# ALGOMA PUBLIC HEALTH

## BOARD OF HEALTH MEETING

## JANUARY 27, 2016

5:00 PM

SAULT STE MARIE ROOM, 1ST FLOOR, APH SSM

294 WILLOW AVE, SAULT STE MARIE, ON

www.algomapublichealth.com

# January 27, 2016 - Board of Health Meeting

## Algoma Public Health

1. **Call to Order**
    a. Declaration of Conflict of Interest
2. **Election of Officers**
    a. Appointment of Chair of the Board
    b. Appointment of Vice-Chair of the Board
    c. Appointment to Finance and Audit Committee
    d. Appointment to Governance Standing Committee
3. **Adoption of Agenda**
    a. January 27, 2016 - Agenda — Page 6
4. **Adoption of Minutes**
    a. November 25, 2015 — Page 11
    b. December 23, 2015 — Page 17
5. **Delegation/Presentations**
    a. Elliot Lake Office ELNOS Renovation Presentation — Page 18
6. **Business Arising**
    *No business arising from previous meeting.*
7. **Reports to Board**
    a. Acting Medical Officer of Health and Acting Chief Executive Officer Report
        i. MOH/CEO Report for January 2016 — Page 23
        ii. Healthy Kids Community Challenge Ball Hockey Poster — Page 32
    b. Finance and Audit Committee Report
        i. Chair's Report for January 2016 — Page 33
        ii. Financial Statements for the Period Ending November 30, 2015 — Page 34
        iii. Terms of Reference - Finance Audit Committee - Draft Changes — Page 41

# ALGOMA PUBLIC HEALTH
# BOARD OF HEALTH MEETING
# JANUARY 27, 2016 @ 5:00 pm
# SAULT STE MARIE ROOM A&B, 1ST FLOOR, APH SSM
# A*G*E*N*D*A

**1.0 Meeting Called to Order** — Christina Luukkonen, Secretary to the Board

**a. Declaration of Conflict of Interest**

**2.0 Election of Officers**

**a. Appointment of Chair of the Board** — Christina Luukkonen, Secretary to the Board

***Resolution***
*THAT the Algoma Public Health Board of Health appoints _____as Chair for the year 2016.*

**b. Appointment of Vice-Chair of the Board** — Chair

***Resolution***
*THAT the Algoma Public Health Board of Health appoints _____as Vice-Chair for the year 2016.*

**c. Appointment to Finance and Audit Committee** — Chair

***Resolution***
*THAT the Algoma Public Health Board of Health appoints the following individuals to the Board Finance and Audit Committee for the year 2016:*

_____

**d. Appointment to Governance Standing Committee** — Chair

***Resolution***
*THAT the Algoma Public Health Board of Health appoints the following individuals to the Board Governance Standing Committee for the year 2016:_____*

**3.0 Adoption of Agenda Items** — Chair

***Resolution***
*THAT the agenda items dated January 27, 2016 be adopted as circulated; and*

*THAT the Board accepts the items on the addendum.*

**4.0 Adoption of Minutes of Previous Meeting** — Chair

***Resolution***
*THAT the minutes of the meeting dated November 25, 2015 and December 23, 2015 be adopted as circulated.*

**5.0 Delegations/Presentations.**

**a. Elliot Lake Office ELNOS Renovation** — Chris Spooney, East Algoma Program Manager

**6.0 Business Arising from Minutes** — Chair

No business arising from previous minutes.

**7.0 Reports to the Board**

**a. Acting Medical Officer of Health and Acting Chief Executive Officer Report** — Tony Hanlon, Chief Executive Officer

***Resolution***

*THAT the report of the Acting Medical Officer of Health and CEO for the month of be adopted as presented.*

**b. Finance and Audit Committee Report** — Ian Frazier, Committee Chair

i. Chair's Report for January 2016
ii. Financial Statements for the Period Ending November 30, 2015
iii. Terms of Reference - Finance and Audit Committee – Draft
iv. November 12, 2015 – Approved Minutes

***Resolution***

*THAT the Finance and Audit report for the month of January 2016 be adopted as presented; and*

*THAT the Financial Statements for the Period Ending November 30, 2015 be approved as presented; and*

*THAT the proposed changes to the Terms of Reference for the Finance and Audit Committee be approved as presented.*

**c. Governance Standing Committee Report** — Ian Frazier Committee Chair

i. Chair's Report for January 2016
ii. Policy 02-05-020 Board of Health Travel Policy
iii. November 12, 2015 – Approved Minutes

***Resolution***

*THAT the Governance Standing Committee report for the month of January 2016 be adopted as presented; and*

*THAT the proposed changes to policy 02-05-020 be approved as presented.*

**8.0 New Business/General Business** — Dr. Tony Hanlon, Chief Executive Officer

**a. Ministry of Health and Long-Term Care Discussion Paper – Patients First**

i. Briefing Note and Resolution — Dr. Penny Sutcliffe Acting MOH
ii. Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario
iii. Letter to the Board of Health for Algoma Public Health from MOHLTC

***Resolution***

*THAT the Algoma Public Health Board of Health receive the briefing note concerning, Patients First: A Proposal to*

*Strengthen Patient-Centred Health Care in Ontario; and*

*THAT the Board of Health direct the Acting Medical Officer of Health to engage with the Association of Local Public Health Agencies (alPHa) in the development of key positions, consistent with the key considerations of this briefing note, for communication with the Ministry of Health and Long-Term Care; and*

*THAT the Board of Health seek engagement with constituent municipalities and with the Federation of Northern Ontario Municipalities (FNOM) to determine any municipal concerns about the proposed changes in governance and funding; and*

*FURTHER THAT the Board of Health seek engagement with the North East LHIN to discuss matters arising from the discussion paper.*

b. Mental Health Operating Budget Submissions — Justin Pino, Chief Financial Officer
   i. 2016/2017 Mental Health & Addictions Housing Program Budget
   ii. 2016/2017 Transformation Supportive Housing Program Budget

***Resolution***

*THAT the Board of Health approves the 2016/2017 Mental Health & Addictions Housing Program Budget and the 2016/2017 Transformation Supportive Housing Program Budget as presented.*

**9.0 Correspondence Items** — Chair

**a. Amendments to the OPHS and Related Protocols**

i. Letter from the MOHLTC to APH Board Chair dated January 5, 2016

**b. Basic Income Guarantee**

i. Letter to Ministers from Leeds, Grenville and Lanark District Health Unit dated December 21, 2015

**c. Cannabis Regulation and Control**

i. Letter to Prime Minister Trudeau from Sudbury and District Health Unit dated December 1, 2015

**d. First Nations Evacuations**

i. Letter from Premier Wynne to Algoma Public Health Board dated November 23, 2015

**e. Food Security**

i. Letter to Minister Jaczek from Huron County Health Unit dated January 7, 2016

**f. Healthy Babies Health Children Funding Support**

i. Letter from Thunder Bay District Health Unit to Minister MacCharles dated November 20, 2015

**g. Public Health Funding**

i. Letter from Elgin St. Thomas Public Health to Minister Hoskins dated January 5, 2016
ii. Letter from Haliburton, Kawartha, Pine Ridge District Health Unit to Minister Hoskins dated November 19, 2015
iii. Letter from Sudbury and District Health Unit to Minister Hoskins dated December 1, 2015

**h. Reducing Smoking Rates by 5% in 5 Years in the District of Algoma**

i. Letter of Support from Blind River dated November 12, 2015
ii. Letter of Support from Bruce Mines dated November 3, 2015
iii. Letter of Support from Dubreuilville dated November 4, 2015
iv. Letter of Support from Elliot Lake dated October 27, 2015
v. Resolution of Support from Hilton Township dated December 3, 2015
vi. Letter of Support from Huron Shores dated November 4, 2015
vii. Letter of Support from MacDonald, Meredith & Aberdeen dated November 23, 2015
viii. Letter of Support from Spanish dated November 4, 2015
ix. Letter of Support from Sault Ste. Marie dated January 13, 2016
x. Letter of Support from Tarbutt & Tarbutt Additional dated November 9, 2015
xi. Letter of Support from Thessalon dated November 24, 2015
xii. Letter of Support from Township of Johnson dated October 30, 2015
xiii. Letter of Support from Township of Plummer Additional dated October 30, 2015
xiv. Letter of Support from Township of St. Joseph dated October 30, 2015
xv. Resolution in Support from White River dated November 12, 2015

**i. Smoke-Free Multi-Unit Housing**

i. Letter from Sudbury and District Health Unit to Smoke-Free Housing Ontario dated December 1, 2015
ii. Letter from North Bay Parry Sound Health Unit to Smoke-Free Housing Ontario dated January 20, 2016

**10.0 Items for Information** Chair

**a.** Save the Date: alPHa Conference and BoH Section Meeting February 24-25, 2016

**11.0 Addendum**

**12.0 That The Board Go Into Committee** Chair

***Resolution***

*THAT the Board of Health goes into committee.*

**Agenda Items:**

a. Adoption of previous in-committee minutes dated November 25, 2015 and December 23, 2015.
b. Litigation or Potential Litigation
c. Personal Matter about an identifiable individual

**13.0 That The Board Go Into Open Meeting** Chair

***Resolution***

*THAT the Board of Health goes into open meeting*

**14.0 Resolution Resulting From In-Committee Session** Chair

**15.0 Announcements:** Chair

Next Board Meeting:
February 24, 2016
Sault Ste. Marie Room A&B, 1st Floor,
Algoma Public Health, Sault Ste. Marie

**16.0 That The Meeting Adjourn** Chair

***Resolution***

*THAT the Board of Health meeting adjourns*

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# Elliot Lake ELNOS Building Renovation

31 Nova Scotia Walk, Elliot Lake, ON P5A 1Y9

## Successful bid / completion schedule

- October 28, 2015 the board passed a motion to award the renovation contract to W.M. Morgan Contracting.
- Renovation began on Friday November 6, 2015.
- Renovation was estimated to be a 16 week project.

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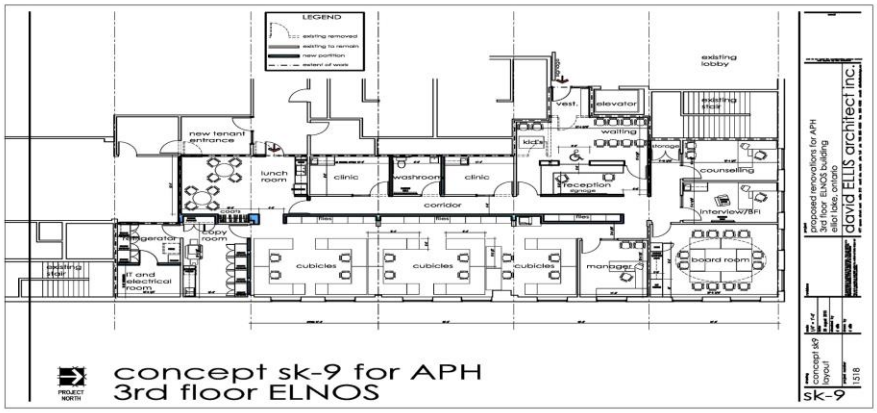
## Architect Design

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## Site inspections & completion dates

- In order to ensure the project is completed on time. Site inspections were conducted every two weeks commencing on November 12, 2015 until project completion.
- These meetings included (contractor, engineer, aph chief finance officer, district program manager, and multiple partners).

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## Photographed timeline of completed work to date

November 12, 2015

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## November 26, 2015

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## December 10, 2015

## January 8, 2016

## Tentative Target Opening Date
## March 7, 2016


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Questions???

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**MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER**
**BOARD REPORT**
**January 2016**

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


*On November 9th, 2016 the North Channel Family Poverty event was held at Central Algoma Secondary School (CASS). Families and guest speakers gathered together to engage in a conversation about poverty and potential strategies to address change. Student volunteers and their 'Foods' teacher helped prepare and serve a low budget dinner including spaghetti, a simple salad and bread to reflect what eating healthy looks like on a budget.*

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## *INTRODUCTION*

On behalf of APH L. Zeppa and T.Hanlon attended the Healthy Kids Community Challenge presentation to City Council that was made by Daneen Denomme, APH Project Manager for the Healthy Kids Challenge. The Council passed a resolution in support of the program. We are a lead partner with the City of Sault Ste. Marie. The City is championing this program and members of the Algoma Leadership Table (several agencies across the city and Algoma including the Boards of Education and Police are participating in this initiative. The "kick off" event is a ball hockey tournament for children in the Essar Centre parking lot in later January. Members of the Soo Greyhounds will participate. Please see poster in your board package.

We expect the new Elliot Lake Office renovations to be completed by the end of January and anticipate moving staff to the new location in the ELNOS building by the end of February/early March.

APH is also part of a Health Links initiative partnering with several health and social service organizations, The Group Health Centre is the lead partner and funding is provided by the N.E. LHIN and MOHLTC. The purpose is to improve health outcomes and patient experience for medically complex patients, while also reducing system costs and to develop a sustainable, ongoing process for the identification of 'new' high needs patients and the development of care plans for them.

Dr. Sutcliffe has been supporting the Board for Algoma Public Health to transition to a new model for MOH coverage. The Board is working diligently to recruit and it is expected that they will have a new model in place within the first quarter of this year. Dr. Sutcliffe has been providing Acting MOH coverage to the Algoma Public Health since January 2015.

## PROGRAM HIGHLIGHTS

### *CHILD HEALTH*

**Topic:** Baby Friendly Initiative

**This report addresses** the following requirements of the Ontario Public Standards (2014) or program guidelines/deliverables: Ministry of Health and Long Term Care-Health Promotion Division-Baby Friendly Initiative Accountability Indicator

**This report addresses** the following strategic directions:

- Improve Health Equity
- Collaborate Effectively

On February 24th to 26th, 2016, Algoma Public Health will undergo an external assessment for Baby- Friendly Initiative (BFI) re-designation. Three assessors and one assessor in training from the Breastfeeding Committee of Canada will be at APH to ensure that we have met the outcome criteria of the *Integrated 10 Step Practice Outcome Indicators for Hospitals and Community Health Services*.

The Baby-Friendly Initiative (BFI) is a global campaign of the World Health Organization and United Nations Children's Fund that was initiated in 1991. BFI helps to improve breastfeeding outcomes for mothers and babies by improving the quality of their care. The term Baby-Friendly was selected because it points to the importance of an agency being inclusive of all babies regardless of how they are fed.

The Baby-Friendly Initiative is a Public Health Funding and Accountability Agreement Indicator. Every health unit must be designated and ensure that re-designation is completed every five years. APH received official BFI designation through the Breastfeeding Committee for Canada in January 2010.

Since designation in 2010, APH has since implemented breastfeeding policies and practices outlined in the *Integrated 10 Step Practice Outcome Indicators for Hospitals and Community Health Service*. APH staff within the family health program are trained to educate and support families to initiate and maintain breastfeeding.

Breastfeeding is important because it:

- Improves the health of infants and children by reducing the risk of asthma, SIDS, certain childhood cancers, bacterial meningitis
- Assists with chronic disease prevention (i.e. cancer, type 2 diabetes, osteoporosis, obesity)
- Helps families save money
- Helps with food security

Mothers are welcome to breastfeed anywhere they choose within our agency. If they request a private place to feed in the Sault Ste. Marie office the Baby-Friendly room is located in the lobby by the clinic rooms labeled accordingly. The district offices may provide a private room if requested. For breastfeeding assistance clients are referred to the Parent Child Information Line, the Parent Child Information Center or individual Lactation Consultant appointments.

We look forward to a successful re-designation.

## *COMMUNITY ALCOHOL DRUG ASSESSMENT PROGRAM*

**Topic:** Accessible Addiction Services

**This report addresses** the following requirements of the Ontario Public Standards (2014) or program guidelines/deliverables: Community Alcohol/Drug Assessment Program. Ontario Healthcare Reporting Standards (OHRS V9.0) Functional Center – MSAA Service Plan: Partnerships/Integration Opportunities

**This report addresses** the following strategic directions:

- Improve Health Equity
- Collaborate Effectively

Providing Addiction Services at the right place and the right time to reduce barriers for individuals accessing services.

Community Alcohol/Drug Assessment Programs (CADAP) delivers a number of programs to assist individuals with alcohol and substance misuse issues with most of these programs are delivered onsite at Willow Ave. CADAP and the Sault Ste. Marie Addiction and Mental Health system table has identified that the current state of service waitlists, no show rates and agency structures are an ongoing barriers for clients accessing services at the right place and the right time. In considering an improved client centered system, CADAP is participating in two new initiatives that provide services at the right place and the right time.

CADAP is offering a new type of walk in service in two locations. These services propose to:

- reduce waitlists for traditional longer term services
- enhance ease of access and improve client satisfaction
- offer services to be available when client motivation is high
- reduce visits to SAH onsite and mobile crisis
- improve pathways to care and access for new clients
- increase and provide ongoing capacity building of clinicians and community
- enhance services to individuals who may best be served in an outreach capacity and with a walk in service that is available at their time of readiness
- provide an enhanced level of service to priority populations

To add to our already existing service offered at the John Howard Society (JHS) (note: the needle exchange program is delivered at JHS), CADAP is offering assessment and counselling service one half day a week at this site. Many of our assessment and counselling referrals come from JHS. The response has been successful with an average of 3 individuals accessing this service per week. Once we have reviewed the results and determine need, this service may be expanded to other days of the week. Since September, CADAP has seen 20 individuals over 48 sessions.

CADAP, Algoma Family Services and Canadian Mental Health Association have partnered together to make mental health and addiction services more accessible by offering a walk in counselling service to children, youth, families, adults and couples. This Walk in Counselling Service is a culturally competent, single session model that focuses on brief narrative therapy and cognitive behavioural modalities to help clients effect the change they are seeking. This initiative and partnership is unique in that it is the first time agencies have partnered to provide a new service. The core team of trained counsellors, mental health workers and

supervisors have unique specialization in adult mental health, child and family counselling and addictions counselling. This partnership has also created an opportunity to share resources and provide opportunity for cross training for the counsellors. Since the opening of the walk in service in November 2015, 62 individuals have received counselling with close to 50% completing the session without a referral for additional services.

## *FAMILY HEALTH*

**Topic:** Infant Child Development Program

**This report addresses** the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/Deliverables: Family Health programs under Child Health: Infant Child Development Program (ICDP) requirements 5-9 and 11.

**This report addresses** the following Strategic Directions:

- Improve Health Equity
- Collaborate Effectively

The Infant Child Development Program (ICDP) funded under Ministry of Child and Youth Services is a voluntary program for families within Algoma Public Health District and is offered to parents with infants and young children (birth to six years of age) and who meet any the following criteria:

- difficulty during pregnancy, labour or delivery
- significant prematurity or underweight
- neonatal illness
- congenital handicaps
- developmental delays

Our referrals come from a variety of sources including other APH programs, Health Care Providers, Schools and parents and include children with Autism Spectrum Disorder, Neonatal Abstinence Syndrome, to children with behaviour concerns such as aggression, social delays, and communication delays.

The ICDP program focuses on a family centered approach where the Parent Child Advisor (PCA) works collaboratively with families dealing with family concerns which include but are not limited to the child's development, teaching parent skills, providing parents with information on such things as child development, what services are available in their community, how to advocate and stress management techniques. The PCA visits the family's home on a regular basis and an individual plan of intervention is developed based on results of assessments and family needs.

Currently the APH staffing component breakdown to manage this program district wide includes:

- 3.75 FTE in SSM
- 1 FTE in Blind River/Elliot Lake
- 0.25 FTE in Wawa

The fiscal year statistics for last year April 1, 2014 to March 31, 2015 highlight the number of clients we were able to assist and include:

- Clients receiving services throughout the year-923 children
- Clients discharged-218
- New referrals-326 children

Of these 923 children the majority 663-children were 0-3 years old and the remaining 260-were 4-6 years old meeting our mandated age requirements.

The ICDP program also saw 68 children in their clinic which runs every Wednesday from 1:00 to 4:00

## *INJURY PREVENTION*

**Topic:** Stay on Your Feet Falls Prevention Strategy

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

- **Injury Prevention Requirement #2:** The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs, and the creation or enhancement of safe and supportive environments that address falls across the lifespan.
- **Requirement #3:** The board of health shall use a comprehensive health promotion approach to increase the capacity of priority populations to prevent injury by collaborating with partners, promoting access to resources, providing skill building opportunities and sharing best practices.
- **Requirement *#4:*** The board of health shall increase public awareness of falls prevention.

**This report addresses** the following Strategic Directions:

- Improve Health Equity
- Collaborate Effectively

Stay On Your Feet (SOYF) is a multi-faceted, collaborative falls prevention strategy between NELHIN and five Public Health Units in North Eastern Ontario. The goal is to improve the quality of life for older adults (65+) by reducing the rate and severity of falls in this age group. Falls are the most common cause of hospitalization for seniors and the leading cause of preventable injury that results in avoidable emergency department visits.

To reduce the rate and severity of falls, the SOYF Strategy contains multiple approaches including the implementation of *Stand Up!* a best practice Falls Prevention Program for Seniors 65+. *Stand Up!* is a 12 week program that consists of group exercises, home exercise and education and awareness sessions about falls prevention. On October 22nd, 2015 Algoma Public Health hosted its second *Stand Up!* facilitator training workshop. In this session, fifteen health care service providers, fitness instructors and other professionals were trained to deliver *Stand Up!* To date, 12 *Stand Up!* programs have been offered throughout Algoma. The North Shore Tribal will be delivering *Stand Up!* programs in their First Nations communities of Thessalon, Garden River and Batchewana. Sessions are also scheduled for Blind River, Wawa, Elliot Lake, Dubreuilville, St. Joseph's Island and locations throughout Sault Ste. Marie.
On November 17, 2015, a SOYF multi media campaign was launched in order to increase awareness of fall prevention. This campaign includes a commercial which airs on CTV from Nov 2015-Feb 2016, as well as posters and distribution of print resources to the community.

The Canadian Falls Prevention Curriculum was delivered via OTN in partnership with Ontario Injury Prevention Resource Centre (OIPRC), NEHLHIN and the five public health units. A CFPC trained facilitator from each of the health units presented a curriculum lesson. Fifteen health care providers in Algoma have been trained.

The recently developed Staying Independent Fall Risk Assessment Tool is now available and is being distributed to health care providers in the Algoma District.

A new and unique Intergenerational Strategy called "Safety Super Hero" which involves interactive theatre based on a children's book related to fall prevention is being launched on March 17th at the Sault Ste. Marie Seniors Drop In Centre. This strategy engages children ages 4-8 to help grandparents identify hazards and prevent falls. Further theatre performances by the Sault Rising Stars older adult acting troupe focusing on falls prevention are being planned for 2016.

Algoma Public Health injury prevention program will continue to collaborate with NELHIN, community and regional partners, and community seniors to roll out the comprehensive SOYF strategy in 2016.

## RISK MANAGEMENT

### *INFECTIOUS DISEASES*

**Topic:** Influenza

**This report addresses:** Foundational Standard Req #7: The board of health shall interpret and use surveillance data to communicate information on risks to relevant audiences in accordance with the Infectious Diseases Protocol, 2008 (or as current); the Population Health Assessment and Surveillance Protocol, 2008 (or as current); the Public Health Emergency Preparedness Protocol, 2008

**This report addresses** the following Strategic Direction: Collaborate Effectively

| | |
|---|---|
| **Risk** | Influenza immunization is one of the key ways to prevent a serious infectious disease in immunocompromised populations. Having a high coverage rate in both staff and patient/resident groups is an important block to outbreak incidence in these institutions. |
| **Recommendations** | Each year, APH acknowledges healthcare institutions who lead the way in influenza immunization coverage in their staff who work for those in high risk locations such as hospitals and long term care homes and who cannot easily fight off this virus. |
| **Key Points** | This influenza season the following institutions will be recognized by APH for the following accomplishments for influenza vaccinations:<br>1. Highest Long-Term Care - St. Joseph's Manor (93%)<br>2. Highest Hospital- St. Joseph's General (89%)<br>3. Most Improved- Lady Dunn Health Centre (from 64% to 79%) (note: only 3 locations improved their rate this year, the others have gone down)<br>4. Community plaque - still being assessed |

| | |
|---|---|
| **Analysis** | Influenza vaccine uptake is slightly down across the district in institutional facilities, particularly the Sault Area Hospital (almost 50% lower potentially due to the change in mandatory vaccination policy) |
| **Action** | APH continues to work with interagency partners to promote influenza immunization in high-risk immunocompromised populations and support the Infection control teams in case of outbreak to minimize morbidity and mortality. |
| **Financial Implications** | None currently but can result in significant overtime costs should outbreaks of influenza result from poor uptake or strain mismatch. |
| **Staffing Implications** | Staff in both communicable disease control and environmental health is involved with flu immunization coverage and outbreak management. In a year with poorer vaccine uptake or strain mismatch, the staff time involved in outbreak management can be very significant and lessen available resources to conduct inspections. |

Respectfully submitted,

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

HEALTHY KIDS
COMMUNITY CHALLENGE
SAULT STE. MARIE

SOO GREYHOUNDS

# FREE BALL HOCKEY WITH THE SOO GREYHOUNDS

January 23rd, 2016

1:30-3:30 p.m.

Outside of the Essar Centre

Games for **ALL** kids **12 & Under**

**Free Hockey Stick and Ball to first 500 players!**

Registration forms available at: **saultstemarie.ca/HKCC** or at the event January 23rd, 2016.

