ALGOMA PUBLIC HEALTH

BOARD OF HEALTH MEETING

April 27, 2016

5:00 - 7:00 PM

SAULT STE MARIE ROOM, 1ST FLOOR, APH SSM

294 WILLOW AVE, SAULT STE MARIE, ON

www.algomapublichealth.com

April 27, 2016 - Board of Health Meeting

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7. **New Business**

    a. 2016 alPHa Annual Conference June 5-7, 2016 Novotel Toronto Centre Hotel

8. **Correspondence**

    a. Enactment of Legislation to Enforce IPAC Practices within Invasive Personal Service Settings

        i. Letter to Premier Wynne from Grey Bruce Health Unit — Page 84

    b. Environmental Health Program Funding

        i. Letter to Minister Hoskins from Grey Bruce Health Unit — Page 87

    c. Herpes Zoster Vaccine

        i. Letter to Minister Hoskins from Grey Bruce Health Unit — Page 90

    d. Ontario HPV Vaccination Program Expansion

        i. Letter to Boards of Health from Minister Hoskins — Page 93

        ii. Letter to Minister Hoskins from alPHa — Page 95

    e. Patients First: A Proposal to Stengthn Patient-Centred Health Care

        i. Letter to Premier Wynne and Minister Hoskins from Peterborough County-City Health Unit — Page 97

        ii. Letter to Minister Hoskins from Perth District Health Unit — Page 99

        iii. Memo to Boards of Health and Medical Officers of Health from Minister Hoskins — Page 107

    f. Smoke-Free Schools Act Bill 139

        i. Letter to Minister Hoskins from Grey Bruce Health Unit — Page 109

9. **Items of Information**

10. **Addendum**

11. **In Committee**

12. **Open Meeting**

13. **Resolutions Resulting From In Committees**

14. **Announcements**

a. Elliot Lake Grand Opening Celebration - May 25, 2016 at 2:30pm

b. Next Board of Health Meeting - May 25, 2016 at 4:00pm

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15. Adjournment

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
APRIL 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 — Lee Mason, Board Chair

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda Items — Lee Mason, Board Chair

Resolution
THAT the agenda items dated April 27, 2016 be adopted as circulated; and
THAT the Board accepts the items on the addendum.

3.0 Adoption of Minutes of Previous Meeting — Lee Mason, Board Chair

Resolution
THAT the Board of Health minutes for the meeting dated March 30, 2016 be adopted as circulated.

4.0 Delegations/Presentations.

a. Health and Safety: Reporting on Hazards and Incidents — Suzanne Irwin, Manager of Corporate Services and Facilities

5.0 Business Arising from Minutes

No business arising from previous minutes.

6.0 Reports to the Board

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

Resolution
THAT the report of the Associate Medical Officer of Health and CEO for the month of April 2016 be adopted as presented.

b. Finance an Audit Committee Report — Justin Pino, Chief Financial Officer

i. Chair's Report for April 2016
ii. Draft Financial Statements for the Period Ending February 29, 2016

Resolution
THAT the Finance and Audit Committee report for the month of April 2016 be adopted as presented; and

THAT the Financial Statements for the Period Ending February 29, 2016 be approved as presented.

iii. 2015 Audited Financial Statements

Resolution
T*HAT the 2015 Audited Financial Statements be approved as presented.*

iv. Approved minutes ***– for information only***

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

i. Chair's Report for April 2016

Resolution
THAT the Governance Standing Committee report for the month of April 2016 be adopted as presented.

ii. Marketing to Children

Resolution

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

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

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

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

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

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

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

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

NOW THEREFORE BE IT RESOLVED THAT:
The Board of Health of Algoma:

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

iii. Basic Income Guarantee

Resolution

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

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

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

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

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

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

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

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

Therefore Be It Resolved That *the Board of Health of Algoma supports Leeds, Grenville and Lanark District Health Units request for a joint federal-provincial consideration and investigation into a Basic Income Guarantee as a policy option for reducing poverty and improving income security as a basis to improve the health and wellbeing of the residents of the District of Algoma, Ontario and Canada as a whole.*

Further That *this resolution be shared with Federal and Provincial elected representatives for the Algoma ridings, all Ontario Boards of Health, Association of Local Public Health Agencies, Minister of Families, Children and Social Development and Minister Responsible for the Poverty Reduction Strategy.*

iv. Approved Minutes – ***for information only***

7.0 New Business/General Business

a. 2016 alPHa Annual Conference — Tony Hanlon, Chief Executive Officer
June 5-7, 2016
Novotel Toronto Centre Hotel

8.0 Correspondence — Lee Mason, Board Chair

a. Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings
- i. Letter to Premier Wynne from Grey Bruce Health Unit dated March 24, 2016

b. Environmental Health Program Funding
- i. Letter to Minister Hoskins from Grey Bruce Health Unit dated March 24, 2016

c. Herpes Zoster Vaccine
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d. Ontario HPV Vaccination Program Expansion
- i. Letter to Boards of Health from Minister Hoskins dated April 21, 2016
- ii. Letter to Minister Hoskins from alPHa dated April 21, 2016

e. Patients First: A Proposal to Strengthen Patient-Centred Health Care
- i. Letter to Premier Wynne and Minister Hoskins from Peterborough County-City Health Unit dated March 31, 2016
- ii. Letter to Minister Hoskins from Perth District Health Unit dated March 24, 2016
- iii. Memo to Boards of Health and Medical Officers of Health from Minister Hoskins dated April 20, 2016

f. Smoke-Free Schools Act Bill 139
- i. Letter to Minister Hoskins from Grey Bruce Health Unit dated March 24, 2016

9.0 Items for Information

10.0 Addendum — Lee Mason, Board Chair

11.0 That The Board Go Into Committee — Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into committee.

Agenda Items:

a. Adoption of previous in-committee minutes dated March 30, 2016

12.0 That The Board Go Into Open Meeting — Lee Mason, Board Chair

Resolution
THAT the Board of Health goes into open meeting

13.0 Resolution(s) Resulting from In-Committee Session — Lee Mason, Board Chair

14.0 Announcements: Lee Mason, Board Chair

Elliot Lake Office Grand Opening Celebration
May 25, 2016 at 2:30pm

Next Board Meeting:
May 25, 2016 at 4:00pm
Algoma Public Health Elliot Lake Office

15.0 That The Meeting Adjourn Lee Mason, Board Chair

Resolution
THAT the Board of Health meeting adjourns

Algoma
PUBLIC HEALTH
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Health and Safety
Reporting on Hazards and Incidents

Presented by:
Suzanne Irwin
Manager of Corporate Services and Facilities


health and safety
Safety
Is
as
simple
as . . .
Always
Be
Careful

Overview

- Hazards
  - History (how APH hazard list was determined)
  - Top (3) Significant Hazards
- Statistics/Trends
- Health and Safety Training
- New Developments

Top (3) Significant Hazards

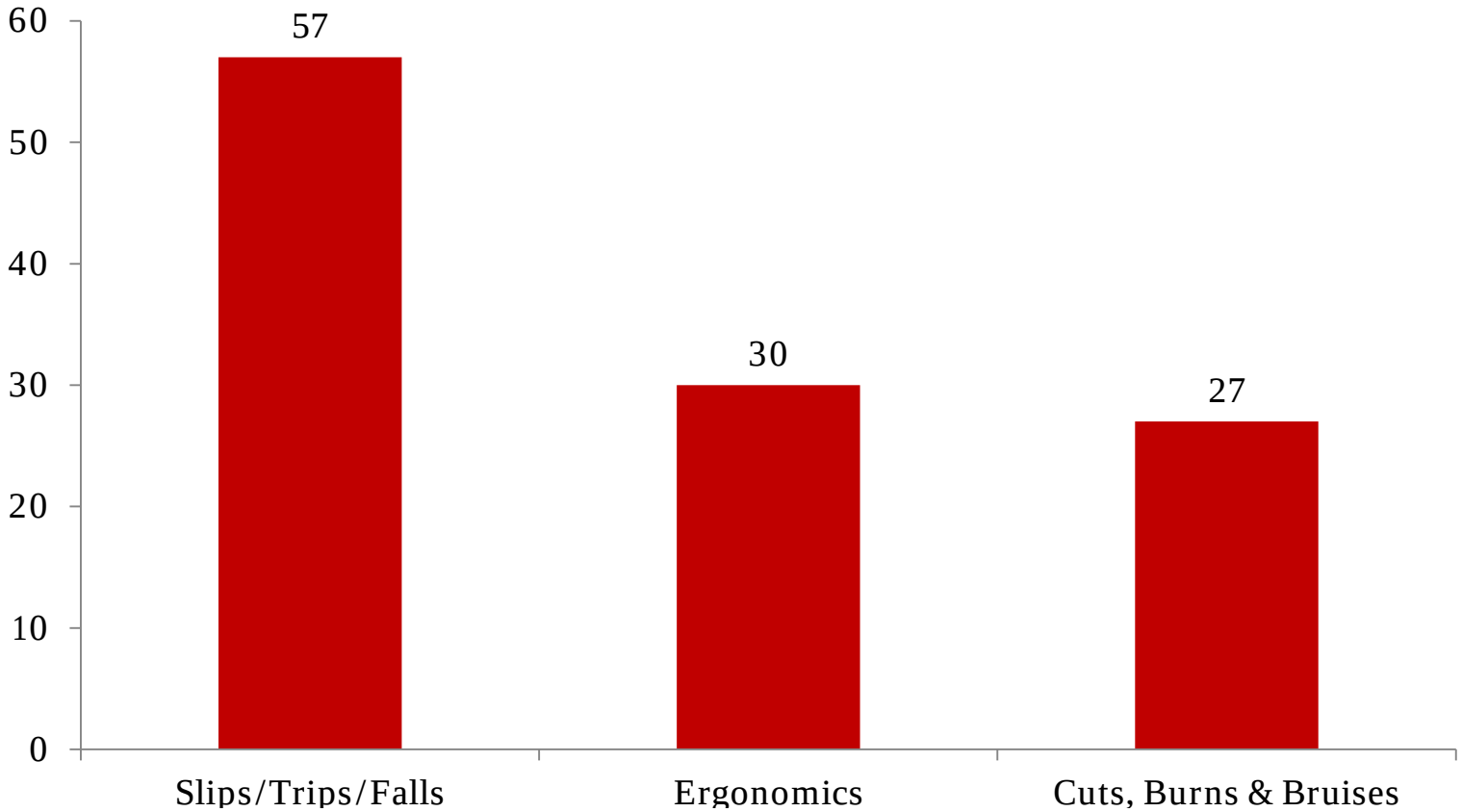
Ranked *(Highest to Lowest)*

- Slips/Trips/Falls
- Ergonomics
- Cuts, Burns and Bruises

***Formulized Part 2 Certification Training — In accordance with Ministry of Labour requirements, APH provides training on a minimum of six (6) hazards relevant to the workplace.*

