to improve public knowledge and confidence in immunization for school-aged children
Requirement 10. Promote and provide provincially funded immunization programs to eligible students through school-based clinics

Key Messages

- Ontario's Immunization of School Pupils Act (ISPA) requires children and adolescents attending primary or secondary school to be appropriately immunized against designated diseases unless they have a valid exemption.
- School-based immunization clinics are offered to grade 7 students(hepatitis B, meningococcal disease and human papilloma virus) and in high schools to those due for their Tdap "booster."
- The majority of Algoma 7-year olds and 17-year-olds are up to date with their immunizations.
- Immunization Connect Ontario (ICON) tool is a web-based program designed for the public to access and report immunization records.

Introduction

Students and parent/ guardian awareness of the importance of immunization is one of the desired School Health Program outcomes. Schools are key settings to reach children and families and to integrate health promotion programs and services.[1] Development and maintenance of effective partnerships and collaboration between boards of health, school communities and parents/ guardians are fundamental to public health practice. Strong working relationships are needed to support the development of healthy environments, curriculum, resources and healthy policies.[2]

Algoma Public Health (APH) is responsible for assessing immunization coverage of Ontario's school-aged children. Immunization coverage refers to the proportion of a population appropriately immunized against vaccine preventable diseases. Ontario's Immunization of School Pupils Act (ISPA) directs Medical Officers of Health (MOH) of public health units to maintain a record of immunization for each pupil. Children and adolescents attending primary or secondary school in Ontario must have proof of immunization against Diphtheria, Tetanus, Polio, Pertussis (whooping cough), Measles, Mumps, Rubella, Meningococcal Disease, and Varicella (chickenpox).

Additionally, Ontario's Child Care and Early Years Act (CCEA) requires licensed daycare operators to receive proof of immunization for children enrolled in childcare programs.[5] This information is shared with APH, who helps daycare operators determine if children attending their centres are appropriately for their age.

Public health nurses identify and notify parents/ guardians about any required immunizations and remind them of various ways in which they can access the mandatory vaccines. Parents/ guardians are responsible for reporting vaccines administered to their school-aged children outside of the school setting to their local public health unit.

The Immunization Connect Ontario (ICON) tool is a web-based program designed for the public to look up current immunization records and submit additional immunizations.

Should parents/ guardians wish to exempt their child from immunizations required for school entry, the Immunization of School Pupils Amendment Act, 2016 requires parents to complete an immunization education session before filing a statement of conscience or religious belief; a non-medical exemption from immunization. Children may also be exempted for medical reasons after providing documentation from their healthcare provider.

Population Health Snapshot

In Algoma, the majority of 7-year olds are up to date with their immunizations and so are the majority of 17-year olds.

- 93.4% of school-aged children in Algoma had immunization coverage for measles, mumps and rubella at the end of the 2018-2019 school year.[6]
- 85.7% of school-aged children in Algoma had immunization coverage for diptheria, tetanus and poliomyelitis at the end of the 2018-2019 school year.[6]

In 2018-19, school health public health nurses immunized:[7]

- 72.89% of grade 7 students against meningococcal disease
- 63.85% of grade 7 students with their first dose of Hepatitis B vaccine
- 57.32% of grade 7 students with their second dose of Hepatitis B vaccine
- 62.58% of grade 7 students with their first dose of Human Papillomavirus vaccine
- 56.01% of grade 7 students with their second dose of Human Papillomavirus
- 43% of high school students in Algoma received TdaP (tetanus, diphtheria, pertussis) “booster” in their school setting.

For additional details, please refer to Immunization Coverage Report for School Pupils in Ontario, 2017-2018 School Year;

Immunization as a component of Comprehensive School Health

The School Health team uses a Comprehensive School Health (CSH) approach to address public health issues in schools. CSH is a coordinated, integrated approach that engages and empowers students, school staff, parents/ guardians and the broader school community to address and influence healthy school policies.[1] The CHS approach includes promoting and providing provincially funded immunization programs to eligible students at school-based clinics.

The immunization program demonstrates the core functions of public health in the following ways: assessment and surveillance of immunization status, health promotion, health protection, and disease prevention. Providing immunizations in the school setting provides an opportunity to *reach* the child and youth population, thus decreasing access barriers that some families experience.

Next Steps

To maintain and improve vaccine coverage rates the 2019-2020 school year, the school health team will continue working collaboratively with schools, school boards, parents/ guardians, and the broader school community to:

- Promote the importance of immunization for school-aged children
- Promote the use of ICON to simplify reporting
- Continue to assess the immunization status of children through record maintenance

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PROGRAM ACTIVITY INDICATORS

		2019 Q1 JAN - MAR	2019 Q2 APR - JUN	2019 YEAR END					2018 YEAR END
HBHC POSTPARTUM		**Q1**	**Q2**	**WW**	**SSM**	**BR**	**EL**	**2019 YE**	**2018 YE**
	Phone Calls	139	180	29	254	17	19	319	475
	Home Visits	47	66	4	99	4	6	113	173
COMMUNITY MENTAL HEALTH		**Q1**	**Q2**					**2019 YE**	**2018 YE**
	CMH New Clients: Individuals receiving 1st service	60	53					113	203
	CMH non registered: Client Interactions	407	271					678	1,325
CADAP LHIN FUNDED PROGRAMS		**Q1**	**Q2**					**2019 YE**	**2018 YE**
	New Client admissions Clinics / programs	182	122					182	458
	Direct Client interactions / group or individual including anonymous clients AS / SRP groups included	363	551					363	1,369
	Back on Track Group 1 and 2 day course participants / Group Participants - every 90 days	36	29					36	75
SUBSTANCE MISUSE		**Q1**	**Q2**	**WW**	**SSM**	**BR**	**EL**	**2019 YE**	**2018 YE**
Needle Exchange	Needles distributed	35,811	68,116	240	94,929	20	8,738	103,927	312,147
	Needles returned - NEP (estimates)	9,185	29,164	20	37,542	0	787	38,349	68,021
	Needles returned - Drop Bins SSM (estimates)	82,688	84,896	0	167,584	0	0	167,584	250,457
Addictions - Overdose Prevention	Naloxone trainings completed - with at risk individuals	187	183	0	187	0	0	370	590
HEALTH PROTECTION		**Q1**	**Q2**	**WW**	**SSM**	**BR**	**EL**	**2019 YE**	**2018 YE**
Safe Water	Private Wells - Adverse Reports	8	49	0	43	13	0	57	282
	Regulated Premise - ADW (O.reg.319)	1	16	1	6	10	0	17	13
	Boil Water Advisory	3	3	1	5	0	0	6	21
	Drinking Water Advisory	0	3	1	2	0	0	3	3
	Beach Closures	0	2	0	0	2	0	2	6
Rabies	Risk investigations initiated	31	65	9	64	12	11	96	193

HEALTH PROTECTION (CONT'D)		Q1	Q2	WW	SSM	BR	EL	2019 YE	2018 YE
Food Safety	Special Event Permits issued	32	79	6	61	38	6	111	298
	Food Handler Training (# persons)	475	288	0	619	99	45	763	608
	Farmers Market Approvals	36	47	0	48	35	0	83	89
Health Hazard	Complaint / Investigations all types	27	74	1	85	14	1	101	148
Land Control - OBC	Applications / Permits - Class IV	0	46	1	34	8	3	46	148
Communicable Disease Control	Institutional outbreaks	12	5	1	13	3	0	17	26
	Outbreak days in quarter	162	75	16	156	65	0	237	299
	Gonorrhea	5	7	0	9	0	2	12 *	17
	Chlamydia	48	99	1	119	9	13	147 *	243
	BBI (Hep B, C, HIV)	0	27	0	14	0	0	27 *	79
	Confirmed influenza cases	72	14	0	81	2	3	86	154
	Other reportable diseases	4	14	0	14	4	0	18	62

* total includes instances of uncategorized location

CONTRACEPTIVE PURCHASES	Q1	Q2	WW	SSM	BR	EL	2019 YE	2018 YE
14-19 years	16	12		16			28	155
20-24 years	52	48		52			100	267
25-29 years	107	123		107			230	606
30 + years	170	138		170			308	709
Total	345	321		345			666	1,737

*the SSM column is the cumulative district data

CALLS TO THE SEXUAL HEALTH LINE	159	984					1,143	4,000

TOBACCO CESSATION	Q1	Q2	SSM	DISTR.	2019 YE	2018 YE
Number of APH clients assessed or reassessed for tobacco use using Brief Contact Interventions (BCI)	624	508	963	169	1,132	2,349
Number of clients referred by staff to further intensive smoking cessation supports at APH during BCI (includes district)	136	59	0	0	195	364
Number of clients receiving clinic or in-home intensive tobacco cessation services from APH staff	87	67	108	46	154	290

Shaded - Indicates data not available

Algoma Public Health
(Unaudited) Financial Statements July 31, 2019

Algoma Public Health
Statement of Operations
July 2019
(Unaudited)

	Actual YTD 2019	Budget YTD 2019	Variance Act. to Bgt. 2019	Annual Budget 2019	Variance % Act. to Bgt. 2019	YTD Actual/ YTD Budget 2019
Public Health Programs						
Revenue						
Municipal Levy - Public Health	**$ 2,647,601**	$ 2,639,768	$ 7,834	$ 3,519,690	0%	100%
Provincial Grants - Cost Shared Funding	**4,388,536**	4,388,533	3	7,523,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	**1,747,805**	1,748,220	(415)	2,996,950	0%	100%
Fees, other grants and recovery of expenditures	**365,435**	394,775	(29,340)	695,214	-7%	93%
Total Public Health Revenue	**$ 9,149,377**	$ 9,171,296	$ (21,919)	$ 14,735,054	0%	100%
Total Public Health Programs Expenditures	**$ 8,406,202**	$ 8,674,200	$ 267,998	$ 14,735,055	-3%	97%
Total Rev. over Exp. Public Health	**$ 743,175**	$ 497,096	$ 246,079	$ (1)		
Healthy Babies Healthy Children						
Provincial Grants and Recoveries	**$ 356,011**	356,011	-	1,068,011	0%	100%
Expenditures	**355,794**	355,270	523	1,068,011	0%	100%
Excess of Rev. over Exp.	**217**	741	(523)	(0)		
Public Health Programs - Fiscal 19/20						
Provincial Grants and Recoveries	**$ -**	-	-	-		
Expenditures	**7,289**	-	7,289	-		
Excess of Rev. over Fiscal Funded	**(7,289)**	-	(7,289)	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	**$ -**	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	**232,875**	232,875	0	363,118	0%	100%
Total Community Health Revenue	**$ 232,875**	$ 232,875	$ 0	$ 363,118	0%	100%
Expenditures						
Child Benefits Ontario Works	**13,706**	14,292	585	24,500	-4%	96%
Algoma CADAP programs	**219,357**	220,625	1,268	338,619	-1%	99%
Total Calendar Community Health Programs	**$ 233,063**	$ 234,917	$ 1,854	$ 363,119	-1%	99%
Total Rev. over Exp. Calendar Community Health	**$ (189)**	$ (2,042)	$ 1,854	$ (1)		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	**$ 1,875,961**	$ 1,898,169	$ (22,208)	$ 5,719,507	-1%	99%
Municipal, Federal, and Other Funding	**121,116**	87,491	33,625	253,547	38%	138%
Other Bill for Service Programs	**17,854**		17,854			
Total Community Health Revenue	**$ 2,014,931**	$ 1,985,660	$ 29,271	$ 5,973,054	1%	101%
Expenditures						
Brighter Futures for Children	**27,984**	38,149	10,165	114,447	-27%	73%
Infant Development	**221,990**	214,010	(7,979)	644,031	4%	104%
Preschool Speech and Languages	**192,260**	204,085	11,825	614,256	-6%	94%
Nurse Practitioner	**48,482**	47,817	(665)	145,452	1%	101%
Genetics Counseling	**44,412**	-	(44,412)	-	0%	0%
Community Mental Health	**1,204,131**	1,204,105	(26)	3,612,862	0%	100%
Community Alcohol and Drug Assessment	**227,568**	245,802	18,234	737,406	-7%	93%
Stay on Your Feet	**31,025**	33,333	2,308	100,000	-7%	93%
Bill for Service Programs	**19,041**	-	(19,041)	-		
Misc Fiscal	**124**	1,533	1,409	4,600		
Total Fiscal Community Health Programs	**$ 2,017,018**	$ 1,988,835	$ (28,183)	$ 5,973,054	1%	101%
Total Rev. over Exp. Fiscal Community Health	**$ (2,086)**	$ (3,175)	$ 1,088	$ 0		

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months

and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health

Revenue Statement

For Seven Monthes Ending July 31, 2019

(Unaudited)