Adult accompaniment required for kids 12 and under.

For more information visit above website or call Daneen Dénommé **(705) 942-4646 ext. 5233**

**ALGOMA PUBLIC HEALTH**

**FINANCE AND AUDIT COMMITTEE REPORT**

**FOR THE JANUARY 13, 2016 BOARD MEETING**

In attendance:

Tony Hanlon, Justin Pino, Ian Frazier, Candace Martin, Lee Mason, Dennis Thompson

Invited Guest – Pat Policicchio, Brokerlink

Secretary – Christina Luukkonen

The Committee received a presentation from APH's insurance broker, Pat Policicchio. Mr. Policicchio went through the coverage categories of Casualty, Crime, Accident, Legal Expense and Property Coverage. He also noted a number of coverages that could have higher limits of insurance but did not make a recommendation to increase the limits. Premiums this year are expected to increase 5%. After Mr. Policicchio left the Committee discussed the possibility of going through the tendering process and will be considered for next year.

Justin made a presentation on risk management. This was a follow-up from the November alPHa conference. The Executive applied the risk management process and identified 11 top agency risks. The Committee shall review the list and provide feedback to Justin regarding the risk identified, the significance, the steps taken to mitigate the risk and if the residual risk is acceptable or not.

The November 2015 financial statements were reviewed and it was identified that no significant variances occurred during the month. The salary and wage positive variance continues to be offset by the program negative variance due to the contractual cost arrangement of the Acting MOH versus payment of a salary (classification). It was also noted that travel expenditures were less than projected. This was due to less professional development (PD) occurring during the year and was not due to less travel to provide services to the community. It was discussed and PD is important for any profession and will be priority in 2016.

The Committee's Terms of Reference was reviewed and a few minor adjustments were identified and will be submitted to the Board for approval. The Committee also reviewed its 2015 activities compared to the Terms of Reference and will be submitting its results to the Board in February so the Board can determine the effectiveness of the Committee.

Dan McBrayne

Chair, Finance and Audit Committee
Algoma Public Health

11/18/16

Date

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

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

| | Actual YTD 2015 | Budget YTD 2015 | Variance Bgt to Actual 2015 | Annual Budget 2015 | 2015 YTD Actual/ YTD Budget % |
|---|---|---|---|---|---|
| **Revenue** | | | | | |
| Municipal Levy -public health | $ 3,371,761 | $ 2,982,781 | $ 388,980 | $ 3,253,897 | 113% |
| Provincial Grants -public health | $ 9,164,863 | $ 8,951,342 | $ 213,521 | $ 9,765,100 | 102% |
| Grants/Levies - Capital | $ - | - | $ - | - | |
| Provincial Grants - community health | 5,637,214 | 5,369,402 | $ 267,812 | 7,632,958 | 105% |
| Fees, other grants and recovery of expenditures | 577,744 | 755,520 | $ (177,776) | 824,204 | 76% |
| | $ 18,751,583 | $ 18,059,045 | $ 692,537 | $ 21,476,159 | 104% |
| **Expenditures** | | | | | |
| ***Public Health Programs*** | | | | | |
| Public Health | $ 12,192,244 | $ 12,689,643 | $ 497,400 | $ 13,843,201 | 96% |
| Public Health (Capital) | 0 | - | - | - | |
| ***Community Health Programs*** | | | | | |
| Healthy Babies and Children | 997,616 | $ 979,010 | (18,607) | 1,068,011 | 102% |
| Child Benefits Ontario Works | 16,529 | $ 18,333 | 1,804 | 20,000 | 90% |
| Dental Benefits Ontario Works | 264,612 | $ - | (264,612) | - | #DIV/0! |
| Early Years Development (NPClinic II) | 1,000 | $ 127,417 | 126,417 | 139,000 | 1% |
| Misc Calendar | 426 | $ - | (426) | - | #DIV/0! |
| Healthy Community Partnership | 480 | $ - | (480) | - | #DIV/0! |
| Northern Ontario Fruit & Vegetable Program | 59,902 | $ 77,503 | 17,601 | 117,400 | 77% |
| Brighter Futures for Children | 64,172 | $ 75,629 | 11,457 | 113,448 | 85% |
| Infant Development | 422,974 | $ 450,657 | 27,684 | 675,986 | 94% |
| Preschool Speech and Languages | 384,823 | $ 409,504 | 24,680 | 614,256 | 94% |
| Nurse Practitioner | 77,990 | $ 81,902 | 3,912 | 122,853 | 95% |
| Genetics Counseling | 211,553 | $ 245,204 | 33,651 | 367,806 | 86% |
| Community Mental Health | 1,944,923 | $ 2,115,999 | 171,075 | 3,173,998 | 92% |
| Community Alcohol and Drug Assessment | 443,322 | $ 452,126 | 8,804 | 678,210 | 98% |
| Remedial Measures | 114,099 | $ 112,127 | (1,972) | 122,320 | 102% |
| Diabetes | 73,960 | $ 100,000 | 26,040 | 150,000 | 74% |
| Healthy Kid Community Challenge | 14,289 | $ 15,051 | 761 | 169,669 | 95% |
| Stay on Your Feet | 58,016 | $ 66,667 | 8,651 | 100,000 | 87% |
| Misc Fiscal | 35,136 | $ - | (35,136) | - | #DIV/0! |
| | $ 17,378,066 | $ 18,016,771 | $ 638,704 | $ 21,476,158 | 96% |
| **Excess of revenues over expenses - CH** | 451,392 | 42,275 | | 1 | |
| **Excess of revenues over exp. - Public Health** | 922,125 | (0) | | - | |
| **Operating fund balance**, beginning of year | 3,009,266 | | | | |
| **Operating fund & capital**, end of month (Note 1) | $ 2,921,061 | | | | |

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

***Algoma Public Health***
***Revenue Statement***
*For the Eleven Months Ending November 30, 2015*

| | Current YTD | Budget YTD | Variance | YTD Actual to Annual Bgt % | Annual Budget | Comparison Prior Year: YTD Actual 2014 | YTD BGT 2014 | Variance 2014 |
|---|---|---|---|---|---|---|---|---|
| MOH Public Health Funding | 6,872,889 | 6,892,508 | ( 19,619 ) | 91% | 7,519,100 | 6,853,662 | 6,872,983 | (19,321) |
| MOH Funding- Needle Exchange | 46,464 | 46,475 | ( 11 ) | 92% | 50,700 | 41,056 | 41,068 | (12) |
| MOH Funding Haines Food Safety | 22,552 | 22,550 | 2 | 92% | 24,600 | 22,485 | 22,489 | (4) |
| MOH Funding CINOT/Healthy Smiles | 376,380 | 376,383 | ( 3 ) | 92% | 410,600 | 391,908 | 391,914 | (6) |
| MOH Funding - Social Determinants of Health | 165,452 | 165,458 | ( 6 ) | 92% | 180,500 | 162,163 | 165,411 | (3,248) |
| MOH Funding Vector Bourne Disease | 99,642 | 99,642 | 0 | 92% | 108,700 | 99,553 | 99,560 | (7) |
| MOH Funding Chief Nursing Officer | 111,368 | 111,375 | ( 7 ) | 92% | 121,500 | 109,103 | 111,296 | (2,193) |
| MOH Funding Safe Water | 65,086 | 63,800 | 1,286 | 94% | 69,600 | 63,759 | 63,766 | (7) |
| MOH Enhanced Funding Safe Water | 12,905 | 14,208 | ( 1,303 ) | 83% | 15,500 | 14,195 | 14,208 | (13) |
| MOH Funding Unorganized | 458,607 | 458,608 | ( 1 ) | 92% | 500,300 | 391,732 | 399,567 | (7,835) |
| IC Prevention & Control Week | 0 | 0 | - | 0% | 0 | 0 | 0 | 0 |
| CINOT Expanded Funding | 57,117 | 31,167 | 25,950 | 168% | 34,000 | 12,782 | 20,625 | (7,843) |
| MOH Funding Infection Control | 286,352 | 286,367 | ( 15 ) | 92% | 312,400 | 284,641 | 286,274 | (1,633) |
| Levies Sault Ste Marie | 2,301,476 | 1,805,337 | 496,140 | 117% | 1,969,458 | 1,878,969 | 1,695,737 | 183,232 |
| Levies Sault Ste Marie Capital | 0 | 269,152 | ( 269,152 ) | 0% | 293,620 | 265,360 | 265,360 | (0) |
| Levies Vector/ SDWS | 0 | 60,967 | ( 60,967 ) | 0% | 66,463 | 54,442 | 54,442 | (0) |
| Levies District | 1,070,285 | 737,391 | 332,894 | 133% | 804,427 | 797,445 | 719,919 | 77,526 |
| Levies District Capital | 0 | 109,935 | ( 109,935 ) | 0% | 119,929 | 113,726 | 113,726 | (0) |
| Recoveries from Programs | 9,227 | 9,222 | 5 | 92% | 10,061 | 10,194 | 9,222 | 971 |
| Program Fees | 188,815 | 226,548 | ( 37,733 ) | 76% | 247,143 | 174,882 | 226,548 | (51,666) |
| Land Control Fees | 160,055 | 146,667 | 13,388 | 100% | 160,000 | 147,581 | 146,667 | 914 |
| Program Fees Immunization | 184,334 | 146,667 | 37,667 | 115% | 160,000 | 179,672 | 146,667 | 33,005 |
| HPV Vaccine Program | 3,026 | 9,167 | ( 6,141 ) | 30% | 10,000 | 2,941 | 9,167 | (6,226) |
| Influenza Program | 835 | 55,000 | ( 54,165 ) | 1% | 60,000 | 7,305 | 55,000 | (47,695) |
| Meningococcal C Program | 714 | 9,167 | ( 8,453 ) | 7% | 10,000 | 740 | 9,167 | (8,427) |
| Interest Revenue | 10,746 | 1,833 | 8,913 | 537% | 2,000 | 6,380 | 1,833 | 4,547 |
| Other Revenues | 19,992 | 151,250 | ( 131,258 ) | 12% | 165,000 | 30,183 | 68,750 | (38,567) |
| Funding Holding | 0 | 0 | - | 0% | 0 | 0 | 0 | 0 |
| Funding Ontario Tobacco Strategy | 424,935 | 382,800 | 42,135 | 102% | 417,600 | 384,918 | 390,133 | (5,215) |
| Elliot Lake Office Relocation | 0 | 0 | - | 0% | 0 | 0 | 0 | 0 |
| Panorama | 52,900 | 0 | 52,900 | 100% | 0 | 70,392 | 0 | 70,392 |
| IT Platform Stabilization - One Time | 0 | 0 | - | 0% | 0 | 0 | 293,333 | (293,333) |
| First Nations Inititative -One Time | 112,214 | 0 | 112,214 | 100% | 0 | 0 | 137,500 | (137,500) |
| | $ 13,114,368 | $ 12,689,643 | $ 424,725 | | $ 13,843,201 | $ 12,572,169 | $ 12,832,332 | $ ( 260,163 ) |
| **Summary** | | | | | | | | |
| Levies | 3,371,761 | 2,982,781 | 388,980 | 113% | 3,253,897 | 3,109,942 | 2,849,185 | 260,757 |
| Funding Grants | 9,164,863 | 8,951,342 | 213,521 | 102% | 9,765,100 | 8,902,349 | 9,310,127 | ( 407,778 ) |
| Fees & Recoveries | 577,744 | 755,520 | ( 177,776 ) | 76% | 824,204 | 559,878 | 673,020 | ( 113,142 ) |
| | $ 13,114,368 | $ 12,689,643 | 424,725 | 103% | $ 13,843,201 | $ 12,572,169 | $ 12,832,332 | $ ( 260,163 ) |

***Algoma Public Health***

***Expense Statement- Public Health***

*For the Eleven Months Ending November 30, 2015*

| | Current YTD | Budget YTD | Variance | YTD Actual to Annual Bgt % | Annual Budget | Comparison Prior Year: YTD Actual 2014 | YTD BGT 2014 | Variance 2014 | |
|---|---|---|---|---|---|---|---|---|---|
| Salaries & Wages | $ 7,159,036 | $ 7,431,165 | 272,129 | 88% | $ 8,103,927 | $ 7,218,688 | $ 7,595,027 | $ 376,339 | 1 |
| Benefits | 1,648,569 | 1,860,881 | 212,312 | 81% | 2,030,047 | 1,840,549 | 1,898,754 | 58,205 | 2 |
| Travel - Car Allowances | 39,664 | 56,797 | 17,133 | 64% | 61,960 | 86,766 | 136,293 | 49,527 | 3 |
| Travel - Mileage | 133,198 | 114,993 | ( 18,205 ) | 106% | 125,447 | 102,966 | 129,323 | 26,357 | 3 |
| Travel - Other | 59,679 | 115,782 | 56,104 | 47% | 126,308 | 106,972 | 121,282 | 14,310 | 3 |
| Program | 919,133 | 649,377 | ( 269,756 ) | 129% | 711,175 | 745,588 | 795,009 | 49,422 | 4 |
| Program Equipment Purchased | | 0 | - | 0% | 0 | 307 | 458 | 152 | |
| Office | 50,806 | 120,954 | 70,148 | 39% | 131,950 | 91,676 | 156,017 | 64,340 | 4 |
| Computer Services | 630,034 | 705,585 | 75,551 | 82% | 769,729 | 672,556 | 354,979 | (317,577) | 4 |
| Telephone Charges | 27,212 | 44,241 | 17,029 | 56% | 48,263 | 38,032 | 97,866 | 59,834 | 5 |
| Telecommunications | 156,825 | 156,781 | ( 44 ) | 92% | 171,028 | 158,447 | 131,083 | (27,364) | 5 |
| Program Promotion | 114,868 | 193,951 | 79,083 | 54% | 211,583 | 101,414 | 185,382 | 83,968 | 4 |
| Facilities Expenses | 616,749 | 695,843 | 79,094 | 81% | 759,102 | 754,015 | 688,510 | (65,505) | 6 |
| Renovations | 595 | 0 | ( 595 ) | 100% | 0 | 128,431 | 59,583 | (68,847) | |
| Fees & Insurance | 292,754 | 256,199 | ( 36,555 ) | 105% | 279,490 | 198,559 | 199,833 | 1,275 | 7 |
| Special Projects | 113 | 0 | ( 113 ) | 100% | 0 | 0 | 0 | 0 | |
| Debt Management | 417,868 | 418,000 | 132 | 92% | 456,000 | (67,375) | (135,070) | (67,695) | |
| Recoveries | (74,860) | (130,907) | ( 56,047 ) | 52% | (142,808) | 79,827 | 0 | (79,827) | 8 |
| Elliot Lake Relocation | 0 | | - | 0% | | 417,868 | 418,000 | 132 | |
| | $ 12,192,244 | $ 12,689,643 | $ 497,400 | | $ 13,843,201 | $ 12,675,286 | $ 12,832,330 | $ 157,044 | |

## Notes to Financial Statements – November 2015

### Reporting Period

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

### Public Health – Statement of Operations (see page 1)

General Comments

As of November 30th, 2015, Public Health programs are reporting a surplus of approximately $922k. On the Revenue side, $388k positive variance is attributable to the timing of receipts of municipal levies from the City of Sault Ste. Marie and the District. There is a positive $213k variance associated with timing of receipts of Provincial Grants. Offsetting these positive variances is a $177k negative variance related to the timing of the collection of Program Fees & Recoveries.

There is a positive variance of $497k related to Public Health Expenses being less than budgeted. This is primarily due to gapping of two vacant positions as a means of safeguarding against uncertainty surrounding approval of the Provincial portion of the 2015 budget. APH was notified on September 4th, 2015 that it will receive a 0% increase in mandatory program funding from the Ministry. The inherent time lag in filling positions within the agency is also contributing to this variance.

Community Health programs are reporting a surplus of $451k. $126k of the variance noted is attributable to a vacant position within APH's Nurse Practitioner Clinic. APH has returned these funds to the Ministry. In addition, there is a $171k positive variance associated with the Community Mental Health Program. The program received additional funding for positions related to transitional case management. The lag in time to fill these positions is driving the noted variance. There is a positive $24k variance related to the Preschool Speech and Language Program and a $26k positive variance related to the Diabetes Program. Purchases related to these programs typically occur within the last quarter of the year. There is a positive variance of $33k associated with the Genetics Program. This is a result of the inherent time lag in filling positions within the agency.

Notes Continued…

**Revenue (see page 2 for details)**

Public Health funding revenues are indicating a positive variance of $424k. Driving this is a $388k positive variance related to the timing of receipts of the municipal levy from the City of Sault Ste. Marie and the District. The timing of receipts of Funding Grants is also contributing to the variance. Fees and Recoveries are offsetting this positive variance. In an effort to balance the budget, recognition of deferred revenue was planned for 2015. Management has determined this is not required which is impacting the negative $131k variance related to Other Revenues. The negative $54k variance related to the Influenza Program is a result of timing issues. APH is reimbursed by the Ministry quarterly for the previous quarter actual immunizations administered. Collection of Land Control fees is now showing a positive $13k variance.

**Public Health Expenses Budget (see page 3)**

Note 1/2– Salaries/Benefits

The positive variance of $272k is a result of two vacant positions which have been gapped as a means of mitigating uncertainty surrounding the Board of Health request to the Ministry of a 2.5% funding increase for mandatory programs. In addition, the vacant permanent Medical Officer of Health (MOH) position is impacting the noted positive variance. The inherent time lag in filling positions within the agency is also contributing to this variance.

The two vacant positions are driving the positive variance of $212k with regards to benefits. In addition, the vacant permanent MOH role is contributing to this positive variance.

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

Car allowance is showing a positive $17k variance. This is a result of the elimination of car allowance as collectively bargained.

Mileage is showing a negative $18k variance. This is a result of staff now being reimbursement at or near CRA rates as collectively bargained.

Travel - Other is showing a positive $56k variance. Staff travel has been less than in previous years.

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

Program expenses are indicating a negative variance of $269k. The purchased services for the Acting CEO and MOH role are driving the noted variance.



Office expense is showing a positive $70k variance as a result of timing of office supply expenditures not yet incurred. Office expense will be less than what was budgeted.

# Algoma Public Health
**Statement of Financial Position**

| Date: As of November 2015 | November 2015 | December 2014 |
|---|---|---|
| **Assets** | | |
| **Current** | | |
| Cash & Investments | $ **2,809,456** | $ 2,289,828 |
| Accounts receivable | **387,414** | 413,625 |
| Receivable from municipalities | **132,127** | 12,840 |
| Receivable from Province of Ontario | **-** | |
| *Subtotal Current Assets* | ***3,328,996*** | *2,716,292* |
| Financial Liabilities: | | |
| Accounts Payable & Accrued Liabilities | **1,560,770** | 1,698,086 |
| Payable to Gov't of Ont/Municipalities | **254,727** | 701,964 |
| Deferred Revenue | **639,415** | 555,359 |
| Employee Future Benefit Obligations | **2,417,999** | 2,417,999 |
| Capital Lease Obligation | **213,730** | 539,027 |
| Term Loan | **6,114,240** | 6,114,240 |
| *Subtotal Current Liabilities* | **11,200,880** | 12,026,675 |
| **Net Debt** | **(7,871,884)** | (9,310,383) |
| **Non-Financial Assets:** | | |
| Building Construction in Progress | **22,732,421** | 22,732,421 |
| Furniture & Fixtures | **1,914,772** | 1,914,772 |
| Leasehold Improvements | **892,431** | 892,431 |
| IT | **3,029,040** | 3,029,040 |
| Automobile | **29,740** | 29,740 |
| Accumulated Depreciation | **-6,118,846** | -6,118,846 |
| *Subtotal Non-Financial Assets* | **22,479,558** | 22,479,558 |
| **Accumulated Surplus** | **14,607,674** | 13,169,175 |

# ALGOMA PUBLIC HEALTH

## TERMS OF REFERENCE

**Name:** Finance and Audit Committee

**Mandate:** To assist the Board in meeting its responsibilities, the Finance and Audit Committee (the "Committee") shall:

- Act in an advisory capacity to the Board; and
- Ensure the adequacy and effectiveness of financial reporting by reviewing and recommending approval to the Board of all financial statements, accounting policies, internal and external audits, internal controls, management plans and information.

The Committee shall assist with fulfillment of the Board's mandate and those specific responsibilities and duties assigned to the Committee; however, unless specifically stated otherwise, the Committee shall act in advisory capacity only, recommending decisions to the Board for approval.

**Scope/Duties:** The Finance and Audit Committee shall have the following specific functions, duties and responsibilities and where necessary recommend for approval to the Board:

- Review and make recommendations to the Board regarding monthly financial statements and other monthly/quarterly financial reporting being presented to the Board;
- Review and make recommendations to the Board regarding the annual Operating and Capital Plan;
- Review and make recommendations to the Board regarding the annual audited financial statements;
- Review and recommend the annual audit plan, audit fees, and scope of audit services (engagement letter);
- Meet with external auditors to review the findings of the audit including but not limited to the auditor's Management Letter, any weaknesses in internal controls and the Executive Management's response to such letter;
- Review and report to the Board any changes in accounting policies or significant transactions which impact the financial statements in a significant manner as per the annual financial statements;
- Periodically review the need for an internal audit and if required make such recommendation to the Board;
- Monitor the internal audit process, ensure all items from the internal auditor's reports are resolved and assess the internal audit performance;
- Monitor the effectiveness of internal controls to ensure compliance with Board policies and standard accounting principles;
- Review and ensure that all risk management is complete with respect to all insurance coverage for the Board;

- Review and make recommendations to the Board regarding long-term financial goals and long-term revenue and expense projections;
- Review and make recommendation to the Board concerning any material asset acquisitions;
- Review and make recommendations to the Board regarding financial, Investing and banking transactions, providers and signing officers; and
- Review other projects or developments as directed by the Board.
- Develop an Annual Work Plan for approval by the Board.

**Reporting Relationship:** Finance and Audit Committee shall report on significant issues and year end progress of the Annual Work Plan through the Committee Chair or other Committee Designate to the Board.

**Committee Performance:** The performance and effectiveness of the Committee shall be assessed annually as part of the Board's evaluation process. The evaluation will be based on the Committee fulfilling its Mandate.

**Membership:** The Finance and Audit Committee shall be comprised of:

- Up to five (5) members of the Board of Health ~~or~~ and ~~one~~ no less than ~~the number required for Board quorum, whichever is less~~ three(3) voting members;
- CFO of Algoma Public Health, non-voting member
- MOH/CEO of Algoma Public Health, non-voting member

**Chair:** The Chair of the Committee shall be elected annually by the ~~Committee.~~Board.

**Frequency:** A minimum of four (4) meetings will be held annually. Additional meetings can be held at the call of the Chair. The location of the meetings will be at APH's main office unless otherwise agreed upon by the Committee.

**Term:** The Committee shall be appointed annually by the Board.

**Quorum:** A Quorum shall be ~~a majority~~50% of the members on the committee~~.~~

**Amendments:** The Committee will review the Terms of Reference on an annual basis and make recommendation(s) for any amendments. Any amendments are made by the Board.

**Minutes:** Minutes shall be provided to the Board of Health

Signature of Board of Health Chair _____ Date _____

# TERMS OF REFERENCE MEMBERSHIP

| | Name | Position |
|---|---|---|
| 1 | Ian Frazier | Chair, Finance Committee |
| 2 | Candace Martin | Board Member |
| 3 | Lee Mason | Board Member |
| 4 | Dennis Thompson | Board Member |
| | Ex-Officio | |
| 5 | ~~Sandra Laclé~~Tony Hanlon | ~~Acting~~ Chief Executive Officer |
| 6 | Justin Pino | Chief Financial Officer |
| 7 | Christina Luukkonen | Recording Secretary |
| 8 | | |
| 9 | | |
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# Guide for Completing Terms of Reference

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

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

**ALGOMA PUBLIC HEALTH FINANCE AND AUDIT COMMITTEE MEETING**
**NOVEMBER 12, 2015**
**SAULT STE MARIE ROOM B 1ST FLOOR, APH SSM**
**MINUTES**

| | | | |
|---|---|---|---|
| BOARD MEMBERS PRESENT | Ian Frazier | Lee Mason | Candace Martin |
| | Dennis Thompson | | |
| ALGOMA PUBLIC HEALTH STAFF PRESENT: | Acting Chief Executive Officer | | Tony Hanlon |
| | Chief Financial Officer | | Justin Pino |
| | Recording Secretary | | Christina Luukkonen |
| GUESTS: | Michael Marinovich, KPMG | | |
| | Steve Murray, KPMG | | |

**1) CALL TO ORDER:**
Mr. Frazier called the meeting to order at 4:28 pm.

**2) DECLARATION OF CONFLICT OF INTEREST**
None were reported.

**3) ADOPTION OF AGENDA ITEMS dated November 12, 2015**
KPMG requested that their presentation be moved to in-committee as it pertains to the security of property. Item 5a was moved into item 10).

FC2015-45 Moved: L. Mason
Seconded: C. Martin
THAT the agenda items for the Finance and Audit Committee dated October 28, 2015, be adopted as amended.
CARRIED.

The Committee decided to discuss item 10 first to accommodate the attending guests from KPMG.