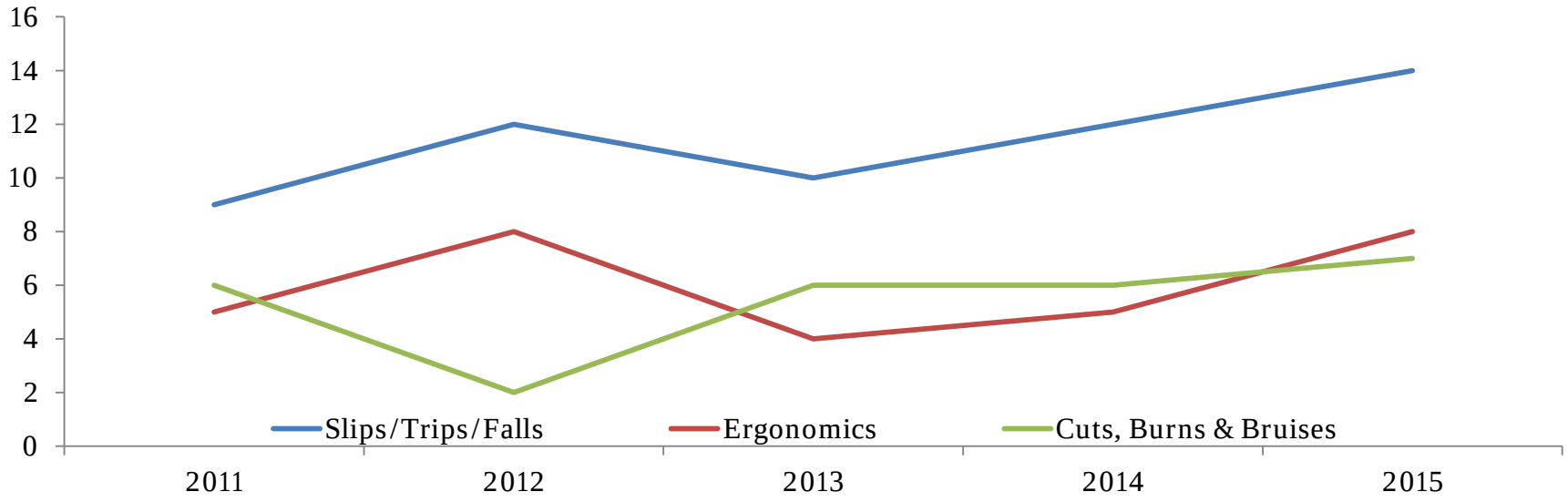
Statistics/Trends

Incident Reporting – Top (3) Significant Hazards by Type 2011-2015



Statistics/Trends

Incident Reporting – Top (3) Significant Hazards by Year 2011-2015



Health and Safety Training

APH will continue to promote a culture of occupational health and safety by:

- Providing refresher training in various formats
- Apprising APH employees of new legislation as it is introduced
- Developing in-house expertise
- Engaging employees in participatory exercises

New Developments

- Delivery of health messages (commencing with the top two (3) hazards)
- Going above and beyond during workplace inspections
- Health and safety video
- Implementation of an awareness blitz during Health and Safety Week *(May 1 - May 7, 2016)*
- Electronic reporting system
- JHSC attendance at team meetings, annually

Thank You

Algoma
PUBLIC HEALTH
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MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER
BOARD REPORT
February 2016

Prepared by Tony Hanlon Ph.D., CEO and Dr. Alex Hukowich, Associate MOH

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APH AT-A-GLANCE

April is National Oral Health Month. Remember to brush twice a day, floss daily, eat a well-balanced diet, avoid tobacco products and see your dentist regularly. As part of oral health month in Canada National Dental Hygienists Week takes place from April 9-15, 2016. This year's theme, *"Oral Health for Total Health"*, reminds all of us that taking care of our mouth, teeth, and gums benefit our overall physical and mental well- being.

Algoma Public Health hosted an Incident Management System (IMS) for Public Health Emergency Preparedness workshop on April 13, 2016. Members of the Executive and Management teams along with our Public Health Inspectors participated in this full day event facilitated by Public Health Ontario.

April 10-16, 2016 was National Volunteer Week in Canada. Algoma Public Health currently has approximately 40 active volunteers that assist various programs throughout the agency. Some of the program activities they have assisted with are:

- Packaging for Dental, Sexual Health, Community Mental Health, school screening and Injury Prevention
- Brain Day
- APH Flu Clinics
- APH Staff Day
- Annual alPHa Challenge
- IT
- Community Closet

We hosted the volunteers for breakfast on April 13, 2016 to express our appreciation for their service throughout the year. The new APH Code of Conduct was also overviewed with the volunteers.

"Volunteers are the roots of strong communities. Just like roots are essential for trees to bloom, volunteers are essential for communities to boom."

The MOHLTC has announced that Zostavax will be publicly funded for individuals aged 65-70 years. The National Advisory Committee on Immunization (NACI) recommends Zostavax for individuals aged 60-69 years. For ease of program delivery within the publicly funded schedule, the inclusion of the vaccine at age 65 correlates with the Pneumovax 23 dose recommended at age 65. This would be an ideal opportunity for physicians to deliver both vaccines at the same visit. From a program perspective, we feel that this is appropriate. The MOHLTC also announced a change to the Human Papilloma Virus vaccine (Gardasil 4) program to include males in Grade 7.

Algoma Public Health, as well as other health units across the province, will be providing Hepatitis A immunization for free as a result of the Costco recall of frozen berries that may be contaminated with the Hepatitis A virus.

RISK MANAGEMENT

Minister of Health and Long-Term Care (MOHLTC) Patient's First Discussion Paper: Next Steps

There is interest and support among northeastern MOH/CEO colleagues to act collectively to further engage with the NE LHIN. The FONOM Board was also supportive of this approach and has offered to write a letter of support, highlighting the need for both groups to work together to ensure that northern concerns are taken into consideration.

APH will collaborate with the boards of health for Porcupine, Timiskaming, and North Bay/Parry Sound to engage further with the North East LHIN for the purposes of relationship building and exploring the potential implications for the northeast of the proposals in *Patients First*: An initial meeting will be sought between the respective Board of Health Chairs and Medical Officers of Health/Chief Executive Officers and the Board and Chief Executive Officer for the North East LHIN. The purpose of engagement with the NE LHIN at this time would be to build and strengthen relationships, explore the potential implications, issues and concerns for public health of the proposals within Patients First, and to further orient LHIN leadership to the public health system and functions.

PROGRAM HIGHLIGHTS

CHILD HEALTH

Topic: Baby-Friendly Initiative

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

This report addresses the following Strategic Directions:

- Improve Health Equity
- Collaborate Effectively

On April 5, 2016 The Breastfeeding Committee for Canada (BCC) announced that Algoma Public Health has been officially re-designated a "Baby-Friendly" Community Health Facility. 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.

The Baby-Friendly Initiative 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 in Ontario must be designated and is eligible for re-designation every five years.

The BFI External Assessment took place on February 24-26, 2016. During the assessment 3 assessors and 1 assessor in training conducted interviews with 15 direct care staff, 45 non-clinical staff, 14 prenatal mothers, 20 post-natal mothers and 35 phone interviews with mothers. The assessors also observed, a 48 hour follow

up phone call, breastfeeding clinic, home visit, prenatal class, immunization clinic, Canada Prenatal Nutrition Program, You and Your Baby class and the Parent Child Information Centre.

According to the Community Health Services Site Visit Report, the assessors highlighted areas of achievements and recommendations. The recommendations focused on continued infant feeding surveillance and strengthening breastfeeding education within the community.

The Assessment team reported that they observed excellent practice during the External Assessment and the Breastfeeding Committee for Canada congratulated everyone involved in their efforts to ensure the promotion, protection and support of breastfeeding in our community.

The following message was received from The Breastfeeding Committee for Canada:

> *"The Board of Directors recognizes the hard work of everyone involved in maintaining and improving on the standards and the journey to become "Baby-Friendly". They congratulate Algoma Public Health on having achieved this recognition of the standard of care provided to mothers and babies served which is embodied in the "Baby-Friendly" designation. The work of Algoma Public Health serves as an inspiration to others working in community health services across Canada. The assessment revealed excellent attitudes, knowledge and skills to support women to meet their breastfeeding goals within the community."*

COMMUNITY MENTAL HEALTH

Topic: **Transitional Case Management Program – First Year Evaluation**

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

This report addresses the following Strategic Directions:

- Improve Health Equity
- Collaborate Effectively

April 1, 2016 marks the first year anniversary of the new Community Mental Health-Transitional Case Management (TCM) Program, and along with it, opportunity to both formally and reflectively, evaluate the program's usefulness and effectiveness. TCM differs from our Intensive Case Management Program (ICM) in three important ways: individuals do not require confirmed diagnoses of severe and persistent mental illness in order to receive services, services are short-term rather than long-term, and currently the program is only available in Sault Ste. Marie. The goal of TCM is to proactively intervene, so that individuals receive timely, appropriate support to address needs and avert potential crisis. In addition, the program aims at providing short-term (up to 6 months) transitional case management follow-up until ongoing supports are in place (e.g. natural support systems, housing, income maintenance, food security, Intensive Case Management, outpatient Psychiatry follow-up, Addiction Services, Counselling) for the individual, or by extending hours of an individual's existing supports (the TCM program is available until 8pm weeknights and 10am - 6pm weekends).

LHIN Accountabilities Indicators for TCM 15/16

Indicator	Target	Outcomes: 15/16
Number of New Individuals Served	80	262
Number of Direct Visits	2,750	3,853

The referrals for the TCM program have been received from Sault Area Hospital (crisis, emergency department, and adult inpatient unit), Self-Referrals, Neighborhood Resource Centers, Rapid Response Table, Police, & Primary Care. The program has made important linkages for individuals and families to other services, with a total of 352 referrals made on behalf of clients served. The majority of referrals and calls for service have been received between the hours of 8:30am- 4:30pm = 855, while weeknights and weekends accounted for only = 174 calls. During this first year of implementation it has been noted that making service connection with other health and social services on behalf of individuals is difficult during the extended hours as most supports are not available after 5pm or on weekends. As noted in the above, TCM has exceeded the projected targets set out for the program. Additional evaluation will be occurring related to the programs hours of operation.

In addition, to the data evaluation provided above, the program has also received community accolades, for example, several primary care physicians, Health Links committee, SSM police, SAH crisis services and the Neighborhood Resource Center, have publically endorsed the impact and effectiveness of TCM as a system enhancement. Overall, the evaluation thus far suggests that the Transitional Case Management Program has enhanced community based navigational supports and improved access to mental health and addiction services for individuals, families, and community supports in Sault Ste. Marie and area. The APH-Director of Community Services and the CMH Program Manager will be meeting shortly with the LHIN to review and discuss the program data and look for opportunities to expand the positive outcomes and improve upon program utility.

ENVIRONMENTAL HEALTH

Topic: Safe Food Handling Training Opportunities for Food Premises

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

- The board of health shall ensure food handlers in food premises have access to training in safe-food handling practices and principles in accordance with the Food Safety Protocol, 2008 (or as current). Req #4

This report addresses the following Strategic Directions:

- Collaborate Effectively
- Be Accountable

Algoma Public Health (APH) inspectors meet the MOHLTC program standard by providing training/education and certification of food handlers by providing safe food handling courses throughout the year within the District of Algoma. Post training evaluations are done to ensure that the program is always adjusting to the needs of the food handlers.