	Actual YTD 2019	Budget YTD 2019	Variance Bgt. to Act. 2019	Annual Budget 2019	Variance % Act. to Bgt. 2019	YTD Actual/ Annual Budget 2019	*Comparison Prior Year:* *YTD Actual 2018*	*YTD BGT 2018*	*Variance 2018*
Levies Sault Ste Marie	1,828,575	1,828,575	0	2,438,100	0%	75%	1,819,323	1,819,323	0
Levies Vector Bourne Disease and Safe Water	44,574	44,574	0	59,433	0%	75%	44,574	44,574	0
Levies District	774,452	766,617	7,835	1,022,157	1%	76%	762,738	762,738	0
Total Levies	**2,647,601**	**2,639,766**	**7,835**	**3,519,690**	**0%**	**75%**	**2,626,635**	**2,626,635**	**0**
MOH Public Health Funding	4,284,529	4,284,525	4	7,344,900	0%	58%	4,284,529	4,284,529	0
MOH Funding Vector Borne Disease	63,407	63,408	(1)	108,700	0%	58%	63,407	63,408	(1)
MOH Funding Small Drinking Water Systems	40,600	40,600	0	69,600	0%	58%	40,600	40,600	0
Total Public Health Cost Shared Funding	**4,388,536**	**4,388,533**	**3**	**7,523,200**	**0%**	**58%**	**4,388,536**	**4,388,537**	**(1)**
MOH Funding Needle Exchange	37,743	37,742	1	64,700	0%	58%	37,743	37,743	0
MOH Funding Haines Food Safety	14,350	14,350	0	24,600	0%	58%	14,350	14,350	0
MOH Funding Healthy Smiles	449,107	449,108	(1)	769,900	0%	58%	449,108	449,109	(1)
MOH Funding - Social Determinants of Health	105,293	105,292	1	180,500	0%	58%	105,293	105,293	0
MOH Funding - MOH / AMOH Top Up	73,332	73,763	(431)	126,450	-1%	58%	73,332	73,763	(431)
MOH Funding Chief Nursing Officer	70,879	70,875	4	121,500	0%	58%	70,879	70,879	0
MOH Enhanced Funding Safe Water	9,043	9,042	1	15,500	0%	58%	9,043	9,043	0
MOH Funding Unorganized	309,400	309,400	0	530,400	0%	58%	309,400	309,400	0
MOH Funding Infection Control	182,236	182,233	3	312,400	0%	58%	182,236	182,236	0
MOH Funding Diabetes	87,500	87,500	0	150,000	0%	58%	87,500	87,500	0
MOH Funding Northern Ontario Fruits & Veg.	68,486	68,483	3	117,400	0%	58%	68,472	68,472	0
Funding Ontario Tobacco Strategy	252,936	252,933	3	433,600	0%	58%	252,936	252,936	0
MOH Funding Harm Reduction	87,500	87,500	0	150,000	0%	58%	87,500	87,500	0
One Time Funding	0	0	0	0		0%	0	0	0
Total Public Health 100% Prov. Funded	**1,747,805**	**1,748,221**	**(416)**	**2,996,950**	**0%**	**58%**	**1,747,792**	**1,748,224**	**(432)**
Recoveries from Programs	23,065	23,429	(364)	27,621	-2%	84%	36,440	23,283	13,157
Program Fees	123,027	139,179	(16,152)	238,593	-12%	52%	125,934	138,696	(12,762)
Land Control Fees	84,760	97,500	(12,740)	160,000	-13%	53%	83,160	93,333	(10,173)
Program Fees Immunization	68,903	90,417	(21,513)	155,000	-24%	44%	60,437	107,916	(47,479)
HPV Vaccine Program	442	4,000	(3,558)	12,000	0%	4%	298	14,000	(13,703)
Influenza Program	885	0	885	25,000	0%	4%	0	0	0
Meningococcal C Program	349	0	349	8,000	0%	4%	77	2,000	(1,924)
Interest Revenue	26,688	18,667	8,021	32,000	43%	83%	19,494	8,167	11,327
Other Revenues	37,316	21,583	15,733	37,000	0%	101%	2,164	11,667	(9,503)
Total Fees, Other Grants and Recoveries	**365,435**	**394,775**	**(29,340)**	**695,214**	**-7%**	**53%**	**328,003**	**399,062**	**(71,059)**
Total Public Health Revenue Annual	**$ 9,149,377**	**$ 9,171,296**	**$ (21,919)**	**$ 14,735,054**	**0%**	**62%**	**$ 9,090,966**	**$ 9,162,458**	**$ (71,492)**

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months
and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health

Expense Statement- Public Health

For Seven Monthes Ending July 31, 2019

(Unaudited)

	Actual YTD 2019	Budget YTD 2019	Variance Act. to Bgt. 2019	Annual Budget 2019	Variance % Act. to Bgt. 2019	YTD Actual/ Budget 2019	*Comparison Prior Year:* *YTD Actual 2018*	*YTD BGT 2018*	*Variance 2018*
Salaries & Wages	$ 5,067,242	$ 5,268,331	$ 201,089	$ 9,031,427	-4%	56%	$ 4,827,877	$ 5,200,836	$ 372,959
Benefits	1,324,133	1,274,635	(49,498)	2,185,088	4%	61%	1,237,894	1,232,554	(5,340)
Travel	121,837	111,457	(10,380)	191,069	9%	64%	118,263	114,666	(3,597)
Program	278,679	368,336	89,657	631,433	-24%	44%	360,934	399,425	38,491
Office	53,886	60,401	6,515	103,544	-11%	52%	53,089	68,197	15,108
Computer Services	484,269	491,126	6,857	806,927	-1%	60%	382,315	447,764	65,449
Telecommunications	155,364	172,816	17,453	267,685	-10%	58%	149,349	176,927	27,578
Program Promotion	11,486	36,709	25,223	62,930	-69%	18%	30,063	38,937	8,874
Professional Development	52,570	56,410	3,840	96,702	-7%	54%	46,821	59,998	13,177
Facilities Expenses	455,956	443,333	(12,623)	760,000	3%	60%	464,279	463,750	(529)
Fees & Insurance	188,680	182,880	(5,800)	242,080	3%	78%	121,549	165,888	44,339
Debt Management	268,858	268,858	1	460,900	0%	58%	268,858	268,858	0
Recoveries	(56,758)	(61,092)	(4,334)	(104,730)	-7%	54%	(58,740)	(60,840)	(2,100)
	$ 8,406,201	$ 8,674,200	$ 267,998	$ 14,735,055	**-3%**	**57%**	$ 8,002,550	$ 8,576,961	$ 574,411

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months and variances of 10% and $10,000 occurring in the final 6 months

Notes to Financial Statements – July 2019

Reporting Period

The July 2019 financial reports include seven months of financial results for Public Health and the following calendar programs; Child Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting four month result from operations year ended March 31st, 2020.

The Ministry of Children, Community and Social Services has advised Health Units in Ontario that the Healthy Babies & Healthy Children program is now operating under a fiscal year (April 1st 2019 to March 31st 2019). The July 2019 statements reflect this change).

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

Note: On August 20th 2019, Algoma Public Health received the 2019-2020 Public Health funding approval letters from the Ministry of Health and Long-Term Care. APH will receive up to $523,425 in additional base funding related to the Ontario Seniors Dental Care Program and up to $148,500 one-time funding for the 2019-2020 funding year. APH's Public Health budget will be revised as of August 2019 as funding letters were received in August.

One-time funding requests and approvals are summarized below:

One-Time Request	Amount BoH Requested ($)	2019 Approved Allocation ($)
Mandatory Programs: Northeastern Collaboration/Shared Services Project (100%)*	124,000	124,000
Tobaccco Cessation (100%)	40,000	-
New Purpose-Built Vaccine Refrigerators (100%)	14,466	14,500
Public Health Inspector Practicum Program (2) (100%)	13,000	10,000
Total One Time Funding	**191,466**	**148,500**

Note: * Submission was on behalf of the Northeastern Collaborative with funds to be proportionately shared.

The Ministry also advised Public Health units that effective January 1st 2020 municipalities will fund 30% of all public health costs. The province currently covers 100% of certain public health programs and 75% of others. It was noted that the Ministry will provide one-time mitigation funding to assist all public health units and municipalities to manage this increase so as to protect from any cost increases resulting from this cost-sharing change that exceed 10% of existing costs.

Notes Continued…

As of July 31st 2019, Public Health programs are reporting a $246k positive variance.

Total Public Health Revenues are indicating a negative $22k variance. This is a result of Fees, Other Grants and Recoveries being less than budgeted. APH typically captures the bulk of its fees between the spring and fall months. This negative variance is being somewhat offset by a positive variance associated with the municipal levy as some smaller municipalities have paid their portion of the levy in full.

There is a positive variance of $268k related to Total Public Health expenses being less than budgeted. Salary and Wages expense is driving this positive variance.

Community Health Calendar programs are within budget.

APH's Community Health Fiscal Programs are four months into the fiscal year.

Genetics counseling program funding has now been fully transitioned to Health Sciences North. Operationally, APH continued to help with the transition in terms of client services utilizing deferred revenue associated with the program. Costs associated with the transition are now complete. APH is waiting on invoices from service providers to finalize expense figures.

Public Health Revenue (see page 2)

Overall, Public Health funding revenues are within budget.

The municipal levies are showing a positive $8k variance. This is a result of timing of receipts of the municipal levy as some smaller municipalities have paid their portion of the levy in full.

Cost Shared Funding is within budget.

100% Provincially Funded Grants are within budget.

Fees, Other Grants & Recoveries are showing a negative variance of $29k. Land Control Fees are showing a negative $13k variance. As expected, the size of this negative variance is decreasing month-over month as APH typically captures the bulk of its Land Control fees between the spring and fall months. In addition, Program Fees is showing a negative $16k variance and Program Fees Immunization is reflecting a $22k negative variance. This is a result of actual revenues being less than anticipated. Management will continue to monitor these line items as the year progresses.

Public Health Expenses (see page 3)

Salary & Wages
The $201k positive variance associated with Salary and Wages expense is a result of the time it takes to recruit suitable candidates when a position becomes vacant within the agency. A Public Health supervisor position was budgeted for the full calendar year. The successful candidate started in late

February. Currently, there is one Public Health vacant Public Health Inspector position within the agency that has been budgeted but yet to be filled.

Program
Program expense is indicating a positive $90k variance. Program Fees Immunization is $22k under budget which directly impacts the costs of associated Program expenses. Additionally, expenses are less than budgeted.

Telecommunications
Telecommunications expense is indicating a positive $17k variance. This is a result of savings being generated by moving the software associated with APH telephone warranty to APH servers for 2019.

Program Promotion
Program Promotion expense is indicating a positive $25k variance. This is a result of timing of expenses not yet incurred.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of July 31st, 2019. Cash includes $842k in short-term investments.

Long-term debt of $5.00 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $288k of the loan relates to the financing of the Elliot Lake office renovations with the balance related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie.

There are no collection concerns for accounts receivable.

Note: *Management is tracking costs associated with the Ransomware attack that occurred in April 2019 for insurance claim purposes. Costs incurred to date are not reflected in the July Statements.*

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of July 2019	**July 2019**	December 2018
Assets		
Current		
Cash & Investments	**$ 3,479,952**	$ 3,095,904
Accounts Receivable	**258,413**	513,364
Receivable from Municipalities	**235,526**	75,726
Receivable from Province of Ontario		
Subtotal Current Assets	**3,973,891**	3,684,994
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,371,018**	1,345,384
Payable to Gov't of Ont/Municipalities	**109,464**	344,305
Deferred Revenue	**404,610**	428,341
Employee Future Benefit Obligations	**2,811,714**	2,811,714
Term Loan	**5,199,815**	5,199,815
Subtotal Current Liabilities	**9,896,621**	10,129,560
Net Debt	**(5,922,730)**	(6,444,566)
Non-Financial Assets:		
Building	**22,732,421**	22,732,421
Furniture & Fixtures	**1,936,985**	1,936,985
Leasehold Improvements	**1,572,807**	1,572,807
IT	**3,244,030**	3,244,030
Automobile	**40,113**	40,113
Accumulated Depreciation	**(9,476,105)**	(9,476,105)
Subtotal Non-Financial Assets	**20,050,250**	20,050,250
Accumulated Surplus	**14,127,520**	13,605,684

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION I: SUMMARY, CERTIFICATION and VERIFICATION

Board of Health for the Algoma Health Unit

Mar. 31, 2018 (e.g. Mar. 31, 2018)

SERVICE CONTRACT/CF 0

PART A: SUMMARY

LINE	SERVICES					
100	Service (Detail Code) Name	Service (Detail Code) Name	Executive and Allotment Control	Total Eligible Expenditures (pending final Ministry review and approval)	Total Approved Ministry Funding	Summary of Revised Ministry Funding after Financial Flexibility (pending final Ministry review and approval)
101	A478	Infant Development	CYSEX034-AL09	$ 608,845	$ 624,935	$ 608,845
102	0			$ -	$ -	$ -
103	0			$ -	$ -	$ -
104	0			$ -	$ -	$ -
105	0			$ -	$ -	$ -
106	0			$ -	$ -	$ -
107	0			$ -	$ -	$ -
108	0			$ -	$ -	$ -
109	0			$ -	$ -	$ -
110	0			$ -	$ -	$ -
111	0			$ -	$ -	$ -
112	0			$ -	$ -	$ -
113	0			$ -	$ -	$ -
114	0			$ -	$ -	$ -
115	0			$ -	$ -	$ -
116	0			$ -	$ -	$ -
117	0			$ -	$ -	$ -
118	0			$ -	$ -	$ -
119	0			$ -	$ -	$ -
120	0			$ -	$ -	$ -
121	0			$ -	$ -	$ -
122	0			$ -	$ -	$ -
123	0			$ -	$ -	$ -
155	0			$ -	$ -	$ -
156	0			$ -	$ -	$ -
157	0			$ -	$ -	$ -
158	0			$ -	$ -	$ -
159	0			$ -	$ -	$ -
160	0			$ -	$ -	$ -
161	0			$ -	$ -	$ -
162	0			$ -	$ -	$ -
187	0			$ -	$ -	$ -
188	0			$ -	$ -	$ -
189	0			$ -	$ -	$ -
190	0			$ -	$ -	$ -
191	0			$ -	$ -	$ -
192	0			$ -	$ -	$ -
193	0			$ -	$ -	$ -
194	0			$ -	$ -	$ -
195	0			$ -	$ -	$ -
196	0			$ -	$ -	$ -
197	0			$ -	$ -	$ -
198	0			$ -	$ -	$ -
199	0			$ -	$ -	$ -
200	0			$ -	$ -	$ -
TOTAL				$ 608,845	$ 624,935	$ 608,845