**4) THAT THE BOARD GO INTO COMMITTEE 4:30 p.m.**
Agenda items:

a) Security of Property
b) Adoption of In-committee minutes dated:
October 22, 2015
October 28, 2015

FC2015-46 Moved: L. Mason
Seconded: D. Thompson
THAT the Committee goes in-committee.
CARRIED.

**5) THAT THE BOARD GO INTO OPEN MEETING: 5:27 p.m.**

FC2015-48 Moved: L. Mason
Seconded: D. Thompson
THAT the Committee goes into open meeting.
CARRIED.

**6) ADOPTION OF MINUTES OF PREVIOUS MEETINGS:**

FC2015-49 Moved: C. Martin
Seconded: D. Thompson

THAT the minutes for the Finance and Audit Committee dated:
October 14, 2015; and
October 22, 2015; and
October 28, 2015 be adopted as amended.

CARRIED.

**7) Financial Statements for the Period ending: October 31, 2015**

Mr. Pino presented the financial statements that were provided to the Committee. Mr. Pino highlighted that APH does currently have a surplus of funds that they are looking at spending by the end of the year. The Management Team has been asked to submit one-time requests for their programs.

RBC has approved a $350,000 loan to complete the renovations for the Elliot Lake office. Some of the surplus funds will be used for the Elliot Lake office to help reduce the cost.

FC2015- Moved:
Seconded:

THAT the Finance and Audit Committee recommends the Financial Statements for the Period ending October 31, 2015 and puts for to the Board for approval.

CARRIED.

**8) NEW BUSINESS/GENERAL BUSINESS**

a) Community Accountability Planning Submission (CAPS)

The ministry has requested a 3 year forecast report based on our approved Community Mental Health and Addictions budget.

FC2015-50 Moved: D. Thompson
Seconded: L. Mason

THAT the Finance and Audit Committee recommends the Community Accountability Planning Submission and put forth to the Board of Health for approval.

CARRIED.

b) 2016 Draft Public Health Operating Budget

Mr. Pino submitted APH 2016 Public Health Operating Budget to the Committee for recommendation. APH is required to submit a balanced budget to the ministry by the end of February 2016. Mr. Pino discussed the various options for balancing the budget. Recommendations included but not limited to spending up to $50,000 of the surplus funds on new IT equipment to help reduce the payment on the sale lease back agreement; a decrease in the allocated funds for staff professional development to bring in line with what was spent for 2015; and a 4.5% increase to the municipal levies.

The ministry has advised all public health units to plan for no growth funding for mandatory programs.

FC2015-51 Moved: L. Mason
Seconded: D. Thompson

THAT the Finance and Audit Committee recommends that the Board of Health approve up to an incremental $50,000 in IT purchases.

CARRIED.

FC2015-52 Moved: D. Thompson
Seconded: L. Mason
THAT the Finance and Audit Committee recommends proposed 2016 Public Health Operating Budget as amended and put forth to the Board of Health for approval.
CARRIED.

c) Resolution – Elliot Lake Renovation Loan

No resolution additional resolution was needed as the Board passed a resolution on June 17, 2015 regarding the renovation loan.

d) Electronic Board Management System

Dr. Hanlon and Ms. Luukkonen spoke to the briefing note provided in the meeting package regarding purchasing an electronic board management system and hardware. By moving to an electronic system the Board will improve meeting efficiencies and save on the environment. An electronic system will allow for better organization and reduce the time spent preparing packages.

FC2015-53 Moved: L. Mason
Seconded: D. Thompson
THAT the Finance and Audit Committee recommends the purchase of an electronic board management system and required hardware and put forth to the Board for approval.
CARRIED.

**9) NEXT MEETING:** Thursday, November 12, 2015

**10) THAT THE MEETING ADJOURN: 4:58 p.m.**

FC2015-54 Moved: C. Marten
Seconded: L. Mason
THAT the meeting adjourns.
CARRIED.

**ALGOMA PUBLIC HEALTH**

**GOVERNANCE COMMITTEE REPORT**

**FOR THE JANUARY 13, 2016 BOARD MEETING**

In attendance:

Tony Hanlon, Antoniette Tomie, Ian Frazier, Candace Martin, Lee Mason

Secretary – Christina Luukkonen

Policy 02-05-020 – Board of Health Travel Policy was revised and submitted to the Committee for review and comment. A few adjustments were made and the Committee will recommend the approval of this revised policy to the Board.

The second of three reports from the Executive team was submitted for the Committee's review and comment regarding the Strategic Direction. This was a qualitative report whereby Improving Health Equity, Collaborating Effectively, Be Accountable and Enhance Employee Engagement was identified and described in detail. As this is the first year of implementation of these reports it was noted that some of the topics have some overlap and the Executive Team continues to work on collaboration within the team and refining the report's template.

The Committee reviewed its 2015 activities compared its Terms of Reference and will be submitting its results to the Board in February so the Board can determine the effectiveness of the Committee.

The Committee discussed the committee election process. It is normal process to have the Board appoint volunteer Board members to each of the committees and appoint the Chair of each Committee. Due to the Board's reduced numbers the Board may need to vary from this practice until the following year when the Board has full membership.

The Committee received an update on the governance review the Ministry is in the process of completing. The Board will have a meeting with the consultants in prior to the January Board meeting and expectations for the completed provincial wide report will be in the summer of 2015.

Chair, Governance Committee
Algoma Public Health

1/18/16
Date

| | | | |
|---|---|---|---|
| **APPROVED BY:** | Board of Health | **REFERENCE #:** | 02-05-020 |
| **DATE:** | O: January 18, 1995<br>Reviewed: May 16,2012<br>Reviewed: March 19, 2014<br>Revised: January 27, 2016 | **SECTION:** | Board |
| **PAGE:** | 1 of 3 | **SUBJECT:** | Board of Health Travel Policy |

## PURPOSE:

The Board of Directors of Algoma Public Health recognizes that Board Members may be required to travel or incur other expenses from time to time to conduct APH business and further the mission of the health unit.

The purpose of this policy is to ensure that adequate costs controls are in place, travel and other expenditures are appropriate and to provide a consistent approach for the timely reimbursement of authorized expenses incurred.

APH will reimburse Board members for all reasonable and necessary expenses while travelling on authorized APH business.

When incurring expenses, APH expects board members to:

- Exercise discretion and good judgment with respect to those expenses
- Be cost conscious and spend public funds carefully and judiciously.
- Report expenses, supported by original itemized receipts.

APH assumes no responsibility to reimburse Board members for expenses that are not in compliance with this policy. APH will not be responsible for the expenses incurred by the spouse of a Board member.

## TRAVEL AUTHORIZATION:

When travelling out of the district, all Board Member travel must be approved by the Chair of the Board or the Vice Chair of the Board in advance of any bookings. The Chair of the Board must have out of district travel approved by the Vice Chair of the Board.

## METHOD OF TRAVEL:

Board Members will travel to places outside the health unit area by the most practical and economical method. In some cases, travel by air is the most economical giving consideration to out of office time. In other cases, vehicle travel is the better alternative.

### Air Travel

When booking travel via air, Board Members must coordinate their ~~own~~ travel arrangements with the Board Secretary. Economy flights are to be booked.

Personal Automobiles

~~$0.45 per kilometer reimbursement will be provided to APH Board Members when traveling via automobile while on APH business.~~ Board Members will NOT be reimbursed for any traffic or parking tickets resulting from business travel.

The rate of reimbursement for use of a personal automobile is the straight kilometer rate as per the current General Administrative Manual – Non-Union Employees.

Verification of kilometers traveled should be provided from a reliable source (i.e. Google Maps) and submitted with the Board Member's expense report.

Car Rental

If required and economically prudent, Board Members can rent a vehicle while on APH business. Mid-sized vehicles must be reserved unless a larger vehicle is required to accommodate the number of travelers sharing the vehicle.

**ACCOMODATIONS:**

When travelling out of the district, Board Members are expected to stay in a Standard-type room in a good standing hotel. Each Board Member is entitled to an individual room.

Hotel reservations will ~~must~~ be made by the Board ~~Member travelling~~ Secretary. Where possible, the accommodations chosen should be a government approved hotel or the host hotel of the conference or seminar.

In the event of an emergency or travel difficulties, reimbursement for accommodation may be booked by a Board member and subject to a review and justification of the claim provided proper receipts are submitted.

~~For all Board Members, hotel expenses must be paid using a personal credit card. The Board Member will subsequently be reimbursed by APH when submitting their expense report.~~

**MEALS & OTHER EXPENSES:**

**Original itemized receipts** are required for meals and other allowable expenses such as parking, taxis, buses, in order to be eligible for reimbursement. Original itemized receipts must state date, place and cost (VISA receipts will **NOT** be accepted).

Reimbursement for meal expenses is *up to* the rates set out in the chart below. These rates include gratuities.

| Meals | Maximum Amount |
|---|---|
| Breakfast | ~~$10.00~~ $12.00 |
| Lunch | ~~$15.00~~ $16.00 |
| Dinner | ~~$23.00~~ $25.00 |

**The following are NOT a reimbursable expense**.

- Alcohol

- Breakfast the day when the board member leaves his/her home
- Evening meal when the board member is out of town but returns home at a reasonable hour, giving adequate time for the preparation of an evening meal

If meals are provided at the event or are part of the hotel booking, the Board Member will not be eligible for reimbursement (i.e. if breakfast is provided at the hotel or conference, the Board member will not be eligible to submit expenses for breakfast on the date of the conference).

If an APH Board Member is hosting a stakeholder of the agency for dinner, the name of the individual and the name of the stakeholder's affiliated agency must be identified on the itemized receipt for approval purposes.

APH will not provide a per diem to Board members.

**TRAVEL ADVANCES**

Travel advances are NOT permitted.

**EXPENSE REPORTS:**

Board members must submit an expense report within **15 business days** of the completion of each board meeting/travel instance. Any expenses submitted after that time will NOT be reimbursed by APH. Expense reports must be approved by the Chair of the Board or Chair of Finance and one of the MOH/CEO or CFO.

Original itemized receipts should be attached to the expense report. Expense reports are to be submitted to the MOH/CEO. Board members will be reimbursed for expenses via the cheque run to ensure prompt reimbursement of expenses.

**ALGOMA PUBLIC HEALTH**
**GOVERNANCE STANDING COMMITTEE MEETING**
**NOVEMBER 12, 2015**
**SAULT STE MARIE ROOM B, 1ST FLOOR, APH SSM**
**MINUTES**

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

**1) CALL TO ORDER:**
Mr. Frazier called the meeting to order at 7:15 pm.

**2) DECLARATION OF CONFLICT OF INTEREST**
None were reported.

**3) ADOPTION OF AGENDA ITEMS dated October 14, 2015**
Mr. Mason requested an additional item be added to the In-committee session 8a) Personnel Item.

GC2015-26 Moved: L. Mason
Seconded: C. Martin

THAT the agenda items for the Governance Standing Committee dated November 12, 2015 be adopted as amended.
CARRIED.

**4) ADOPTION OF MINUTES**

GC2015-27 Moved: C. Martin
Seconded: L. Mason

THAT the minutes for the Governance Standing Committee dated October 14, 2015 be adopted as amended.
CARRIED.

**5) BUSINESS ARISING FROM MINUTES**

**6) NEW BUSINESS/GENERAL BUSINESS**

a) 02-05-025 – Board Member Remuneration

Dr. Hanlon highlighted the changes to the Board Member Remuneration Policy.

GC2015-28 Moved: L. Mason
Seconded: C. Martin

THAT the Governance Standing Committee recommends the proposed changes to policy 02-05-025 Board Remuneration and puts forth to the Board of Health for approval as amended.

b) 02-05-010 – Board Minutes – Posting Circulation

Dr. Hanlon highlighted the changes to the Board Minutes – Posting Circulation policy.

The Governance Standing Committee recommends the proposed changes to policy 02-05-010 Board Minutes – Posting Circulation and puts forth to the Board of Health for approval.

c) alPHa Conference Summary – November 5, 2015

Mr. Frazier and Ms. Marten provided an update from the alPHa conference they attended on November 5, 2015 in Toronto. Ms. Luukkonen will contact alPHa for electronic copies of the material and presentations.

d) Consent Agenda

Dr. Hanlon brought forward to the Committee a sample of a consent agenda for consideration. The committee decided to not recommend adopting a consent agenda at this time but to continue to look at ways to restructure our current agenda to improve efficiencies.

e) Strategic Direction Report

The first qualitative report was presented to the committee on the agencies strategic directions. Copies were provided to the committee at the beginning of the meeting. The report will be presented to the Board as part of the Governance Standing Committee report.

**7) Additions to Agenda**

There were no additions to the Agenda.

**8) THAT THE BOARD GO INTO COMMITTEE: 8:10pm**

Agenda Items:

a) Adoption of In-committee minutes dated August 26, 2015
b) Personnel Item

GC2015-29 Moved: C. Martin
Seconded: L. Mason
THAT the Governance Standing Committee goes in-committee.
CARRIED.

**9) THAT THE BOARD GO INTO OPEN MEETING: 8:44pm**

GC2015-31 Moved: L. Mason
Seconded: C. Martin
THAT the Governance Standing Committee goes into open meeting
CARRIED.

**10) ITEMS IDENTIFIED TO BE BROUGHT FORTH TO THE BOARD**

a) Policy 02-05-025 – Board Remuneration
b) Policy 02-05-010 – Board Minutes – Posting Circulation

**11) NEXT MEETING:** January 13, 2015 @ 5:40pm

**12) THAT THE MEETING ADJOURN: 8:45 pm**

GC2015-32 Moved: C. Martin
Seconded: L. Mason
THAT the Governance Standing Committee meeting adjourns.
CARRIED.

Algoma PUBLIC HEALTH
Santé publique Algoma

# Briefing Note

www.algomapublichealth.com

**To:** The Board of Health

**From:** Dr. Tony Hanlon, CEO and Dr. Penny Sutcliffe, AMOH

**Date:** January 27, 2016

**Re:** Patients First: A Proposal to Strengthen Patient- Centred Health Care in Ontario
MOHLTC Discussion Paper, December 17, 2015

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☐ For Information ☐ For Discussion ☒ For a Decision

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## ISSUE:

The Ministry of Health and Long-Term Care (MOHLTC) December 17, 2015 discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario,* (attached) has significant implications for the role and accountabilities of all local boards of health, including the Algoma Public Health Board of Health, and pulls public health more into the acute care system.

The MOHLTC is seeking feedback on questions posed in the discussion paper. The paper notes an intention to continue the conversation about the proposal in a variety of forums – as yet to be determined. It is understood that feedback should be shared by the end of February. The discussion paper anticipates draft legislation to be before the Legislative Assembly in the spring of 2016.

The Association of Local Public Health Agencies (alPHa) is engaging in a consultative process to gather feedback from local public health and develop key positions to communicate with the MOHLTC.

**Recommended Action:**
**That the Algoma Public Health Board of Health receive the briefing note concerning, Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario; and**

**That the Board of Health direct the Acting Medical Officer of Health to engage with the Association of Local Public Health Agencies (alPHa) in the development of key positions, consistent with the key considerations of this briefing note, for communication with the Ministry of Health and Long-Term Care; and**

**That the Board of Health seek engagement with constituent municipalities and with the Federation of Northern Ontario Municipalities (FNOM) to determine any municipal concerns about the proposed changes in governance and funding; and**

**Further that the Board of Health seek engagement with the North East LHIN to discuss matters arising from the discussion paper.**

## KEY CONSIDERATIONS:

1. Geography and coordination: The proposal greatly expands the role of each of the 14 LHINs and creates geographical sub-LHINs to manage all primary care and other health service resources. The APH is one of five health units within the NE LHIN boundary. Careful consideration needs to be given to jurisdiction and boundary issues and the organizational capacity of public health to engage at multiple tables.

2. Funding: While local boards of health would continue to set budgets, provincial funding (currently up to 75% of the cost-shared budget) would be allocated by the LHINs to public health units. This may imply that each LHIN will receive a global amount of funding for public health and then decide how that total funding is to be allocated amongst the health units within its boundaries. Potential impacts of any transformation on municipal funding allocations to local public health should be explicitly considered and addressed and funding levels for public health programs should be protected and enhanced.

3. Governance and accountability: The MOHLTC would create a formal relationship between the Medical Officer of Health and the LHIN, empowering the Medical Officer of Health to work with the LHIN to plan population health services. There are no further details and the envisioned relationship between the respective boards is not described. Governance roles and respective responsibilities of different governing entities should be clarified.

   The LHIN would be responsible for public health performance management and administering accountability agreements. It is unknown what will happen with the current processes and whether common expectations will be maintained across the province.

4. Programming: Key differences between local public health units and the current LHIN-funded health care sector agencies include that public health is:
   - responsible for programs and services that mainly focus on populations not individuals
   - responsible for programs and services that mainly focus on primary prevention of disease and injury, broad concepts of health promotion, conventional health protection, and epidemiological disease surveillance
   - accountable for advancing healthy public policy agendas
   - accountable for monitoring and supporting the health status of groups within a geographically defined jurisdiction

- closely linked to municipal, educational, social service and community partner agencies
- funded from multiple levels and departments of government and government agencies

Local public health should be supported to ensure that the primary focus of their work remains on prevention and on mechanisms to address non health system determinants of health. As the LHIN will be responsible for integration of health services and division of those services amongst providers, the implications for the role of public health regarding our more clinical services remains uncertain. Any proposed changes should explicitly address the risk of weakening or diverting capacity within local public health from existing roles and responsibilities as set out in statue, standards and accountability agreements for boards of health, medical officers of health and public health inspectors.

**FINANCIAL IMPLICATIONS:**

Unknown at this time. However, there are concerns about an expectation of an increased role for public health within the LHIN system with no additional financial resources.

The financial implications are unknown regarding the current review of the Ontario Public Health Program and Services, including the Organizational Standards.

**CONTACT:**

Dr. Tony Hanlon, CEO
Dr. Penny Sutcliffe, AMOH

Acknowledgement: Adapted with permission from the work of public health colleagues in Ottawa Public Health, Durham Region, Niagara Region and Sudbury and District Health Unit.

# PATIENTS FIRST

## A PROPOSAL TO STRENGTHEN PATIENT-CENTRED HEALTH CARE IN ONTARIO

DISCUSSION PAPER
December 17, 2015

Ontario

# PATIENTS FIRST

## Message from the Minister of Health and Long-Term Care

Over the past decade, Ontario's health care system has improved significantly. Together, we have reduced wait times for surgery, increased the number of Ontarians who have a primary health care provider and expanded services for Ontarians at home and in their communities. There are, however, a number of areas where we need to do more.

Too often, health care services can be fragmented, uncoordinated and unevenly distributed across the province. For patients, that means they may have difficulty navigating the system or that not all Ontarians have equitable access to services. Too often our system is not delivering the right kind of care to patients who need it most.

The next phase of our plan to put patients first is to address structural issues that create inequities. We propose to truly integrate the health care system so that it provides the care patients need no matter where they live. Our proposal is focused on population health and integration at the local level. It would improve access to primary care, standardize and strengthen home and community care, and strengthen population and public health. It would also ensure that services are distributed equitably across the province and are appropriate for patients.

With this paper, we are seeking your input on our proposal, and your advice about how to integrate other improvements including, for example, community mental health and addictions services. Through this engagement process, we want to hear from providers, patients and caregivers around the province, in cities and rural communities, in our diverse cultural communities and in our French-language communities. We want to engage with First Nations, Métis and Inuit partners about how this process can complement our ongoing work to strengthen health outcomes in Indigenous communities.

As Ontario's Minister of Health and Long-Term Care, I am excited that we have the opportunity to work together to continue developing one of the best health care systems in the world—a system that truly puts patients first. I hope you will join us, and contribute your expertise. We can't succeed without it.

Dr. Eric Hoskins
Minister of Health and Long-Term Care

# EXECUTIVE SUMMARY

## PUTTING PATIENTS FIRST

Ontario is committed to developing a health care system that puts patients first. Over the past 10 years, the province has improved access to primary care, provided more care for people at home, reduced hospital wait times, invested in health promotion programs, and taken steps to make the system more transparent and more accountable. But there are still gaps in care.

## GAPS IN CARE

Ontarians, including patients, care providers and system experts have identified challenges in our health care system.

- Some Ontarians – particularly Indigenous peoples, Franco-Ontarians, members of cultural groups (especially newcomers), and people with mental health and addiction challenges – are not always well-served by the health care system.
- Although most Ontarians now have a primary care provider, many report having difficulty seeing their provider when they need to, especially in evenings, nights or weekends — so they go to emergency departments and walk-in clinics instead.
- Some families find home and community care services inconsistent and hard to navigate, and many family caregivers are experiencing high levels of stress.
- Public health services are disconnected from the rest of the health care system, and population health is not a consistent part of health system planning.
- Health services are fragmented in the way they are planned and delivered. This fragmentation can affect the patient experience. It can also result in inefficient use of patient and provider time and resources, and can result in poor health outcomes.

Many of these challenges arise from the disparate way different health services are planned and managed. While local hospital, long-term care, community services, and mental health and addiction services are all planned by the province's 14 Local Health Integration Networks (LHINs), primary care, home and community care services and public health services are planned by separate entities in different ways. Because of these different structures, the LHINs are not able to align and integrate all health services in their communities.

## A PROPOSAL TO STRENGTHEN PATIENT-CENTRED CARE

To reduce gaps and strengthen patient-centred care, the Ministry of Health and Long-Term Care is proposing to expand the role of the Local Health Integration Networks. In *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, the ministry provides more detail about the four components:

1. **More effective integration of services and greater equity.**

   To make care more integrated and responsive to local needs, make LHINs responsible and accountable for all health service planning and performance.

   Identify smaller sub-regions as part of each LHIN to be the focal point for local planning and service management and delivery.

In their expanded role, LHINs would be responsible for working with providers across the care continuum to improve access to high-quality and consistent care, and to make the system easier to navigate – for all Ontarians. The LHIN sub-regions would take the lead in integrating primary care with home and community care.

2. **Timely access to primary care, and seamless links between primary care and other services.**

   Bring the planning and monitoring of primary care closer to the communities where services are delivered. LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management.

The LHINs would work closely with primary care providers to plan services, undertake health human resources planning, improve access to inter-professional teams for those who need it most and link patients with primary care services. The ministry would continue to negotiate physician compensation and primary care contracts.

### 3. More consistent and accessible home and community care.

Strengthen accountability and integration of home and community care. Transfer direct responsibility for service management and delivery from the Community Care Access Centres (CCACs) to the LHINs.

With this change, LHINs would govern and manage the delivery of home and community care, and the CCAC boards would cease to exist. CCAC employees providing support to clients would be employed by the LHINs, and home care services would be provided by current service providers. This shift would create an opportunity to integrate home and community care into other services. For example, home care coordinators may be deployed into community settings, such as community health centres, Family Health Teams and hospitals.

### 4. Stronger links between population and public health and other health services.

Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units.

The Medical Officer of Health for each public health unit would work closely with the LHINs to plan population health services. LHINs would be responsible for accountability agreements with public health units, and ministry funding for public health units would be transferred to the LHINs for allocation to public health units. Local boards of health would continue to set budgets, and public health services would be managed at the municipal level.

With the above four changes the ministry would continue to play a strong role in setting standards and performance targets, which would help ensure consistency across the province. The LHINs would be responsible for performance management, and for preparing reports on quality and performance that would be shared with the public and providers.

## A PATH FORWARD

With *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, the ministry will engage the public and providers to discuss the proposal. The ministry has many questions concerning how to plan for and implement the proposed approach successfully. The full paper includes a series of discussion questions. The ministry is committed to listening. You are invited to review the full paper at www.health.gov.on.ca/en/news/bulletin and submit feedback or pose questions to health.feedback@ontario.ca.

The ministry looks forward to continuing the conversation…and to taking the next steps towards building a high-performing, better connected, more integrated, patient-centred health system.

# OUR PROMISE

## Put Patients First

In the *Patients First: Action Plan for Health Care* (February 2015), the Ontario Ministry of Health and Long-Term Care set clear and ambitious goals for Ontario's health care system:

### Access

Improve access - providing faster access to the right care.

### Connect

Connect services - delivering better coordinated and integrated care in the community closer to home.

### Inform

Support people and patients - providing the education, information and transparency Ontarians need to make the right decisions about their health.

### Protect

Protect our universal public health care system - making decisions based on value and quality, to sustain the system for generations to come.

To achieve these goals, the ministry must put patients, clients and caregivers first. We must create a responsive health system where:

- care providers work together to provide integrated care,
- patients and their caregivers are heard and play a key role in decision making and in their care plans,
- people can move easily from one part of the system to another,
- someone is accountable for ensuring that care is coordinated at the local level.

# OUR PROGRESS

Over the past 10 years, Ontario's health care system has made great progress in improving the patient experience:

- **More access to primary care.** Family physicians, nurse practitioners and other health care providers — often working in team-based practices — have improved access to primary care. Nearly four million Ontarians receive care through these new teams.
- **More care closer to home.** Home and community care providers are providing care for more clients — many with complex conditions — at home, for longer periods of time.
- **Shorter hospital wait times.** Hospitals have reduced wait times for most surgical procedures and improved emergency department wait times, despite the fact that the number of people needing these services continues to increase. Hospitals are actively using evidence, data and information on the patient experience to improve quality.
- **More support for people to stay healthy.** There is a greater focus on disease prevention and health promotion.
- **More protection for our health system.** The *Excellent Care for All Act, 2010* has put in place tools and processes that have increased transparency, enhanced the system's focus on quality, and engaged Ontarians in improving health system performance.