In 2015, there were a total of 228 public complaints regarding food premises. This number can be reduced if we educate and certify more safe food handlers working in food premises. Algoma Public Health would like to see at least one safe food handler working in all food premises for every shift within the District of Algoma. This would increase operator and food handlers' knowledge to promote safe food handling practices, reduce consumer complaints, and minimize the potential risk of foodborne illness.

There were 27 Safe Food Handler Courses offered across the Algoma district in 2015, producing 556 certified safe food handlers working within the 749 food premises.

Algoma Public Health is striving to increase the number of courses provided and increase the number of certified food handlers in 2016 to help increase operator knowledge, reduce consumer complaints, and minimize the potential risk of foodborne illness.

APH's inspectors will continue to collaborate and consult with food premise operators and provide opportunities throughout the year and district to provide safe food handling training.

Algoma Public Health provides the safe food handling course at a cost of $25 per person. This is based on cost recovery for resources and ensures that most can afford the training. The only additional cost to the program is the inspector's time. Public health inspectors work in many programs and often have competing priorities. For effective time management it is essential to know that the training is effective and valuable. Post training evaluations have been done over several years and indicate that those taking the course and exam, rate the training as very important and informative and that they believe that their behavior will change due to the training.

In addition, there is evidence that food handler training is effective to change behaviours and reduce risk of foodborne illnesses.

York Public Health has piloted a similar food handler training program over 4 years (2010-2014) and evaluated their critical infractions pre and post training in establishments and were able to prove a reduction in critical infractions post training. Fewer infractions also resulted in a reduction of time conducting inspections. York region is moving towards passing a by-law that will ensure all food premises will be required to have a safe food handler on-site during operational hours based on this data.

VACCINE PREVENTABLE DISEASES

Topic: Use of Electronic Systems to Enhance the VPD Program

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

1. The board of health shall assess, maintain records and report, where applicable, on:
    - The immunization status of children enrolled in licensed child care programs as defined in the Day Nurseries Act;
    - The immunization status of children attending schools in accordance with the Immunization of School Pupils Act; and

- Immunizations administered at board of health-based clinics as required in accordance with the *Immunization Management Protocol, 2008* (or as current) and the *Infectious Diseases Protocol, 2008* (or as current).

2. The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the *Infectious Diseases Protocol, 2008* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2008* (or as current).

The VPD Program has been progressive in the use of electronic systems and solutions for immunization records. As a result the VPD Program was invited to participate in two recent projects with the Ministry of Health and Long Term Care's Panorama team. Panorama is the provincial immunization database for Ontario.

PHIX:
The Public Health Information Exchange (PHIX) was developed to enable public health units (PHUs) to easily upload demographic information and immunization records into Panorama. APH participated in the testing and dry run of this application and was eager to begin using PHIX on a daily basis. PHIX is now "live" in Panorama, allowing us to take reports of immunizations administered at APH clinics from our electronic medical record (Profile) and upload them into Panorama. VPD clerical staff will review the records in Panorama and assist with processing the uploads. This application will help reduce the volume of vaccine data entry that is currently being processed manually by VPD clerical.

PEAR:
Panorama Enhanced Analytical Reports (PEAR) is a business solution that uses software to extract data from Panorama. PEAR gives PHUs the ability to create reports and queries as required to analyze situations and trends in public health. The VPD program and our Epidemiologist were part of the pilot and testing for PEAR. PEAR will help to support APH in monitoring vaccine coverage, vaccine wastage and usage, and auditing requirements.

PARTNERSHIPS

Health Links
The official launch of Health Links was announced at a media event held at the Water Tower Inn March 31, 2016. Dr. David Fera, Co-Chair Health Links Steering committee, Louise Paquette Ex. Director, NE LHIN and Minister David Orazeitti made remarks. The event was attended by the health care agencies involved in Health Links.

The Health Links "guided care model" will be piloted over the next 6 months, with a sample of medically complex patients/clients. Some of those clients may be part of our CMH and CADAP programs.

The Guided Care model involves:

- Team-based chronic care management to provide comprehensive, coordinated, continuing care.

- A Guided Care Nurse (GCN) works in partnership with the primary care provider (PCP), the patient, the patient's caregiver(s) and other health care professionals and community agencies.

- The patient and his/her care goals is the primary focus, with the right care wrapped around them, facilitated by the Guided Care Nurse (GCN) in partnership and in collaboration with the Primary Care Provider (PCP).

- Together the patient, GCN, PCP and broader health and social services team create a Coordinated Care Plan (CCP). The GCN serves as the primary point of contact and plays a central role in ensuring patients receive high quality, coordinated care through a "quarterback" approach.

City of Sault Ste. Marie

T. Hanlon, on behalf of APH, attended an April 18, 2016 meeting with Mayor Provenzano and staff from the planning department. The Mayor invited leaders from the health care sector for an exploratory discussion on shared challenges and opportunities, short and long term goals, areas where the City could prove to be of assistance, and, potential avenues for collaboration. There was good discussion on possible areas of collaboration. Several examples of collaboration where noted such as Health Links and Healthy Kids that serve as excellent examples of collaboration. A follow up meeting to further explore the opportunities and how we might work together on joint initiatives is expected.

Respectfully submitted,
Tony Hanon, Ph.D., CEO and Dr. Alex Hukowich, Associate MOH

ALGOMA PUBLIC HEALTH

FINANCE AND AUDIT COMMITTEE REPORT

FOR THE APRIL 27, 2016 BOARD MEETING

Meeting held on: April 19, 2016 – Started at 4:32 pm

In attendance:

Tony Hanlon, Justin Pino, Joel Merrylees, Ian Frazier, Lee Mason, Dennis Thompson

Secretary – Christina Luukkonen

Absent – Candace Martin (with regrets)

Guest – Michael Marinovich, KPMG

The Committee completed a review of the draft audited financial statements for the calendar year 2015. Justin provided an in-depth synopsis. A number of questions were asked of the auditor representative (Michael Marinovich) and Justin and Joel, that resulted in modifications to be done to the statements prior to the Board's review. With the modifications, it is going to be the recommendation of the Committee that the Board approve the audited statements.

It was noted the efforts of the financial team to improve the results and preparation time for the audited financial statements. A special mention of Joel's contribution was made.

Justin gave a summary review of the financial statements for the period ended February 29, 2016. A few questions were asked with acceptable answers provided. It is going to be the recommendation of the Committee that the Board approve the statements for the period ended February 29, 2016.

The Committee had a brief discussion on the ELNOS Renovation Budget and it is still projected to be under budget. Holdback releases are in the process of being completed and the final reconciliation should be ready in the near future.

The topic of capital funding for upkeep of capital assets was discussed and the necessity for APH to consider having such a policy. Management will be drafting a policy for our review and would like this to remain on the Agenda going forward.

Once the audited financial statements are complete Management will be reviewing the internal financial statement format and make proposals of more user-friendly statements. This is part of the ongoing discussions between the Board/Committees and Management being proactive and continually improving communication.

Next meeting is scheduled for May 11, 2016.

Meeting was adjourned at 6:20 pm.

Chair, Finance and Audit Committee
Algoma Public Health

April 21, 2016
Date

Algoma Public Health
Financial Statements
For the period ending: February 29, 2016

Algoma Public Health
Statement of Operations and Fund Balances
For the period ending: **February 2016**

	Actual YTD 2016	Budget YTD 2016	Variance Bgt to Actual 2016	Annual Budget 2016	2016 YTD Actual/ YTD Budget %
Revenue					
Municipal Levy -public health	$ 940,752	$ 566,632	$ 374,120	$ 3,399,791	166%
Provincial Grants -public health	$ 1,636,807	$ 1,627,883	$ 8,924	$ 9,767,300	101%
Grants/Levies - Capital	$ -	-	$ -	-	
Provincial Grants - community health	6,010,206	5,958,780	$ 51,426	7,606,547	101%
Fees, other grants and recovery of expenditures	81,597	137,367	$ (55,771)	824,204	59%
	$ 8,669,362	$ 8,290,663	$ 378,699	$ 21,597,842	105%
Expenditures					
Public Health Programs					
Public Health	$ 2,141,672	$ 2,331,883	$ 190,211	$ 13,991,297	92%
Public Health (Capital)	0	-	-	-	
Community Health Programs					
Healthy Babies and Children	173,018	$ 178,002	4,984	1,068,011	97%
Child Benefits Ontario Works	0	$ 3,333	3,333	20,000	0%
Dental Benefits Ontario Works	60,629	$ -	(60,629)	-	#DIV/0!
Misc Calendar	23	$ -	(23)	-	#DIV/0!
Northern Ontario Fruit & Vegetable Program	102,847	$ 107,426	4,579	117,400	96%
Brighter Futures for Children	88,853	$ 110,713	21,860	126,887	80%
Infant Development	590,092	$ 619,654	29,562	675,986	95%
Preschool Speech and Languages	541,577	$ 563,068	21,491	614,256	96%
Nurse Practitioner	108,187	$ 112,615	4,428	122,853	96%
Genetics Counseling	299,363	$ 337,156	37,793	367,806	89%
Community Mental Health	2,720,392	$ 2,889,715	169,323	3,164,598	94%
Community Alcohol and Drug Assessment	621,510	$ 624,187	2,678	683,210	100%
Remedial Measures	38,185	$ 35,387	(2,798)	122,320	108%
Diabetes	123,582	$ 137,500	13,918	150,000	90%
Healthy Kids Community Challenge	75,527	$ 131,040	55,512	169,669	58%
Stay on Your Feet	87,067	$ 98,442	11,375	113,550	88%
Misc Fiscal	35,040	$ -	(35,040)	-	#DIV/0!
	$ 7,807,564	$ 8,280,119	$ 472,556	$ 21,507,843	94%

Excess of revenues over expenses - CH	**344,315**	
Excess of revenues over exp. - Public Health	**517,484**	
Operating fund balance, beginning of year	**3,009,266**	
Operating fund & capital, end of month (Note 1)	$ **3,897,327**	

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 Two Months Ending February 29, 2016