PART B: CERTIFICATION BY SERVICE PROVIDER / DELIVERY AGENT AUTHORITY

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

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

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

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

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

PART C: VERIFICATION BY THE BOARD OF DIRECTORS

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

_____ day of _____ _____ (LINE 160)

Chairperson of the Board of Directors:

_____ (LINE 170)
Signature

Name of Chairperson or Designate

Title

Section I

Financial Information of

ALGOMA PUBLIC HEALTH

Infant Development Program

(unaudited)

Year ended March 31, 2019

KPMG LLP
111 Elgin Street, Suite 200
Sault Ste. Marie ON P6A 6L6
Canada
Telephone (705) 949-5811
Fax (705) 949-0911

REVIEW ENGAGEMENT REPORT

To the Members of the Board of the Algoma Public Health

We have reviewed the Statement of Revenue and Expenditures of the Infant Development Program of the Algoma Public Health (the Entity) for the year ended March 31, 2019 and notes, comprising summary of significant accounting policies (the Statement). The Statement has been prepared by management in accordance with the basis of accounting described in Note 1 to the Statement.

Management's Responsibility for the Statement

Management is responsible for the preparation of the Statement in accordance with the basis of accounting described in Note 1 to the Statement, and for such internal control as management determines is necessary to enable the preparation of the Statement that is free from material misstatement, whether due to fraud or error.

Practitioners' Responsibility

Our responsibility is to express a conclusion on the accompanying Statement based on our review. We conducted our review in accordance with Canadian generally accepted standards for review engagements, which require us to comply with relevant ethical requirements.

A review in accordance with Canadian generally accepted standards for review engagements is a limited assurance engagement. The practitioner performs procedures, primarily consisting of making inquiries of management and others within the entity, as appropriate, and applying analytical procedures, and evaluates the evidence obtained.

The procedures performed in a review are substantially less in extent than, and vary in nature from, those performed in an audit conducted in accordance with Canadian generally accepted auditing standards. Accordingly, we do not express an audit opinion on this Statement.

Conclusion

Based on our review, nothing has come to our attention that causes us to believe that the Statement of Revenue and Expenditures for the Entity for the year ended March 31, 2019 is not prepared, in all material respects, in accordance with the basis of accounting described in Note 1 to the Statement.

ALGOMA PUBLIC HEALTH

Infant Development Program

Statement of Revenue and Expenditures
(unaudited)

Year ended March 31, 2019, with comparative information for 2018

	Budget	2019	2018
Revenue:			
Provincial grants	$ 624,936	$ 624,935	$ 621,935
Expenditures:			
Salaries and benefits	525,884	511,794	518,361
Occupancy	50,354	50,771	52,193
Travel and training	29,000	21,569	29,058
Administration	16,000	16,040	16,040
Program materials and supplies	10,500	12,786	13,089
Telephone	5,400	7,662	6,412
Equipment	–	–	1,356
Professional development	4,645	4,446	2,004
Professional fees	2,000	2,035	2,000
Janitorial	–	131	–
Subscriptions/memberships	–	495	–
Expenses recovered	(18,848)	(18,884)	(18,578)
	624,935	608,845	621,93
Excess of revenue over expenditures	$ 1	$ 16,090	$ –

See accompanying notes to financial information.

Basis of Accounting

Without modifying our conclusion we draw attention to Note 1 to the Statement which describes the basis of accounting. The Statement is prepared to provide information to the Members of the Entity. As a result, the Statement may not be suitable for another purpose.

Restriction on Use

Our report is intended solely for the Members of the Board of the Entity and should not be used by parties other than the Members of the Board of the Entity.

KPMG LLP

Chartered Professional Accountants, Licensed Public Accountants

Sault Ste. Marie, Canada

July 12, 2019

ALGOMA PUBLIC HEALTH

Infant Development Program

Notes to Financial Information
(unaudited)

Year ended March 31, 2019

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1. Basis of accounting:

The Statement of Revenue and Expenditures of the Entity has been prepared in accordance with the recognition and measurement principles of Canadian public sector accounting standards of the CPA Canada Handbook – Accounting (PSAB) and not the presentation principles or the presentation of all financial statements and related note disclosures required for a complete set of financial statements.

The statement is prepared to provide information to the Members of the Board of the Entity, and to the Ministry of Child and Youth Services. As a result, the Statement may not be suitable for another purpose.

2. Significant accounting policies:

(a) Revenue and expenses are reported on the accrual basis of accounting.

(b) Capital expenditures are recorded as expenses rather than being capitalized.

Governance Committee Meeting
September 18, 2019

Attendees:
Deborah Graystone - Chair
Adrienne Kappes
Heather O'Brien
Louise Caicco Tett
Lee Mason - Board Chair

Regrets: Karen Raybould

APHU Executive
Marlene Spruyt - MOH/CEO
Tania Caputo - Board Secretary

The Governance Committee reviewed a Job Description of Board Members - including recruitment for Municipal Board Membership. A skills matrix was developed by Lee Mason using historical data from previous government materials. All of these documents were reviewed and appropriate amendments incorporated. A draft policy will be developed by Marlene Spruyt. This draft policy will be circulated to the Governance Committee for review, recommendations and ultimate approval by the Governance Committee will be made prior to presenting to the Board.

The Travel Policies for Employees and Board Members were reviewed. An amalgamated policy was presented to the Governance Committee. Amendments were discussed and changes were approved by the Committee. Discussion regarding increasing meal expenses and appropriate mileage costs were discussed. Marlene Spruyt will review, make appropriate amendments and send the new "Board" policy which includes guidelines for employee travel also, to the Governance Committee for review and approval.

The Board Remuneration Policy was reviewed. Discussion around Chair remuneration along with consideration of travel time and meeting time amendments were made.
Amendments were discussed and approved to correlate with other Northern Ontario Boards of Health. Meeting payments were increased from $109 to $110; and a $150 stipend will be provided for those with traveling time and meeting time equaling 4 or more hours. Attendance for workshops or conferences changed from $181 to $180. Additional Chair duties stipend was increased from $60/month to $100/month. This discussion included consideration of behind the scenes work not including additional meetings.
This policy will be amended and once approved by the Governance Committee will be presented to the Board.

Public Health Champion

Last year, in honour of Algoma Public Health's 50th anniversary and to celebrate the role public health has in our communities across Algoma, APH awarded a Public Health Champion Award. As you will recall, the recipient was André Riopel who has passionately advocated for safe and active transportation.

Call for Nominations

A healthy community requires contributions from many individuals and organizations. A Public Health Champion is a person or an organization that is making a positive difference where we live, learn, work and play. Their passion is rooted in helping the community live a healthier life, regardless of age, income or socio-economic background.

APH is issuing a Call for Nominations for our second Public Health Champion Award.

The call for nomination runs from **August 19, 2019 - September 27, 2019**.

- What is a public health champion?
- Nominate a person or organization

For more information:
Leo Vecchio
Manager, Communications
705-942-4646, ext. 3066
lvecchio@algomapublichealth.com

How do I nominate?
Choose 1 of 3 options...

1. Complete the nomination online
2. Download a fillable PDF. Complete it and submit it electronically online
3. Download a PDF file and mail it to:

Algoma Public Health
Attn: Leo Vecchio
294 Willow Avenue
Sault Ste. Marie, ON P6B 0A9

Peterborough Public Health
1889-2019 LOCAL & STRONG

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

June 25, 2019

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

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

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

Dear Ministers,

Re: Support for Children Count Task Force Recommendations

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

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

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

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

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

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

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

Thank you for your consideration.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

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

References:

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

simcoe muskoka
DISTRICT HEALTH UNIT

June 27, 2019

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

Dear Minister Elliott:

Re: Public Health Modernization

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

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

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

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

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

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

Thank you for considering our recommendations.

Sincerely,

ORIGINAL Signed By:

Anita Dubeau
Chair, Board of Health

CG:cm

Att. (1)

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

alPHa RESOLUTION A19-12

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

SPONSOR: **Peterborough Public Health**

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

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

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

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

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

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

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

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

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

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

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

ACTION FROM CONFERENCE: Carried as amended

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

519-258-2146 | www.wechu.org

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

July 2, 2019

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

Dear Minister Elliott:

Health Promotion as a Core Function of Public Health

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

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

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

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

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

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

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

Sincerely,

Gary McNamara, Chair
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

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

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

519-258-2146 | www.wechu.org

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

July 2, 2019

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

Dear Minister Elliott:

Immunization for School Children – Seamless Immunization Registry

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

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

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

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

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

Sincerely,

Gary McNamara, Chair
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

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

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

519-258-2146 | www.wechu.org

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

July 2, 2019

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

Dear Minister Elliott:

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

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

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

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

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

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

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

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

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

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

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

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

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

Woodstock Site
410 Buller Street
Woodstock, ON
N4S 4N2

July 8, 2019

christine.elliott@ontario.ca

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

Dear Honourable Christine Elliott,

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you for your consideration.

Sincerely,

Larry Martin
Board Chair, Southwestern Public Health

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

References

[1] Health [Internet]. Toronto Ontario; 2019. p. 1–18. Available from: https://www.amo.on.ca/AMO-PDFs/Reports/2019/AMO-Partners-for-a-Healthy-Ontario-2019-01-18.aspx

[2] Care M of H and L-T. Public Health: Chronic Disease Prevention [Internet]. Ministry of Health and Long-Term Care; 2017. p. 527–69. Available from: http://www.auditor.on.ca/en/content/annualreports/arreports/en17/v1_310en17.pdf

[3] Rebecca Masters, Elspeth Anwar, Brendan Collins, Richard Cookson and SC. Return on investment of public health interventions: a systematic review. J Epidemiol Community Heal [Internet]. 2017;71(8):827–834. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5537512/

[4] MacLeod M, Hussain H. Chronic Disease Prevention & Well-being. Woodstock, ON: Southwestern Public Health; 2019.

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay Parry Sound
Your lifetime partner in healthy living.
345 Oak Street West, North Bay, ON P1B 2T2 TEL 705-474-1400 FAX 705-474-8252 | myhealthunit.ca
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July 5, 2019 **SENT ELECTRONICALLY**

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

The Honourable Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9
christine.elliott@pc.ola.org

Dear Premier Ford and Minister Elliott:

At its regular Board meeting on June 26, 2019, the Board of Health for the North Bay Parry Sound District Health Unit passed the following resolution related to the public health transformation initiative in northeastern Ontario:

> ***Whereas,*** *since November 2017, the boards of health in Northeastern Ontario, namely the Boards for Algoma Public Health, Public Health Sudbury & Districts, Porcupine Health Unit, North Bay Parry Sound District Health Unit, and Timiskaming Health Unit, have proactively and strategically engaged in the Northeast Public Health Collaboration Project to identify opportunities for collaboration and potential shared services; and*
>
> ***Whereas,*** *the Northeast Public Health Collaboration Project work to date has been supported by two one-time funding grants from the Ministry of Health and Long-Term Care (Ministry); and*
>
> ***Whereas,*** *subsequent to the proposed transformation of public health announced in the April 11, 2019, provincial budget, the work of the Collaboration has been accelerated and reoriented as the Northeast Public Health Transformation Initiative with the vision of a healthy northeastern Ontario enabled by a coordinated, efficient, effective, and collaborative public health entity; and*
>
> ***Whereas,*** *the Board understands there will be opportunities for consultation with the Ministry on the regional implementation of public health transformation;*

…/2

Therefore Be It Resolved, *that the Board of Health for the North Bay Parry Sound District Health Unit is committed to the continued collaboration of the boards of health in Northeastern Ontario and looks forward to ongoing Ministry support for this work; and*

Furthermore Be It Resolved, *that the Board, having engaged in this work since 2017, anticipates sharing with the Ministry its experiences so that other regions may benefit and further anticipates providing to the Ministry its expert advice on public health functions and structures for the Northeast; and*

Furthermore Be It Resolved, *that this motion be shared with the Honourable Doug Ford, Premier, the Honourable Christine Elliott, Minister of Health and Long-Term Care, Dr. David Williams, Chief Medical Officer of Health, Vic Fedeli, MPP – Nipissing, Norm Miller, MPP – Parry Sound-Muskoka, John Vanthof, MPP – Timiskaming-Cochrane, the Association of Local Public Health Agencies, Ontario Boards of Health, and member municipalities.*

Sincerely yours,

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

/sb

Copy to: Dr. David Williams, Chief Medical Officer of Health
Vic Fedeli, MPP – Nipissing
Norm Miller, MPP – Parry Sound-Muskoka
John Vanthof, MPP – Timiskaming-Cochrane
Loretta Ryan, Executive Director, Association of Local Public Health Agencies (alPHa)
Ontario Boards of Health
NBPSDHU Member Municipalities (31)

July 19, 2019

The Honourable Christine Elliott
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario
M7A 2C4

Dear Minister Elliott,

Re: Essential Components for Strong Local Public Health

At its meeting on July 18, 2019, the Middlesex-London Board of Health voted to endorse the following motion:

Moved by: Mr. Michael Clarke Seconded by: Mr. Ian Peer

That the Board of Health:

1) Receive Report No. 053-19 re: "Essential Components for Strong Local Public Health" for information; and

2) Direct staff to forward the Report in Appendix A to the Minister of Health, other boards of health, and relevant stakeholders.