These accomplishments are the result of a great deal of planning and hard work by all parts of the health system: hospitals, primary care and specialized offices and clinics, home and community care, long-term care homes, LHINs, CCACs and other health service organizations that provide care to Ontarians.

**TODAY, 94%**
of Ontarians report having a regular primary health care provider.

Compared to 2003,
**OVER 24,000**
more nurses and
**6,600**
more physicians are providing patient care.

Physicians representing more than
**10 MILLION ONTARIANS**
now have electronic medical records.

**OVER 80%**
of primary care physicians use electronic medical records in their practice.

Flu shots are available in
**2,500**
pharmacies.

Vaccines and newborn screening programs have been expanded.

**1,076**
health care organizations submit annual Quality Improvement Programs.

# A PROPOSAL
## to Strengthen Patient-Centred Care

Despite the progress, there is still more to do. Listening to patients, clients, caregivers and providers, we know that some people can struggle to get the primary care and home and community care services they need, and they still find the system fragmented and hard to navigate. We also know services are not as consistent as they should be across the province.

What we have heard from Ontarians has been confirmed in a series of expert reports, including those developed by Health Quality Ontario, the Auditor General of Ontario, the Primary Health Care Expert Advisory Committee, the Expert Group on Home and Community Care, the Commission on the Reform of Ontario's Public Service (the Drummond Report), and the Registered Nurses' Association of Ontario.

To ensure Ontarians receive seamless, consistent, high quality care — regardless of where they live, how much they earn or their ethnicity — we must address the challenges that affect the system's ability to provide integrated patient-centred care.

Many of these challenges arise from the disparate way these different health services are planned and managed. Some — such as hospitals, long-term care, community services and mental health and addiction services — are planned and managed by the province's Local Health Integration Networks (LHINs). Others — such as primary care, home and community care services, and population and public health services — are currently planned and managed in different ways.

We propose expanding the LHINs' mandate to include primary care planning and performance management; home and community care management and service delivery; and developing formal linkages with public health to improve population and public health planning. Under this proposal, LHINs would assume responsibility for planning, managing and improving the performance of all health services within a region, while still maintaining clinician and patient choice.

In this paper, we describe in more detail the challenges facing the health care system as well as the structural changes being proposed. We also pose a series of questions for discussion.

# IMPROVING HEALTH EQUITY AND REDUCING HEALTH DISPARITIES

Our proposed plan focuses specifically on ways to improve access to consistent, accountable and integrated primary care, home and community care, population health and public health services. Informing this proposal are the needs of diverse Ontarians who rely on our health care system, including seniors and people with disabilities, as well as health equity and the importance of the social determinants of health, such as income level and geography.

The ministry also recognizes that some Ontarians struggle to access health and social services.

- The health outcomes of **Indigenous Peoples in Ontario** — particularly those living in remote and isolated communities — are significantly poorer than those of the general population. Improving health care and health outcomes for First Nations, Métis and Inuit peoples is a ministry priority. This means the health care system must provide better supports and services for patients, families and caregivers, and these services must respect traditional methods and be culturally appropriate. To develop these services, we will build and maintain productive and respectful working relationships at both the provincial and local levels. We will meaningfully engage Indigenous partners through parallel bilateral processes. Through collaboration, we will identify the changes needed to ensure health care services address the unique needs of First Nations, Métis and Inuit peoples no matter where they live across the province.
- **Franco-Ontarians** face challenges obtaining health services in French. To meet their needs, and improve their patient experience and health outcomes, we must ensure that the health care system is culturally sensitive and readily accessible in French.
- Members of **other cultural groups, particularly newcomers**, may struggle to get the health care they need. As part of our commitment to health equity, the system must be able to recognize the challenges that newcomers face and provide culturally appropriate care and timely access.

- **People who experience mental health and addiction challenges** also face barriers to getting the care they need when they need it. The ministry is committed to strengthening mental health and addictions services. We will look to the work of the Mental Health and Addictions Leadership Advisory Council to ensure that changes in mental health and addiction services enhance access and improve overall system performance.

Over the next few years, as we continue to transform and restructure the health care system — making it more integrated, accessible, transparent and accountable — we will work to improve health equity and reduce health disparities. In their expanded role, LHINs would be responsible for understanding the unique needs of Indigenous peoples, Franco-Ontarians, newcomers, and people with mental health and addiction issues in their regions, and providing accessible, culturally appropriate services. At the same time, the ministry would pursue discussions with these partners to determine how best to adapt system structures to provide effective person-centred care.

# THE PROPOSAL

### 1. More Effective Integration of Services and Greater Equity

## THE ISSUE

The Ontario health care system offers excellent services, but they are fragmented in the way they are planned and delivered. This fragmentation can affect the patient experience. It can also result in inefficient use of patient and provider time and resources, and have a negative impact on health outcomes.

## THE SITUATION NOW

Under the *Local Health System Integration Act*, *2006*, the 14 LHINs are responsible for managing their local health systems. LHINs plan and manage performance in the acute care, long-term care, community services, and mental health and addictions sectors. Other services are managed differently. For example, CCACs are responsible for planning and contracting home care services and administering the placement process for long-term care. Although CCACs are accountable to the LHINs for their performance and receive funding from the LHINs, they have their own boards and operate rather independently. Other than the ministry, there is no organization accountable for planning primary care or specialist care services, and very little focus on managing or improving primary care performance. The province's public health services also have their own system for planning and delivering services.

Since their creation a decade ago, the LHINs have improved regional planning for and integration of some services. Across the LHINs, we've seen the impact of some successful efforts to integrate providers and services.

However, as the Auditor General recently noted, the LHINs lack the mandate and tools to align and integrate all health services. Under their current mandate, they cannot hold some parts of their local systems accountable or manage improvement in many service areas.

Through Health Quality Ontario, we also learned that there is variation across LHINs in terms of health outcomes. We have also heard that some LHIN boundaries may no longer fit patient care patterns in their communities.

### EXAMPLES OF SUCCESSFUL INTEGRATION

- Collaborative care models, such as Family Health Teams, Community Health Centres, Aboriginal Health Access Centres and Nurse Practitioner-Led Clinics, allow health care providers to work together as an integrated team to deliver comprehensive care and coordinate services with a range of partners, including home and community care.
- Integrated service models, such as Health Links, bring together health care and other providers in a community to better and more quickly coordinate care for patients with complex needs.

To reduce gaps and ensure that services meet local needs, it is time to enhance the LHINs' authority. In a health care system focused on performance management and continuous quality improvement, it is also important for the ministry to hold the LHINs accountable for their performance. As part of any transformation, we must ensure their activities result in better access as well as greater consistency of services across the province.

## PROPOSAL #1

**To provide care that is more integrated and responsive to local needs, make LHINs responsible and accountable for all health service planning and performance.**

**Identify smaller regions as part of each LHIN to be the focal point for local planning and service management and delivery.**

In their expanded role, LHINs would:

- Assess local priorities and current performance, and identify areas for improvement.
- Work with providers across the care continuum to improve patients' access to services, and make it easier for both patients and providers to navigate the system.
- Integrate and improve primary care, home and community care, acute care, mental health and addiction services and public health across the entire health care system.
- Drive the adoption of technology to enhance care delivery through, for example, integrated systems or virtual access to care providers through telemedicine.
- Prepare public reports about the patient experience with different health services and other reported outcomes to help drive improvements.

Although the LHINs have demonstrated that they are the right structure to enhance service integration, accountability and quality, they themselves would need some adjustments and additional tools to take on an expanded role. For example, their governance structures would need to be revisited (see Appendix) and their boundaries would need to be reviewed and possibly refined. In addition, LHINs would be asked to identify smaller geographic areas within their regions — or LHIN sub-regions — that reflect community geography, such as the current Health Links regions. Such LHIN sub-regions would be the focus for strengthening, coordinating and integrating primary health care, as well as more fully integrating primary care with home and community care, and ultimately fulfilling the clinical coordination responsibilities currently provided by the CCACs.

### ACROSS ONTARIO'S 14 LHINs

- **Life expectancy ranges between 78.6 and 83.6 years old.**
- **Smoking, obesity, and physical activity rates vary.**
- **The percentage of people who report that their health status is excellent or very good ranges from 6.8 per cent to 11.7 per cent.**

In the transformed system, the ministry would retain its role in health workforce planning, in collaboration with LHINs and other partners.

## QUESTIONS FOR DISCUSSION:

- How do we support care providers in a more integrated care environment?
- What do LHINs need to succeed in their expanded role?
- How do we strengthen consistency and standardization of services while being responsive to local differences?
- What other local organizations can be engaged to ensure patients are receiving the care they need when they need it? What role should they play?
- What other opportunities for bundling or integrating funding between hospitals, community care, primary care and possibly other sectors should be explored?
- What areas of performance should be highlighted through public reporting to drive improvement in the system?
- Should LHINs be renamed? If so, what should they be called? Should their boundaries be redrawn?

### ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ Care delivered based on community needs
- ✓ Appropriate care options enhanced within communities
- ✓ Easier access to a range of care services
- ✓ Better connections between care providers in offices, clinics, home and hospital

### 2. Timely Access to Primary Care, and Seamless Links Between Primary Care and Other Services

## THE ISSUE

Despite a significant increase in the number of primary care providers, in some cases, Ontarians still find it difficult to get care when they need it. As a result, many patients use costly emergency departments for primary care problems. At the same time, primary care providers report that, because of the way the system is organized, they find it difficult to connect their patients to the other health services they need.

## THE SITUATION NOW

All high-performing health care systems are based on strong primary care services delivered through a variety of models, including family doctors and primary care nurse practitioners working as part of inter-professional teams. Effective primary care is essential to improving health outcomes.

To understand how well Ontario's primary care services perform, Health Quality Ontario compared Ontario data with international data from the Commonwealth Fund. Compared to other developed countries, it found that Ontario performs poorly on access measures, such as same- or next-day appointments when people are sick or weekend after-hours appointments. It also found that, in Ontario, access to primary care is influenced by where people live and factors such as immigration status or the language spoken most often at home

The 2015 report *Patient Care Groups: A new model of population based primary health care for Ontario*, prepared by the Primary Health Care Expert Advisory Committee led by Dr. David Price and Elizabeth Baker, highlighted the challenges that primary care providers face when trying to connect their patients with other health services and suggested ways to address many of these challenges.

**57%**
**of Ontarians cannot see their primary care provider the same day or next day when they are sick.**

**52%**
**find it difficult to access care in the evenings or on weekends.**

**Low-acuity patients account for**
**34%**
**of emergency department visits.**

## PROPOSAL #2

**Bring the planning and monitoring of primary care closer to the communities where services are delivered. LHINs, in partnership with local clinical leaders, would take responsibility for primary care planning and performance management.**

**Set out clearly the principles for successful clinical change, including engagement of local clinical leaders.**

Every Ontarian who wants a primary care provider should have one. Primary care should act as a patient's "Medical Home", offering comprehensive, coordinated, and continuous services and working with other providers across the system to ensure that patient needs are met. Making the LHIN and LHIN sub-regions the focal points for primary care planning and performance measurement would be a crucial step towards achieving these goals.

With the proposed approach:

- LHINs would work closely with primary care leaders, patients and providers to plan and monitor performance within each LHIN sub-region.

- Planning would include improving access to inter-professional teams for those who need it most, facilitating care plans and supporting an integrated, coordinated patient-centred experience.
- LHINs, in partnership with local clinician leaders, would be responsible for recruitment planning, linking new patients with doctors and nurse practitioners, and improving access and performance in primary care.
- To make it easier for patients to connect with primary care, each LHIN sub-region would have a process to match unattached patients to primary care providers.
- Existing relationships between patients and their care providers would continue. Patients will always have the right to choose their primary care provider, and the sub-regions would help patients change physicians or nurse practitioners to get care closer to home. Similarly, clinicians would retain choice for what patients they care for within their sub-regions.
- While LHINs would play a greater role in primary care health human resources planning, physician compensation and primary care contracts would continue to be negotiated by the government and administered centrally. Ontario Medical Association (OMA) representation rights would continue to be respected.
- To help drive continuous quality improvement in primary care, the ministry would more methodically measure patient outcomes in primary care to help understand the patient experience accessing primary care, including same-day and after-hours care, and satisfaction with service.
- LHINs would collect, assess and publish performance indicators at a sub-region level and share that information with health care providers and managers to support performance improvement, as well as to help inform the organization of primary care in each LHIN sub-region.

With the proposed emphasis on local care coordination and performance improvement, the primary care sector would be better positioned to meet the needs of communities across the province. These changes will enable the approach to Patient-Centered Medical Homes as recommended by the Ontario College of Family Physicians and others.

## QUESTIONS FOR DISCUSSION

- How can we effectively identify, engage and support primary care clinician leaders?
- What is most important for Ontarians when it comes to primary care?
- How can we support primary care providers in navigating and linking with other parts of the system?
- How should data collected from patients about their primary care experience be used? What data and information should be collected and publicly reported?

There are more than
**12,000**
primary care physicians in Ontario, and about
**450**
enter practice each year.

### ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ All patients who want a primary care provider have one
- ✓ More same-day, next-day, after-hours and weekend care
- ✓ Lower rates of hospital readmissions
- ✓ Lower emergency department use
- ✓ Higher patient satisfaction

### 3. More Consistent and Accessible Home and Community Care

## THE ISSUE

Home and community care services are inconsistent across the province and can be difficult to navigate. Many family caregivers who look after people at home are experiencing high levels of stress – due in part to the lack of clear information about the home care services available and how to access them. Primary care providers report problems connecting with home care services, and home care providers say the same thing about their links to primary care.

## THE SITUATION NOW

The last major reform of home and community care was in 1996 with the creation of 43 CCACs responsible for planning, coordinating, delivering and contracting services designed to help people leave hospital earlier and stay independent in their homes for as long as possible. In 2007, the 43 CCACs were amalgamated to align geographically with the LHINs.

*Bringing Care Home*, the 2015 report of the Expert Group on Home and Community Care led by Dr. Gail Donner, highlighted the ongoing service challenges in the home and community care sector. According to that report, the current model is cumbersome. It lacks standardization across the province and is not consistently delivering the services that people need, including our growing population of seniors. However, the Expert Group encouraged the government to focus first on functional change before addressing any structural changes.

**Timing of first nursing and personal support visits varies by Community Care Access Centre.**

**One-third of informal caregivers are distressed, twice as many as four years ago.**

The ministry responded with the *Roadmap to Strengthen Home and Community Care*, which outlined a plan to improve care delivery. This work is well underway and includes bundled care initiatives, self-directed care and more nursing services at home for those who need them, among other initiatives.

The Auditor General recommended that the ministry revisit the model of home care delivery in Ontario — echoing recommendations in the 2012 report from the Commission on the Reform of Ontario's Public Service (the Drummond Report). In its 2012 report, *Enhancing Community Care for Ontarians*, the Registered Nurses' Association of Ontario also encouraged the ministry to review the duplication within the current home and community care system, and to improve linkages with primary care.

## PROPOSAL #3

### Strengthen accountability and integration of home and community care. Transfer direct responsibility for service management and delivery from the CCACs to the LHINs.

The ministry proposes to move all CCAC functions into the LHINs to help integrate home and community care with other parts of the health care system, and to improve quality and accountability. The proposed shift will create opportunities to embed home and community coordinators in other parts of the system.

Under this proposal:

- The LHIN board would govern the delivery of home and community care, and the CCAC boards would be dissolved.
- CCAC employees providing support to clients would be transitioned to and employed by the LHINs.
- Home care coordinators would be focused on LHIN sub-regions, and may be deployed into community settings (such as family health teams, community health centres or hospitals).
- Home care services would continue to be provided by current service providers. Over time, contracts with these service providers would be better coordinated and more consistent within the geographic model of the LHIN sub-regions.
- LHINs would be responsible for the long-term care placement process currently administered by CCACs.
- The ministry's ten-point plan for improving home and community care would continue under LHIN leadership.

While care planning and delivery would be done at the local level, the function of establishing clinical standards and outcomes-based performance targets for home and community care would be centralized. Having common standards and targets for the whole province will ensure more consistent and higher-quality care.

## QUESTIONS FOR DISCUSSION

- How can home care delivery be more effective and consistent?
- How can home care be better integrated with primary care and acute care while not creating an additional layer of bureaucracy?
- How can we bring the focus on quality into clients' homes?

### ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ Easier transitions from acute, primary and home and community care and long-term care
- ✓ Clear standards for home and community care
- ✓ Greater consistency and transparency around the province
- ✓ Better patient and caregiver experience

### 4. Stronger Links Between Public Health and Other Health Services

## THE ISSUE

Public health has historically been relatively disconnected from the rest of the health care system. Public health services vary considerably in different parts of the province and best practices are not always shared effectively. While local initiatives and partnerships have been successful, public health experts are not consistently part of LHIN planning efforts to improve population health. Many aspects of the health care system are not able to properly benefit from public health expertise, including issues related to health equity, population health and the social determinants of health.

## THE SITUATION NOW

Public health services in Ontario are managed by 36 local public health units, whose mandate is to assess population health (e.g. the health status of their community) and implement programs to improve health. Because the public health system is municipally based, public health unit areas do not align with LHIN boundaries.

Improving population health is an important goal for both local public health units and the health care system as a whole. However, many of the complex social, economic and environmental factors that affect health — such as income, education, adequate housing and access to healthy foods — lie outside the health system. In their efforts to improve health, public health units look at how these complex determinants collectively affect the health of individuals and communities.

According to the 2015 Health Quality Ontario report, population health outcomes vary across our communities. To close these gaps, the health system needs more consistent and meaningful collaboration and coordination between public health, the rest of the health care system and LHINs.

While many important public health functions — such as restaurant inspections — do not overlap with health care planning or delivery, others — such as surveillance of reportable infectious diseases, documentation of immunizations, smoking cessation programs and other health promotion initiatives — do. Where the system's and public health's interests overlap, public health would benefit from more in-depth knowledge of the population's health status available through LHINs as well as the LHINs' ability to distribute health resources to address health inequities. LHINs would also benefit from greater access to public health expertise when planning health services.

## PROPOSAL #4

### Integrate local population and public health planning with other health services. Formalize linkages between LHINs and public health units.

To better integrate population health within our health system, we propose that LHINs and public health units build on the collaborations already underway, and work more closely together to align their work and ensure that population and public health priorities inform health planning, funding and delivery.

To support this new formal relationship:

- The ministry would create a formal relationship between the Medical Officers of Health and each LHIN, empowering the Medical Officers of Health to work with LHIN leadership to plan population health services.
- The ministry would transfer the dedicated provincial funding for public health units to the LHINs for allocation to public health units. The LHINs would ensure that all transferred funds would be used for public health purposes.
- The LHINs would assume responsibility for the accountability agreements with public health units.
- Local boards of health would continue to set budgets.
- The respective boards of health, as well as land ambulance services, would continue to be managed at the municipal level.

As part of a separate initiative to support more consistent public health services across the province, the ministry is modernizing the Ontario Public Health Standards and Organizational Standards to identify gaps and duplication in service delivery; determine capacity and resource needs; and develop options for greater effectiveness.

The ministry would also appoint an Expert Panel to advise on opportunities to deepen the partnership between LHINs and public health units, and how to further improve public health capacity and delivery.

## QUESTIONS FOR DISCUSSION

- How can public health be better integrated with the rest of the health system?
- What connections does public health in your community already have?
- What additional connections would be valuable?
- What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

### ANTICIPATED PERFORMANCE IMPROVEMENTS

- ✓ Health service delivery better reflects population needs
- ✓ Public health and health service delivery better integrated to address the health needs of populations and individuals
- ✓ Social determinants of health and health equity incorporated into health care planning
- ✓ Stronger linkages between disease prevention, health promotion and care

# WHAT WOULD THE PROPOSED CHANGES MEAN FOR ONTARIANS?

**Patients, clients and family caregivers** would have one point of contact in each LHIN sub-region responsible for connecting them with a primary care provider, as well as other health services and resources. All Ontarians should have better access to inter-professional providers including specialists when they need them, including better access to same-day, next-day, and after-hours and weekend care.

Ontarians — including patients recovering from a stay in hospital and people who are frail or who have chronic conditions — would find it easier to understand, access and navigate the home and community care services available to them.

Patient choice will be respected. People who have pre-existing relationships with primary care providers outside their LHIN sub-region will not have to change providers. One of the guiding principles of home care during and after the transition will be ensuring continuity of care providers.

**Physicians, nurses and other care providers** would work in a system and structure that supports integration, helps them do their jobs, maintains their clinical autonomy, makes the most of their time and expertise, and sets clear accountabilities. Clinicians would benefit from improved access to personal health information that makes it easier to coordinate care and track the care patients receive in different parts of the system. Health care providers would also retain choice for deciding what patients they would care for.

**Specialist physicians** would benefit from local planning that enhances access to their services and promotes the use of technology (e.g. e-consult and e-referral) and shared care using telemedicine to provide services for complex patients who live far from specialty care.

**Hospitals** would benefit because changes in the primary care and home and community care sectors would enable them to provide more continuous care, and help address intractable problems such as high rates of hospital readmissions, alternate level of care and inappropriate use of emergency services.

## PATIENT CHOICE WILL BE PROTECTED

- No one will have to change primary care providers.
- Care decisions will take into account where people live, work and go to school.
- There will be no new restrictions on long-term care home choices.
- There will be no new layer of bureaucracy between Ontarians and the health services they need.

**CCAC employees** perform essential work that will continue under this proposal. CCAC employees who support clients would be integrated into the LHINs and their collective agreements will be respected. Some CCAC coordinators may end up working in hospitals or primary care settings, but they will still be employed by the LHINs. The CCAC management structure would be reviewed in conjunction with the management structure of expanded LHINs in order to support service planning and delivery in a way that maximizes care for patients and clients while improving efficiency.

**Public health staff** would see no change in the critical work they do every day in their communities. However, they would have stronger links with other parts of the health system.

**Long-term care leaders and employees** would have better support in managing transitions for clients between acute home and community care, and long-term care. They should benefit from better service planning and delivery in the home and community sector.

**The health system** itself would be more efficient. There would be less duplication of services, better sharing of information and more effective use of technology to ensure quick access to health information, including lab results and diagnostic imaging. Connections across the full continuum of care would mean, for example, that family physicians receive hospital discharge summaries and providers in the acute sector receive community care assessments. Patients would also have access to publicly available information about health system performance that is specific and relevant to them.

# A PATH FORWARD

The proposed structural changes to Ontario's health care system are designed to strengthen patient-centred care and deliver high-quality, consistent and integrated health services to all Ontarians. Implementing these changes while ensuring the continuity and improvement of high-quality services will require a well-thought-out and carefully implemented plan.

The ministry has questions about how to successfully plan for and implement this proposed approach. With the release of this discussion paper, the ministry will begin an engagement process to discuss the proposal and its refinement. The ministry is committed to listening to staff and clinicians, patients, clients and caregivers, other health care partners, Indigenous peoples, and municipal and other community and government partners.

We hope to receive feedback on the questions in this proposal, including:

- How can clinicians and health care providers be supported in leadership roles in continued system evolution?
- How do we ensure changes are supportive of and responsive to future service changes that are still being worked on, such as home and community care?
- How do we create a platform for further service integration, such as enhanced community mental health and addictions services?
- What accountability measures need to be put in place to ensure progress is being made in integrating health care services and making them more responsive to the needs of the local population?
- How do we support improved integration through enhanced information systems, data collection and data sharing?
- What can be done to ensure a smooth transition from the current system to the one proposed in this proposal?
- How would we know whether the plan is working?

If there are other questions, please submit them for consideration. Feedback and questions can be sent to health.feedback@ontario.ca or submitted at www.health.gov.on.ca/en/news/bulletin.

The ministry looks forward to continuing the conversation about this proposal in a variety of forums. We hope this discussion will result in a plan that can successfully build a high-performing, better connected, more integrated, patient-centred health system — one that responds to local needs and is committed to continuous quality improvement.

**The proposed model would require changes to legislation including but not limited to the *Local Health System Integration Act, 2006,* the *Community Care Access Corporations Act, 2001,* the *Home Care and Community Services Act, 1994,* the *Health Protection and Promotion Act,* among others. The ministry is reviewing relevant acts and intends to propose draft legislation for consideration by the Legislative Assembly in the spring of 2016.**

# APPENDIX

## System Governance

The success of the proposal outlined in this paper is based on the ministry, LHINs and health care providers having the tools they need for effective governance and management. Clear and meaningful accountability relationships will be developed, and transparent performance measurement must be strengthened.

To fulfill their new responsibilities, the LHINs would require expanded boards and leadership with the necessary skills, expertise and local knowledge.

At the same time, LHINs need to be aligned with the ministry's objectives to ensure accountability to Ontarians and consistently equitable services. LHIN activities would need to be carefully defined and performance plans supported and enforced by the ministry. A variety of measures would be put in place to enhance LHIN accountability to the ministry and to Ontarians, including transparency, the identification of standards, funding and enhanced ministry authority.

As the 2008 report *High Performing Healthcare Systems: Delivering Quality by Design* demonstrated, it is possible to develop a culture of quality when objectives and structures are aligned.