	Current YTD	Budget YTD	Variance	YTD Actual to Annual Bgt %	Annual Budget	Comparison Prior Year: YTD Actual 2015	YTD BGT 2015	Variance 2015
MOH Public Health Funding	1,240,949	1,249,633	(8,684)	17%	7,497,800	1,263,056	1,280,874	(17,818)
MOH One Time Funding	8,448	8,450	(2)	17%	50,700	7,451	8,450	(999)
MOH Funding Haines Food Safety	4,105	4,100	5	17%	24,600	4,084	4,089	(5)
MOH Funding CINOT/Healthy Smiles	68,432	68,433	(1)	17%	410,600	71,256	68,428	2,828
MOH Funding - Social Determinants of Health	30,085	30,083	2	17%	180,500	30,072	30,075	(3)
MOH Funding Vector Bourne Disease	18,122	18,117	5	17%	108,700	18,092	18,102	(10)
MOH Funding Chief Nursing Officer	20,257	20,250	7	17%	121,500	20,224	20,236	(12)
MOH Funding Safe Water	11,601	11,600	1	17%	69,600	11,584	11,594	(10)
MOH Enhanced Funding Safe Water	2,580	2,583	(3)	17%	15,500	2,565	2,583	(18)
MOH Funding Unorganized	83,384	83,383	1	17%	500,300	72,648	72,649	(1)
MOH One Time Funding Dental Health	18,644	5,667	12,977	55%	34,000	2,812	5,625	(2,813)
MOH Funding Infection Control	52,069	52,067	2	17%	312,400	52,031	52,050	(19)
Levies Sault Ste Marie	601,261	393,808	207,453	25%	2,362,846	575,369	318,284	257,085
Levies Sault Ste Marie Capital	0	0	-	0%	0	0	48,247	(48,247)
Levies Vector Bourne Disease	0	9,906	(9,906)	0%	59,433	0	10,992	(10,992)
Levies District	339,491	162,919	176,572	35%	977,512	237,978	144,186	93,792
Levies District Capital	0	0	-	0%	0	0	20,677	(20,677)
Recoveries from Programs	1,983	1,677	306	20%	10,061	1,677	1,677	0
Program Fees	33,144	41,191	(8,047)	13%	247,143	6,416	41,191	(34,775)
Land Control Fees	2,250	26,667	(24,417)	1%	160,000	3,845	26,667	(22,822)
Program Fees Immunization	42,106	26,667	15,439	26%	160,000	25,798	26,667	(869)
HPV Vaccine Program	0	1,667	(1,667)	0%	10,000	0	1,667	(1,667)
Influenza Program	0	10,000	(10,000)	0%	60,000	0	10,000	(10,000)
Meningococcal C Program	0	1,667	(1,667)	0%	10,000	0	1,667	(1,667)
Interest Revenue	2,114	333	1,780	106%	2,000	972	333	639
Other Revenues	0	27,500	(27,500)	0%	165,000	11,972	27,500	(15,528)
Funding Holding	0	0	-	0%	0	(0)	0	(0)
Funding Ontario Tobacco Strategy	92,165	73,517	18,648	21%	441,100	77,556	69,600	7,956
Elliot Lake Office Relocation	0	0	-	0%	0	0	0	0
Panorama	(14,034)	0	(14,034)	100%	0	0	0	0
First Nations Inititative -One Time	0	0	-	0%	0	112,214	0	112,214
	$ 2,659,156	$ 2,331,883	$ 327,273		$ 13,991,295	$ 2,609,671	$ 2,324,108	$ 285,564
Summary								
Levies	940,752	566,632	374,120	166%	3,399,791	813,347	542,388	270,959
Funding Grants	1,636,807	1,627,883	8,924	101%	9,767,300	1,745,645	1,644,353	101,292
Fees & Recoveries	81,597	137,367	(55,771)	59%	824,204	50,679	137,367	(86,688)
	$ 2,659,156	$ 2,331,883	327,273	114%	$ 13,991,295	$ 2,609,671	$ 2,324,108	$ 285,564

Algoma Public Health

Expense Statement- Public Health

For the Two Months Ending February 29, 2016

	Current YTD	Budget YTD	Variance	YTD Actual to Annual Bgt %	Annual Budget	Comparison Prior Year: YTD Actual 2015	YTD BGT 2015	Variance 2015	
Salaries & Wages	$ 1,284,060	$ 1,384,441	100,382	15%	$ 8,306,647	$ 1,405,372	$ 1,363,175	$ (42,197)	1
Benefits	318,871	346,110	27,239	15%	2,076,662	311,488	340,794	29,306	2
Travel - Car Allowances	0	0	-	0%		13,539	10,327	(3,212)	3
Travel - Mileage	14,730	24,277	9,546	10%	145,659	18,865	20,908	2,043	3
Travel - Other	6,111	15,634	9,523	7%	93,801	5,795	21,051	15,257	3
Program	95,866	94,968	(899)	17%	569,806	90,200	122,358	32,159	4
Program Equipment Purchase	0	0	-	0%	0	0	0	0	
Office	4,489	15,333	10,844	5%	92,000	7,559	21,992	14,432	4
Computer Services	100,366	149,318	48,952	11%	895,908	133,196	126,405	(6,791)	4
Telephone Charges	998	6,500	5,502	3%	39,000	3,178	8,044	4,866	5
Telecommunications	11,288	31,247	19,960	6%	187,483	17,401	28,494	11,093	5
Program Promotion	16,741	35,681	18,940	8%	214,085	20,183	35,264	15,081	4
Facilities Expenses	97,445	135,654	38,209	12%	813,924	85,568	126,517	40,949	6
Fees & Insurance	129,245	40,201	(89,044)	54%	241,205	12,117	46,582	34,465	7
Special Projects	0	0	-	0%	0	0	0	0	
Debt Management	77,878	76,000	(1,878)	17%	456,000	0	(23,801)	(23,801)	8
Recoveries	(16,417)	(23,481)	(7,064)	12%	(140,883)	0	0	0	9
	$ 2,141,672	$ 2,331,883	$ 190,211		$ 13,991,297	$ 2,200,436	$ 2,324,108	$ 123,672	

	Current YTD	2015	Total	Total % Spent	Total Budget
Elliot Lake Renovations	312,778	277,890	590,668	81%	724,960

Notes to Financial Statements – February 2016

Reporting Period

The February 2016 financial reports include two months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, and Child & Dental Benefits Ontario Works. All other programs are reporting eleven month results from operations year ended March 2016.

Public Health – Statement of Operations (see page 1)

General Comments

As of February 29th, 2016, Public Health programs are reporting a surplus of approximately $517k. On the Revenue side, $374k positive variance is attributable to the timing of receipts of municipal levies from the City of Sault Ste. Marie and the District. Provincial Grants are operating relatively within budget. Program Fees & Recoveries are indicating a negative $55k variance as a result of timing of fees recovered by APH.

There is a positive variance of $190k related to Public Health Expenses being less than budgeted. This is due to the fact that APH is relatively early in its Public Health budget year with only two month of operations completed.

Community Health programs are reporting a surplus of $344k. There is a $169k 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 $29k positive variance related to Infant Development Program, a $21k variance related to the Preschool Speech and Language Program, and a $14k positive variance related to the Diabetes Program. Purchases related to these programs typically occur within the last quarter of the year (January – March). It is anticipated that these positive variances will be reduced by the end of the fiscal year.

There is a positive variance of $37k associated with the Genetics Program and a $55k positive variance related to the Healthy Kid Community Challenge. 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 $327k. Driving this is a $374k positive variance related to the timing of the municipal levy receipts from the City of Sault Ste. Marie and the District. Funding Grants is within budget. There is a negative variance of $55k associated with Fees & Recoveries. APH typically captures the bulk of its fees between the spring and fall months.

Public Health Expenses Budget (see page 3)

Note1 & 2– Salaries/Benefits

The positive variance of $100k is a result of two vacant positions which have been gapped and yet to be filled. 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.

Benefits are indicating a positive variance of $27k. The two vacant positions which have been gapped and the vacant permanent MOH position are contributing to the positive variance noted.

Note 3 –Travel (Mileage, Other)

Mileage is showing a positive $9k variance due to timing of employee claim submissions.

Travel - Other is showing a positive $9k variance. Staff travel typically occurs between the spring and fall months.

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

Program expense is operating relatively within budget.

Office expense is showing a positive $10k variance as a result of timing of expenditures not yet incurred.

Computer Services is showing a positive variance of $48k. This is a result of equipment purchases and software licensing renewals yet to be incurred. It is anticipated that this positive variance will reduce next month.

Program Promotion is showing a positive variance of $18k due to timing of expenditures not yet incurred.

Notes Continued...

Note 5 – Telephone Charges/Telecommunications

Telephone Charges are indicating a positive variance of $5k. This is due to timing of expenditures not yet incurred.

Telecommunications is indicating a positive variance of $19k. This is due to timing of expenditures not yet incurred.

Note 6 – Facilities Expenses/Renovations

Facilities Expenses is showing a positive variance of $38k. This is a result of the timing of expenditures not yet incurred. As the year progresses, this positive variance is anticipated to reduce.

Note 7 – Fees & Insurance

Fees & Insurance is indicating a negative variance of $89k. This is due to the $83k payment of the annual insurance premium paid in full during the month of February. In addition, APH has incurred legal expenses regarding a Public Health policy matter. APH has submitted a one-time funding request to the MOHLTC with the intention of recouping these costs.

Note 8 – Debt Management

Debt Management is indicating a negative variance of $2k. This is a result of interest charges on the short-term debt related to Elliot Lake renovations. These interest charges were not budgeted.

Note 9 – Recoveries

Recoveries are indicating a negative variance of $7k. This is a result of entries not yet posted to the General Ledger as these entries typically occur quarterly.

Community Programs (see page 1)

All community programs are operating without budget issues.

Financial Position - Balance Sheet (see page 7)

Our cash flow position continues to be stable and the bank has been reconciled as of February 29th, 2016. Cash includes $.324 million in short-term investments. Short-term investments has decreased from the prior month as a result of utilizing insurance settlement funds associated with the Elliot Lake mall collapse to help finance renovations for the new Elliot Lake offices. In addition, APH has secured a $350,000 loan with interest only payments until September 1, 2016 to help with the financing of the Elliot Lake office renovations. The loan is open and can be repaid at any time without penalty.

Long term debt of $5.724 million is held by the Royal Bank @ 2.76% for a 20 year term. The loan matures on September 1, 2016. There are no collection concerns for accounts receivable.

NOTE: February 2016 Balance Sheet (page 8) not included. The December 31st, 2015 Balance Sheet has been included in the draft 2015 Annual Audited financial statements and is provided in this month's board package.

Financial Statements of

ALGOMA PUBLIC HEALTH

Year ended December 31, 2015

ALGOMA PUBLIC HEALTH

Financial Statements

Year ended December 31, 2015

KPMG LLP
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INDEPENDENT AUDITORS' REPORT

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

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

Management's Responsibility for the Financial Statements

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

Auditors' Responsibility

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

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

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

Opinion

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

Chartered Professional Accountants, Licensed Public Accountants

April 27, 2016
Sault Ste. Marie, Ontario

ALGOMA PUBLIC HEALTH

Statement of Financial Position

December 31, 2015, with comparative information for 2014

	2015	2014
Financial Assets:		
Cash	$ 2,368,709	$ 2,289,828
Accounts receivable	658,510	413,624
Receivable from participating municipalities	5,134	12,840
	3,032,353	2,716,292
Financial liabilities:		
Accounts payable and accrued liabilities	1,490,108	1,698,086
Payable to the Province of Ontario	641,766	701,964
Deferred revenue (note 3)	664,639	555,359
Employee future benefit obligations (note 4)	2,453,960	2,417,999
Capital lease obligation (note 9)	107,264	539,027
Term loans (note 8)	6,173,490	6,114,240
	11,531,227	12,026,675
Net debt	(8,498,874)	(9,310,383)
Non-financial assets:		
Tangible capital assets (note 5)	22,004,981	22,479,558
Contingencies (note 10)		
Commitments (note 11)		
Accumulated surplus (note 6)	$ 13,506,107	$ 13,169,175

See accompanying notes to financial statements.