The Board of Health also took time to hold a generative discussion concerning public health unit amalgamation. Members are looking forward to the opportunity to be involved in the consultation process. Members wanted to identify what is important about public health work that needs to continue, what input to and involvement in amalgamation plans going forward Board members are seeking.

In our discussion, we concluded that the current mission of the Middlesex-London Health Unit "to promote and protect the health of our community" remains appropriate but requires building a new understanding of the community to be served. Public health should remain a local focus however needs will necessarily arise across a larger more diverse catchment area, and with regionalization, the new public health entity will comprise a collection of very diverse communities.

Good governance for public health has so far reflected the local nature of public health delivery with a locally accountable governance structure. Members are concerned that the governance structure for a regional public health entity will struggle to maintain that important local accountability.

We hope that you will find this brief summary of our generative discussion helpful. We look forward to hearing details about the timelines and structure of the summer consultation process.

A copy of Report No. 053-19 and its Appendix re: *Keeping Middlesex-London Safe and Healthy: Essential components for a strong local public health sector through modernization* is enclosed for your reference.

Yours sincerely,

Trish Fulton
Chair, Middlesex-London Board of Health

c.c. Ontario Boards of Health
County of Middlesex
City of London

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 053-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 July 18

ESSENTIAL COMPONENTS FOR STRONG LOCAL PUBLIC HEALTH

Recommendation

It is recommended that that the Board of Health:

1) ***Receive Report No. 053-19 re: "Essential Components for Strong Local Public Health" for information; and***
2) ***Direct staff to forward the Report in Appendix A to the Minister of Health, other boards of health, and relevant stakeholders.***

Key Points

- Public Health Modernization will result in significant disruption to local public health.
- As the provincial government embarks on this modernization, it is important that key considerations, born out of decades of public health history, be contemplated.
- MLHU has prepared a response paper with key considerations and essential components for strong local public health.

Background

On April 11, 2019, the provincial budget introduced plans to significantly restructure Ontario's public health system, including the dissolution of its 35 health units and creation of 10 new regional public health entities. New boards of health under a common governance model would be established in line with the new regional entities, and substantial adjustments to provincial-municipal cost-sharing would occur over three budget years, as well as a reduction of the overall budget envelope for local public health. Since the announcement in April, the Health Unit has received further information regarding the proposed geographic boundaries and reviewed responses from stakeholders across the province. Please see: https://www.alphaweb.org/page/PHR_Responses.

Response to the 2019 Public Health Modernization

Given the magnitude of the impact that public health modernization will have on Middlesex-London, a response paper titled *Keeping Middlesex-London Safe and Healthy* (see Appendix A) has been prepared.

The paper outlines four essential components for a strong local public health sector:

1. Maintaining public health's unique upstream population health and disease prevention mandate;
2. Keeping public health at the community level to best serve residents and lead strategic community partnerships;
3. Ensuring public health funding and a strong workforce to fulfill its mandate; and
4. Governance structures that are transparent and locally accountable.

Next Steps

The response paper will be forwarded to the Minister of Health, local boards of health, and other relevant stakeholders. Additionally, MLHU will be participating in consultations regarding public health modernization throughout the summer and fall.

This report was prepared by the Healthy Organization Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health/CEO

Keeping Middlesex-London Safe and Healthy

Essential components for a strong local public health sector through modernization

July 2019

For information, please contact:

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Content adapted with permission from, and thanks to, Peel Public Health

Cite reference as: Middlesex-London Health Unit. Keeping Middlesex-London safe and healthy: essential components for a strong local public health sector through modernization. London (ON): Middlesex-London Health Unit; 2019 Jul 18.

Contents

Executive Summary

Public health services provide high returns on investment. On average, one dollar invested in public health generates an eight dollar return through avoided health and social care costs (1). Despite this, public health only receives about two percent of all provincial health care spending in Ontario, with funding projected to decrease in future years.

The Provincial government recently announced plans to modernize the public health system by consolidating 35 public health units into ten new Regional Public Health Entities by 2020-2021. Also, there will be a progressive reduction in the funding cost-share formula with municipalities bearing a more significant portion of the costs. In Middlesex-London, this will mean shifting from a 75 percent provincial and 25 percent municipal share to 60 percent provincial and 40 percent municipal share by 2021-2022. Programs that were 100 percent provincially-funded will change to a cost-share structure in 2019-2020, except for the new Provincial Low-Income Seniors' Dental Program.

History has shown that when the public health system is weakened, serious consequences arise. After the Walkerton drinking water contamination in 2000 and the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003, major expert reports highlighted the need for a strong and autonomous public health sector to protect the health and safety of the public (2,3).

In this paper, we propose that modernization preserve the following components, which are essential for a strong local public health sector:

1. Maintaining public health's unique upstream mandate;
2. Keeping public health local;
3. Ensuring adequate funding and a strong workforce; and
4. Transparent and locally accountable governance.

The following summary illustrates how each component in a strong public health sector helps achieve our shared goal: healthy, productive, and thriving communities.

1. Maintaining public health's unique upstream population health and disease prevention mandate
    - Public health's unique mandate is to keep people healthy, prevent disease, and reduce health inequities.
    - We focus upstream – long before people need hospitals and health care. We collaborate with and complement other health care services to proactively reduce the impact of illness on "hallway medicine" and the acute care system.
    - To be successful leaders in prevention, we have five core public health functions:
        - population health assessment and surveillance – understanding who is sick and why
        - health promotion and policy development – creating supportive environments for healthy living by making the healthy choice the easy choice
        - health protection - identifying hazards to our health and taking action to stop or reduce their risk
        - disease prevention – working directly with clients to prevent and treat some illnesses, and working with community organizations, municipalities and the Province to create healthy public policies
        - emergency management – planning for and leading the response to public health emergencies
2. Keeping public health at the community level to best serve residents and lead strategic community partnerships

- A strong public health sector is responsive to local health priorities through collaborative engagement with local municipalities, schools, health care professionals, community organizations, and residents.
- Middlesex-London has a unique set of health issues that require tailored community responses and coordination.
- Local perspectives add value to provincial priority-setting and decision-making.

3. Ensuring public health has adequate funding and a strong workforce to fulfill its mandate
   - Overall funding for local public health should be sufficient to achieve the mandate and enable communities to thrive. Cost-sharing between the Province and municipalities should be achieved in a way that meets community needs and minimizes the burden on the local taxpayer.
   - The new Regional Public Health Entities should be empowered to identify the number, mix, and distribution of human resources necessary to meet local health needs.

4. Governance structures that are transparent, autonomous, and locally accountable
   - As boards of health are regionalized, it is vital that the role of the Medical Officer of Health and the Board of health, their autonomy, composition, and ability to promote healthy public policy be maintained.

Local public health has a unique mandate not fulfilled by any other organization at the local level. Only public health focuses on upstream population-level approaches to prevent injuries and illnesses before they occur. When the Provincial consultation begins, we strongly recommend the consideration of these essential components of a strong local public health sector to enable the achievement of our shared goal of healthy and thriving communities.

Purpose

The Middlesex-London Health Unit (MLHU) has prepared this report in response to recent provincial announcements regarding the modernization of Ontario's public health sector. The scale of the proposed changes to the governance, organization, and funding of local public health organizations in Ontario is unprecedented.

As the Province consults on modernization of public health there are important considerations, borne out of decades of public health experience, that support the Province's goals of enhancing municipal engagement, better integrating with health care to support more efficient service delivery, and preserving the essential components of a strong public health system in a new structure.

Our vision is: ***People Reaching Their Potential***

Our mission is: ***To protect and promote the health of our community***

To continue to achieve this vision and fulfill this mission, the future regional public health entity must:

1. Maintain public health's unique upstream population health and disease prevention mandate;
2. Keep public health at the community level to best serve residents and lead strategic community partnerships;
3. Ensure public health has adequate funding and a strong workforce to fulfill its mandate; and
4. Implement governance structures that are transparent and locally accountable.

Lessons from history show that when the public health system is weakened, serious consequences arise. After the Walkerton E. coli contamination in 2000 and SARS outbreak in 2003, many expert reports highlighted the need for a strong and autonomous public health sector (2,3).

Background

On April 11, 2019, the Ontario provincial budget introduced sweeping changes to the public health system. Objectives outlined in the provincial budget include replacing Ontario's 35 health units with 10 regional public health entities by April 1, 2020. This would dissolve all existing Boards of Health across the province.

The newly proposed boundaries (Figure 1) would see Middlesex-London Health Unit amalgamate with the Southwestern, Lambton, Chatham-Kent, and Windsor-Essex Health Units. The estimated population of this regional entity would be 1.3M.

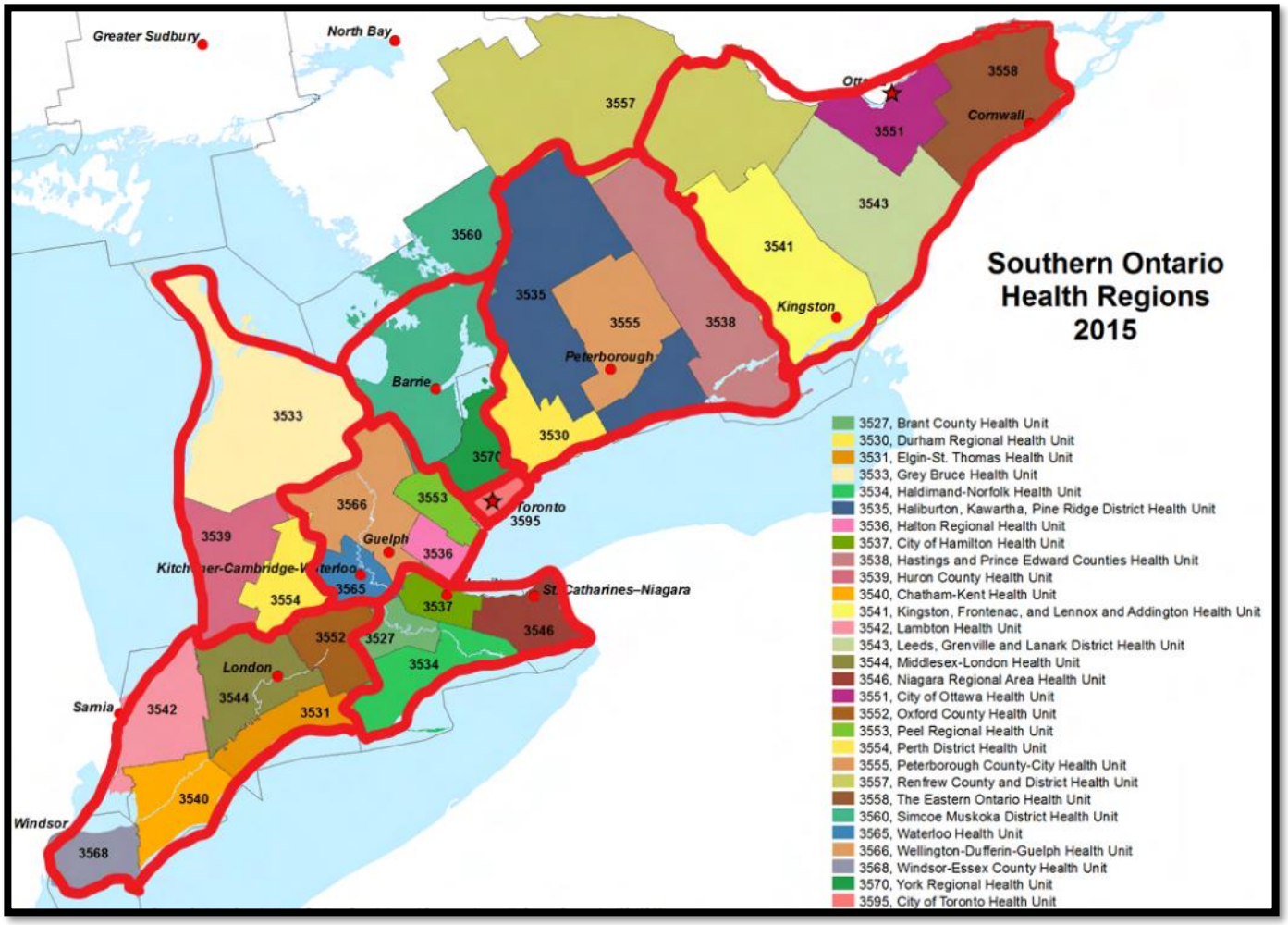
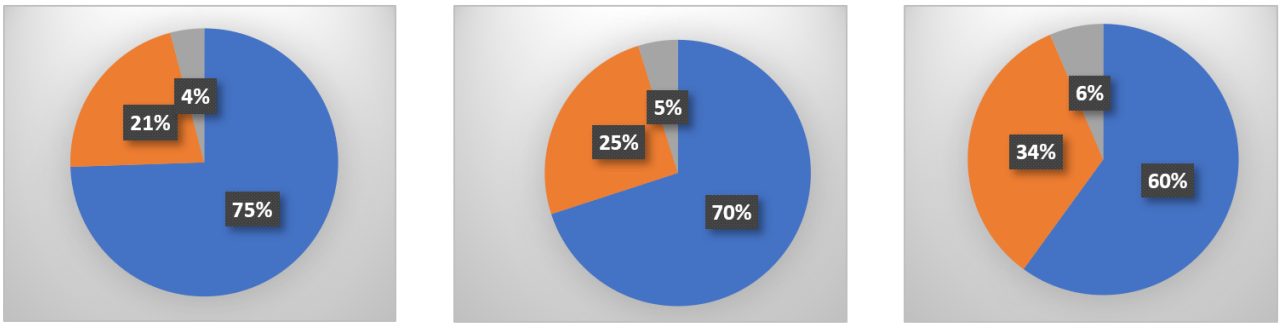


Figure 1 - Regional Public Health Entity Boundaries. Source: Statistics Canada, Health Regions, Boundaries and Correspondence with Census Geography, (82-402-x). Produced by the Statistical Registers and Geography Division for the Health Statistics Division, 2015.