### QUESTIONS FOR DISCUSSION

- What other tools are needed for effective governance?
- What would be the most effective structure for LHIN boards and their executive?
- How can LHINs promote leadership at the local level?

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**Ministry of Health and Long-Term Care**

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel 416-327-4300
Fax 416-326-1571
www.ontario.ca/health

**Ministère de la Santé et des Soins de longue durée**

Bureau du ministre

Édifice Hepburn, 10e étage
80, rue Grosvenor
Toronto ON M7A 2C4
Tél 416-327-4300
Téléc 416-326-1571
www.ontario.ca/sante

Ontario

DEC 17 2015

HLTC2980IT-2015-1706

Mr. Lee Mason
Chair
Board of Health for the District of Algoma Health Unit
294 Willow Avenue
Sault Ste. Marie ON P6B 0A9

Dear Mr. Mason:

Over the past several years, Ontario's care providers and health system partners have worked hard to create meaningful change across the system. There has been significant progress in access to primary care, a greater focus on health promotion, and more supports at home and in the community.

Although there have been many meaningful accomplishments, the Ontario health care system remains characterized by excellent services that are separate in their delivery and funding. This affects access, quality, and consistency of care. We believe that our system needs structural change to improve delivery and sustainability of the services that Ontarians rely on.

The ministry has released *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*, a discussion paper that outlines proposed changes for the health system. The proposed structural changes would see Local Health Integration Networks assume responsibility for home and community care and system integration, and have greater involvement with primary care, and improved linkages with population health planning. The discussion paper can be found here: http://www.health.gov.on.ca/en/news/bulletin/.

The ministry looks forward to continuing the dialogue about this proposal in a variety of forums. We are committed to a meaningful engagement process that includes all health system partners, as well as patients. We hope this input will result in a plan that can successfully build a high-performing health system that is more responsive to local needs, is better connected and integrated, drives quality and performance, and enhances transparency for providers and patients, clients and their families.



.../2

Mr. Lee Mason

Yours sincerely,

Dr. Eric Hoskins
Minister

Algoma
PUBLIC HEALTH
Santé publique Algoma

www.algomapublichealth.com

# MEMORANDUM

Date: January, 26, 2016

To: Susan Poch, Senior Program Consultant (Housing)
Ministry of Health and Long Term Care

From: Jan Metheany, Program Manager
Algoma Public Health-Community Mental Health

RE: 1) 2016/2017 Supportive Housing Operating Budget Submission
2) 2016/2017 Transformation Housing Initiative Operating Budget Submission

---

1) The Program administers four Supportive Housing Rent Supplement funding initiatives:

*Mental Health Homelessness Initiative Phase 2 (HIP 2) & Program 750*....$ 149,268

*Service Enhancement*.....$ 97,932

*Residential Addiction-Rent Supplement Program*.....$ 48,900

*New Mental Health & Addiction Initiative*.....$ 30,800

**Total 2016/17 Rent Supplement Budget Request: $ 326,900**

2) The program also administers one Transformation Supportive Housing Initiative:

*Road to Recovery Supportive Housing Initiative*.....$ 128,000

**Total 2016/17 Transformation Housing Budget Request: $ 128,000**

**Total 2016/17 Algoma Public Health Program # 1536 Supportive Housing Initiative(s) Budget Requests: $ 454,800**

I have attached both the Supportive Housing Operating Budget & Transformation Housing Operating Budget submission for the 2016/2017 fiscal year. Please contact me if you have any questions.

/cs


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

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

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

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

Ministry of Health and Long-Term Care
Negotiations and Accountability
Management Division
Provincial Programs Branch
56 Wellesley Street West, 9th Floor
Toronto ON M5S 2S3
Telephone: (416) 327-7039

Ministère de la Santé et des
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# MENTAL HEALTH & ADDICTIONS HOUSING PROGRAMS

**Budget Forms**

CONTENTS OF PACKAGE:

Ministry of Health and Long-Term Care
Negotiations and Accountability Management Division
Provincial Programs Branch
56 Wellesley Street West,
9th Floor
Toronto ON M5S 2S3
Telephone: (416) 327-7039

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Ontario

# MENTAL HEALTH & ADDICTIONS HOUSING PROGRAM BUDGET

## IDENTIFICATION



| Corporation name |
|---|
| Algoma Public Health - Ministry Program # 1536 |

| Year ended |
|---|
| 2016-2017 |

| | # Units Occupied | # Clients |
|---|---|---|
| MH Rent Supp | 67 | 67 |
| Service Enhancement | 41 | 41 |
| MH & A Strategy | 7 | 7 |
| Addictions | 16 | 16 |

| Corporation address | Mailing address |
|---|---|
| Algoma Public Health - Community Mental Health Program<br>294 Willow Ave<br>Sault Ste. Marie, ON P6B 0A9 | Community Mental Health Program<br>294 Willow Ave<br>Sault Ste Marie, ON P6B 0A0 |

| Program Contact | Position | Telephone number | e-mail address |
|---|---|---|---|
| Jan Metheany | Program Manager | 705-759-3935 | jmetheany@algomapublichealth.com |
| **Finance Contact** | **Position** | **Telephone number** | **e-mail address** |
| Justin Pino | Chief Financial Officer | 705-942-4646 Ext. 5232 | jpino@algomapublichealth.com |
| **Board Chair/President** | **Position** | **Telephone number** | **e-mail address** |
| Lee Mason | Board Chair | 705- 759-5421 | lmason@algomapublichealth.com |
| **Executive Director/CEO** | **Position** | **Telephone number** | **e-mail address** |
| Tony Hanlon | CEO | 705-759-5421 | thanlon@algomapublichealth.com |
| | | **Facsimile** | 05-759-2105 |

## MANAGEMENT DECLARATION BY BOARD OF DIRECTORS

**I declare that, to the best of my knowledge and belief, the information provided in this Mental Health Housing Programs Budget accurately reflects the budget approved by the corporation's Board of Directors.**

| Signature | Name | Board Position | Date |
|---|---|---|---|
| | | | |

| Signature | Name | Board Position | Date |
|---|---|---|---|
| | | | |

Instructions

( 1 ) This form should be used by Agencies which administer Homelessness Phase I and Phase II Capital Projects, and the following Rent Supplement Programs : Homelessness Phase I and Phase II, Service Enhancements Phase I and Phase II, Mental Health Program 750, Mental Health Program 500 & Addictions.

( 2 ) The Management Declaration must be signed by **two members of the Board of Directors** on behalf of the Board.

# SCHEDULE A: CAPITAL PURCHASES AND CAPITAL RESERVE FUND

## (TO BE COMPLETED FOR CAPITAL PROJECTS UNDER THE HOMELESSNESS INITIATIVE)

**Capital Projects:**

| | | | |
|---|---|---|---|
| 1 | **Project address** | **Total No. of Units** | **Dollar amount of Capital reserve** (based on $200 per unit) |
| | | | 0 |
| 2 | **Project address** | **Total No. of Units** | **Dollar amount of Capital reserve** (based on $200 per unit) |
| | | | 0 |
| 3 | **Project address** | **Total No. of Units** | **Dollar amount of Capital reserve** (based on $200 per unit) |
| | | | 0 |
| 4 | **Project address** | **Total No. of Units** | **Dollar amount of Capital reserve** (based on $200 per unit) |
| | | | 0 |
| 5 | **Project address** | **Total No. of Units** | **Dollar amount of Capital reserve** (based on $200 per unit) |
| | | | 0 |
| 6 | **Project address** | **Total No. of Units** | **Dollar amount of Capital reserve** (based on $200 per unit) |
| | | | 0 |
| 7 | **Project address** | **Total No. of Units** | **Dollar amount of Capital reserve** (based on $200 per unit) |
| | | | 0 |
| 8 | **Project address** | **Total No. of Units** | **Dollar amount of Capital reserve** (based on $200 per unit) |
| | | | 0 |
| | **Summary** | **Grand Total No. of Units** | **Total base CRA$** |
| | | | 0 |

**Total subsidy** 0

***Shaded boxes are formulated. Please do not input any data in these boxes***

# SCHEDULE B: OPERATING COSTS FOR CAPITAL PURCHASES

## (TO BE COMPLETED FOR CAPITAL PROJECTS UNDER THE HOMELESSNESS INITIATIVE)

* **Project address:** _____

**OPERATING COSTS:**

| | | | |
|---|---|---|---|
| **Maintenance salaries, wages and benefits** | | | |
| **Maintenance materials and services** | | | |
| **Utilities :** | | | |
| **Electricity** | | | |
| **Fuel** | | | |
| **Water and Sewage** | | | |
| | | **Total Utilities** | 0 |
| **Administrative Overhead** | | | |
| **Insurance** | | | |
| **Municipal Taxes** | | | |
| **Other** | | | |
| **TOTAL OPERATING COSTS** | | | 0 |
| **REVENUE:** | | | |
| **Rental Revenue** | ____ (# of Units) x ____ (Rent) x 12 mos | | 0 |
| **Less: Vacancy Loss** | | | |
| **Net Rental Revenue** | | | 0 |
| **Other** | | | |
| **TOTAL REVENUE** | | | 0 |
| **SHELTER SURPLUS/ (DEFICIT)** | | | 0 |

* **Please prepare one Schedule B for each project's address.**

***Shaded boxes are formulated. Please do not input any data in these boxes***

*Ministry of Health and Long-Term Care*
*Negotiations and Accountability Management Division*
*Provincial Programs Branch*
*56 Wellesley Street West, 9th Floor M5S 2S3*

*Ministère de la Santé et des Soins de longue durée*

Ontario

# SCHEDULE C: RENT SUPPLEMENT - HEAD LEASE AND REFERRAL AGREEMENTS

| | #Units |
|---|---|
| **Mental Health Rent Supplement Initiative** | 66 |
| *(Homelessness Ph I & II and MH 500 & 750)* | #Units |
| **MH & A Strategy New 1000 Units** | |

| | #Units |
|---|---|
| **Service Enhancements** | 42 |
| | #Units |
| **Addictions** | |

*(use a separate sheet for a) the Addictions initiative & b) MH & A Strategy )*

**Agency name**
Algoma Public Health
**Program 1536**

**Rent Supplement :**

| Address of Project: | Unit Type | Headlease/ Referral | No. of Units (A) | No. of Months (B) | Monthly Market Rent (C) | Total Market Rent (D)=(AxBxC) | Monthly Rent Revenue (E) | Total Rent Revenue (F)=(AxBxE) | Total Vacancy Loss (G) | Total Rent Subsidy (H)=(D-F+G) | Unilities (I) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 203-138 Kohler Street | 1 Bedroom | R | 1 | 12 | $594.00 | $7128.00 | $479.00 | $5748.00 | $0.00 | $1380.00 | N/A |
| 8-102 Breton Road | 1 Bedroom | R | 1 | 12 | $566.00 | $6792.00 | $479.00 | $5748.00 | $0.00 | $1044.00 | N/A |
| 210A Cathcart St | 1 Bedroom | R | 1 | 12 | $700.00 | $8400.00 | $479.00 | $5748.00 | $0.00 | $2652.00 | N/A |
| 306-807 Trunk Road | 1 Bedroom | R | 1 | 12 | $650.00 | $7800.00 | $479.00 | $5748.00 | $0.00 | $2052.00 | N/A |
| 25-903 Queen St E | 1 Bedroom | R | 1 | 12 | $685.00 | $8220.00 | $479.00 | $5748.00 | $0.00 | $2472.00 | N/A |
| 410-275 Albert St E | 2 Bedroom | R | 1 | 12 | $814.00 | $9768.00 | $493.00 | $5916.00 | $0.00 | $3852.00 | N/A |
| 2-770 Wellingtond Street East | 1 Bedroom | R | 1 | 12 | $635.00 | $7620.00 | $479.00 | $5748.00 | $0.00 | $1872.00 | N/A |
| 1-50 Boehmer Blvd | 1 Bedroom | R | 1 | 12 | $563.00 | $6756.00 | $479.00 | $5748.00 | $0.00 | $1008.00 | N/A |
| 1-220 Pilgrim St | 1 Bedroom | R | 1 | 12 | $600.00 | $7200.00 | $479.00 | $5748.00 | $0.00 | $1452.00 | N/A |
| 2-571 MacDonald Ave | 2 Bedroom | R | 1 | 12 | $673.00 | $8076.00 | $479.00 | $5748.00 | $0.00 | $2328.00 | N/A |
| 1046 Peoples Rd | 1 Bedroom | R | 1 | 12 | $795.00 | $9540.00 | $479.00 | $5748.00 | $0.00 | $3792.00 | N/A |
| 335 Third Avenue, Upper Level | 1 Bedroom | R | 1 | 12 | $650.00 | $7800.00 | $479.00 | $5748.00 | $0.00 | $2052.00 | N/A |
| 642 Wellington St E | Bachelor | R | 2 | 12 | $400.00 | $9600.00 | $0.00 | $0.00 | $0.00 | $9600.00 | N/A |
| 401-138 Kohler Street | 1 Bedroom | R | 1 | 12 | $604.00 | $7248.00 | $479.00 | $5748.00 | $0.00 | $1500.00 | N/A |
| 208-731 Pine Street | 1 Bedroom | R | 1 | 12 | $749.00 | $8988.00 | $479.00 | $5748.00 | $0.00 | $3240.00 | N/A |
| 312-126 Kohler Street | 1 Bedroom | R | 1 | 12 | $644.00 | $7728.00 | $479.00 | $5748.00 | $0.00 | $1980.00 | N/A |
| 75 Edinburgh Street | 1 Bedroom | R | 1 | 12 | $750.00 | $9000.00 | $479.00 | $5748.00 | $0.00 | $3252.00 | N/A |
| 104-108 Allard Street | 1 Bedroom | R | 1 | 12 | $679.19 | $8150.28 | $479.00 | $5748.00 | $0.00 | $2402.28 | 134 |
| 103-138 Kohler Street | 1 Bedroom | R | 1 | 12 | $594.00 | $7128.00 | $479.00 | $5748.00 | $0.00 | $1380.00 | N/A |
| 11 Arbor Drive | 1 Bedroom | R | 1 | 12 | $600.00 | $7200.00 | $479.00 | $5748.00 | $0.00 | $1452.00 | N/A |
| 304-844 Queen St E | Room | R | 1 | 12 | $595.00 | $7140.00 | $479.00 | $5748.00 | $0.00 | $1392.00 | N/A |
| 102 Breton Road | 2 Bedroom | R | 3 | 12 | $569.00 | $20484.00 | $479.00 | $17244.00 | $0.00 | $3240.00 | N/A |
| 113-365 Lake Street | 1 Bedroom | R | 1 | 12 | $704.69 | $8456.28 | $479.00 | $5748.00 | $0.00 | $2708.28 | N/A |
| 301-138 Kohler Street | 1 Bedroom | R | 1 | 12 | $608.00 | $7296.00 | $479.00 | $5748.00 | $0.00 | $1548.00 | N/A |
| 204-844 Queen St E | Room | R | 1 | 12 | $595.00 | $7140.00 | $479.00 | $5748.00 | $0.00 | $1392.00 | N/A |
| 305-844 Queen Street East | Room | R | 1 | 12 | $595.00 | $7140.00 | $479.00 | $5748.00 | $0.00 | $1392.00 | N/A |
| 180 Elgin St | Room | R | 1 | 12 | $679.00 | $8148.00 | $479.00 | $5748.00 | $0.00 | $2400.00 | N/A |
| 289 Wellington St W | 2 Bedroom | R | 3 | 12 | $800.00 | $28800.00 | $479.00 | $17244.00 | $0.00 | $11556.00 | N/A |
| G11-379 Lake Street | 1 Bedroom | R | 1 | 12 | $678.78 | $8145.36 | $479.00 | $5748.00 | $0.00 | $2397.36 | N/A |
| 2 Third Avenue | 2 Bedroom | R | 1 | 12 | $475.00 | $5700.00 | $376.00 | $4512.00 | $0.00 | $1188.00 | N/A |
| 101-126 Kohler Street | 1 Bedroom | R | 1 | 12 | $638.00 | $7656.00 | $479.00 | $5748.00 | $0.00 | $1908.00 | N/A |
| 510-100 James St | 1 Bedroom | R | 1 | 12 | $636.50 | $7638.00 | $479.00 | $5748.00 | $0.00 | $1890.00 | N/A |
| 406-126 Kohler Street | 1 Bedroom | R | 1 | 12 | $662.00 | $7944.00 | $479.00 | $5748.00 | $0.00 | $2196.00 | N/A |
| 2-586 MacDonald Avenue | 2 Bedroom | R | 1 | 12 | $695.00 | $8340.00 | $479.00 | $5748.00 | $0.00 | $2592.00 | N/A |
| 204-619 Wellington St E | 1 Bedroom | R | 1 | 12 | $489.00 | $5868.00 | $479.00 | $5748.00 | $0.00 | $120.00 | N/A |
| 407-94 Allard Street | Room | R | 1 | 12 | $703.32 | $8439.84 | $479.00 | $5748.00 | $0.00 | $2691.84 | N/A |
| B-39 Chiblow Street | 1 Bedroom | R | 1 | 12 | $600.00 | $7200.00 | $479.00 | $5748.00 | $0.00 | $1452.00 | N/A |

| Address of Project: | Unit Type | Headlease/ Referral | No. of Units (A) | No. of Months (B) | Monthly Market Rent (C) | Total Market Rent (D)=(AxBxC) | Monthly Rent Revenue (E) | Total Rent Revenue (F)=(AxBxE) | Total Vacancy Loss (G) | Total Rent Subsidy (H)=(D-F+G) | Unilities (I) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 3-634 Wellington St E | 1 Bedroom | R | 1 | 12 | $650.00 | $7800.00 | $406.50 | $4878.00 | $0.00 | $2922.00 | N/A |
| 308-76 Allard Street | 1 Bedroom | R | 1 | 12 | $736.00 | $8832.00 | $479.00 | $5748.00 | $0.00 | $3084.00 | N/A |
| 201-138 Kohler Street | 1 Bedroom | R | 1 | 12 | $606.00 | $7272.00 | $479.00 | $5748.00 | $0.00 | $1524.00 | N/A |
| 144-760 Great Northern Road | Room | R | 1 | 12 | $1437.77 | $17253.24 | $907.62 | $10891.44 | $0.00 | $6361.80 | N/A |
| 2-104 Albert St E | 1 Bedroom | R | 1 | 12 | $685.00 | $8220.00 | $479.00 | $5748.00 | $0.00 | $2472.00 | N/A |
| 603 Wellington St. W. - Main Floor | 1 Bedroom | R | 1 | 12 | $625.00 | $7500.00 | $479.00 | $5748.00 | $0.00 | $1752.00 | N/A |
| 109-352B Dacey Road | 1 Bedroom | R | 1 | 12 | $869.85 | $10438.20 | $543.85 | $6526.20 | $0.00 | $3912.00 | N/A |
| 205-27 Terry Fox Place | 1 Bedroom | R | 1 | 12 | $758.77 | $9105.24 | $518.11 | $6217.32 | $0.00 | $2887.92 | N/A |
| 408-126 Kohler Street | 1 Bedroom | R | 1 | 12 | $662.00 | $7944.00 | $479.00 | $5748.00 | $0.00 | $2196.00 | N/A |
| 2-420B McNabb Street | 1 Bedroom | R | 1 | 12 | $695.00 | $8340.00 | $479.00 | $5748.00 | $0.00 | $2592.00 | N/A |
| 3-76 Willow Avenue | 1 Bedroom | R | 1 | 12 | $600.00 | $7200.00 | $479.00 | $5748.00 | $0.00 | $1452.00 | N/A |
| 205-126 Kohler Street | 1 Bedroom | R | 1 | 12 | $677.00 | $8124.00 | $479.00 | $5748.00 | $0.00 | $2376.00 | N/A |
| 205-1046 Peoples Road | 1 Bedroom | R | 1 | 12 | $565.61 | $6787.32 | $479.00 | $5748.00 | $0.00 | $1039.32 | N/A |
| G13-379 Lake Street | 1 Bedroom | R | 1 | 12 | $601.06 | $7212.72 | $479.00 | $5748.00 | $0.00 | $1464.72 | N/A |
| 1-482 Second Line West | 1 Bedroom | R | 1 | 12 | $580.00 | $6960.00 | $479.00 | $5748.00 | $0.00 | $1212.00 | N/A |
| 204-980 Wellington St E | 1 Bedroom | R | 1 | 12 | $655.00 | $7860.00 | $479.00 | $5748.00 | $0.00 | $2112.00 | N/A |
| 21-110 Breton Rd | 1 Bedroom | R | 1 | 12 | $538.48 | $6461.76 | $479.00 | $5748.00 | $0.00 | $713.76 | N/A |
| 311 North St | Room | R | 1 | 12 | $635.00 | $7620.00 | $479.00 | $5748.00 | $0.00 | $1872.00 | N/A |
| 31 McKinley Avenue | 2 Bedroom | R | 1 | 12 | $650.00 | $7800.00 | $479.00 | $5748.00 | $0.00 | $2052.00 | N/A |
| 72 Churchill Blvd | House | R | 1 | 12 | $604.42 | $7253.04 | $479.00 | $5748.00 | $0.00 | $1505.04 | N/A |
| 6-21 Ferguson Ave | 1 Bedroom | R | 1 | 12 | $586.00 | $7032.00 | $479.00 | $5748.00 | $0.00 | $1284.00 | N/A |
| 207-379 Lake | 2 Bedroom | R | 1 | 12 | $758.58 | $9102.96 | $479.00 | $5748.00 | $0.00 | $3354.96 | N/A |
| 2-362 Queen Street East | 1 Bedroom | R | 1 | 12 | $650.00 | $7800.00 | $479.00 | $5748.00 | $0.00 | $2052.00 | N/A |
| 206-99 Cambridge Place | 2 Bedroom | R | 1 | 12 | $850.00 | $10200.00 | $529.00 | $6348.00 | $0.00 | $3852.00 | N/A |
| **Totals:** | | | **66** | | **$40345.02** | **$521796.24** | **$29161.08** | **$372924.96** | **$0.00** | **$148871.28** | **134** |
| 580 Charles Street | Room | R | 2 | 12 | $664.00 | $15936.00 | $479.00 | $11496.00 | $0.00 | $4440.00 | N/A |
| 209-760 Great Northern Road | Room | R | 1 | 12 | $1600.71 | $19208.52 | $1020.13 | $12241.56 | $0.00 | $6966.96 | N/A |
| 2-37 Hughes St | 1 Bedroom | R | 1 | 12 | $516.08 | $6192.96 | $479.00 | $5748.00 | $0.00 | $444.96 | N/A |
| 29 Third Avenue | House | R | 1 | 12 | $800.00 | $9600.00 | $479.00 | $5748.00 | $0.00 | $3852.00 | N/A |
| 642 Wellington Street East | 1 Bedroom | R | 2 | 12 | $400.00 | $9600.00 | $0.00 | $0.00 | $0.00 | $9600.00 | N/A |
| 508 Kelly Creek Rd | 1 Bedroom | R | 1 | 12 | $600.00 | $7200.00 | $479.00 | $5748.00 | $0.00 | $1452.00 | N/A |
| 2-527 Farewell Terrace | 1 Bedroom | R | 1 | 12 | $650.00 | $7800.00 | $479.00 | $5748.00 | $0.00 | $2052.00 | N/A |
| 4-246 Wellington St W | 1 Bedroom | R | 1 | 12 | $660.00 | $7920.00 | $479.00 | $5748.00 | $0.00 | $2172.00 | N/A |
| 3-67 Mackey St | 2 Bedroom | R | 1 | 12 | $600.00 | $7200.00 | $479.00 | $5748.00 | $0.00 | $1452.00 | N/A |
| 3B-181 Elgin St | 1 Bedroom | R | 1 | 12 | $525.00 | $6300.00 | $479.00 | $5748.00 | $0.00 | $552.00 | 26 |
| 916B Second Line West | 1 Bedroom | R | 1 | 12 | $650.00 | $7800.00 | $479.00 | $5748.00 | $0.00 | $2052.00 | N/A |
| 78 Grace St | 1 Bedroom | R | 1 | 12 | $700.00 | $8400.00 | $479.00 | $5748.00 | $0.00 | $2652.00 | N/A |
| 10-21 Ferguson Ave | 1 Bedroom | R | 1 | 12 | $579.00 | $6948.00 | $479.00 | $5748.00 | $0.00 | $1200.00 | N/A |
| 2 Wood St | 1 Bedroom | R | 1 | 12 | $700.00 | $8400.00 | $479.00 | $5748.00 | $0.00 | $2652.00 | N/A |
| 1-139 Gladstone Avenue | 1 Bedroom | R | 1 | 12 | $550.00 | $6600.00 | $479.00 | $5748.00 | $0.00 | $852.00 | N/A |
| 208-627 MacDonald Ave | 1 Bedroom | R | 1 | 12 | $632.90 | $7594.80 | $479.00 | $5748.00 | $0.00 | $1846.80 | N/A |
| 859 Trunk Road | Room | R | 1 | 12 | $650.00 | $7800.00 | $479.00 | $5748.00 | $0.00 | $2052.00 | N/A |
| 10-5 Huntington Park | 1 Bedroom | R | 1 | 12 | $638.00 | $7656.00 | $479.00 | $5748.00 | $0.00 | $1908.00 | N/A |
| 180 Elgin St. | Room | R | 1 | 12 | $495.63 | $5947.56 | $479.00 | $5748.00 | $0.00 | $199.56 | N/A |
| 102-536A Goulais Avenue | 1 Bedroom | R | 1 | 12 | $625.00 | $7500.00 | $479.00 | $5748.00 | $0.00 | $1752.00 | N/A |
| 408-94 Allard Street | 1 Bedroom | R | 1 | 12 | $751.14 | $9013.68 | $479.00 | $5748.00 | $0.00 | $3265.68 | N/A |
| 311-27 Terry Fox Place | 1 Bedroom | R | 1 | 12 | $782.01 | $9384.12 | $479.00 | $5748.00 | $0.00 | $3636.12 | N/A |
| 3-37 Hughes St | 1 Bedroom | R | 1 | 12 | $500.00 | $6000.00 | $428.00 | $5136.00 | $0.00 | $864.00 | N/A |
| 312-149 Mississauga Avenue | 1 Bedroom | R | 1 | 12 | $572.00 | $6864.00 | $479.00 | $5748.00 | $0.00 | $1116.00 | N/A |
| 119-31 Old Garden River Road | 1 Bedroom | R | 1 | 12 | $654.00 | $7848.00 | $479.00 | $5748.00 | $0.00 | $2100.00 | N/A |