ALGOMA PUBLIC HEALTH

Statement of Operations and Accumulated Surplus

Year ended December 31, 2015, with comparative information for 2014

	2015	2014
Revenue:		
Municipal levy - public health	$ 3,263,351	$ 3,104,783
Provincial grants:		
Public health	9,875,054	10,227,367
Community health	6,473,350	6,054,170
Fees, other grants and recovery of expenditures	2,547,094	1,882,511
	22,158,849	21,268,831
Expenses:		
Public Health Programs (Schedule 1)	13,246,362	13,496,647
Community Health Programs (Schedule 2)		
Healthy Babies and Children	1,089,620	947,129
Healthy Babies and Children - CAS	43,638	44,051
Healthy Babies and Children - Screening	-	100,000
Child Benefits Ontario Works	20,000	20,000
Dental Benefits Ontario Works	308,448	356,935
Nurse Practitioner	120,613	124,107
Pre-Natal and Post-Natal Nurse Practitioner	1,000	72,932
Northern Ontario School of Medicine	359	7,776
Health Links	-	55,561
Special Needs	40,707	32,848
Healthy Kids Community Challenge	22,090	-
Genetics Counseling	348,185	384,361
Diabetes	139,304	158,293
Stay on Your Feet	104,966	4,340
Northern Ontario Fruits and Vegetables	120,567	92,093
Health Communities Partnership	33,468	22
Community Alcohol and Drug Assessment	671,136	683,694
Remedial Measures	23,472	19,060
Community Alcohol and Drug Assessment - Ontario Works	78,597	97,319
OW-CADAP District	20,927	-
Community Mental Health Housing	54,791	10,022
Community Mental Health	2,941,458	2,636,719
Garden River CADAP Program	8,855	-
Infant Development	623,902	634,717
CHPI (District)	2,401	-
Brighter Futures for Children	124,072	106,796
Preschool Speech and Languages Initiative	355,433	331,239
PSL Communication Development	278,142	242,024
Employee future benefits (recovery)	35,961	(11,752)
Interest on long-term debt	171,550	176,278
Amortization on tangible capital assets	791,893	891,537
	21,821,917	21,714,748
Annual surplus (deficit)	336,932	(445,917)
Accumulated surplus, beginning of year	13,169,175	13,615,092
Accumulated surplus, end of year	$ 13,506,107	$ 13,169,175

See accompanying notes to financial statements.

ALGOMA PUBLIC HEALTH

Statement of Change in Net Debt

Year ended December 31, 2015, with comparative information for 2014

	2015	2014
Annual surplus (deficit)	$ 336,932	$ (445,917)
Additions to tangible capital assets	(317,316)	-
Amortization of tangible capital assets	791,893	891,537
	811,509	445,620
Net debt, beginning of year	(9,310,383)	(9,756,003)
Net debt, end of year	$ (8,498,874)	$ (9,310,383)

See accompanying notes to financial statements.

ALGOMA PUBLIC HEALTH

Statement of Cash Flows

Year ended December 31, 2015, with comparative information for 2014

	2015	2014
Cash provided by (used in):		
Operating activities:		
Annual surplus (deficit)	$ 336,932	$ (445,917)
Items not involving cash:		
Amortization of tangible capital assets	791,893	891,537
Gain on sale of tangible capital assets	(10,836)	(19,241)
Increase (decrease) in employee future benefit obligations	35,961	(11,752)
	1,153,950	414,627
Change in non-cash working capital:		
Decrease in accounts receivable	(244,886)	19,857
Decrease (increase) in receivable from participating municipalities	7,706	(11,009)
Increase (decrease) in accounts payable and accrued liabilities	(207,978)	(50,278)
Increase in payable to the Province of Ontario	(60,198)	214,480
Increase (decrease) in deferred revenue	109,280	52,526
	757,874	640,203
Financing activities:		
Repayment of term loan	(290,750)	(283,319)
Term loan funds received	350,000	
Proceeds from sale of tangible capital assets	10,836	873,908
Principal payments on obligation under capital lease	(431,763)	(320,192)
	(361,677)	270,397
Capital activities:		
Additions to tangible capital assets	(317,316)	-
Increase in cash	78,881	910,600
Cash, beginning of year	2,289,828	1,379,228
Cash, end of year	$ 2,368,709	$ 2,289,828

See accompanying notes to financial statements.

The Board of Health for the District of Algoma operating as Algoma Public Health (the "Board") is governed by a public health board as mandated by the Health Protection and Promotion Act for the purpose of promoting and protecting public health.

1. Significant accounting policies:

The financial statements are prepared in accordance with the Canadian generally accepted accounting principles for government organizations as recommended by the Public Sector Accounting Board ("PSAB") of the Chartered Professional Accountants of Canada. Significant aspects of the accounting policies adopted by the Board are as follows:

(a) Basis of accounting:

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

The accrual basis of accounting recognizes revenue as they are earned and measurable. Expenses are recognized as they are incurred and measureable as a result of receipt of goods or services and the creation of a legal obligation to pay.

(b) Revenue recognition:

The operations of the Board are funded by the Province of Ontario, levies to participating municipalities and user fees. Funding amounts not received at year end are recorded as receivable. Funding amounts in excess of actual expenditures incurred during the year are repayable and are reflected as liabilities.

Certain programs of the Board operate on a March 31 fiscal year. Revenues received in excess of expenditures incurred at December 31 are deferred on the statement of financial position until related expenditures are incurred or upon final settlement.

(c) Prior years' funding adjustments:

The Ministry of Health and Long-Term Care undertakes financial reviews of the Board's operations from time to time, based on the Board's submissions of annual settlement forms. Adjustments to the financial statements, if any, a result of these reviews are accounted for in the period when notification is received from the Ministry.

1. Significant accounting policies (continued):

(d) Non-financial assets:

Non-financial assets are not available to discharge existing liabilities and are held for use in the provision of services. They have useful lives extending beyond the current year and are not intended for sale in the ordinary course of operations.

(e) Tangible capital assets:

Tangible capital assets are recorded at cost which includes amounts that are directly attributable to acquisition, construction, development or betterment of the asset. The cost, less residual value, of the tangible capital assets are amortized on a straight-line basis over the following number of years:

Asset	Years
Building	40
Leasehold improvements	20
Furniture and equipment	10
Vehicle	4
Computer equipment	3

Annual amortization is charged in the year of acquisition and in the year of disposal. Assets under construction are not amortized until the asset is available for productive use.

(f) Employee future benefit obligations:

The Board sponsors a defined benefit life and health care plan for all employees who retire from active service with an unreduced OMERS pension. The Board accrues its obligations under the defined benefit plan as the employees render the services necessary to earn these retirement benefits. The cost of future benefits earned by employees is actuarially determined using the projected benefit method prorated on service and incorporates management's best estimates with respect to mortality and termination rates, retirement age and expected inflation rate with respect to employee benefit costs.

Actuarial gains (losses) on the accrued benefit obligation arise from the differences between actual and expected experience and from changes in the actuarial assumptions used to determine the accrued benefit obligation.

1. Significant accounting policies (continued):

(g) Use of estimates:

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting periods. Significant items subject to estimates and assumptions include the carrying amount of tangible capital assets, valuation allowances for accounts receivables and obligations related to employee future benefits. Actual results could differ from those estimates. These estimates are reviewed periodically, and, as adjustments become necessary, they are reported in earnings in the year in which they become known.

2. Participating municipalities:

The participating municipalities are as follows:

City of Sault Ste. Marie
City of Elliot Lake
Town of Blind River
Town of Bruce Mines
Town of Thessalon
Village of Hilton Beach
Municipality of Huron Shores
Township of Dubreuilville
Township of Hilton
Township of Jocelyn
Township of Johnson
Township of Laird
Township of MacDonald, Meredith & Aberdeen Additional
Municipality of Wawa
Township of North Shore
Township of Plummer and Plummer Additional
Township of Prince
Township of St. Joseph
Township of Spanish
Township of Tarbutt & Tarbutt Additional
Township of White River
Township of Hornepayne
Certain unincorporated areas in the District of Algoma

3. Deferred revenue:

The Board operates several additional programs funded by the Ministry of Health and Long-Term Care. Excess funding received for these programs or programs funded for a program year which differs from the Health Unit's fiscal year is deferred in the accounts until the related costs and final settlements are determined.

A summary of the year's activity relating to those programs is as follows:

	2015	2014
Deferred revenue, beginning of year	$ 555,359	$ 502,833
Funds received during the year	114,798	96,435
Expenses incurred in the year	(5,518)	(43,909)
Deferred revenue, end of year	$ 664,639	$ 555,359

4. Employee future benefits:

(a) Pension agreements:

The Board makes contributions to the Ontario Municipal Employees Retirement Fund ("OMERS"), which is a multi-employer plan, on behalf of 182 (2014 - 194) members of its staff. The plan is a multi-employer, defined-benefit plan which specifies the amount of the retirement benefit to be received by the employees based on the length of service and rates of pay. The multi-employer plan is valued on a current market basis for all plan assets.

The Board's contributions to OMERS equal those made by the employees. The amount contributed was $1,165,825 (2014 - $1,190,353) for current service and is included as an expenses on the Statement of Operations and Accumulated Surplus. No pension liability for this type of plan is included in the Board's financial statements.

(b) Employee future benefit obligations:

Employee future benefit obligations are future liabilities of the Board to its employees and retirees for benefits earned but not taken as at December 31, 2015. The liabilities will be recovered from future revenues and consist of the following:

	2015	2014
Post-retirement benefits (i)	$ 1,094,044	$ 1,060,321
Non-vested sick leave (ii)	250,530	220,134
Accrued vacation pay (iii)	1,109,386	1,137,544
	$ 2,453,960	$ 2,417,999

4. Employee future benefits (continued):

(i) Post-retirement benefits:

The post-retirement benefit liability is based on an actuarial valuation performed by the Board's actuaries. The date of the most recent actuarial valuation of the post-retirement benefit plan is December 31, 2015. The significant actuarial assumptions adopted in estimating the Board's liability are as follows:

- Discount Rate 3.75%
- Health Care Trend Rate 4.5% to 8%

Information about the Board's future obligations with respect to these costs is as follows:

	2015	2014
Accrued benefit obligations, beginning of year	$ 1,060,321	$ 1,018,644
Current service cost	56,867	48,158
Interest cost	31,289	39,073
Benefits paid	(30,006)	(30,538)
Amortization of actuarial gains	(24,427)	(15,016)
Accrued benefit obligations, end of year	$ 1,094,044	$ 1,060,321

(ii) Non-vested sick leave:

Accumulated sick leave credits refers to the balance of unused sick leave credits which accrue to employees each month. Unused sick days are banked and may be used in the future if sick leave is beyond their yearly entitlement. No cash payments are made for unused sick time upon leaving the Board's employment.

(iii) Accrued vacation pay:

Accrued vacation pay represents the liability for vacation entitlements earned by employees but not taken as at December 31.