The budget also proposes reducing total provincial funding for public health by $200 million over the next two to three years and amending the cost-sharing arrangements between the provincial government and the municipalities from 75% Provincial / 25% Municipal to 70% Provincial / 30% Municipal in the 2020-2021 fiscal year and then to a 60% Provincial / 40% Municipal in the 2021-2022 fiscal year.

A significant increase in contributions from municipalities would be necessary to accommodate the change to the cost-sharing formula if health units are expected to continue providing comprehensive public health programs and services to communities that are served. The potential changes to the municipal contributions are outlined in Figure 2.



Funding by Source	2019	%	2020	%	2021	%
MOHLTC	21,167,800	74.5%	19,896,674	70.0%	17,054,292	60.0%
City of London	6,095,059	21.4%	7,162,803	25.2%	9,550,404	33.6%
County of Middlesex	1,160,961	4.1%	1,364,343	4.8%	1,819,124	6.4%
Total Funding	**28,423,820**		**28,423,820**		**28,423,820**	
	TODAY		**70/30**		**60/40**	

Figure 2 – Potential Impact of the Proposed Cost-Sharing Arrangements of the City of London and County of Middlesex

The Ministry of Health and Long-Term Care (MOHLTC) expects to find the $200 million in savings from public health through the centralization of leadership, streamlining of back-office functions, IT services as well as the move to digital solutions at the regional level. These savings are expected to be achieved by 2021.

To lessen the immediate impact of these changes, the Province is considering one-time funding to offset costs as well as potential exceptions, or “waivers”, from some aspects of the Ontario Public Health Standards. Such funding and exceptions would be considered on a board-by-board basis.

The Province has also committed to consulting with public health units and municipalities on the phased implementation of the proposed changes.

Each of the following sections illustrates the vital elements of a strong local public health sector that will support the Province’s desired outcomes and ensure the public health needs of communities are met. These elements should be carried forward to a new structure.

Essential Considerations for Local Public Health

The essential components for local public health are drawn from the Ontario Public Health Standards, peer-reviewed literature and reports that have been previously prepared for the Middlesex-London Health Unit, and all levels of government in Canada.

1. *Maintaining public health's unique upstream population health and disease prevention mandate*

As outlined in the Ontario Public Health Standards:

> *The role of boards of health is to support and protect the physical and mental health and well-being, resiliency and social connectedness of the health unit population, with a focus on promoting the protective factors and addressing the risk factors associated with health outcomes (4).*

MLHU's focus on the health of the population stands in contrast to many of the other organizations and health service providers in the Middlesex-London region and it is imperative that its focus be maintained, if not strengthened.

What does this mean?

- Public health's unique mandate is to keep people healthy, prevent disease, and reduce health inequities.

- To be successful leaders in prevention, we have five core public health functions:

  - **Population Health Assessment and Surveillance** – understanding who is sick and why
  - **Health Promotion and Policy Development** – creating supportive environments for healthy living by making the healthy choice the easy choice
  - **Health Protection** - identifying hazards to our health and how to stop or reduce their risk
  - **Disease Prevention** – delivering comprehensive disease prevention services by working directly with clients to prevent and treat some illnesses, and working with community organizations, municipalities, and the Province to create healthy public policies
  - **Emergency Management** – planning for and leading the response to public health emergencies

- We focus upstream – long before people need hospitals and health care. We collaborate with and complement other health care services to proactively reduce the impact of illness on "hallway medicine" and the acute care system.

- The Medical Officer of Health and Chief Executive Officer (MOH / CEO) and the Board of Health use evidence and data to act in the interest of the health and safety of the community. The MOH / CEO leads a group of multi-disciplinary public health professionals to ensure public health crises are addressed quickly and effectively, ensure the public is aware of how to prevent disease and enhance health, and provide expert advice to decision-makers.

Why is this important?

Local public health's mandate is unique and considers everyone in the community, particularly those most vulnerable (e.g., low-income, newcomers, children, seniors).

Public health uses a population health approach, which means reducing the factors that cause disease, injury, and death in the community. While some actions should be taken across all communities, we also recognize that communities are diverse and the importance of building on strengths and reducing vulnerabilities in individual communities. Figure 3 provides examples of core public health activities that keep people healthy, productive, and out of the health care system.

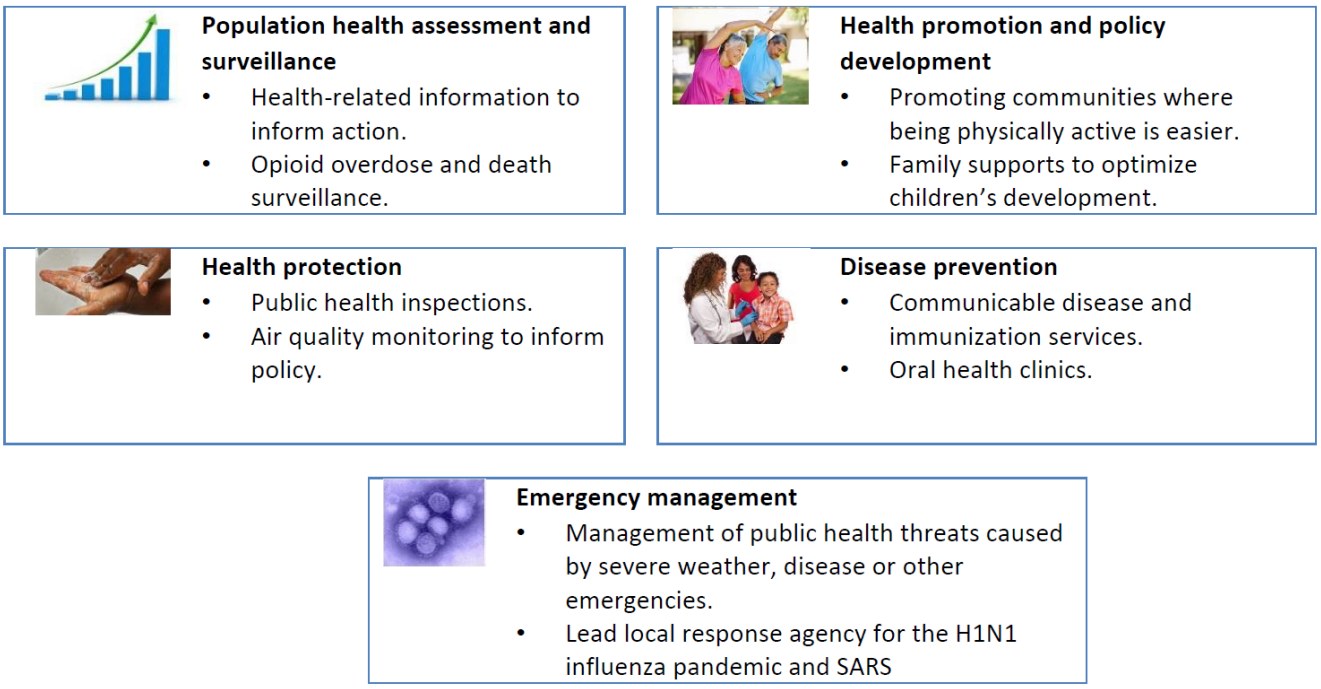


Figure 3 - Core Public Health Functions with Examples

While the success of prevention is mostly invisible, social and economic benefits are immense. When people avoid disease and injury, they are more likely to be productive and contribute to the economy. They require fewer hospital visits and rely less on health care throughout their lives (5). Figure 4 illustrates the loss in productivity due to communicable diseases.

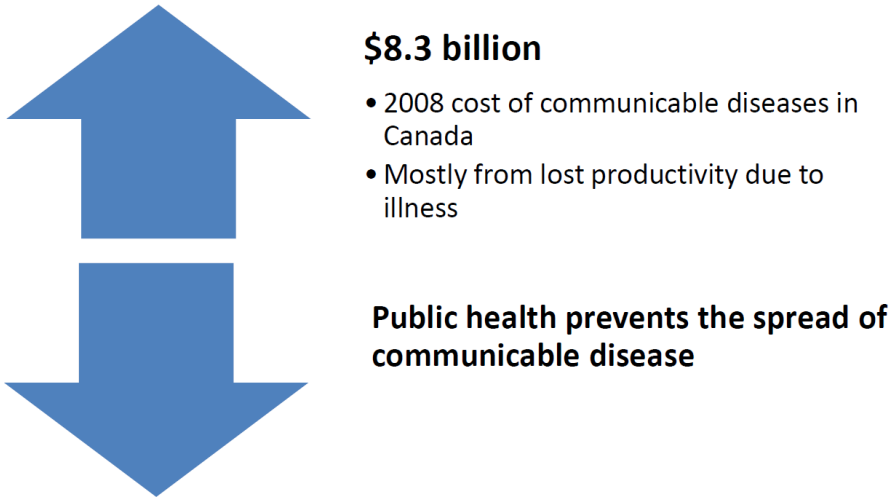


Figure 4 - Public Health Helps Decrease Lost Productivity due to Communicable Diseases (6)

The economic impact of SARS provides an example of the costs associated with outbreaks that are not prevented. Looking at the increase in provincial expenditures alone, and not considering the personal financial costs of those affected, there were $1.073 billion in unforeseen expenditures in the 2003-4 fiscal year (7).

A strong public health sector keeps people out of overcrowded hospitals.

The goal of public health is to keep people healthy, long before they become patients in the health care system. Public health programs focus on reducing risks to all residents. This ultimately drives down health care costs and makes the health care system more sustainable.

To achieve optimal health, both health care and public health are needed, and their roles are essential and complementary (Figure 5). Public health focuses on interventions with the greatest potential impact across a population and efforts to address the conditions where people live, work, play, grow and age to make healthy choices easier (8).

No other entity is primarily focused on upstream efforts to prevent illness before it arises. Investment in preventive strategies is an essential component to reduce “hallway medicine” and other strains on acute health care services.

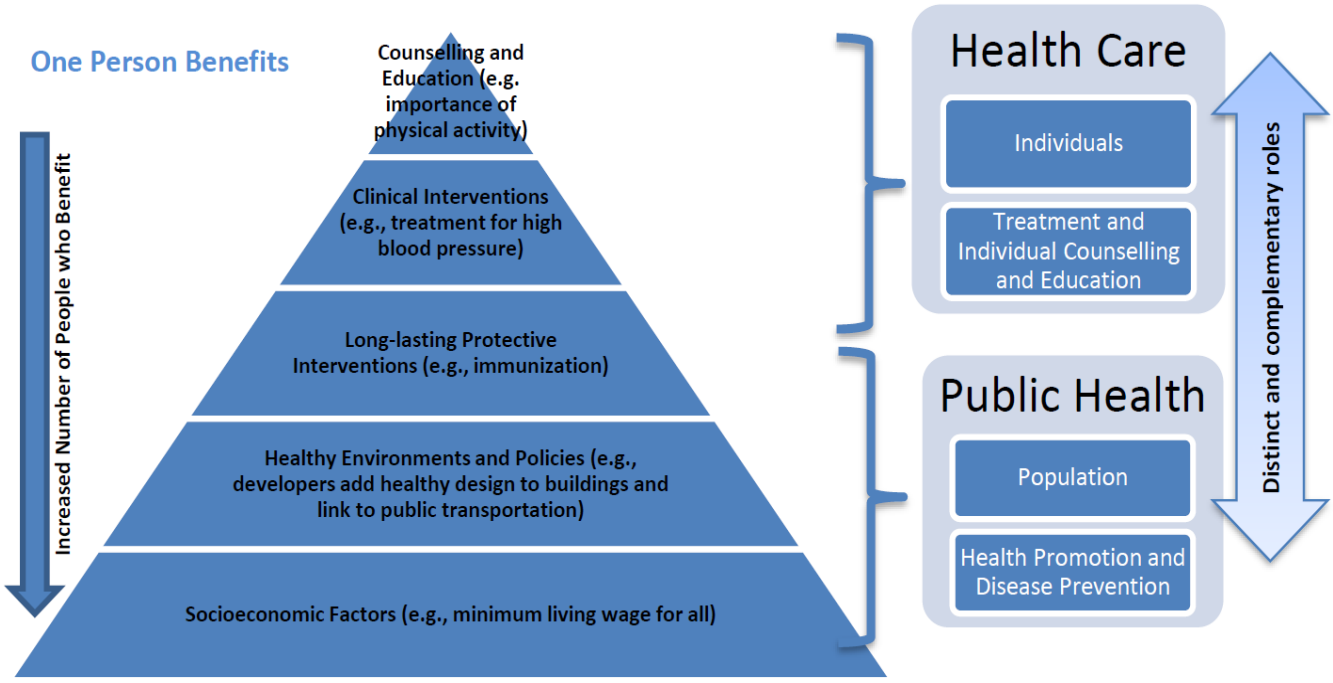


Figure 5 - How Public Health Complements Primary / Acute Care (Adapted from the Health Impact Pyramid)

A strong public health sector leads to multiple invisible benefits.