| Address of Project: | Unit Type | Headlease/ Referral | No. of Units (A) | No. of Months (B) | Monthly Market Rent (C) | Total Market Rent (D)=(AxBxC) | Monthly Rent Revenue (E) | Total Rent Revenue (F)=(AxBxE) | Total Vacancy Loss (G) | Total Rent Subsidy (H)=(D-F+G) | Unilities (I) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2-113 Edmonds Avenue | 1 Bedroom | R | 1 | 12 | $700.00 | $8400.00 | $479.00 | $5748.00 | $0.00 | $2652.00 | N/A |
| 1-183 Brock St | 1 Bedroom | R | 1 | 12 | $750.00 | $9000.00 | $479.00 | $5748.00 | $0.00 | $3252.00 | N/A |
| 2-518 Queen St E | 1 Bedroom | R | 1 | 12 | $550.00 | $6600.00 | $479.00 | $5748.00 | $0.00 | $852.00 | N/A |
| 309-23 Terry Fox Place | 1 Bedroom | R | 1 | 12 | $610.38 | $7324.56 | $479.00 | $5748.00 | $0.00 | $1576.56 | N/A |
| 314-552A Dacey Roac | 1 Bedroom | R | 1 | 12 | $576.93 | $6923.16 | $479.00 | $5748.00 | $0.00 | $1175.16 | N/A |
| 315-23 Terry Fox Place | 1 Bedroom | R | 1 | 12 | $834.52 | $10014.24 | $513.52 | $6162.24 | $0.00 | $3852.00 | N/A |
| 413-365 Lake Street | 1 Bedroom | R | 1 | 12 | $678.78 | $8145.36 | $479.00 | $5748.00 | $0.00 | $2397.36 | N/A |
| 180 Elgin St. | Room | R | 1 | 12 | $614.00 | $7368.00 | $474.00 | $5688.00 | $0.00 | $1680.00 | N/A |
| 26-903 Queen Street East | 1 Bedroom | R | 1 | 12 | $575.00 | $6900.00 | $479.00 | $5748.00 | $0.00 | $1152.00 | N/A |
| 306-108 Allard St | 1 Bedroom | R | 1 | 12 | $669.33 | $8031.96 | $479.00 | $5748.00 | $0.00 | $2283.96 | N/A |
| 201-108 Allard St | 1 Bedroom | R | 1 | 12 | $787.30 | $9447.60 | $479.00 | $5748.00 | $0.00 | $3699.60 | N/A |
| 6-102 Breton Road | 1 Bedroom | R | 1 | 12 | $775.00 | $9300.00 | $479.00 | $5748.00 | $0.00 | $3552.00 | N/A |
| 203-126 Kohler Street | Bachelor | R | 1 | 12 | $515.00 | $6180.00 | $479.00 | $5748.00 | $0.00 | $432.00 | N/A |
| 209-126 Kohler St | 2 Bedroom | R | 1 | 12 | $648.00 | $7776.00 | $479.00 | $5748.00 | $0.00 | $2028.00 | N/A |
| 7-15 Charles Walk | 1 Bedroom | R | 1 | 12 | $600.00 | $7200.00 | $479.00 | $5748.00 | $0.00 | $1452.00 | N/A |
| | | Totals | 42 | | $26379.71 | $329324.52 | $19200.65 | $236155.80 | $0.00 | $93168.72 | $26.00 |
| | | Totals | 108 | | $66,724.73 | $851,120.76 | $48,361.73 | $609,080.76 | $0.00 | $242,040.00 | $160.00 |

242,200

| Other Eligible Costs ** | | $ | | |
|---|---|---|---|---|
| Bed bug remedial expense | | | | |
| Unit maintenance/repairs | | | | |
| Last month's rent | | | | |
| etc. | | | | |
| 5,000 | | 5,000 | | |
| | | | | |
| | | | | |
| Total | | 5000 | | 5000 |

247,200

***Shaded boxes are formulated. Please do not input any data in these boxes***

** Provide details of the amounts budgeted

*Ministry of Health and Long-Term Care*
*Negotiations and Accountability Management Division*
*Provincial Programs Branch*
*5th Floor, 5700 Yonge Street, Toronto ON M2M 4K5*

*Ministère de la Santé et des Soins de longue durée*

Ontario

# SCHEDULE C: RENT SUPPLEMENT - HEAD LEASE AND REFERRAL AGREEMENTS

| Agency name |
|---|
| Algoma Public Health |

**Mental Health Rent Supplement Initiative** (# Units): 
*(Homelessness Ph I & II and MH 500 & 750)*

**Service Enhancements** (# Units): 

**Addictions** (# Units): 16
*(use a separate sheet for the Addictions initiative)*

**Rent Supplement :**

| Address of Project: | Unit Type | Headlease/Referral (H)/(R ) | No. of Units (A) | No. of Months (B) | Monthly Market Rent (C) | Total Market Rent (D)=(AxBxC) | Monthly Rent Revenue (E) | Total Rent Revenue (F)=(AxBxE) | Total Vacancy Loss (G) | Total Rent Subsidy (H)=(D-F+G) | Utilities (I) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 103 Albert Street East, Upstairs | 1 Bedroom | R | 1 | 12 | 725.00 | 8,700.00 | 485.00 | 5,820.00 | 0.00 | 2,880.00 | N/A |
| 2-737 McKenzie Ave | 3 Bedroom | R | 1 | 12 | 750.00 | 9,000.00 | 552.00 | 6,624.00 | 0.00 | 2,376.00 | 592 |
| 314 Devon Rd - Upstairs | 2 Bedroom | R | 1 | 12 | 700.00 | 8,400.00 | 479.00 | 5,748.00 | 0.00 | 2,652.00 | N/A |
| 594 Northland Road | 2 Bedroom | R | 1 | 12 | 800.00 | 9,600.00 | 560.00 | 6,720.00 | 0.00 | 2,880.00 | N/A |
| 310 Dacey Road | 2 Bedroom | R | 1 | 12 | 860.00 | 10,320.00 | 530.00 | 6,360.00 | 0.00 | 3,960.00 | 592 |
| 8-212 Albert Street East | 1 Bedroom | R | 1 | 12 | 647.00 | 7,764.00 | 479.00 | 5,748.00 | 0.00 | 2,016.00 | N/A |
| 30-1547 Trunk Road | Room | R | 1 | 12 | 800.00 | 9,600.00 | 500.00 | 6,000.00 | 0.00 | 3,600.00 | N/A |
| 3-606 McNabb St | 2 Bedroom | R | 1 | 12 | 750.00 | 9,000.00 | 510.00 | 6,120.00 | 0.00 | 2,880.00 | N/A |
| 118 Breton Road | 1 Bedroom | R | 1 | 12 | 750.00 | 9,000.00 | 450.00 | 5,400.00 | 0.00 | 3,600.00 | N/A |
| B-14 Park Street | 2 Bedroom | R | 1 | 12 | 950.00 | 11,400.00 | 753.00 | 9,036.00 | 0.00 | 2,364.00 | 572 |
| 1587 Trunk Road | Bachelor | R | 1 | 12 | 550.00 | 6,600.00 | 376.00 | 4,512.00 | 0.00 | 2,088.00 | N/A |
| 88 Pilgrim Street (Upstairs) | 1 Bedroom | R | 1 | 12 | 600.00 | 7,200.00 | 376.00 | 4,512.00 | 0.00 | 2,688.00 | N/A |
| 181 James Street | 1 Bedroom | R | 1 | 12 | 587.00 | 7,044.00 | 376.00 | 4,512.00 | 0.00 | 2,532.00 | N/A |
| 239 Beverly St | 1 Bedroom | R | 2 | 12 | 500.00 | 12,000.00 | 376.00 | 9,024.00 | 0.00 | 2,976.00 | N/A |
| 2-452 Wellington St E | 1 Bedroom | R | 1 | 12 | 700.00 | 8,400.00 | 479.00 | 5,748.00 | 0.00 | 2,652.00 | N/A |
| | | Totals | 16 | | 10,669.00 | 134,028.00 | 7,281.00 | 91,884.00 | 0.00 | 42,144.00 | 1,756.00 |
| | | | | | | | | | | 43,900 | |

| Other Eligible Costs ** | | $ | | |
|---|---|---|---|---|
| Last months Rent | | 5,000 | | |
| | | | | |
| | | | | |
| Total | | 5,000 | | 5,000 |

***Shaded boxes are formulated. Please do not input any data in these boxes***

48,900

** Provide details of the amounts budgeted

*Ministry of Health and Long-Term Care*
*Negotiations and Accountability Management Division*
*Provincial Programs Branch*
*5th Floor, 5700 Yonge Street, Toronto ON M2M 4K5*

*Ministère de la Santé et des Soins de longue durée*

Ontario

# SCHEDULE C: RENT SUPPLEMENT - HEAD LEASE AND REFERRAL AGREEMENTS

| Agency name |
|---|
| Algoma Public Health |

**Mental Health Rent Supplement Initiative** (# Units: )
*(Homelessness Ph I & II and MH 500 & 750)*
*(Homelessness Ph I & II and MH 500 & 750)*
**MH & A Strategy New 1000 Units** (#Units: 7)

**Service Enhancements** (# Units: )

**Addictions** (# Units: )
*(use a separate sheet for the Addictions initiative)*

**Rent Supplement :**

| Address of Project: | Unit Type | Headlease/Referral (H)/(R ) | No. of Units (A) | No. of Months (B) | Monthly Market Rent (C) | Total Market Rent (D)=(AxBxC) | Monthly Rent Revenue (E) | Total Rent Revenue (F)=(AxBxE) | Total Vacancy Loss (G) | Total Rent Subsidy (H)=(D-F+G) | Utilities (I) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 310 Dacey Road | 1 Bedroom | R | 1 | 12 | 860.00 | **10,320.00** | 530.00 | **6,360.00** | 0.00 | **3,960.00** | N/A |
| 118 Breton Road | 1 Bedroom | R | 2 | 12 | 750.00 | **18,000.00** | 450.00 | **10,800.00** | 0.00 | **7,200.00** | N/A |
| 180 Brock St | 1 bedroom | H | 3 | 12 | 480.00 | **17,280.00** | 0.00 | **0.00** | $0.01 | **17,280.01** | N/A |
| 180 Elgin St | Room | R | 1 | 12 | 676.00 | **8,112.00** | 479.00 | **5,748.00** | $0.00 | **2,364.00** | N/A |
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| | | Totals | 7 | | **2,766.00** | **53,712.00** | **1,459.00** | **22,908.00** | **0.00** | **30,804.01** | **0.00** |

**30,804**

| Other Eligible Costs ** | | $ | | |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| Total | | 0 | | 0 |

***Shaded boxes are formulated. Please do not input any data in these boxes***

**30,804**

** Provide details of the amounts budgeted

Schedule D: Units Located Within Affordable Housing Program (AHP) Buildings, Investment in Affordable Housing (IAH) Buildings, Non-Profit/Social Housing Market Units

| Unit Number and Address of Project | Unit Type (ie. bachelor) | # of Occupants | Program (AHP,IAH,NP, SH) |
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Ministry of Health and Long-Term Care
Negotiations and Accountability Management Division
Provincial Programs Branch
56 Wellesley Street West,
9th Floor
Toronto ON M5S 2S3
Telephone: (416) 327-7039

Ministère de la Santé et des Soins de longue durée

Ontario

# TRANSFORMATION SUPPORTIVE HOUSING PROGRAM BUDGET

## IDENTIFICATION



| Corporation name |
|---|
| Algoma Public Health; Community Mental Health Program-Ministry Program# 1536 |

| Year ended |
|---|
| 2016-17 |

| Corporation address | Mailing address |
|---|---|
| 294 Willow Ave<br>Sault Ste. Marie, ON<br>P6B-0A9 | Same |

| Program Contact | Position | Telephone number | e-mail address |
|---|---|---|---|
| Jan Metheany | Program Manager | 705-759-3935 | jmetheany@algomapublichealth.com |
| **Finance Contact** | **Position** | **Telephone number** | **e-mail address** |
| Justin Pino | Chief Financial Officer | 705-942-4646 Ext. 5232 | jpino@algomapublichealth.com |
| **Board Chair/President** | **Position** | **Telephone number** | **e-mail address** |
| Lee Mason | Board Chair | 705-759-5421 | lmason@algomapublichealth.com |
| **Executive Director/CEO** | **Position** | **Telephone number** | **e-mail address** |
| Tony Hanlon | Interim Chief Executive Officer | 705-759-5421 | thanlon@algomapublichealth.com |
| | | **Facsimile** | |

## MANAGEMENT DECLARATION BY BOARD OF DIRECTORS

**I declare that, to the best of my knowledge and belief, the information provided in this Transformation Supportive Housing Programs Budget accurately reflects the budget approved by the corporation's Board of Directors.**

| Signature | Name | Board Position | Date |
|---|---|---|---|
| | | | |

| Signature | Name | Board Position | Date |
|---|---|---|---|
| | | | |

Instructions

( 1 ) This form should be used by Agencies which administer Transformation Supportive Housing Programs.

( 2 ) The Management Declaration must be signed by two members of the Board of Directors on behalf of the Board.

# BASE OPERATING COSTS FOR TRANSFORMATION SUPPORTIVE HOUSING

*(One budget must be submitted for each project)*

| | | | | |
|---|---|---|---|---|
| **Project's address:** (fill in the attached shedule for a project with scattered units) | | | Road to Recovery House/Address not yet determined | |
| **OPERATING COSTS:** | | | | |
| **Housing Related Costs** | | | | |
| **Rent For Housing Units/Head Lease Expense** | | | 34,488 | |
| **Maintenance - Salaries, Materials and Contracted Services** | | | | |
| **Utilities :** | | | | |
| **Electricity** | | | | |
| **Fuel** | | | | |
| **Water and Sewage** | | | | |
| **Total Utilities** | | | 0 | |
| **Other Costs** | | | | |
| **Total Housing Related Costs** | | | | 34,488 |
| **Support Related Costs** | | | | |
| **Staff Salaries and Benefits** | | | 122,177 | |
| **Administration Costs** | | | 2,000 | |
| **Food Costs** | | | 26,280 | |
| **Tenant Personal Needs, Tenant Travel, Tenant Recreation** | | | 7,571 | |
| **Other Costs** | Cable-phone -internet | | 2,000 | |
| **Total Support Related Costs** | | | | 160,028 |
| **TOTAL OPERATING COSTS** | | | | 194,516 |
| **REVENUE:** | | | | |
| **Rental Revenue** | 7 (# of Units) | 479 (Rent) x 12 mos | 40,236 | |
| **Less: Vacancy Loss** | | | | |
| **Net Rental Revenue** | | | | 40,236 |
| **Other Revenue** | Food($11.74 per unit per day) | | | 26,280 |
| **Ministry Subsidy** | | | | 128,000 |
| **TOTAL REVENUE** | | | | 194,516 |
| **SHELTER SURPLUS/ (DEFICIT)** | | | | 0 |

***Shaded boxes are formulated. Please do not input any data in these boxes***

| Address of Scattered Units: | Units | Unit Type | |
|---|---|---|---|
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| **Total Units** | | | |

Schedule D: Units Located Within Affordable Housing Program (AHP) Buildings, Investment in Affordable Housing (IAH) Buildings, Non-Profit/Social Housing Market Units

| Unit Number and Address of Project | Unit Type (ie. bachelor) | # of Occupants | Program (AHP,IAH,NP, SH) |
|---|---|---|---|
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**Ministry of Health and Long-Term Care**

**Assistant Deputy Minister's Office**

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

**Telephone: (416) 212-8119**
**Facsimile: (416) 325-8412**

**Ministère de la Santé et des Soins de longue durée**

**Bureau du sous-ministre adjoint**

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

**Téléphone: (416) 212-8119**
**Télécopieur: (416) 325-8412**

January 5, 2016

# MEMORANDUM

**TO:** Board of Health Chairs and Medical Officers of Health

**RE:** Anticipated amendments to the Ontario Public Health Standards (OPHS) and related Protocols

---

As previously communicated, changes are required to the Ontario Public Health Standards (OPHS) and related protocols regarding three initiatives:

- The integrated Healthy Smiles Ontario Program;
- Amendments to the *Smoke Free Ontario Act* (SFOA); and
- The implementation of the *Electronic Cigarettes Act, 2015* (ECA).

Ministry staff have worked very closely with public health program staff over the past year to communicate programmatic changes for both the newly integrated Healthy Smiles Ontario Program as well as changes to the SFOA and the implementation of the ECA. We will continue to provide additional materials and information to support implementation in the weeks to come.

In December 2013, the Ontario government announced its intent to integrate six dental benefits and/or programs for children and youth from low income families into one new program with simplified eligibility requirements and enrolment processes, and improved access for eligible children and youth. The newly integrated Healthy Smiles Ontario Program was launched on January 1, 2016.

Some revisions to the OPHS and Protocols are required to facilitate the January 2016 implementation date.

Changes related to the newly integrated Healthy Smiles Ontario Program include:

- A new requirement for boards of health to deliver the integrated Healthy Smiles Ontario Program in accordance with a new Healthy Smiles Ontario Program Protocol. The new Healthy Smiles Ontario Program Protocol incorporates key features and detailed Board of Health activities taken from the current *Preventive Oral Health Services Protocol, 2008* and *Children in Need of Treatment (CINOT) Program Protocol, 2008*.

..../2

- Addition of “Children in need of emergency and essential oral health care have access to such care” and “Children from low income families have access to oral health care” to the Board of Health Outcomes.
- Removal of Requirement 12 and 13 (provision of CINOT and Preventive Oral Health Services).
- Removal of “Children urgently in need of oral health care have access to such care” from the Board of Health Outcomes.
- Removal of the *Preventive Oral Health Services Protocol, 2008* and the *Children in Need of Treatment (CINOT) Program Protocol,* 2008.
- Minor changes to the *Oral Health and Surveillance Protocol, 2008* that are required to replace references to the *CINOT Program Protocol, 2008* and *Preventive Oral Health Services Protocol, 2008* and to include references to the *Healthy Smiles Ontario Program Protocol,* 2016.
- Other oral health requirements including Assessment and Surveillance (screening) and oral health promotion, continue to be included as requirements in the Child Health Standard.

Changes related to the SFOA include:

- Revisions to the *Tobacco Compliance Protocol* to reflect recent amendments to the SFOA*:*
  - Describe expanded entry powers of inspectors.
  - Describe new “smoke-free” areas where signage must be posted (i.e. outdoor grounds of hospitals and certain office buildings owned by the Province).
  - Specify new titles of signs for tobacco retailers.
  - Clarify that automatic prohibitions can only be issued based on tobacco sales offence convictions registered against business owners.

Changes related to the implementation of the ECA include:

- Revisions to the Chronic Disease Prevention Program to incorporate a new requirement to implement and enforce the ECA in accordance with the *Electronic Cigarettes Compliance Protocol, 2016*.
- The protocol provides direction to support the implementation and enforcement of provisions in the ECA that will come into effect January 1, 2016, including:
  - Prohibiting the sale and supply of e-cigarettes to persons under age 19,
  - Prohibiting the sale of e-cigarettes in retail settings if prescribed signs are not posted; and
  - Prohibiting the sale of e-cigarettes in vending machines.
- The protocol includes direction to employ a balance of inspection, education and progressive enforcement to achieve compliance with the ECA.
- The protocol includes direction to collect and maintain inspection and enforcement data using the Tobacco Inspection System.

…./3

The changes to the OPHS and related protocols, as described above, are pending Minister's approval. In the meantime, I would ask that boards of health proceed with program implementation for all initiatives as of January 1, 2016.

Further communication will be forthcoming once approvals are finalized. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

*Original signed by*

Roselle Martino
Assistant Deputy Minister
Population and Public Health Division

c: Dr. David C. Williams, Acting Chief Medical Officer of Health
Elizabeth Walker, Director, Public Health Planning and Liaison Branch
Laura Pisko, Director, Health Promotion Implementation Branch
Paulina Salamo, Director (A), Public Health Standards Practice and Accountability Branch

December 21, 2015

The Honourable Jean-Yves Duclos
Minister of Families, Children and
Social Development
House of Commons
Ottawa, Ontario K1A 0A6

The Honourable MaryAnn Mihychuk
Minister of Employment, Workforce and Labour
Ministry of Labour
House of Commons
Ottawa, ON K1A 0A6

The Honourable Jane Philpott
Minister of Health
Ministry of Health
House of Commons
Ottawa, ON
K1A 0A6

The Honourable Kevin Daniel Flynn
Minister of Labour
Ministry of Labour
14th Floor
400 University Avenue
Toronto, ON M7A 1T7

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

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

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

Dear Minister Duclos, Minister Mihychuk, Minister Philpott, Minister Flynn, Minister Hoskins, Minister MacCharles, and Minister Matthews:

**Re: Basic Income Guarantee**

I am writing today to express our support for a joint federal-provincial (Ontario) investigation into a basic income guarantee for Ontarians and all Canadians.

Several reports in recent years have described the extent of poverty and growing income inequality in Ontario and Canada.[1,2] The relationship between income and health has also been well established; countless analyses have consistently and clearly shown that as income rises, health outcomes improve. In doing so, they also demonstrate that lower income people are at far greater risk from a range of preventable medical conditions, including cancer, diabetes, heart disease and mental illness.[3] From a public health perspective, there is a strong literature base demonstrating the relationship between both low absolute income, the extent of income inequality in a society, and a range of adverse health and social outcomes. It is, therefore, reasonable to conclude that improving incomes would be an effective public health intervention.

Given that 16.5% of people in Leeds, Grenville and Lanark live in low income situations based on the after-tax low-income (2011 National Household Survey, Statistics Canada), the avoidable burden of disease from low income and income inequalities is substantial.

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

Basic income is a concept that has been examined and debated for decades, including through pilot projects in the United States, Canada, and other countries more recently.[4,5] Mincome, in particular, a pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in the 1970s, demonstrated several improved health and educational outcomes.[4] Basic income concepts which are already present in our current system of progressive taxation, credits and benefits for families with children and income guarantee for seniors have contributed to health and social improvements in those age groups. [6,7] While these measures are undoubtedly important and valuable to those who benefit from them, we are convinced that there would be great merit in a serious exploration of the arguments that favour a basic income guarantee as a simpler solution that would benefit more people.

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

Advocating for improved income security policies is supportive of the Leeds, Grenville and Lanark District Health Unit's strategic direction on Health Equity, which states that the health unit 'strives to address the challenges that prevent all residents from having the opportunity to reach their optimal health.'

We hope that you will respond favourably to our request for joint federal-provincial consideration and investigation into a basic income guarantee as a policy option for reducing poverty and income insecurity.

Sincerely,

Anne Warren, Chair
Leeds, Grenville and Lanark District Health Unit

c. The Right Honourable Justin Trudeau, Prime Minister of Canada
The Honourable Kathleen Wynne, Premier of Ontario
Dr. David Williams, Ontario Chief Medical Officer of Health
Linda Stewart, Association of Local Public Health Agencies
Pegeen Walsh, Ontario Public Health Association
Ontario Boards of Health
Leeds, Grenville and Lanark Members of Parliament
Leeds, Grenville and Lanark Members of Provincial Parliament
Champlain and South East Local Health Integration Network
Gary McNamara, President, Association of Municipalities Ontario
Brock Carlton, Chief Executive Officer, Federation of Canadian Municipalities
Leeds, Grenville and Lanark Municipalities

**References**


1. Canadian Index of Wellbeing. How are Ontarians Really Doing?: A Provincial Report on Ontario Wellbeing. Waterloo, ON: Canadian Index of Wellbeing and University of Waterloo, 2014

2. Conference Board of Canada. How Canada Performs: A Report Card on Canada. 2013. Accessed April 27, 2015. http://www.conferenceboard.ca/hcp/details/society/incomeinequality.Aspx

3. Auger, N and Alix, C. Income, Income Distribution, and Health in Canada. In: Raphael, D (Ed). Social Determinants of Health, 2nd edition. Toronto: Canadian Scholars Press Inc, 2009.