5. Tangible capital assets:

Cost	Balance December 31, 2014	Additions	Disposals	Balance at December 31, 2015
Building	$ 22,732,421	$ -	$ -	$ 22,732,421
Leasehold improvements	892,431	-	-	892,431
Furniture and equipment	1,914,772	-	-	1,914,772
Vehicle	29,740	40,113	29,740	40,113
Computer equipment	3,029,040	-	-	3,029,040
Construction in progress	-	277,203	-	277,203
Total	$ 28,598,404	$ 317,316	$ 29,740	$ 28,885,980

Accumulated amortization	Balance December 31, 2014	Disposals	Amortization expense	Balance at December 31, 2015
Building	$ 1,840,293	$ -	$ 536,499	$ 2,376,792
Leasehold improvements	367,976	-	37,901	405,877
Furniture and equipment	869,243	-	200,047	1,069,290
Vehicle	29,740	29,740	-	-
Computer equipment	3,011,594	-	17,446	3,029,040
Total	$ 6,118,846	$ 29,740	$ 791,893	$ 6,880,999

	Net book value December 31, 2014	Net book value December 31, 2015
Building	$ 20,892,128	$ 20,355,629
Leasehold improvements	524,455	486,554
Furniture and equipment	1,045,529	845,482
Vehicle	-	40,113
Computer equipment	17,446	-
Construction in progress	-	277,203
Total	$ 22,479,558	$ 22,004,981

5. Tangible capital assets (continued):

Cost	Balance December 31, 2013	Additions	Disposals	Balance at December 31, 2014
Building	$ 22,732,421	$ -	$ -	$ 22,732,421
Leasehold improvements	892,431	-	-	892,431
Furniture and equipment	1,914,772	-	-	1,914,772
Vehicle	29,740	-	-	29,740
Computer equipment	3,029,040	-	-	3,029,040
Total	$ 28,598,404	$ -	$ -	$ 28,598,404

Accumulated amortization	Balance December 31, 2013	Disposals	Amortization expense	Balance at December 31, 2014
Building	$ 1,305,794	$ -	$ 534,499	$ 1,840,293
Leasehold improvements	318,798	-	49,178	367,976
Furniture and equipment	669,200	-	200,043	869,243
Vehicle	29,740	-	-	29,740
Computer equipment	2,903,777	-	107,817	3,011,594
Total	$ 5,227,309	$ -	$ 891,537	$ 6,118,846

	Net book value December 31, 2013	Net book value December 31, 2014
Building	$ 21,426,627	$ 20,892,128
Leasehold improvements	573,633	524,455
Furniture and equipment	1,245,572	1,045,529
Vehicle	-	-
Computer equipment	125,263	17,446
Total	$ 23,371,095	$ 22,479,558

6. Accumulated surplus:

Accumulated surplus is comprised of:

	2015	2014
Invested in tangible capital assets	$ 22,004,981	$ 22,479,558
Reserves (note 7)	706,335	322,233
Operating	(577,759)	(1,100,377)
Unfunded:		
Employee future benefits	(2,453,960)	(2,417,999)
Term loan	(6,173,490)	(6,114,240)
Balance, end of year	$ 13,506,107	$ 13,169,175

7. Reserves:

The Board has a reserve fund set aside for specific capital purposes by the Board.

	2015	2014
Balance, beginning of year	$ 322,233	$ 319,863
Additions to capital reserves	374,940	410,129
Amounts expended for capital purposes	-	(412,639)
Investment Income	9,162	-
Balance, end of year	$ 706,335	$ 322,233

8. Term loans:

	2015	2014
Term loan #1	$ 5,823,490	$ 6,114,240
Term loan #2	350,000	-
	$ 6,173,490	$ 6,114,240

Principal payments due on the term loan are as follows:

Year	Annual payments
2016	$ 6,173,490
	$ 6,173,490

Term loan #1 is a non-revolving loan bearing interest of 2.76%. The loan is repayable in blended monthly interest and principal payments of $37,988 and matures on September 1, 2016.

The Board added a term loan #2 in 2015 to fund renovations of the new Elliot Lake office. The outstanding balance at December 31, 2015, is $350,000. The Board is making interest only payments on the balance at 2.2%. The loan is due on September 1, 2016.

Interest paid in the year is $171,550 (2014 - $170,618).

9. Obligation under capital leases:

The following is a schedule of the future minimum lease payments of the capital lease for IT assets expiring March 31, 2016, together with the balance of the obligation:

Total minimum lease payments	$ 108,609
Less amount representing interest at an average rate of 0.75%	(1,345)
Present value of net minimum capital lease payments	$ 107,264

Principal payments due on the lease for the next year is as follows:

Year	Annual payments
2016	$ 107,264
	$ 107,264

10. Contingencies:

The Board is periodically subject to claims or grievances. In the opinion of management, the ultimate resolution of any current claims or grievances would not have a material effect on the financial position (or results of operations) of the Board and any claims would not exceed the current insurance coverage. Accordingly, no provisions for losses has been reflected in the accounts of the Board for these amounts.

11. Commitments:

The Board is committed to minimum annual lease payments under various operating leases as follows:

Years	Annual payments
2016	$ 142,004
2017	146,090
2018	146,090
2019	146,090
2020	146,090

The annual lease payments are exclusive of maintenance and other operating costs.

12. Expenditures by object:

	2015	2014
Salaries and benefits	$ 15,645,123	$ 15,317,617
Materials and supplies	5,384,901	5,505,594
Capital	791,893	891,537
	$ 21,821,917	$ 21,714,748

ALGOMA PUBLIC HEALTH

Statement of Revenue and Expenses – Public Health Programs Schedule 1

Year ended December 31, 2015, with comparative information for 2014

	2015 Budget	2015 Total	2014 Total
Revenue	$ 9,845,100	$ 10,474,802	$ 10,251,900
Levies	3,253,897	3,263,350	3,104,783
Recoveries	744,204	691,971	753,995
Total revenue	13,843,201	14,430,123	14,110,678
Expenses:			
Salaries and wages	8,103,927	7,836,268	7,855,853
Benefits	2,030,047	1,862,219	2,000,990
Accounting and audit	50,000	105,022	61,093
Equipment	259,370	247,592	188,940
Insurance	84,000	85,310	79,669
Occupancy and renovations	796,102	780,025	1,034,603
Office supplies	87,450	70,892	73,423
Other	65,500	72,892	60,081
Professional development	115,006	106,803	103,965
Program promotion	124,067	47,063	64,943
Program supplies	403,589	577,316	565,651
Program administration (recovery)	(142,808)	(89,833)	(89,833)
Purchase professional services	877,945	1,075,416	970,587
Telephone and telecommunications	219,291	230,390	265,661
Travel	313,715	238,987	261,021
	13,387,201	13,246,362	13,496,647
Excess of revenue over expenses before the undernoted	$ 456,000	$ 1,183,761	$ 614,031
Interest on long-term debt	-	171,550	176,278
Amortization	-	791,893	891,537
Excess of revenue over expenses	$ 456,000	$ 220,318	$ (453,784)

ALGOMA PUBLIC HEALTH

Schedule 2

Expenditures - Community Health Programs

Year ended December 31, 2015, with comparative information for 2014

	Healthy Babies and Children $	Healthy Babies and Children CAS $	Child Benefits Ontario Works $	Dental Benefits Ontario Works $	Nurse Practitioner $	Pre-Natal and Post-Natal Nurse Practitioner $	Northern Ontario School of Medicine $	Special Needs $	Healthy Kids Community Challenge $	Genetics Counselling $	Diabetes $	Stay on Your Feet $	N. Ont Fruits/Veg. $
Salaries and employee benefits:													
Salaries	837,377	33,669	17,283		84,629				18,952	193,833	48,034	56,415	32,362
Employee benefits	202,066	8,416	2,717		21,600				2,497	49,009	9,622	12,077	7,344
	1,039,443	42,085	20,000	-	106,229	-	-	-	21,449	242,842	57,656	68,492	39,706
Supplies and services:													
Equipment	2,350	-	-	-	-	-	-	-	-	-	-	-	-
Occupancy and renovations	-	-	-	-	4,687	-	-	-	-	13,338	-	-	-
Office supplies	454	1,475	-	-	1,191	-	-	-	-	10,814	212	-	-
Insurance	-	-	-	-	250	-	-	-	-	-	-	-	-
Audit fees	-	-	-	-	1,001	-	-	-	-	-	-	-	2,345
Professional development	7,312	-	-	-	2,438	-	-	17,514	161	548	875	1,411	-
Program administration	-	-	-	-	-	-	-	-			7,500	-	-
Program promotion	-	-	-	-	-	-	-	-	-	-	22,843	-	-
Program supplies	4,974	78	-	-	-	1,000	359	23,193	159	10,564	40,545	32,414	78,509
Purchased professional services	4,219	-	-	308,448	-	-	-	-	302	54,753	8,833	-	-
Purchased services	-	-	-	-	1,704	-	-	-	-	-	-	-	-
Telephone and telecommunications	8,146	-	-	-	750	-	-	-	-	3,250		-	7
Travel	22,722	-	-	-	2,363	-	-	-	19	12,076	840	2,649	-
	50,177	1,553	-	308,448	14,384	1,000	359	40,707	641	105,343	81,648	36,474	80,861
Total expenditures	1,089,620	43,638	20,000	308,448	120,613	1,000	359	40,707	22,090	348,185	139,304	104,966	120,567

ALGOMA PUBLIC HEALTH

Schedule 2

Expenditures - Community Health Programs, continued

Year ended December 31, 2015, with comparative information for 2014

	Healthy Communities Partnership	Community Alcohol and Drug Assessment	Remedial Measures	Community Alcohol and Drug Assessment Ontario Works	OW-CADAP District	Community Mental Health Housing	Community Mental Health	Garden River CADAP Program	Infant Development	CHPI (District)	Brighter Futures for Children	Preschool Speech and Languages Initiative	PSL Communication Development	2015 Total	2014 Total
	$	$	$	$	$	$	$	$	$	$	$	$	$	$	$
Salaries and employee benefits:															
Salaries	-	459,635	21,726	70,585	18,045	48,408	1,905,944	7,724	405,400		61,427	314,053	175,355	4,810,856	4,397,593
Employee benefits	-	115,154	1,579	7,397	2,232	4,504	478,556	1,131	98,098		14,180	25,892	71,711	1,135,782	1,063,181
	-	574,789	23,305	77,982	20,277	52,912	2,384,500	8,855	503,498	-	75,607	339,945	247,066	5,946,638	5,460,774
Supplies and services:															
Equipment	-	152	-	-		-	1,311		4,000		-	-	3,747	11,560	42,404
Occupancy and renovations	-	46,351	-	-		-	321,524		50,466		2,851	-	269	439,486	430,800
Office supplies	-	888	-	-		-	1,297		1,132		-	667	2,142	20,272	17,203
Insurance	-	-	-	-		-	-		-		-	-	-	250	150
Audit fees	-	-	-	-		-	18,667		-		-	-	-	22,013	22,350
Professional development	1,500	2,776	-	-	650	-	8,695		4,624		-	1,423	4,293	54,220	29,925
Program administration	-	10,000	-	-		-	56,333		16,000		-	-	-	89,833	89,833
Program promotion	3,643	-	-	-		-	-		-		-	-	-	26,486	30,164
Program supplies	4,536	6,959	167	-		-	33,592		7,114	2,401	41,828	2,102	15,420	305,914	251,164
Purchased professional services	23,789	9,428	-	-		178	10,168		343		-	-	1,278	421,739	513,106
Purchased services	-	-	-	-		-	-		-		-			1,704	956
Telephone and telecommunications		4,395	-	-		-	27,449		6,058		(316)	967	2,400	53,106	59,344
Travel	-	15,398	-	615		1,701	77,922		30,667		4,102	10,329	1,527	182,930	213,865
	33,468	96,347	167	615	650	1,879	556,958	-	120,404	2,401	48,465	15,488	31,076	1,629,513	1,701,264
Total expenditures	33,468	671,136	23,472	78,597	20,927	54,791	2,941,458	8,855	623,902	2,401	124,072	355,433	278,142	7,576,151	7,162,038