Some of public health's key successes, such as safe food and water or the control of communicable, vaccine-preventable diseases, have paradoxically reduced its perceived value among voters and decision-makers, making it vulnerable to budget cuts and weakened governance structures (9). The average lifespan of Canadians has increased by almost 25 years since 1920, with public health advances being among the main reasons for improvement (10).

Public health has a unique role in helping everyone have a fair chance to live a healthy life.

All Middlesex-London residents should have the opportunity to make healthy choices regardless of their income, education or ethnic background. It is known that the poorest people in Ontario are nearly twice as likely as the richest people to report multiple chronic conditions (11). This impacts municipalities through health service utilization, lower productivity, and other social costs.

Public health collaborates with municipalities and other stakeholders to decrease health inequities in their communities. Health inequities are differences in health that groups of people experience because of unfair and modifiable social advantage or disadvantage. Public health addresses health inequities through programs that benefit everyone and some that help those most in need. For instance, mothers who give birth in the Middlesex-London region are screened for a referral to the Healthy Babies, Healthy Children or Nurse Family Partnership home visiting program. Mothers at highest risk for poor infant and maternal outcomes (e.g., postpartum depression, lack of social or financial support) are prioritized for at home support from a Public Health Nurse and/or Family Visitor.

In addition, we offer free services to all residents of Middlesex-London in our dental, immunization, and sexual health clinics, regardless of health insurance (OHIP)-coverage or immigration status.

In sum, local public health has a unique mandate not fulfilled by any other organization at the local level. It keeps people healthy and out of overcrowded hospitals. It has multiple invisible benefits, including a great return on investment and it has a special role in helping everyone have a fair chance to live a healthy life.

2. *Keeping public health at the community level to best serve residents and lead strategic community partnerships*

Middlesex-London Health Unit is located in Southwestern Ontario. These are the traditional lands of the Attawandaran (Neutral) peoples who once settled this region alongside the Algonquin and Haudenosaunee peoples. The three First Nations communities with longstanding ties to this geographic area are Chippewa of the Thames First Nation (Anishinaabe), Oneida Nation of the Thames (Haudenosaunee); and Munsee-Delaware Nation (Leni-Lunaape) (12).

Middlesex-London covers 3,317 square kilometers; a relatively small land area compared to other health units with a relatively large population of 455,526 people in 2016. Nine out of 10 people in Middlesex-London live in urban areas, predominately London, and Strathroy (12).

What does this mean?

- A strong public health sector is responsive to local health priorities through collaborative engagement with local municipalities, schools, health care professionals, community organizations and residents.
- Middlesex-London has a unique set of health issues that require tailored community responses and coordination.
- Local perspectives add value to provincial priority-setting and decision-making.

Why is this important?

Unique public health issues in Middlesex-London.

There are many health issues to consider locally. The community health status resource details the health status of Middlesex-London and highlights several issues that demand attention (12):

1. The projected growth rate between 2016 and 2041 for Middlesex-London is 26.1% (with those aged 65 years and older doubling in this period). This translates to increased demand for public health services (e.g., immunizations, clinic visits, dental screening, and inspections).
2. In Middlesex-London, approximately 1 in 5 people are immigrants and over one in ten immigrants are recent immigrants (12.9%).
3. Injuries represent an area of substantial burden in the Middlesex-London, particularly in the rural population. Falls are the leading cause of injury-related deaths and visits to the emergency department and disproportionately those who are elderly.
4. Middlesex-London has multiple overlapping drug-related crises: opioid-related overdoses, invasive Group A Streptococcal (iGAS) disease, endocarditis, hepatitis C, HIV, and hepatitis A.
5. The proportion of women reporting a mental health concern during their pregnancy is significantly higher in Middlesex-London compared to Ontario and increased over time from 2013 to 2017.

“Moving the needle” on complex health issues like these requires keen local insight, solid knowledge of health behaviour and illness prevention, combined with strong local partnerships.

Engaged and empowered communities and stakeholders are essential for public health.

Public health emergencies, such as SARS and pandemic influenza H1N1, demonstrate that local investments are needed to ensure clear coordination among hospitals, health care providers, and government. Beyond emergencies, strong collaboration is essential to tackle complex health issues, such as substance use.

An example of the latter is MLHU's work on the Community Drug and Alcohol Strategy. This brought a collaborative focus to addressing the multiple and overlapping challenges gripping the community, including opioids, crystal meth, alcohol, and other substances. The partnership leading the development of this strategy included representatives from the health, education and social services sectors, as well as from law enforcement, the private sector, municipal government, and people with lived experience. Extensive community input was vital in helping to shape the Strategy. The Strategy consists of 23 recommendations with 98 associated actions and sets a long-term comprehensive plan to prevent and address local substance-related harms. Work to implement the recommendations is underway and will continue through 2019 and beyond (13).

In sum, engagement with municipal partners and community members improves the health outcomes of whole population groups, including those involved, and saves money. Public health governance is an opportunity to increase community involvement, reflect the diversity of residents, and maintain local priorities.

Additionally, research has shown that public health engagement and empowerment of local communities leads to better health outcomes:

- Higher performing public health units were found to have greater community interaction (14).
- Public health departments that prioritize the community's needs and who partner with the community will see differences in health outcomes (15).
- Partnerships not only with academia but also with hospitals, community organizations, social services, private businesses, and law enforcement are important (16).
- Engaging outside agencies in planning of program and service delivery is significantly related to public health performance (17).
- The longer that public health agencies have been engaging in partnerships, the better their performance metrics related to partnership development (18).

3. Ensuring public health funding and a strong workforce to fulfill its mandate

Public health is the responsibility of all levels of government. In Ontario, Provincial policy has typically cost-shared public health funding with municipalities being legally obligated to pay their cost-share as per the Health Protection and Promotion Act.

In addition to having the appropriate resources, all health units in Ontario should be fully staffed with enough people and the right mix of people and competencies. There must be strong and effective leadership at all levels.

What does this mean?

- Overall funding for local public health should be adequate to achieve the mandate and enable communities to thrive. Cost-sharing between the Province and municipalities should be achieved in a way that meets community needs and minimizes the burden on the local taxpayer.

- The new Regional Public Health Entities should have the capacity to identify the optimal number, mix and distribution of public health skills, and workers to meet local health needs.

Why is this important?

Imagine you are raising a child. If you feed, clothe, and give the child a roof over their head, they will live. But to thrive, the child also needs social interaction, love, interesting experiences, and so much more.

Public health is in the business of helping community health to thrive. If public health funding is not increased or protected, and if human resource capacity is compromised, there will be significant implications, such as:

- Challenges meeting current and future community health needs;
- Inability to detect and respond to future public health emergencies;
- Difficulties delivering mandated public health programs and services; and
- Needing to divert resources from some programs to others or stop completely.

Adequate funding is required to meet community health needs.

Provincial contributions to public health spending have fluctuated since the mid-1990s, as illustrated in Figure 6.

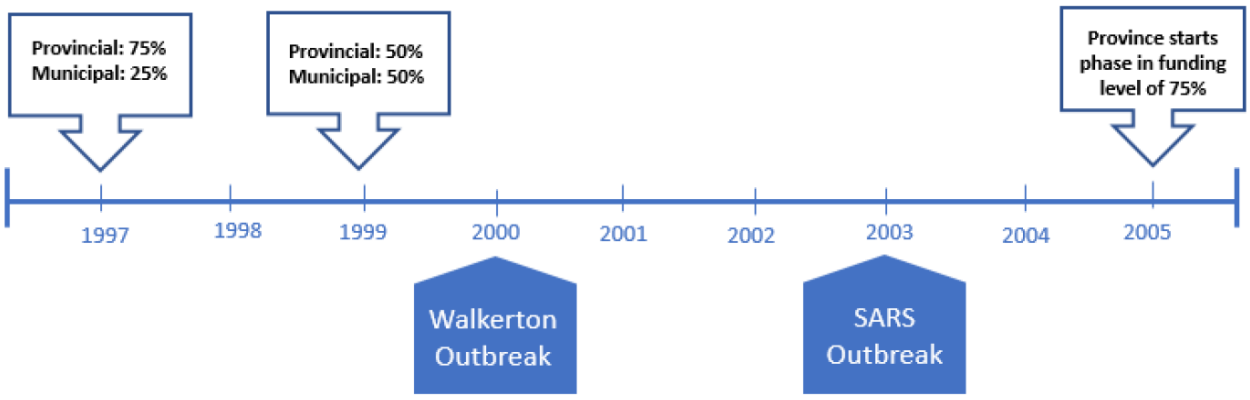


Figure 6 - Timeline of Provincial and Municipal Funding Share for Public Health Services in Ontario (19, 20)

The increase in provincial funding in 2005 was in response to the two public health emergencies – the outbreak in Walkerton in 2000 and the SARS epidemic in 2003. The purpose of the increased contribution was to enhance the capacity of the public health system, which had been weakened by reduced investment in public health in the years prior.

The Province intended to reach the 75/25 funding split within three years, but this did not occur. For example, in 2011, only 17 of the 36 health units had reached the 75/25 funding split for mandatory programs (21).

In 2015, the Ministry of Health and Long-Term Care Funding Review Working reviewed the funding formula and made recommendations. The recommended funding allocations for public health units were based on population and equity measures and identified MLHU as one of the lowest provincially funded public health units on a per capita basis. Middlesex-London benefited from a needs-adjusted funding model and saw an increase in mandatory program funding in 2016 and 2017.

The Middlesex-London Health Unit has already identified program efficiencies given historical provincial underfunding.

Since 2005, MLHU has been able to maintain municipal funding increases at 0%. This has been accomplished through responsible financial governance and stewardship and using a Program Budgeting Marginal Analysis (PBMA) process. Every health organization has limited resources and the need to make choices about how to allocate these resources. The PBMA process aims to align resources with the mandate and strategic priorities of the organization, improve decision-making transparency and rigor, and provide staff and public ownership of the decision-making process.

Over the past five budget cycles, MLHU has been able to find savings of $3.9 million and approve ongoing investments of $3 million and $1.6 one-time investments to maximize the impact our services have on the community. Examples of these investments include:

- Increased public health nursing capacity for outreach work with people who use injection drugs and who have HIV, Hepatitis C, or other blood-borne diseases to prevent the spread of these diseases and improve health outcomes. This program has essentially ended an HIV outbreak in people who inject drugs.

- The Nurse-Family Partnership home visiting program for young, low-income, and first-time mothers. This program helps teenage mothers meet their education and employment related objectives, and set their children up for success in life.
- An innovative needle-syringe recovery partnership program where a team sweeps high-risk urban areas to reduce waste related to discarded harm reduction equipment

Investment in public health saves money and improves health.

The public health sector receives a small portion (about two percent) of the provincial health care budget, yet it provides a high return on investment. Under proposed modernization plans, this already small portion of the provincial health care budget will be reduced even further over the next three years.

This is counterintuitive, given that public health programs offer such a high return on investment. For example, every dollar invested in public health programming saves eight dollars of avoided health and social care costs (1). The return on investment, illustrated in Figure 7, is even more favorable for interventions that changed public policies such as limiting tobacco marketing or using infrastructure to make active transportation easier (1).