4. Forget, E. The Town with No Poverty: The Health Effects of a Canadian Guaranteed Annual Income Field Experiment. Canadian Public Policy xxxvii(3) 283-306, 2011. http://utpjournals.metapress.com/content/xj02804571g71382/fulltext.pdf

5. Pasma, C. Basic Income Programs and Pilots. Ottawa: Basic Income Canada Network, 2014. http://www.thebigpush.net/uploads/2/2/6/8/22682672/basic_income_programs_and_pilots_february_3_2014.pdf

6. Emery, J.C.H., Fleisch, V.C., and McIntyre, L. How a Basic income guarantee Could Put Food Banks Out of Business. University of Calgary School of Public Policy Research Papers 6 (37), 2013. http://www.policyschool.ucalgary.ca/sites/default/files/research/emery-foodbankfinal.pdf

7. Milligan, K., and Stabile, M. "Do Child Tax Benefits Affect the Well-Being of Children? Evidence from Canadian Child Benefit Expansions". American Economic Journal: Economic Policy 3(3): 175-205, 2011.

Sudbury & District
Health Unit
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www.sdhu.com

December 1, 2015

VIA ELECTRONIC MAIL

The Right Honourable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6

Dear Prime Minister Trudeau:

**Re:** ***CANNABIS REGULATION AND CONTROL: Public Health Approach to Cannabis Legalization***

At its meeting on November 19, 2015, the Sudbury & District Board of Health carried the following resolution #54-15:

*WHEREAS the election platform of Canada's recently elected federal government includes the intention to legalize, regulate, and restrict access to marijuana; and*

*WHEREAS within the current criminalization context, cannabis is widely used in the SDHU catchment area: 23.5% of youth used in the previous 12 months, 52.3% of people aged ≥19 have tried cannabis and 13% currently use cannabis; and*

*WHEREAS the health risks of cannabis use are significantly lower than tobacco or alcohol but are increased in those who use it frequently, begin at an early age and/or who have higher risk of cannabis-related problems (i.e. certain psychiatric conditions, cardiovascular disease, pregnancy); and*

*WHEREAS a public health approach focused on high-risk users and practices – similar to the approach favoured with alcohol and tobacco that includes strategies such as controlled availability, age limits, low risk use guidelines, pricing, advertising restrictions, and general and targeted prevention initiatives – allows for more control over the risk factors associated with cannabis-related health and societal harms; and*

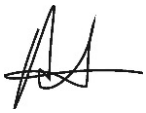
*WHEREAS the Ontario Public Health Standards require boards of health to reduce the frequency, severity, and impact of preventable injury and of substance misuse;*

*THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support a public health approach to the forthcoming cannabis legalization framework, including strict health-focused regulations to reduce the health and societal harms associated with cannabis use; and*

*FURTHER THAT this resolution be shared with the Honourable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-Term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.*

Members of the Sudbury & District Board of Health respectfully request that the Right Honorable Prime Minister use a public health approach to the regulation and legalization of cannabis in Canada.

Sincerely,



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

cc: Hon. Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada
Hon. Jane Philpott, Minister of Health
Carol Hughes, MP Algoma, Manitoulin, Kapuskasing
Paul Lefebvre, MP Sudbury
Marc Serré, MP Nickel Belt
Hon. Kathleen Wynne, Premier of Ontario
Hon. Madeleine Meilleur, Attorney General of Ontario
Glenn Thibeault, MPP Sudbury
France Gélinas, MPP Nickle Belt
Michael Mantha, MPP, Algoma-Manitoulin
Dr. David Williams, Chief Medical Officer of Health (Interim)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Dr. Catherine Zahn, President and Chief Executive Officer, Centre for Addiction and Mental Health
Ontario Boards of Health

The Premier
of Ontario

Legislative Building
Queen's Park
Toronto ON M7A 1A1

La première ministre
de l'Ontario

Édifice de l'Assemblée législative
Queen's Park
Toronto ON M7A 1A1

Ontario

November 23, 2015

Mr. Lee Mason
Chair
Board of Health
District of Algoma Public Health
294 Willow Avenue
Sault St. Marie, Ontario
P6B 0A9

Dear Mr. Mason:

Thank you for your letter informing me of the board's resolution regarding evacuations of First Nations communities in Northern Ontario. I appreciate your keeping me updated on the board's activities.

As this issue falls within the area of responsibility of my colleague the Honourable Yasir Naqvi, Minister of Community Safety and Correctional Services, I have sent a copy of your correspondence to him for his information. I trust that he will also give the board's views his consideration.

Once again, thank you for the information.

Sincerely,

Kathleen Wynne
Premier

c: The Honourable Yasir Naqvi

HURON COUNTY

January 7, 2016

The Honorable Helena Jaczek
Ministry of Community and Social Services
6th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1E9
hjaczek.mpp@liberal.ola.org

**Re: Food Security and the Transformation of Social Assistance in Ontario**

Dear Minister Jaczek,

As the Minister of Community and Social Services, we are writing to you to request an update on the transformation of social assistance in Ontario. The results of the 2015 Nutritious Food Basket Costing for the Huron County Health Unit were accepted at the December 3, 2015 Board of Health meeting. The report demonstrates an urgent need to address the financial barriers that people living with low income experience in accessing nutritious food.

The cost of the Nutritious Food Basket in Huron County in May 2015 for a family of four (male between 31-50 years of age, female between 31-50 years of age, 14 year old boy, 8 year old girl) is $883. This is a 17% increase in food costs since 2009. Despite the increasing costs of food, the real issue is that incomes are too low and many individuals and families just do NOT have enough money to pay for their basic needs such as shelter and food. This issue poses serious health risks for our community.

We look forward to receiving a response detailing next steps towards Social Assistance Reform as supported by Ontario's Poverty Reduction Strategy. People in Huron County living on income from Ontario Works or the Ontario Disability Supoprt Program are unable to make ends meet. Your urgent attention is required to ensure people living with low incomes have access to healthy food.

Sincerely,

Tyler Hessel
Chair, Huron County Board of Health

cc. MPP Lisa Thompson, Huron-Bruce, lisa.thompson@pc.ola.org
Association of Local Public Health Agences
Ontario Boards of Health

**Huron County Health Unit**
77722B London Road, RR 5, Clinton, ON N0M 1L0 CANADA
Tel: 519.482.3416 Confidential Fax: 519.482.9014 www.huronhealthunit.ca

Thunder Bay District
Health Unit

MAIN OFFICE
999 Balmoral Street
Thunder Bay, ON
P7B 6E7
Tel: (807) 625-5900
Toll-Free in 807 area code
1-888-294-6630
Fax: (807) 623-2369

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or (807) 887-2908
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Fax: (807) 825-7774

TBDHU.COM

November 20, 2015

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

Dear Minister MacCharles:

**Re: Healthy Babies Healthy Children Program Funding**

On October 21, 2015, at a regular meeting of the Board of Health for the Thunder Bay District, the Board considered the attached resolution from Sudbury and District Health Unit regarding the Healthy Babies Healthy Children Program. The following resolution was passed.

Resolution No. 129-2015

> **"THAT with respect to Report No. 52 – 2015 (Healthy Babies Healthy Children), we recommend that a letter be sent to the Minister of Children and Youth Services to support the resolution from the Sudbury and District Health Unit advocating to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs."**

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

Sincerely,

Norm Gale, Chair
Thunder Bay District Board of Health

Cc: Ontario Boards of Health

Encl.

Sudbury & District
Health Unit
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6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
☎ : 705.370.9200
🖷 : 705.377.5580

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

Toll-free / Sans frais
1.866.522.9200

www.sdhu.com

June 30, 2015

*VIA ELECTRONIC MAIL*

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

Dear Minister MacCharles:

**Re: Healthy Babies Healthy Children Program**

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

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

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

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

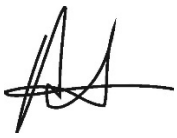
*FURTHER THAT the Sudbury & District Board of Health advocate strongly to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.*

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

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

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

Sincerely,



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

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

ELGIN ST. THOMAS
PUBLIC HEALTH

January 5, 2016

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

Dear Minister Hoskins,

**RE: Public Health Funding**

At its meeting on December 9, 2015 the Elgin St. Thomas Board of Health endorsed the attached correspondence and resolution concerning the public health funding formula passed October 30, 2015 by the Association of Local Public Health Agencies' Board of Directors.

Sincerely,

Heather Jackson

Heather Jackson, Chair
Elgin St. Thomas Board of Health

c Association of Local Public Health Agencies
Ontario Boards of Health



Elgin St. Thomas Public Health
1230 Talbot Street, St. Thomas, ON N5P 1G9
Phone: 519-631-9900 Toll Free 1-800-922-0096 Fax: 519-633-0468
www.elginhealth.on.ca

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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



November 3, 2015

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

Dear Minister Hoskins:

**Re: Public Health Funding Model**

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations of the Association of Local Public Health Agencies (alPHa), I am writing today to provide our comments following the October 2nd alPHa Board of Directors dialogue with Ministry staff about the development and implementation of the Public Health Funding Formula that was announced to our members on September 4th 2015.

We were very pleased to welcome Paulina Salamo and Brent Feeney from the Public Health Division and Brian Pollard from the Health Sector Models Branch to our meeting. They provided us with details about the development of the new public health funding model, its relationship to the fiscal management of the health care sector as a whole and its implementation in the short term. This and the ensuing dialogue were very helpful to us in formulating the following comments.

We recognize the fiscal challenges that Ontario continues to face and understand the reality that governments are under intense pressure to demonstrate fiscal accountability to the public. We fully understand that there was a need to develop a defensible formula for how tax dollars are allocated to boards of health, and appreciate that efforts were made to develop an evidence-informed model that would facilitate their equitable distribution.

As you are likely aware, our members have been awaiting the release of the Funding Review Working Group's report, Public Health Funding Model for Mandatory Programs (December 2013), for nearly two years, with the expectation that an opportunity to provide fully informed feedback on the proposed recommendations would be afforded to them prior to a Government response. As it was not offered, we are taking this opportunity to present our initial response.

Our major concern is about the cumulative impact of the new approach to funding boards of health in the coming years. Boards of health have received modest funding increases in recent years even while other parts of the health sector have been frozen, and this underscores the essential roles boards of health play in the prevention of disease and the protection and promotion of health in Ontario. We would argue that imposing a freeze on boards of health, which, as annual costs rise, is essentially a cut to health protection, prevention and promotion, will have negative impacts on the communities served by boards of health.

Many of Ontario's boards of health experience difficulties in meeting the public health needs of their communities, let alone their health promotion and protection obligations at current funding levels. If these levels remain static or decline for the foreseeable future, cuts to already stretched services will be inevitable and it is not unreasonable to assume that the impact of such cuts will be magnified in the smaller health units, where health status is poorer and the capacity to improve it is already limited. This, we fear, may inadvertently demonstrate public health's value-for-money as negative health outcomes and increasing pressures on local health care providers rise in correlation to ever-increasing limitations on the capacity of local boards of health to mitigate them.

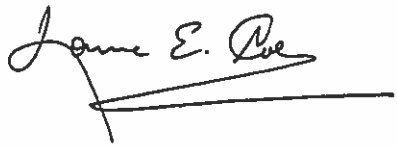
In the broader context of health system transformation, we continue to argue that curtailing investments in demonstrably cost-effective upstream health promotion and protection interventions is short-sighted. The Commission on the Reform of Ontario's Public Services (chaired by Don Drummond), recommended a heightened focus on public health's role in preventing health problems, having observed a correlation between health outcomes and the amount provinces spend on public health. The Commission also recommended avoiding applying the same degree of fiscal restraint to all parts of the health system.

In your strategic plan for Ontario's health care system, Patients First: Action Plan for Health Care, you recognize the importance of supporting people to be as healthy as possible. We share that primary interest with you and are concerned about the erosion of what is arguably the best local public health system in Canada. Local boards of health need to continue to build and maintain capacity to work with communities to effect healthy conditions in which people can thrive in good health.

We know that the new funding model comes with the understanding that, as a new model, it will need to be evaluated, revised and improved. We urge you to work closely with us to establish a process to review the model with a view to exploring whether relatively minor changes can result in a distribution of growth money that may better reflect the needs of boards of health and the communities they serve across Ontario.

For your consideration, we have attached the resolution passed by alPHa's Board of Directors following the October 2nd meeting. We look forward to working with you to ensure that Ontario's boards of health can fulfill their mandates and continue their essential role in making Ontario the healthiest place in which to grow up and grow old.

Yours truly,



Lorne Coe
President

COPY: Hon. Kathleen Wynne, Premier of Ontario
Hon. Charles Sousa, Minister of Finance
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health (A)
Roselle Martino, Executive Director, Public Health Division
Jackie Wood, Assistant Deputy Minister (A), Health Promotion Division
Laura Pisko, Assistant Deputy Minister (A), Health Promotion Division
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Paulina Salamo, Director (A) Public Health Standards, Practice and Accountability Branch
Brent Feeney, Manager, Funding and Accountability Unit (MOHLTC)
Brian Pollard, Director, Health Sector Models Branch (MOHLTC)
Victor Fedeli, Critic, Finance (PC)
Catherine Fife, Critic, Finance (NDP)
Jeff Yurek, Critic, Health (PC)
France Gélinas, Critic, Health and Long-Term Care (NDP)
Gary McNamara, President, Association of Municipalities of Ontario (AMO)
Chairs, Boards of Health



ATTACHED: Resolution

alPHa
Association of Local PUBLIC HEALTH Agencies

**alPHa Board of Directors' Resolution**

**Passed October 30, 2015**

**TITLE:** **Public Health Funding Formula**

WHEREAS public health interventions result in significant improvements in the health of the population and cost savings in the health care system; and

WHEREAS the reviews of the Walkerton E.coli outbreak in 2001 and the SARS epidemic in 2005 resulted in widespread recognition that Ontario's public health system had significant weaknesses and that investments were required to create a robust public health system essential for the protection of the health of the citizens of Ontario; and

WHEREAS investments in Ontario's public health system have occurred since the SARS epidemic, however, public health programs delivered through boards of health still only receive 1.4 percent or $700.4 million of the $50.2 billion total Ministry of Health and Long Term Care 2015-16 budget; and

WHEREAS grants provided by the Ministry of Health and Long-Term Care, enabled by the *Health Protection and Promotion Act,* constitute the majority of funding for boards of health in Ontario; and

WHEREAS the majority of the remaining funding for boards of health comes from the obligated municipalities as assigned in the *Health Protection and Promotion Act*; and

WHEREAS the Ministry of Health and Long-Term Care has accepted the recommendations contained in the December 2013 report: *Public Health Funding Model for Mandatory Programs: The Final Report of the Funding Review Working Group*; and

WHEREAS the intent of the recommendations was to develop a funding model for grants from the Ministry of Health and Long-Term Care to boards of health that identify an appropriate funding share for each Board that reflects its needs in relation to all other; and

WHEREAS in 2015, the Ministry of Health and Long-Term Care began the application of the public health funding model recommended in the Report without further consultation with boards of health; and

WHEREAS boards of health have been advised to plan for 0% funding increases for the foreseeable future; and



WHEREAS funding increases at or near 0% are de facto cuts as annual costs rise; and

WHEREAS the primary goals of boards of health are to prevent illness and to protect and promote the health of Ontarians; and

WHEREAS the impacts on public health programming, municipal funding contributions and population health outcomes resulting from the changes to the Ministry of Health and Long-Term Care's funding model need to be examined with a view to quality improvement;

**NOW THEREFORE BE IT RESOVED THAT** alPHa urge the Ministry of Health and Long Term Care to commit to maintaining a minimum cost of living annual growth rate for grants provided to all boards of health to fund public health programs;

**AND FURTHER THAT** alPHa urge the Ministry of Health and Long-Term Care to make an evidence-informed decision to adjust upwards the overall percentage of the Ministry's total budget that is allocated to fund public health programs delivered through boards of health;

**AND FURTHER THAT** alPHa urge the Ministry of Health and Long-Term Care to engage in a process to implement a comprehensive monitoring strategy in close consultation with Ontario's boards of health to evaluate the impacts of the new funding model, both in terms of health outcomes and total public health expenditures at the local level.

HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT
HEALTH UNIT

1-866-888-4577 • www.hkpr.on.ca • info@hkpr.on.ca

November 19, 2015

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

Dear Minister Hoskins

RE: Association of Local Public Health Agencies' (alPHa) Resolution: Public Health Funding Formula

On behalf of the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit, I am writing to endorse alPHa's correspondence and related Resolution: Public Health Funding Formula (enclosed).

We share your primary interest in supporting people to be as healthy as possible, as outlined in Ontario's heatlh care system's strategic plan, Patients First: Action Plan for Health Care. The new Public Health Funding Model will make it challenging for Boards of Health to continue to build and maintain capacity to work within our communities to protect and promote health and prevent disease.

We appreciate your consideration of the resolution and your commitment to work with alPHa and Ontario's boards of health, so we can fulfill our mandates and serve our communities.

Yours truly

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

Mark Lovshin, Chair
Board of Health, HKPR District Health Unit



**HEAD OFFICE**
200 Rose Glen Road
Port Hope, Ontario L1A 3V6
Phone · (905) 885-9100
Fax · (905) 885-9551

**BRIGHTON OFFICE**
Box 127
35 Alice Street
Brighton, Ontario K0K 1H0
Phone · (613) 475-0933
Fax · (613) 475-1455

**HALIBURTON OFFICE**
Box 570
191 Highland Street, Unit 301
Haliburton, Ontario K0M 1S0
Phone · (705) 457-1391
Fax · (705) 457-1336

**LINDSAY OFFICE**
108 Angeline Street South
Lindsay, Ontario K9V 3L5
Phone · (705) 324-3569
Fax · (705) 324-0455

Encl./ 1

Copy to: Hon. Kathleen Wynne, Premier of Ontario
Hon. Charles Sousa, Minister of Finance
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health (A)
Roselle Martino, Executive Director, Public Health Division
Jackie Wood, Assistant Deputy Minister (A), Health Promotion Division
Laura Pisko, Assistant Deputy Minister (A), Health Promotion Division
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Paulina Salamo, Director (A) Public Health Standards, Practice & Accountability
Brent Feeney, Manager, Funding and Accountability Unit (MOHLTC)
Brian Pollard, Director, Health Sector Models Branch (MOHLTC)
Victor Fedeli, Critic, Finance (PC)
Catherine Fife, Critic, Finance (NDP)
Jeff Yurek, Critic, Health (PC)
France Gélinas, Critic, Health and Long-Term Care (NDP)
Gary McNamara, President, Association of Municipalities of Ontario (AMO)
Chairs, Boards of Health

Sudbury & District
Health Unit
Service de santé publique

*Make it a Healthy Day!*

*Visez Santé dès aujourd'hui!*

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

Rainbow Centre
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
☎ : 705.522.9200
🖷 : 705.677.9611

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

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

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

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

Toll-free / Sans frais
1.866.522.9200

www.sdhu.com

November 30, 2015

VIA ELECTRONIC MAIL

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

Dear Minister Hoskins:

**Re: Provincial Public Health Funding**

At its meeting on November 19, 2015, the Sudbury & District Board of Health carried the following resolution #49-15:

> *THAT the Sudbury & District Board of Health endorse the correspondence and resolution concerning the public health funding formula, passed October 30, 2015 from the alPHa Board of Directors;*
>
> *AND FURTHER THAT the Sudbury & District Board of Health call on the Ministry of Health and Long Term Care to increase investments in public health, ensuring Ontarians benefit from a world-class public health system within Ontario's transformed health system;*
>
> *AND FURTHER THAT this motion be forwarded to constituent municipalities, the Association of Municipalities of Ontario, the Federation of Northern Ontario Municipalities, Ontario Boards of Health, the Association of Local Public Health Agencies, and other local partners.*

The Sudbury & District Board of Health is committed to an effective and accountable public health system as a key component of a transformed health system. We look forward to further engagement with the Ministry and provincial government partners to ensure all Ontarians benefit from such a system.

Sincerely,

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

cc: Constituent Municipalities
Association of Municipalities of Ontario
Federation of Northern Ontario Municipalities
Ontario Boards of Health
Association of Local Public Health Agencies

TOWN OF
VILLE DE BLIND RIVER

OFFICE OF THE CLERK ADMINISTRATOR

11 Hudson St./rue Hudson
P.O. Box/C.P. 640
Blind River, Ontario P0R 1B0



November 23, 2015

Algoma Public Health
294 Willow Avenue
Sault Ste. Marie ON P6B 0A9
Attn: Dr. Penny Sutcliff
Acting Medical Officer of Health

Dear Ms. Sutcliff:

I am please to advise you that the Council of the Town of Blind River supports the Algoma Health Unit's district-wide initiative to reduce smoking rates by 5% over the next five years.

Council wishes you every success with this initiative.

I trust this is satisfactory to your needs, should you require anything further, please do not hesitate to contact the undersigned.

Yours truly,

Kathryn Scott

Kathryn Scott
Clerk Administrator



KS/pwp

Tel./Tél. 705-356-2251

Fax/Télécopieur 705-356-7343

# The Corporation of the Town of Bruce Mines

PO Box 220
9126 Hwy. 17 East
Bruce Mines ON P0R 1C0

MAYOR: LORY PATTERI
CLERK: DONNA BRUNKE

Phone: (705)785-3493
Fax: (705)785-3170
Email: brucemines@bellnet.ca
www.brucemines.ca



November 3, 2015

Algoma Public Health
294 Willow Avenue
Sault Ste. Marie ON P6B 0A9

**Attention: Dr. Penny Sutcliffe/Tony Hanlon**

Dear Dr. Sutcliffe and Mr. Hanlon:

**RE: Reduce Smoking Rates**

Please be advised that the following resolution was passed at our regular council meeting of November 2, 2015:

> **RESOLUTION NUMBER: 2015-243**
> **MOVED BY: RICHARD O'HARA**
> **SECONDED BY: JODY ORTO**
> **BE IT RESOLVED THAT THE COUNCIL OF THE CORPORATION OF THE TOWN OF BRUCE MINES SUPPORTS THE RESOLUTION OF ALGOMA PUBLIC HEALTH IN THEIR ENDORSEMENT OF THE CONCEPT OF A DISTRICT-WIDE GOAL TO REDUCE SMOKING RATES BY 5% OVER THE NEXT 5 YEARS.**
> **CARRIED.**

Yours truly,
CORP. OF THE TOWN OF BRUCE MINES

Jamie Hunter

Jamie Hunter, AMCT
ADMINISTRATIVE ASSISTANT

The Corporation of the Township of
La Corporation du Canton de
Dubreuilville

Prenez le temps de vivre Experience the Freedom

November 4, 2015

Algoma Public Health
294 Willow Avenue
Sault Ste. Marie, ON P6B 0A9

**RE: Reduce smoking rates by 5% over the next 5 years**

At its regular meeting of October 20, 2015 our Municipal Council passed the following resolution:

15-336 Moved by: Councillor Moore
Seconded by: Councillor Perth

Whereas that the Council of the Corporation of the Township of Dubreuilville supports the attached letter dated October 15, 2015 from the Algoma Public Health with regards to their district-wide initiative to reduce smoking rates by 5% over the next 5 years.

Carried

Sincerely,

Brigitte Tremblay
Office Clerk

RECEIVED
NOV 09 2015
ALGOMA PUBLIC HEALTH

Enclosure Resolution No. 15-336



23 rue des Pins • C.P. / P.O. Box 367, Dubreuilville, Ontario, Canada P0S 1B0
☎ (705) 884-2340 (705) 884-2626 township@dubreuilville.ca www.dubreuilville.ca utm 16u681716 5358011

# COUNCIL RESOLUTION

The Corporation of the Township of
La Corporation du Canton de
Dubreuilville
Prenez le temps de vivre Experience the Freedom

**Moved By:** Léandre **DATE:** October 20, 2015

**Seconded By:** Hélène **Resolution No.** 15-336

Whereas that the Council of the Corporation of the Township of Dubreuilville supports the attached letter dated October 15, 2015 from the Algoma Public Health with regards to their district-wide initiative to reduce smoking rates by 5% over the next 5 years.

✓

**Carried** **Defeated** **Deferred**

| **RECORDED VOTE:** | **YES** | **NO** |
|---|---|---|
| **Councillor** Beverly Nantel | ____ | ____ |
| **Councillor** Hélène Perth | ____ | ____ |
| **Councillor** Martin Bergeron | ____ | ____ |
| **Councillor** Léandre Moore | ____ | ____ |
| **Mayor** Alain Lacroix | ____ | ____ |



Declaration of Pecuniary Interest and General Nature Thereof:

City of Elliot Lake

CITY CLERK'S *Department*

Clerk's Department

October 27, 2015

Dr. Penny Sutcliffe
Acting Medical Officer of Health
Algoma Public Health
294 Willow Avenue
Sault St.e Marie, ON P6B 0A9

**RE: REDUCE SMOKING IN ALGOM ABY 5% IN 5 YEARS**

Dear Dr. Sutcliffe:

We wish to advise that at the regular meeting of the Council of the City of Elliot Lake held Monday, October 26, 2015, the Council passed the attached Resolution No. 387/15 in support of the Algoma Public Health initiative to reduce smoking rates in Algoma District by 5% over the next five years.

Sincerely,

Lesley Sprague, CMO(A)
City Clerk

c. Janet Allen jallen@algomapublichealth.com

**THE CORPORATION OF THE TOWNSHIP OF HILTON**

Resolution No. 2008 – 127

December 3, 2008

Moved by R E Donald

Seconded by David J Rusk

Resolved that we do support Algoma Public Health's district-wide strategy to reduce smoking rates by 5% over the next five years.