ALGOMA PUBLIC HEALTH

Summary of Public Health Programs — Schedule 3

Year ended December 31, 2015, with comparative information for 2014

	2015 Total	2014 Total
Revenue:		
MOH Public Health Funding	$ 7,497,800	$ 7,518,694
Medical Officer of Health Compensation	4,579	80,592
Needle Exchange Program Initiative	49,200	44,801
MOH Funding Haines Food Safety	18,740	24,533
Social Determinants of Health	180,500	180,448
MOH Funding Vector Bourne Disease	98,261	108,610
Funding - Chief Nursing Officer	121,500	121,414
MOH Funding Smoke Free Ontario	312,997	316,604
MOH Funding SFO Youth Engagement	79,968	80,000
MOH Funding SFO E - Cigarettes	3,247	-
MOH One Time Funding Ontario Tobacco	11,556	8,000
MOH Funding Safe Water	43,992	69,563
MOH One Time Funding Safe Water Enhanced Safe Water	15,500	15,500
MOH Funding Unorganized	500,300	435,891
Panorama	119,834	214,132
MOH Funding Infection Control	186,139	222,233
MOH Funding Infection Control Nurse	90,100	90,066
MOH Funding CINOT Enhanced	29,494	16,875
MOH Funding Healthy Smiles	382,254	380,523
First Nations Initiative	76,511	286
IT Platform Stabilization	-	240,000
MOH Funding PHI Practicum Student	10,000	8,000
MOH Funding HR System upgrade	7,007	-
Levies	3,263,351	3,104,783
Recoveries from Programs	691,971	716,262
Interest revenue	16,614	26,292
Other revenue	618,708	86,576
	14,430,123	14,110,678
Expenses:		
Public Health	11,820,097	11,623,481
Medical Officer of Health Compensation	4,579	80,592
STI Education Week		-
PHI Practicum Student	10,000	7,962
HR System upgrade	9,343	-
Needle Exchange Program Initiative	49,200	47,652
Pharmacist Integration	-	4,819
Haines Food Safety	18,740	24,533
Infection Control & Prevention Week	-	-
Social Determinants of Health	180,500	180,448
Vector Bourne Disease	131,015	144,813
Chief Nursing Officer	121,500	121,414
Smoke Free Ontario	312,997	316,604
SFO Youth Engagement	79,968	80,000
MOH Funding SFO E - Cigarettes	3,247	-
SFO Workplace Cessation	-	-
Safe Water	58,656	92,749
Safe Water Enhanced	15,500	15,500
Unorganized	500,300	435,891
IT Platform Stabilization	-	320,000
First Nations Initiative	76,511	286
Panorama	119,834	246,042
Infection Control	186,139	222,233
Infection Control Nurse	90,100	90,066
CINOT	-	83,527
CINOT Enhanced	39,325	45,327
Healthy Smiles	382,254	380,523
	14,209,805	14,564,462
Excess of revenue over expenses	$ 220,318	$ (453,784)

ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE MEETING
FEBRUARY 10, 2016
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Ian Frazier	Candace Martin
	Dennis Thompson (Teleconference)	
	Lee Mason	

APH STAFF PRESENT:	Tony Hanlon, Ph.D.	Chief Executive Officer (Teleconference)
	Justin Pino	Chief Financial Officer
	Christina Luukkonen	Recording Secretary

1) CALL TO ORDER:
Mrs. Luukkonen called the meeting to order at 4:29 pm.

2) ELECTION OF OFFICERS

a. Election of Committee Chair

Mrs. Luukkonen called for nominations for the position of Chair for the Finance and Audit Committee. Mr. Frazier was nominated.

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

Mr. Frazier accepted the nomination and was acclaimed Chair for the Finance and Audit Committee.

FC2016-06 Moved: L. Mason
Seconded: C. Martin

THAT the Finance and Audit Committee appoints Ian Frazier as Chair of the committee for the year 2016.
CARRIED.

b. Election of Committee Vice-Chair

Mr. Frazier called for nominations for the position of Vice-Chair for the Finance and Audit committee. Mr. Thompson was nominated.

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

Mr. Thompson accepted the nomination and was acclaimed Vice-Chair for the Finance and Audit Committee.

FC2016-07 Moved: L. Mason
Seconded: C. Martin

THAT the Finance and Audit Committee appoints Dennis Thompson as Vice-Chair of the committee for the year 2016.
CARRIED.

3) DECLARATION OF CONFLICT OF INTEREST
None were reported.

4) ADOPTION OF AGENDA ITEMS

Adopted with the addition of 9c) March committee meeting.

FC2016-08 Moved: L. Mason
Seconded: D. Thompson

THAT the agenda items for the Finance and Audit Committee dated February 10, 2016 be adopted as amended.

CARRIED.

5) ADOPTION OF MINUTES

Following the January 13, 2016 Committee meeting Mr. Pino provided an update by way of email on January 14, 2016 on a few outstanding questions.

1. APH's insurance policy does have coverage for the use of a rental vehicle(s) under the Non-Owned Auto Liability coverage.
2. No the current number of Board members does not affect our policy??

FC2016-09 Moved: C. Martin
Seconded: L. Mason

THAT the minutes for the Finance and Audit Committee dated January 13, 2016 be adopted as amended.

CARRIED.

6) PRESENTATION/DELEGATION - None

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

Mr. Pino presented the draft financial statements for the period ending December 31, 2015 that were provided to the Committee.

The committee requested a copy of the email sent to Mr. Wray in Wawa in response to his letter dated December 16, 2015 regarding APH Governance Concerns and 2016 Levy is included in the minutes.

The Board requested that "draft" be included in the resolution.

FC2016-10 Moved: D. Thompson
Seconded: L. Mason

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

CARRIED.

8) BUSINESS ARISING FROM MINUTES

a. Report of Committee Activities for 2015
   The committee members provided feedback on the report from the Chair of the Finance and Audit Committee. Mr. Frazier to verify dates of internal audits and clarify the language of "internal" audits. Mr. Frazier to present report to the Board at the next meeting on February 24, 2016.

9) NEW BUSINESS/GENERAL BUSINESS

a) ELNOS Renovations Budget Update

Mr. Pino provided an update on the progress and budget of the ELNO renovations for the Elliot Lake office. Mr. Pino discussed the battery back-up rebate he is negotiating for with the contractor. We currently have battery backup for vaccine fridges at our current location that we will be taking with us to the new space so additional batteries are not needed.

The committee requested a change in document title and that the date of the report to be added for clarification. Mr. Pino to make the changes and revised budget report to be included in the committee Chair's report.

b) Transfer of Funds

Mr. Pino presented a resolution to the committee for consideration. As per the Board policy 02-05-065 Algoma Board of Health Reserve Fund Board approval is required for any transfer over $50,000. At the June 17, 2015 Board meeting the Board passed resolution 2015-105 delegating authority to the Finance and Audit Committee in regards to ELNOS renovations. Suggested change to the resolution to include Finance and Audit Committee.

FC2016-11 Moved: L. Mason
Seconded: D. Thompson

WHEREAS Algoma Public Health received an insurance settlement in the amount of $374,939.89 from the collapse of the Algo Mall in Elliot Lake which housed the former Elliot Lake office for Algoma Public Health; and

WHEREAS these funds were placed in a GIC for future use for renovations for a new office space in Elliot Lake.

THEREFORE BE IT resolved that the Board of Health Finance and Audit Committee for Algoma Public Health approves the transfer of funds in the amount of $374,939.89 from APH's reserve account (GIC) to the agencies operating account to be used for costs incurred during the renovations of the new Elliot Lake office in the ELNOS Building.

CARRIED

c) March Committee Meeting

Dr. Hanlon requested the March finance committee meeting be cancelled at this time. Next meeting would then be April 10, 2016.

The committee also discussed having a one month lag in the presentation of financial statements to the finance committee and board (i.e. At the March board meeting, financial statements for the month of January would be presented as opposed to the month of February). This would allow staff more time to complete the financial statements and would provide added assurance to the committee and board members that the information they are reviewing is more accurate and reliable. Dr. Hanlon indicated that in his previous experiences at other agencies, this lag in presentation of financial statements is common and allowed for a more accurate reporting to help with decision making.

As the committee agreed to cancel the March meeting the financial statements for January 2016 will go directly to the Board on March 30, 2016.

10) Addendum

11) In-Committee

FC2016-12 Moved: L. Mason
Seconded: D. Thompson

THAT the Finance and Audit Committee goes in-committee at 5:15pm.

Agenda items:

a. Adoption of in-committee minutes: November 12, 2015
b. Personal matters about an identifiable individual, including municipal employees

CARRIED.

12) Open Meeting

FC2016-14 Moved: D. Thompson
Seconded: L. Mason

THAT the Finance and Audit Committee goes into open meeting at 5:23pm.

CARRIED.

13) NEXT MEETING: Wednesday, April 10, 2016 @ 4:30pm

14) THAT THE MEETING ADJOURN: 5:24pm

FC2016-15 Moved: L. Mason
Seconded: C. Martin

THAT the meeting of the Finance and Audit Committee adjourns at 5:24pm.

CARRIED.

From: Tony Hanlon
To: "cwray@wawa.cc"
Cc: "rrody@wawa.cc"; Lee Mason; Christina Luukkonen
Subject: Muncipality of Wawa letter to Algoma Public Health
Date: Monday, January 18, 2016 2:48:54 PM

Dear Mr. Wray,
I am writing to respond to your letter Re: APH Governance Concerns and 2016 Levy.

Regarding your first question, The Ministry of Health and Long Term Care has recently appointed The Institute on Governance(IOG) as a consultant to assist with the appointment process of the APH Board and to ensure that tools and guidelines are developed that can be used by all boards of health in Ontario. The Ministry advised APH that no vacant seats should be filled until the consultant completes its work.

Regarding your second question, the Ministry advised the Board Chair and myself that with respect to quorum, section 54 of the HPPA states that a majority of the members of a board of health constitutes a quorum of the board. It is the Ministry's position that section 54 of the HPPA refers to the current members of the board of health i.e. does not include vacant seats.

Regarding your third question, we are not aware of any section of the Municipal Act that prohibits board of health members to attend board meetings via teleconference. Further the APH Board passed Policy 02-05-045 Attendance at Meetings Using Electronic Means on April 17, 2013. This policy allows a board to attend via teleconference when circumstances prevent the member from attending in person. In past meetings where a member has attended via teleconference the majority of members have attended in person.

Regarding your fourth question, it is the position of the District of Algoma Public Health Board that it has the authority to determine the 2016 levy to the municipalities in the District of Algoma. Under Section 72 of the HPPA, obligated municipalities are required to pay the expenses of boards of health and medical officers of health when provided with written notice which meets the requirements of section 72.

I trust the above answers your concerns and we look forward to continuing to provide excellent public health programs and services to the citizens of Wawa.