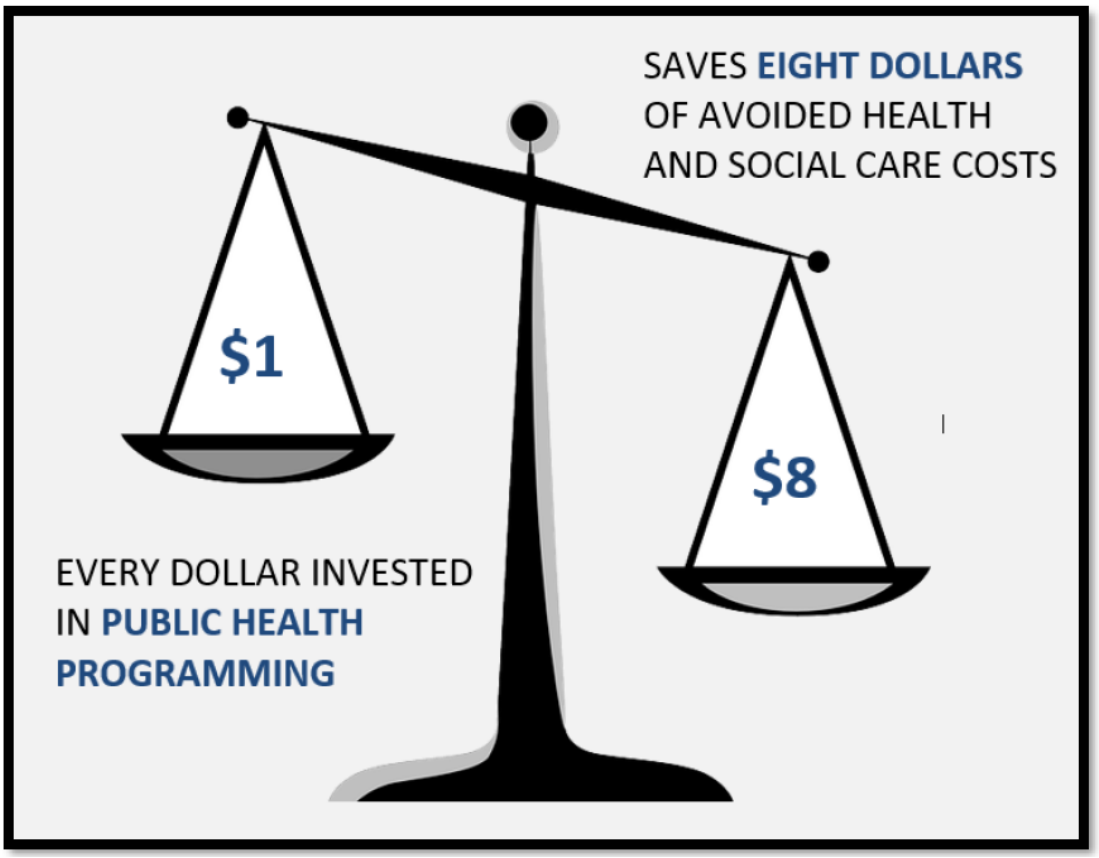


Figure 7 – Public Health Return on Investment

Some additional examples of the extent to which public health is a good return on investment include:

• $1 invested in immunizing children saves $14 in health and social costs (22).
• $1 invested in heart disease prevention pays back $11 in health and social benefits (23).
• $1 invested for improved walkability pays back $2 in health benefits (24).

Public health investments are a crucial way to improve the “social determinants of health” within a population. As seen in Figure 8 below, the most important factors in health or illness are socially determined, such as income, early childhood experiences, education, and housing. In contrast, only 25 percent of what influences our health is related to health care.

Despite this, nearly all funding goes to the health care system. In fact, only about two percent of health care funding goes to public health initiatives, even though these focus on improving the environment and social determinants of health.

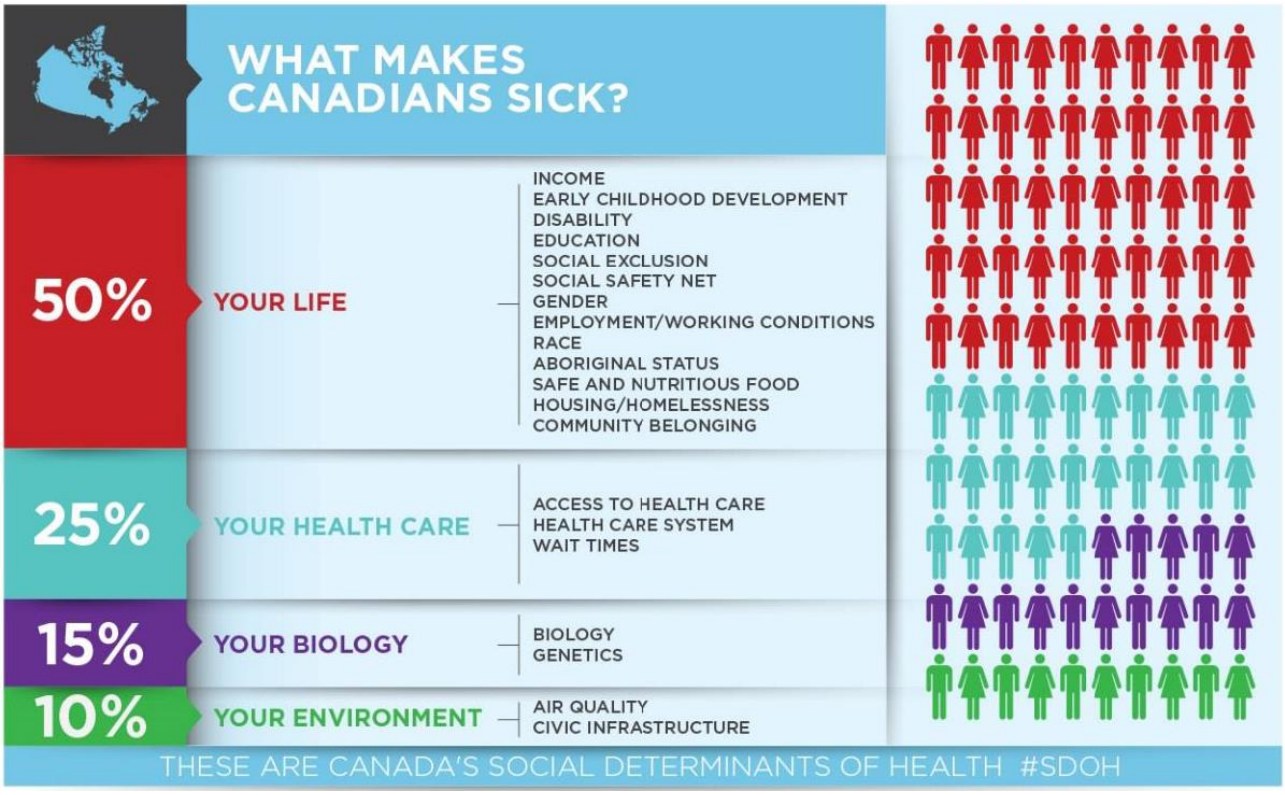


Figure 8 – What Makes Canadians Sick (25)

The new Regional Public Health Entities should have the capacity to identify the optimal number, mix and distribution of public health skills, and staff to meet local health needs.

One of the most important strengths of our public health system lies in its dedicated workforce. Public health expertise spans several health disciplines, including nutritionists, nurses, health promoters, inspectors, epidemiologists, and many more. The distribution of public health expertise, resources and services should be tailored to meet current and future local needs and priorities (26).

Reduced available funding would impact the critical mass of staff required to deliver quality programs and services and reduce our capacity to respond to public health emergencies or

periods of increased need. In addition, the application of cost-cutting initiatives that limit staffing (e.g., hiring freezes) compromise efforts to attract and keep qualified individuals in the public health workforce (27).

4. Governance structures that are transparent and locally accountable

Transparency and local accountability are essential for health units to maintain the trust of the public and to be able to respond effectively in the event of a public health emergency. Governance structures contribute significantly to the ability of a regional health entity's ability to act in this way.

What does this mean?

- As boards of health are regionalized, it is important that the role of the Medical Officer of Health and the Board of health, their autonomy, composition, and ability to promote healthy public policy be maintained.

Why is this important?

Weakening the roles of the Medical Officer of Health and Board of Health can compromise key parts of the public health sector and negatively impact the community.

- Public health and safety. The Medical Officer of Health and Board of Health must act quickly and effectively during public health crises. This includes the ability to rapidly deploy a skilled team of public health professionals to work with municipalities, health care, and others, and have the continuing legal authority to put the public's health first.

- Public trust. All residents have the right to know about the health of the community and what can be done to improve it. As the doctor for the community, the Medical Officer of Health should never be prevented from being honest and transparent about the community's health. Additionally, the Board of Health should have the ability to act on the independent advice provided by the Medical Officer of Health to ensure public health and safety.

The independence to allocate resources to local public health needs and engage in the promotion of healthy public policy ensures that community health needs are addressed.

Allocation and expenditure of resources are some of the most important predictors of health unit performance (16). Additionally, the presence of a local board of health with policymaking authority is associated with positive performance of essential public health standards (16, 28).

The strongest predictor of public health agency performance is the size of the population served (16, 28). Specifically, the larger the jurisdiction size, up to a maximum of 500,000 people, was found to be a positive predictor of performance (29).

The socioeconomic status of a community is a strong predictor of health status in a community (28, 30, 31). Addressing the social determinants of health in a community may be one of the most successful methods of elevating health status in the community.

Conclusion

Public health plays a distinct role in protecting the health of residents. Only public health focuses on upstream population-level approaches to prevent injuries and illnesses before they occur. Investments in public health should be viewed as a cost-effective way to improve the sustainability of our health care system by relieving the strain on primary and acute care.

Investments in public health have proven to generate high returns on investment. We know, for example, that for every dollar invested in public health, communities benefit from an $8 return on investment (1). Despite this, public health receives just about two percent of all provincial health care spending.

As the Ontario Government considers its approach to public health modernization, it is critical the core components of a strong public health system are maintained or strengthened. Positive public health outcomes require:

- Maintaining public health's unique upstream population health and disease prevention mandate;
- Keeping public health at the community level to best serve residents and lead strategic community partnerships;
- Ensuring public health has adequate funding and a strong workforce to fulfill its mandate; and
- Governance structures that are transparent and locally accountable.

Analyses of historical public health crises clearly show that, without these components in place, our communities are less protected and at higher risk for avoidable illness and death.

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From: Gordon Fleming
To: All Health Units
Subject: alPHa and Climate Change
Date: Wednesday, July 24, 2019 10:48:03 AM

FOR BROAD DISTRIBUTION
****

Dear alPHa members,

alPHa's Membership passed two resolutions related to climate change at the 2019 Annual General Meeting. Resolution A19-2, Affirming the Impact of Climate Change on Health was passed to formalize our agreement that climate change is the greatest global health threat of the 21st century and, as such, is the defining public health issue of our time. A19-1, Climate Change and Health in Ontario: Adaptation and Mitigation provides more specific guidance on the way forward for multi-disciplinary collaboration on robust climate change mitigation and adaptation strategies to minimize the effect of climate change on the health of Ontarians.

Tackling climate change as a public health issue will require a deep commitment to forming partnerships at all levels of government, collaborating with other partners within the health system, and engaging with our communities to develop specific, evidence-informed actions on climate change and health.

Following the communication of our 2019 Climate Change resolutions to the Province, alPHa created an online page of resources related to climate change and health that we believe will be useful to our members and partners as policy responses to climate change and health are formulated. This page will include all alPHa communications related to this public health issue, a selection of materials from partner organizations, and government responses. We would like to draw your attention to two entries in particular, as we received specific requests to share them with our members:

- Canadian Association of Physicians for the Environment (CAPE) – Climate Change Toolkit for Health Professionals and Call to Action on Climate Change
- Ontario Public Health Association (OPHA) – Health-focused Climate Communications Campaign

We invite you to visit the alPHa Climate Change and Health Resource page and encourage you send material related to local actions for inclusion in the library at the bottom of the page to gordon@alphaweb.org.

Gordon WD Fleming, BA, BASc, CPHI(C)
Manager, Public Health Issues

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www.niagararegion.ca

July 19, 2019

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

ALL BOARDS OF HEALTH

SENT ELECTRONICALLY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOW THEREFORE BE IT RESOLVED:

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

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

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

Yours truly,

Ann-Marie Norio
Regional Clerk
:KL

CLK-C 183-2019

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

Response to the Proposed Provincial Restructuring of Local Public Health Agencies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOW THEREFORE BE IT RESOLVED:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

From: Kolar, Loren
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health Correspondence- April 24, 2019 (Items 5.1 and 5.2))
Date: Friday, July 26, 2019 11:00:53 AM
Attachments: EDRMS-#638658-v1-05_1_Windsor_Essex_County_Health_Unit_-_Increase_Action_in_Response_to_the_Current_Opioid_Crisis.pdf
EDRMS-#638660-v1-05_2_City_of_Toronto_-_Expanding_Opioid_Substitution_Treatment_with_Managed_Opioid_Programs.pdf

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

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

The following correspondence item was received:

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

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

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

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

From: Kolar, Loren
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health endorsements - May 22, 2019 (Items 5.14 and 5.15)
Date: Friday, July 26, 2019 11:17:03 AM
Attachments: EDRMS-#640044-v1-5_14_To_be_endorsed_Sudbury_and_Districts_Public_Health_Support_for_Bill_S-228_Child_Health_Protection_Act.pdf
EDRMS-#640045-v1-5_15_To_be_endorsed_Simcoe_Muskoka_District_Health_Unit_Urgent_Provincial_Action_to_Address_Harms_from_Alcohol_Retail_Sales.pdf

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

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

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

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

Loren Kolar
Legislative Coordinator
City Clerk's Office
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Vision:
The Legislative Division is Dedicated to Excellence in the Provision of Service to the Community, Corporation & Council with Integrity, Accuracy and Transparency.