Carried: ✓ Defeated: _____

Reeve: Robert Kilcup

*The Corporation of the*

# *Municipality of Huron Shores*

November 4, 2015

Dr. Penny Sutcliffe, Acting Medical Officer of Health
Tony Hanlon, Ph.D., Chief Executive Officer
Algoma Public Health

SENT VIA E-MAIL: CLuukkonen@algomapublichealth.com

Dear Dr. Sutcliffe and Dr. Hanlon:

***Re: Res. #15-24-23 – Support APH - Reduce Smoking Rates***

The Council of the Corporation of the Municipality of Huron Shores passed Resolution #15-24-23 at the Regular Meeting held Wednesday, October 28th, 2015, as follows:

> "BE IT RESOLVED THAT the Council of the Corporation of the Municipality of Huron Shores supports in principle Resolution No. 2015-130 from the **Board of Algoma Public Health (APH)** in its district-wide goal to **reduce smoking rates** by 5% over the next 5 years and its proposed strategies to achieve said goal;
> AND THAT a copy of this resolution be forwarded to Algoma Public Health."

Should you require anything further from this office in order to address the above resolution, please do not hesitate to contact the undersigned.

Sincerely,

Deborah Tonelli

Deborah Tonelli, AMCT
Clerk/Administrator

DT/cks

Cc: Janet Allen, Tobacco Control Coordinator, APH

*P.O. Box 460, 7 Bridge Street, Iron Bridge, ON P0R 1H0*
*Phone 705-843-2033 * Fax 705-843-2035 * email@huronshores.ca*

TOWNSHIP OF
**Macdonald, Meredith & Aberdeen Add'l.**

P.O. Box 10 • 208 Church Street
ECHO BAY, ONTARIO
P0S 1C0
(705) 248-2441
FAX (705) 248-3091

INCORPORATED
1892

November 23, 2015

Algoma Public Health
294 Willow Avenue
Sault Ste. Marie, ON
P6B 0A9

Attention: Dr. Penny Sutcliffe, Acting Medical Officer of Health

At our November 3, 2015 Regular Council Meeting your letter was presented to Council and the following motion passed stating "that we support the Algoma Public Health of Algoma in endorsing the concept of a district-wide goal to reduce smoking rates by 5% over the next five years."

We thank you for your ambitious goal and all the assistance you provide those who choose to quit smoking. Hopefully together we can reduce smoking rates and decrease the number of incidence related to smoking illnesses.

Yours truly,

Lynne Duguay

Lynne Duguay
Clerk Administrator

8 Trunk Road
P.O. Box 70
Spanish, Ontario
P0P 2A0

THE CORPORATION OF THE TOWN OF
SPANISH

Tel.: (705) 844-2300
Fax.: (705) 844-2622
E-Mail: info@townofspanish.com
Web Site:www.townofspanish.com

November 4th, 2015

Algoma Public Health
294 Willow Avenue
Sault Ste. Marie, ON P6B0A9

Attention: Dr. Penny Sutcliffe
Acting Medical Officer of Health

Dear Dr. Sutcliffe:

Thank you for your correspondence of October 15th 2015.

Attached please find Council motion 15-10-26 supporting the call to action; relating to a district-wide strategy to reduce smoking rate by 5% over the next 5 years.

Sincerely yours,

Pam Lortie
CA0
pamlortie@townofspanish.com

RECEIVED
NOV 09 2015
ALGOMA PUBLIC HEALTH

THE CORPORATION OF THE TOWN OF SPANISH

RESOLUTION OF COUNCIL

RESOLUTION #15-10-26

DATE: OCT 21 2015

MOVED BY: Karen VanLuchene

SECONDED BY: Ruth ann Bacon

**BE IT RESOLVED THAT** Whereas the Board of Health for the District of Algoma is calling on municipalities and townships across the Algoma district to support a district-wide strategy to reduce smoking rates by 5% over the next 5 years;
Therefore be it resolved that the Council of the Corporation of the Town of Spanish supports this call to action.

SIGNATURE OF PRESIDING OFFICER

Mayor

I hereby certify this to be a true and correct Copy of the Corporation of the Town of Spanish, Resolution #15-_____, passed on the____Day of_____, 2015.

CAO



letter to Algoma Public Health

**Malcolm White** B.P.H.E., CMO
City Clerk



January 13, 2016

Algoma Public Health
Dr. Penny Sutcliffe
Acting Medical Officer of Health
294 Willow Avenue
Sault Ste. Marie, ON P6B 0A9

Algoma Public Health
Dr. Tony Hanlon
Chief Executive Officer
294 Willow Avenue
Sault Ste. Marie, ON P6B 0A9

Dear Dr. Sutcliffe and Dr. Hanlon,

At the regular City Council meeting of the Corporation of the City of Sault Ste. Marie held on January 11, 2016 the following resolution was approved.

Moved by: Councillor S.Butland
Seconded by: Councillor J. Krmpotich
Resolved that City Council endorses the Board of Health for the District of Algoma resolution no. 2015-130 concerning Reducing Smoking Rates by 5% in 5 Years in the District of Algoma.

Yours sincerely,

Malcolm White
City Clerk



THE CORPORATION OF THE CITY OF SAULT STE. MARIE
P.O. BOX 580 * 99 FOSTER DRIVE * SAULT STE. MARIE, ONTARIO, P6A 5N1
TEL: (705) 759-5388 * FAX: (705)759-2310

*Municipality of*
***Tarbutt & Tarbutt Additional***
*R.R. #1, Desbarats, ON P0R 1E0*
*Phone 705-782-6776*
*Fax 705-782-4274*

*November 9th 2015*

*Dr. Penny Sutcliffe*
*Algoma Public Health*
*294 Willow Avenue*
*Sault Ste. Marie, ON P6B 0A9*

*Dear Dr. Sutcliffe,*

***Re: Reduction of Smoking Rates***

*The following resolution was passed at the October 21st regular meeting of Council.*
*Res.: 121-2015 R. Wigmore, S. Flood*
*WHEREAS Algoma Public Health is committed to preventing disease and promoting the health of individuals and communities; and*
*WHEREAS the incidence of lung and bronchus cancer for the District of Algoma at 23.6% is higher than that of the Province which is 17.8%.*
*THEREFORE The Township of Tarbutt and Tarbutt Additional join the Algoma Public Health and endorse the concept of a district wide goal to reduce smoking rates by 5% over the next 5 years. (cd)*

*Yours truly,*

Jean Palmer

*Jean Palmer*
*Administrative Assistant*

# The Corporation of the Town of Thessalon

**P.O. Box 220** **187 Main Street** **Thessalon, Ontario P0R 1L0**
**Phone: (705) 842-2217** **Fax: (705) 842-2572**
**Email: townthess@bellnet.ca** **Website: www.thessalon.ca**

***Mayor: JAMES ORLANDO*** ***Clerk: ROBERT P. MacLEAN***

November 24, 2015

RECEIVED
NOV 26 2015
ALGOMA PUBLIC HEALTH

Dr. Penny Sutcliffe
Acting Medical Officer of Health
Algoma Public Health
294 Willow Avenue
Sault Ste. Marie, Ontario
P6B 0A9

Dear Dr. Sutcliffe:

At the November 16, 2015 meeting of the Council of the Town of Thessalon, the following resolution was passed:

> "Be it resolved that the Council of the Town of Thessalon support the resolution passed by the Board of Health of Algoma endorsing the concept of a district-wide goal to reduce smoking rates by 5% over the next 5 years; and further that in keeping with the Algoma Public Health's endorsement of a district-wide goal, supports the development of a strategy that engages community partners including those from health care, education, and the private sector to support the implementation of a 5 year smoking reduction plan across the district; and further supports the development of an internal and external branded communication strategy directed at smokers to make quit smoking attempts; and further endorses a proposal submission in partnership with the Ontario Tobacco Research Unit to the Ministry of Health to fund a 5 year smoking reduction strategy." CARRIED

Thank you for giving Council the opportunity to support this initiative.

Yours truly,

Robert P. MacLean

Robert P. MacLean
Clerk-Treasurer

RPM/pw
G:\Agendas-Council 2015\November 16, 2015.wpd

Township of
JOHNSON

*1 Johnson Drive, Box 160 Desbarats - Ontario - P0R 1E0*
*Phone (705) 782-6601 Fax (705) 782-6780*
*johnsontwp@bellnet.ca*
*Mayor*
*Ted Hicks*

October 30, 2015

Mr. Tony Hanlon, Ph.D.
Chief Executive Officer
Algoma Public Health
294 Willow Avenue
Sault Ste. Marie, ON
P6B 0A9

Attention: Mayor Watson

**RE: Reducing Smoking Rates**

Council at their regular meeting held October 21, 2015 reviewed your correspondence requesting support of your resolution dated September 22, 2015. The following is the Resolution # 385 of support.

Moved by: M. Hopkins Seconded by: J. Kern
Be it resolved that the Council of the Township of Johnson endorses and supports the resolution from Algoma Public Health to endeavor a district-wide strategy to reduce the smoking rates by 5% over the next 5 years. Carried

Thank you for given us such a worthwhile cause to support.

Regards,

Ruth Kelso
Clerk

**The Corporation of the Township of Plummer Additional**

RR # 2, 38 Railway Crescent, Bruce Mines ON POR ICO
Tel: (705) 785-3479 Fax: (705) 785-3135
email:plumtwsp@onlink.net

**Mayor: Beth West** **Clerk: Vicky Goertzen-Cooke**

October 30, 2015

Mr. Tony Hanlon
Chief Executive Officer
294 Willow Avenue
Sault Ste. Marie, ON
P6B 0A9

Dear Mr. Hanlon,

Please find below a resolution of support from our council meeting of October 21, 2015:

**Resolution 2015-259** **Moved: Tasha Strum** **Seconded: Boris Koehler**
**WHEREAS** the incidence of lung and bronchus cancer for the district of Algoma is significantly higher than that of the province of Ontario;
**BE IT RESOLVED** that the Township of Plummer Additional supports the Algoma Public Health's resolution #2015-130 to implement a district wide strategy, a call to action to reduce smoking rates by 5% over the next 5 years. CARRIED

Respectfully yours,

Gina Marie Wilson
Deputy Clerk-Treasurer

**THE CORPORATION OF THE TOWNSHIP OF ST. JOSEPH**
1669 Arthur Street
P.O. Box 187
Richards Landing, ON P0R 1J0
Telephone: 705-246-2625
Fax: 705-246-3142
www.stjosephtownship.com

October 30, 2015

Dr. Tony Hanlon
Algoma Public Health
294 Willow Avenue
Sault Ste. Marie, ON
P6B 0A9

Dear Dr. Hanlon:

Thank you for your letter of October 15, 2015, seeking support for your district-wide call to action to reduce smoking rates by 5% over the next years.

At its meeting of October 21, 2015, the Council of The Township of St. Joseph endorsed your resolution and agree with your position that a strategy should be developed that engages community partners including those from health care, education and the private sector to support the implementation of a 5 year smoking reduction plan across the district.

If you require additional information, or support, please do not hesitate to contact me.

Yours truly,

Carol O. Trainor, A.M.C.T.
Clerk Administrator

mp

Resolution No. 2015 - 149

# THE CORPORATION OF THE

# TOWNSHIP OF WHITE RIVER

White River, Ontario November 12, 2015

Moved by Raymond St. Pierre

Seconded by [signature]

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

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

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

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

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

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

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

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

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

FURTHER THAT the Township of White River supports the development of an internal and external branded communication strategy directed at smokers to make quit smoking attempts; and

FURTHER THAT the Township of White River endorses a proposed submission from the Algoma Board of Health in partnership with the Ontario Tobacco Research Unit to the Ministry of Health to fund a 5 year smoking reduction strategy.

Mayor

| RECORDED VOTE | FOR | AGAINST |
|---|---|---|
| Mayor Angelo Bazzoni | ✓ | |
| Councillor Ted Greenwood | | |
| Councillor Rodney Swarek | | |
| Councillor Louise Seguin | | |
| Councillor Raymond St. Louis | | |

Sudbury & District

Health Unit

Service de santé publique

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🖷 : 705.677.9611

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Box / Boîte 485
Chapleau ON P0M 1K0
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🖷 : 705.864.0820

Espanola
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Unit / Unité 100 C
Espanola ON P5E 1J3
☎ : 705.222.9202
🖷 : 705.869.5583

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

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

Toll-free / Sans frais
1.866.522.9200

www.sdhu.com

December 2, 2015

VIA ELECTRONIC MAIL

Ms. Lorraine Fry and
Ms. Donna Kosmack
Co-chairs
Smoke-Free Housing Ontario

Dear Ms Fry and Ms. Kosmack:

**Re:** ***Endorsement of Action for Smoke-Free Multi-Unit Housing***

At its meeting on November 19, 2015, the Sudbury & District Board of Health carried the following resolution #55-15:

*WHEREAS smoking in multi-unit housing results in significant exposure to the health harming effects of tobacco smoke; and*

*WHEREAS area municipalities and service boards that are landlords of multi-unit housing can adopt no-smoking policies that set an example and protect health, such as that adopted by the Manitoulin Sudbury District Services Board to support smoke-free social housing effective January 1, 2015;*

*THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Northwestern Health Unit motion (88-2015) on smoke-free multi-unit housing, the efforts of the Smoke-Free Housing Ontario Coalition and others, in the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:*

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

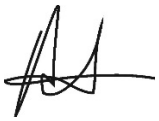
*FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Smoke-Free Housing Ontario Coalition, the Ontario Minister of*

*Municipal Affairs and Housing, local members of Provincial Parliament (MPP), the Chief Medical Officer of Health, the Association of Local Public Health Agencies (alPHa), all Ontario Boards of Health, the Association of Municipalities of Ontario, the Federation of Northern Ontario Municipalities and SDHU municipalities for their information and support.*

Members of the Sudbury & District Board of Health hope that this motion will impact the tobacco control decisions you make, in an effort to protect all Ontario residents living in multi-unit housing from the impact of second-hand smoke exposure. I am confident that together, we can ensure a healthier Ontario for all.

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

Sincerely,



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

cc: The Honourable Ted McMeekin, Ontario Minister of Municipal Affairs and Housing
Glenn Thibeault, MPP, Sudbury
France Gélinas, MPP, Nickel Belt
Michael Mantha, MPP, Algoma-Manitoulin
Dr. David Williams, Interim Chief Medical Officer of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Gary McNamara, President, Association of Municipalities of Ontario
Alan Spacek, President, Federation of Northern Ontario Municipalities
Sudbury & District Health Unit Constituent Municipalities

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound
in your community . . . here for your health
681 Commercial Street, North Bay, ON P1B 4E7 TEL 705.474.1400 FAX 705.474.8252
70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705.746.5801 FAX 705.746.2711
myhealthunit.ca TOLL FREE 1 800 563 2808

January 20, 2016

Smoke-Free Housing Ontario Coalition
Co-Chairs

**Sent Electronically**

Lorraine Fry
Executive Director
Non-Smokers' Rights Association
720 Spadina Avenue, Suite 221
Toronto, ON M5S 2T9

Donna Kosmack
Manager
South West Tobacco Control Area Network
Middlesex-London Health Unit
50 King Street
London, ON N6A 5L7

Dear Lorraine Fry and Donna Kosmack:

**Subject: Board of Health Resolution #BOH/2015/11/04 - Smoke-Free Multi-Unit Housing**

As part of an ongoing effort to protect the health of our community by reducing exposure to second-hand smoke, the Board of Health for the North Bay Parry Sound District Health Unit has passed a resolution to sign the Smoke-Free Housing Ontario Coalition's letter of Endorsement of Action for Smoke-Free Multi-Unit Housing. At the November 25, 2015 regular meeting, the Board of Health passed the following resolution:

***Now Therefore Be It Resolved**, that the Board of Health for the North Bay Parry Sound District Health Unit endorse the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:*

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

***Furthermore Be It Resolved**, that a copy of this resolution be forwarded to the Smoke-Free Housing Ontario Coalition, the Ontario Minister of Municipal Affairs and Housing, the Ministry of Health and Long-Term Care, member municipalities within the North Bay Parry Sound District Health Unit service area, Ontario Boards of Health, Ontario Medical Officers of Health, and the Association of Local Public Health Agencies.*

Thank you for your attention to this issue.

Respectfully yours,

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

Attachment (1)

Copied to:
Honourable Ted McMeekin, Minister of Municipal Affairs and Housing
Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
Ontario Boards of Health
Ontario Medical Officers of Health
Member Municipalities
Linda Stewart, Executive Director, Association of Local Public Health Agencies

October 10, 2014

Dear colleague,

**Re: Act now to reduce the impact of second-hand smoke exposure in multi-unit housing in Ontario**

As you are aware, tobacco use is the number one cause of preventable disease and death in Ontario. Every year, more than 13,000 people in Ontario die because of tobacco use – one person almost every 40 minutes. Tobacco is the only legal product that, when used as intended, kills half of its users prematurely. It can also kill others through involuntary exposure to second-hand smoke (SHS).

Approximately one third of Ontarians living in multi-unit housing (MUH) report regular exposure to SHS that originates in neighbouring units,and 80% of Ontarians would choose a smoke-free building if the choice existed.[1] However, many stakeholders in the housing sector erroneously believe that no-smoking policies are illegal, unenforceable or discriminatory and so many Ontarians continue to be involuntarily exposed to SHS in their home.

Studies have demonstrated that there is no safe level of exposure to SHS—all exposure is harmful and should be eliminated. According to the U.S. Department of Health and Human Services, exposure to SHS among children and adults causes a range of adverse health effects, including premature death and disease.[2] Second-hand smoke is a serious problem for many Ontario residents living in apartments and condominiums, especially those who suffer from chronic health conditions such as heart disease, asthma, allergies, diabetes, and respiratory illnesses. Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported. For many forced to breathe their neighbour's smoke, the only remedy is to move; however, moving is not always an option for people with disabilities, older adults or those with limited incomes. This is why we need to work toward making smoke-free housing in Ontario the norm, not the exception.

The 2010 Tobacco Strategy Advisory Group (TSAG) report[3] regarding Ontario's renewed Smoke-Free Ontario Strategy contains a number of recommendations pertaining to MUH. First and foremost, the report recommends continuing and intensifying a voluntary approach to smoke-free MUH. **The primary goals of the Smoke-Free Housing Ontario Coalition are to facilitate the adoption of no-smoking policies within the housing sector and to create a favourable environment to foster the adoption of those policies. We seek your endorsement in helping us achieve this end.**

Please submit a letter of endorsement of the Smoke-Free Housing Ontario Coalition to either of co-chairs Lorraine Fry at lfry@nsra-adnf.ca or Donna Kosmack at donna.kosmack@mlhu.on.ca. Endorsements are being compiled online the Smoke-Free Housing Ontario website.www.smokefreehousingon.ca. A sample statement of endorsement, and a space for your endorsement signature is attached.

Sincerely,

Lorraine Fry
Executive Director, Non-Smokers' Rights Association

Donna Kosmack
Manager, SW Tobacco Control Area Network

---

[1] Smoke-Free Housing Ontario. 80% of People Living in Apartments, Condos and Co-ops Want to Live Smoke Free. Press release 8 December 2011. http://www.newswire.ca/en/story/892061/80-of-people-living-in-apartments-condos-and-co-ops-want-to-live-smoke-free.

[2] U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. 2006.

[3] *Building on our Gains, Taking Action Now: Ontario's Tobacco Control Strategy for 2011-2016.* Report from the Tobacco Strategy Advisory Group to the Minister of Health Promotion and Sport, October 18, 2010. http://www.mhp.gov.on.ca/en/smoke-free/TSAG%20Report.pdf.

## ENDORSEMENT OF ACTION FOR SMOKE-FREE MULTI-UNIT HOUSING

Tobacco use is the number one cause of preventable disease and death in Ontario. Leaders in public health units, local boards of health, non-governmental organizations and health charities in Ontario have a history of speaking out in favour of actions to reduce the harmful impact of tobacco use.

**Whereas** tobacco use is the leading cause of preventable death and disability in Canada, accounting for the deaths of approximately 13,000 people in Ontario alone each year;[4]

**Whereas** Second-hand smoke kills 1,000 Canadians annually.[5],[6]

**Whereas** Approximately one-third of Ontarians living in multi-unit housing (MUH) report regular exposure to second-hand smoke that originates in neighbouring units, and 80% would choose a smoke-free building if the choice existed.[7]

**Whereas** Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported.

**Whereas** Indoor air studies show that, depending on the age and construction of a building, up to 65% of the air in a private residence can come from elsewhere in the building[8] and no one should be unwilling exposed or forced to move due to unwanted second-hand smoke exposure.

**Whereas** second-hand smoke in multi-unit housing can lead to third-hand tobacco exposure as semi-volatile and volatile organic chemicals like nicotine and polycyclic aromatic hydrocarbons (carcinogens, also known as PAHs) are oily or waxy and more likely to stick to surfaces than be removed by ventilation.

**Therefore be it resolved that** the North Bay Parry Sound Dist. Health Unit **[name of organization] endorses the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:**

(1) Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties;

(2) All future private sector rental properties and buildings developed in Ontario should be smoke-free from the onset;

(3) Encourage public/social housing providers to voluntarily adopt no-smoking policies in their units and/or properties;

(4) All future public/social housing developments in Ontario should be smoke-free from the onset.

(5) Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.

Rick Champagne, Board Chair — North Bay Parry Sound District Health Unit

Signatory Official (please print name and title) — Organization/Agency/Institution

Signature: _____ Date: 2015/11/25

[4] http://www.mhp.gov.on.ca/en/smoke-free/default.asp Accessed August 17 2010

[5] Health Canada, 2004. "Cigarette Smoke: It's Toxic." Second-hand Smoke: FAQs & Facts. 2004. www.hc-sc.gc.ca/hlvs/tobac-tabac/second/fact-fait/tox/index_e.html (Accessed Jan. 2006)

[6] Makomaski-Illing EM and Kaiserman MJ, 1999. Mortality attributable to tobacco use in Canada and its regions- 1998. *Canadian Journal of Public Health* 1999; 95(1):38-44. www.cpha.ca/shared/cjph/archives/abstr04.htm#38-44 (Accessed Dec. 2005)

[7] Smoke-Free Housing Ontario. 80% of People Living in Apartments, Condos and Co-ops Want to Live Smoke Free. Press release 8December 2011. http://www.newswire.ca/en/story/892061/80-of-people-living-in-apartments-condos-and-coops-want-to-live-smoke-free.

[8] "Second-hand smoke in Multi-Unit Dwellings." Non-Smokers' Rights Association (2011). Available from http://www.nsra-adnf.ca/cms/page1433.cfm.

*Smoke-Free Housing Ontario's membership includes the Canadian Cancer Society, Ontario Division; Heart and Stroke Foundation of Ontario; Non-Smokers' Rights Association; Ontario Lung Association; Ottawa Public Health exposé; Physicians for a Smoke -Free Canada; Tobacco Control Area Networks—Central East, Central West, South West… HEALTH UNITS etc, Modify list as needed.*

**Date: January 19, 2016**

## Please forward to all Board of Health Members.

Thank you. Linda Stewart, Executive Director, alPHa

---

Dear Board of Health Member.

**UPDATE: Please note that the Board of Health Section meeting on February 25, 2016 will now be a full day session. A half day will be dedicated to the Patients First discussion paper and a half day will be dedicated to the recommendations in the Algoma report (skills-based boards, etc). The meeting will be scheduled for 8:30 AM to 4:00 PM. The Risk Management session on February 24, 2016 will continue as previously planned.**

Following the successful session on Risk Management held in Toronto on November 5, 2015, alPHa received many requests for more education focused on Risk Management. A working group was established and have been working on a follow up session that will be held on **Wednesday, February 24, 2016**. The session will provide a brief overview of material covered in November and then help you to build on that knowledge. You can expected an engaging, interactive session that will get you started on identifying your top risks locally.

In addition to members of boards of health, the Risk Management session will be open to medical officers of health, associate medical officers of health and senior management.

On the next day, **Thursday, February 25th**, there will be a full-day Board of Health Section meeting that will provide board of health members with the opportunity to discuss:

1. the recommendations in the *Assessors Report on Algoma Public Health Unit*, and
2. the proposals for changes to local public health units that were included in Minister Hoskins' December 17th discussion paper entitled, *Patients First – A Proposal to Strengthen Patient-Centred Health Care in Ontario*.

The meetings on February 24th and 25th will both take place at the Hotel Novotel Toronto, Centre, 45 The Esplanade, Toronto, Ontario M5E 1W2. Registration for both sessions will open soon, as well as a block of rooms available at a discounted rate for alPHa members.

**At this time, we are asking you to hold the dates for these important meetings.**

Thank you.
Linda

---

Linda Stewart
Executive Director

**Association of Local Public Health Agencies (alPHa)**
2 Carlton Street, Suite 1306
Toronto, ON M5B 1J3
Tel: (416) 595-0006 ext. 22
Fax: (416) 595-0030
linda@alphaweb.org

*For scheduling, please contact Karen Reece, Administrative Assistant, at karen@alphaweb.org or call 416-595-0006 ext 24.*

For more information visit our web site: http://www.alphaweb.org