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

From: Kolar, Loren
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health endorsements - June 26, 2019 (Item 5.1)
Date: Friday, July 26, 2019 11:22:29 AM
Attachments: EDRMS-#642108-v1-05_1_Endorse_-_(2019-05-23)_Kingston_Frontenac_Lennox_Addington_Public_Health_-_Health_Promotion_as_Core_Function.pdf

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

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

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

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From: Kolar, Loren
To: Distribution to All Boards of Health & alPHa (allhealthunits@lists.alphaweb.org)
Subject: City of Hamilton - Board of Health endorsements - July 12 2019 (Item 5.5 - 5.7))
Date: Friday, July 26, 2019 11:59:54 AM
Attachments: EDRMS-#644570-v1-05_5_Endorse_-_(2019-06-07)_Sudbury_and_Districts_Public_Health_-_Public_Mental_Health_Parity_of_Esteem_Position_Statement.pdf
EDRMS-#644571-v1-05_6_Endorse_-_(2019-06-25)_Peterborough_Public_Health_-_Children_Count_Task_Force.pdf
EDRMS-#644572-v1-05_7_Endorse_-_(2019-05-22)_Windsor_Essex_County_Health_Unit_-_Smoke_Free_Multi_Unit_Dwellings.pdf

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

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

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

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

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

Copies of the original correspondence has been attached to this email

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KFL&A Public Health

August 6, 2019

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

Dear Minister Elliott:

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

Key Principles for Restructuring Local Public Health in Ontario:

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

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

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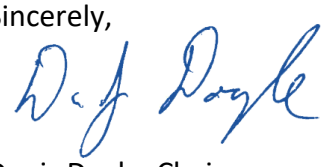
Decision-Making Criteria for Boundary Development:

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

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

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

Sincerely,



Denis Doyle, Chair
KFL&A Board of Health

KFL&A Public Health

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

From: Erin Meneray
To: AllHealthUnits@lists.alphaweb.org; Karen@alphaweb.org
Subject: Grey Bruce Health Unit BOH Motions of Support
Date: Tuesday, August 27, 2019 1:05:58 PM

Attention: Boards of Health:

On June 28, 2019 the Board of Health for the Grey Bruce Health Unit passed the following motions:
GBHU BOH Motion 2019-43, Smoke-Free Multi-Unit Dwelling
GBHU BOH Motion 2019-44, Protecting Children through Immunization

On July 26, 2019 the Board of Health for the Grey Bruce Health Unit passed the following motions:
GBHU BOH Motion 2019-56, Smoke/Vape Free Outdoor Space

Heather Smith on behalf of
Erin Meneray
Executive Assistant to the Medical Officer of Health and Board of Health
Grey Bruce Health Unit
101 17th Street East
Owen Sound ON N4K 0A5
Phone: 519-376-9420, Ext. 1241 **Fax:** 519-376-0605 **Email:** e.meneray@publichealthgreybruce.on.ca
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alPHa
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alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

Dear alPHa Members, September 11, 2019

Re: Update on Public Health Modernization

As summer is a time for many of us to step away from the demands of our professional lives, at least for a little while, September means "back to business", and I would like to welcome you all back from what I hope was a relaxing and enjoyable July and August.

Recognizing that the Government's Public Health Modernization initiative was likely not too far from anyone's mind over the past two months, I would like to take this opportunity to provide information on developments that have occurred since the update that was sent by alPHa's Executive Director, Loretta Ryan, on July 25th.

During the alPHa Conference, on June 11th, the Chief Medical Officer of Health, Dr. David Williams outlined a process that was to include a consultation during the month of July followed by Ministry analysis of the feedback in August. Although there were some preliminary discussions of proposals in the spring with members of the alPHa Executive (the confidential "Technical Tables" that were mentioned during his conference presentation), no further meetings have taken place and the consultation has not yet commenced.

Shortly after the July 25th member update, alPHa wrote a letter to Dr. Williams requesting further information, given that the timeframe he provided in June had passed. We have not yet received a written response to that letter, but additional details were provided by the Minister of Health at the 2019 Association of Municipalities of Ontario (AMO) Conference on August 19th, with Loretta Ryan (alPHa Executive Director), Paul Roumeliotis (COMOH Chair) and I in attendance.

Minister Elliott confirmed changes to the previously announced cost-sharing arrangement, which will now be 70/30 for almost all programs in all health units as of January 1, 2020, and then announced that a renewed consultation on the restructuring aspect, to be managed by a yet-to-be-named "special advisor", will begin soon with public health partners and municipalities. This is expected to begin with the release of a discussion paper and we will communicate the details and timelines as soon as possible.

Finally, I am pleased to confirm that Dr. Williams will be attending the next meeting of the alPHa Board of Directors, which takes place on September 27th and that both Dr. Williams and the Minister of Health are confirmed speakers at alPHa's November 6th Fall Symposium in Toronto. These will be further opportunities for direct dialogue with our provincial partners and we hope that the record attendance at our June Conference will be repeated as a further demonstration of the commitment of our membership to working with the Province while ensuring that the capacity and mandate of Ontario's public health system are maintained and, where possible, strengthened.

alPHa remains committed to working hard on behalf of its members to ensure the best possible outcome for Ontario's public health system once the promised consultations begin. Please see alPHa's dedicated web page that houses our communications and updates, statements from other stakeholders, local board resolutions and other related information. Please check this page often and note that further details about the information outlined above can be found there. (https://www.alphaweb.org/page/PHR_Responses).

We hope that you find this information useful and I look forward to continuing to work with all boards and to ensure effective communication with everyone over the coming months. If you have any questions or concerns, please contact Loretta Ryan, Executive Director, alPHa, at loretta@alphaweb.org or 647-325-9594.

Yours sincerely,

Carmen McGregor,
alPHa President

Public Health
Santé publique
SUDBURY & DISTRICTS

North East Public Health Transformation Initiative (Motion #24-19)

Moved by Signoretti – Thain. Approved by Board of Health for Public Health Sudbury & Districts, June 20, 2019.

WHEREAS since November 2017, the boards of health in Northeastern Ontario, namely the Boards for Algoma Public Health, Public Health Sudbury & Districts, Porcupine Health Unit, North Bay Parry Sound District Health Unit, and Timiskaming Health Unit, have proactively and strategically engaged in the Northeast Public Health Collaboration Project to identify opportunities for collaboration and potential shared services; and

WHEREAS the Northeast Public Health Collaboration Project work to date has been supported by two one-time funding grants from the Ministry of Health (MOH); and

WHEREAS subsequent to the proposed transformation of public health announced in the April 11, 2019, provincial budget, the work of the Collaboration has been accelerated and reoriented as the Northeast Public Health Transformation Initiative with the vision of a healthy northeastern Ontario enabled by a coordinated, efficient, effective, and collaborative public health entity; and

WHEREAS the Board understands there will be opportunities for consultation with the MOH on the regional implementation of public health transformation;

THEREFORE be it resolved that the Board of Health for Public Health Sudbury & Districts is committed to the continued collaboration of the boards of health in Northeastern Ontario and looks forward to ongoing MOH support for this work;

AND FURTHER that the Board, having engaged in this work since 2017, anticipates sharing with the MOH its experiences so that other regions may benefit and further anticipates providing to the Ministry its expert advice on public health functions and structures for the North East;

AND FURTHER that this motion be shared with the Premier of Ontario, Minister of Health, Chief Medical Officer of Health, the Association of Local Public Health Agency, Ontario Boards of Health, AMO, FONOM, and constituent municipalities.

CARRIED

This item was last modified on August 19, 2019

Sudbury	Chapleau	Sudbury East	Espanola	Manitoulin Island
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Ghazawi et al. present a study of AML incidence and mortality trends in Canada between 1992 and 2010, revealing what they describe as "clusters" of AML in Sarnia, Sault Ste. Marie, Thunder Bay, St. Catharines, and Hamilton - cities in Ontario that are located near industrial activity.[1] We recognize that this type of study is subject to several limitations that were appropriately highlighted by Samet & Cockburn in their editorial response to the paper.[2] As a correlative study to guide further investigation, the study may have had value except that the authors failed to conduct age standardization of incidence rates. Crude rates of cancer incidence cannot be used for comparison, when as the authors have stated themselves, "age alone is also an important risk factor for developing AML" (p.1896).[1] As an example, 16.7% of Ontario residents are over 65 years of age, while in St. Catharines, 21.7% of the population is over 65. This represents a 30% more people over 65 compared to the Ontario average, so we would expect that diseases correlated with age would be more common in St. Catharines than the rest of Ontario.[3] "Age distribution analysis"[1], as described by the authors, is not a recognized or sufficient method to enable statistical comparison between populations. Age standardization, however, is a well-recognized method of accounting for differences in the age distribution of different populations.[4,5]

First, we are concerned that the authors have missed this critical step, which means the incidence rates cannot be compared between different geographic areas, and therefore the analysis should either be retracted or resubmitted. Second, we are surprised that this rudimentary omission was not flagged by reviewers of the paper. Finally, we reiterate the importance of engaging local public health professionals and communities when conducting such analyses, to understand the local geography and context and to ensure that the work meets the needs of affected communities. However, studies which describe conditions that are already of concern in our populations must be conducted with methodological rigour if they are to yield meaningful information for further investigation.

In Sarnia and Lambton County, we have previously been adversely impacted by research that drew attention to a possible health issue, but whose lack of scientific rigour prevented us from drawing any meaningful conclusions.[6,7] As public health practitioners, we welcome interest and study into the quality of life and burden of disease in our communities. However, studies such as this one over-reach in their conclusions and have significant consequences for our communities by generating fear at the expense of knowledge.

Sudit Ranade MD MPH MBA CCFP FRCPC
Medical Officer of Health, County of Lambton

Crystal Palleschi, MSc.
Epidemiologist, County of Lambton

M. Mustafa Hirji
Medical Officer of Health & Commissioner (Acting), Niagara Region Public Health & Emergency Services
Assistant Professor (Part Time); Department of Health Research Methods, Evidence, and Impact;
McMaster University

Marlene Spruyt BSc, MD, CCFP, FCFP, MSc.

Medical Officer of Health/CEO
Algoma Public Health

Elaina MacIntyre, PhD
Dalla Lana School of Public Health, University of Toronto

References

1. Ghazawi FM, Le M, Cyr J, et al. Analysis of acute myeloid leukemia incidence and geographic distribution in Canada from 1992 to 2010 reveals disease clusters in Sarnia and other industrial US border cities in Ontario. *Cancer* 2019; 125: 1886-1897. doi:10.1002/cncr.32034.
2. Samet JM, Cockburn M. What can be learned from mapping the occurrence of acute myeloid leukemia?. *Cancer* 2019; 125: 1771-1773. doi:10.1002/cncr.32031.
3. Statistics Canada. St. Catharines [Federal electoral district], Ontario and Ontario [Province] (table). Census Profile. 2016 Census. Statistics Canada Catalogue no. 98-316-X2016001. Ottawa. Released November 29, 2017. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E. Accessed May 30, 2019.
4. Statistics Canada. Age-standardized rates. https://www.statcan.gc.ca/eng/dai/btd/asr. Accessed May 31, 2019.
5. Centers for Disease Control and Prevention. United States Cancer Statistics - Incidence and Death Rates. https://www.cdc.gov/cancer/uscs/technical_notes/stat_methods/rates.htm. Accessed May 31, 2019.
6. Fung KY, Luginaah IN, Gorey KM. Impact of air pollution on hospital admissions in Southwestern Ontario, Canada: generating hypotheses in sentinel high-exposure places. Environmental Health: A Global Access Science Source (2007); 6, 18. https://doi.org/10.1186/1476-069X-6-18.
7. Mackenzie CA, Lockridge A, Keith M. Declining Sex Ratio in a First Nation Community. Environmental Health Perspectives 2005; 113(10): 1295–1298. https://doi.org/10.1289/ehp.8479.

SAVE THE DATE!

alPHa
Association of Local PUBLIC HEALTH Agencies

Fall 2019 Symposium

Wednesday, November 6
Dalla Lana School of Public Health
Health Sciences Building, 6th Floor
University of Toronto
155 College Street, Toronto
(main intersection: University & College)

- Plenary: 8:30 AM – 4:30 PM
  (lunch on your own)
- Reception & Guest Lecture: 5 – 7 PM

Section Meetings

Thursday, November 7
Chestnut Conference Centre
3rd Floor
89 Chestnut Street, Toronto
(main intersection: University & Dundas)

- 8:30 AM – 12 Noon
- Separate meetings for board of health members and COMOH members

Fall 2019 Symposium: November 6
Section Meetings: November 7

IMPORTANT NOTES:

- The November 6 Symposium and November 7 Section meetings will be held at *different* locations (see above).
- Attendees are advised to start booking their guest accommodations. Nearby hotels include the Chelsea Hotel, DoubleTree by Hilton Hotel, and Courtyard by Marriott Toronto Downtown. Guestroom blocks have *not* been arranged with these hotels; reservations at these and other lodgings must be made individually by conference attendees.