Sincerely,

Tony Hanlon Ph.D.
Chief Executive Officer,
Algoma Public Health,
294 Willow Ave.,
Sault Ste Marie, ON
P6B 0A9
T 705 759-5421
F 705 759-2540
thanlon@algomapublichealth.com

ALGOMA PUBLIC HEALTH

GOVERNANCE COMMITTEE REPORT

FOR THE APRIL 27, 2016 BOARD MEETING

Meeting held on: April 13, 2016 – Started at 4:30 pm

In attendance:

Tony Hanlon, Sherri Cleaves, Ian Frazier, Candace Martin, Lee Mason, Sue Jensen

Secretary – Christina Luukkonen

Discussed the planning of the grand opening celebration at the Elliot Lake new office location. This will take place the latter part of May and hope to have this coincide with the Board's monthly meeting and the Board can be present for the grand opening.

A briefing note was provided regarding Marketing to Children. A number of questions were asked and ample answers provided. It will be the Committee's recommendation that the Board approval the resolution in support of this initiative.

A briefing note was provided regarding Basic Income Guarantee and the number of residents of our District would be affected by such an initiative. A number of questions were asked and answers provided. Modifications were recommended to the resolution to be brought to the Board to approve the further investigation of the basic income guarantee initiative and the positive impact it would have on the health and wellbeing of our residents by the reduction in poverty.

The Committee discussed the monthly meeting evaluation results from February. It was noted that changing to an electronic version that some Board members had difficulty finding the evaluation. It was discussed the importance of having the feedback as part of our continual monitoring efforts to improve information flow.

It was noted that alPHa annual conference will be held June 5-7 in Toronto if any board members are interested in attending.

The Committee received its first APH Program Performance Quantitative Report. All Committee members commented that they appreciated the effort that went into the report and that the information was very informative and useful. Timing of the qualitative and quantitative reports was discussed and will be adjusted to better coincide with other Government reporting requirements to be able to provide the most complete amount of information without duplication of work. This would include the accountability agreement review on an annual basis.

Governance training was discussed. With the anticipated addition of board members a full day orientation will be planned. Early in the fall additional training will be scheduled for any particular subject the board members would like address.

The Committee discussed communication in general between management and the board, and APH and the Municipalities and the public. The Committee suggested to have an APH representative visit each of the municipalities and make a brief presentation about APH in their respective communities. It was also discussed how APH advertises its participation in events and some of the hurdles APH faces in doing so.

Next meeting is scheduled for May 11, 2016.

Meeting was adjourned at 6:21 pm.

Chair, Governance Committee
Algoma Public Health

April 21, 2016
Date

Algoma PUBLIC HEALTH
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Briefing Note

To: The Board of Health

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

Date: April 27, 2016

Re: Marketing to Children

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

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

RECOMMENDED ACTION:

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

BACKGROUND:

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

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

The Ottawa Principles

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

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

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

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

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

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

1. **AFFORD SUBSTANTIAL PROTECTION TO CHILDREN.** Children are particularly vulnerable to commercial marketing. Policies and regulations need to be sufficiently powerful to provide them with a high level of protection. Child protection is the responsibility of every sector of society – parents and guardians, non-governmental organizations, the private sector, and government.

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

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

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

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

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

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

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

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

ASSESSMENT OF RISKS AND MITIGATION:

No conceivable risks are identified at this time.

FINANCIAL IMPLICATIONS:

No conceivable financial implications are identified at this time.

OPHS STANDARD:

Ontario Public Health Standards (2014):

- Chronic Disease Prevention Program – Healthy Eating and Healthy Weights
- Child Health Program – Healthy Eating and Healthy Weights

STRATEGIC DIRECTION:

Collaborate Effectively, Improve Health Equity

CONTACT:

Laurie Zeppa, CNO/Director of Community Services

Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health

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

Resolution:

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

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

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

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

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

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

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

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

Now Therefore Be It Resolved That:

The Board of Health of Algoma:

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

CARRIED: Chair's Signature _____

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

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Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: The Board of Health

From: Tony Hanlon, Chief Executive Officer

Laurie Zeppa, CNO/Director of Community Services

Date: April 27, 2016

Re: Basic Income Guarantee

☒ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

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

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

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

RECOMMENDED ACTION:

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

2. That the Board of Health of Algoma supports Leeds, Grenville and Lanark District Health Units request for a joint federal-provincial consideration and investigation into a Basic Income Guarantee as a policy option for reducing poverty and improving income security as a basis to improve the health and well-being of the residents of the District of Algoma, Ontario and Canada as a whole.

BACKGROUND:

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

Low Income Families in Algoma

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

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

A BIG Solution for Public Health Impact

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

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

Who Benefits from a Basic Income Guarantee?

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

- Adults receiving Ontario Works
- Adults in the Ontario Disability Support Program

- The working poor

It is estimated that 45-70% of those currently living in poverty are the working poor. It is a common misunderstanding that those living in poverty are either not working or unwilling to work. A number of circumstances contribute to why individuals who are working are living in low income. These include the changing job market, lack of education and training, lack of opportunity, and a significant increase in precarious employment in the last 20 years. Precarious employment exists where the labour market is uncertain and marked by substantial change. These changes often include a decrease in full-time or permanent positions and an increase in part-time, temporary or contractual positions. These jobs frequently have no benefits, pension opportunities or job security. **In Algoma, almost 16,000 people are living in low income.**

The Health Care Sector Supports BIG

Basic Income is a movement that has been around for decades but has had a resurgence of support in the last few years. Many key players in the health care sector have publically endorsed BIG as a strategy to explore as part of multipronged approach to poverty. These include the Alberta Public Health Association, Association of Local Public Health Agencies (Ontario), Canadian Medical Association, Canadian Public Health Association, Ontario Public Health Association, the Canadian Association of Social workers, to name a few.

There has also been growing public and political backing for BIG with support ranging from endorsements by prominent Canadians, to municipal and regional council motions, to local and regional income support groups, to provincial governments, such as Quebec, examining the strategy and most currently the announcement of an Ontario pilot in the works. The research is very clear **poverty is the single largest contributor to poor health outcomes** and with Canadian healthcare costs well over 200 billion dollars annually it is not only ethically but economically sound to consider supporting poverty reduction strategies such as a Basic Income Guarantee.

ASSESSMENT OF RISKS AND MITIGATION:

None

FINANCIAL IMPLICATIONS:

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

OPHS STANDARD:

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

STRATEGIC DIRECTION:

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

CONTACT:

Laurie Zeppa, CNO/Director of Community Services

Algoma PUBLIC HEALTH
Santé publique Algoma

Board of Health

Date: April 27, 2016	**RESOLUTION NO.: 2016 -**
MOVED:	**SECONDED:**

SUBJECT: Public Health Support for Basic Income Guarantee

Resolution:

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

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

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

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

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

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

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

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

Therefore Be It Resolved That the Board of Health of Algoma supports Leeds, Grenville and Lanark District Health Units request for a joint federal-provincial consideration and investigation into a Basic Income Guarantee as a policy option for reducing poverty and improving income security as a basis to improve the health and wellbeing of the residents of the District of Algoma, Ontario and Canada as a whole.

Further that this resolution be shared with Federal and Provincial elected representatives for the Algoma ridings, all Ontario Boards of Health, Association of Local Public Health Agencies, Minister of Families, Children and Social Development and Minister Responsible for the Poverty Reduction Strategy.

CARRIED: Chair's Signature

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

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

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

1) CALL TO ORDER:
Mrs. Luukkonen called the meeting to order at 5:35pm.

2) ELECTION OF OFFICERS

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

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

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

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

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

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

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

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

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

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

3) DECLARATION OF CONFLICT OF INTEREST

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

4) ADOPTION OF AGENDA ITEMS

Approved with the addition of 7d) March Committee Meeting

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

THAT the agenda items for the Governance Standing Committee dated February 10, 2016 be adopted as amended; and

THAT the Committee accepts the items on the addendum.

CARRIED.

5) ADOPTION OF MINUTES

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

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

CARRIED.

6) BUSINESS ARISING FROM MINUTES

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

7) NEW BUSINESS/GENERAL BUSINESS

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

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

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

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

8) ADDENDUM

a. Basic Income Guarantee

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

9) IN COMMITTEE at 6:20pm

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

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

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

CARRIED.

10) OPEN MEETING at 623pm

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

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

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

12) THAT THE MEETING ADJOURN: 6:24pm

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

THAT the Governance Standing Committee meeting adjourns.
CARRIED.

March 24, 2016

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

Dear Premier Wynne:

Re: Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached resolution #11-16 from Sudbury and District Health Unit regarding the enactment of legislation to enforce Infection Prevention and Control (IPAC) practices within Invasive Personal Service Settings. A motion to endorse this resolution was passed.

Sincerely,

Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

Encl.

Sudbury & District
Health Unit
Service de santé publique

Make it a Healthy Day!

Visez Santé dès aujourd'hui!

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🖷 : 705.677.9611

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March 7, 2016

VIA ELECTRONIC MAIL

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

Dear Premier Wynne:

Re: Enactment of Legislation to Enforce Infection Prevention and Control Practices within Invasive Personal Service Settings

At its meeting on February 18, 2016, the Sudbury & District Board of Health carried the following resolution #11-16:

WHEREAS adherence to Infection Prevention and Control (IPAC) best practices is essential in reducing the risk of infectious disease transmission through invasive procedures performed in personal services settings such as tattoo and body piercing establishment; and

WHEREAS the Ontario Public Health Standards requires that boards of health perform routine inspections of all personal services settings at least once per year to ensure adherence to best practices for IPAC; and

WHEREAS the Ontario Public Health Standards requires that boards of health investigate complaints regarding potential health hazards including IPAC lapses in personal services settings; and

WHEREAS provincial legislation does not currently exist outlining legal requirements for IPAC practices and operator responsibility and;

WHEREAS creation of provincial legislation governing invasive Personal Services Settings would support a consistent progressive enforcement model amongst Ontario's 36 public health units;

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health support the Haliburton, Kawartha, Pine Ridge District Health Unit motion recommending that the Government of Ontario enact legislation implementing IPAC requirements for invasive personal services settings under the Health Protection and Promotion Act with short-form wording under the Provincial Offences Act.

FURTHER BE IT RESOLVED THAT a copy of this motion be submitted to the Premiere of Ontario, the Minister of Health and Long-term Care, local members of Provincial Parliament, the Chief Medical Officer of Health, the Association of Local Public Health Agencies (alPHa), and all Ontario Boards of Health.

It is the Board's hope that the Government of Ontario will seriously consider enacting provincial legislation implementing IPAC requirements for invasive personal services settings under the *Health Protection and Promotion Act*, supported with short-form wording under the *Provincial Offenses Act*.

Sincerely,

Original signed by

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

cc: The Honorable Dr. Eric Hoskins, Minister of Health and Long-Term Care
France Gélinas, MPP, Nickel Belt
Michael Mantha, MPP, Algoma-Manitoulin
Glenn Thibeault, MPP, Sudbury
Dr. David Williams, Chief Medical Officer of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

March 24, 2016

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

Dear Minister Hoskins:

Re: Environmental Health Program Funding

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached resolution #BOH/2016/01/13 from North Bay Parry Sound District Health Unit regarding the Environmental Health Program Funding. A motion to endorse this resolution was passed.

Sincerely,

Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Ontario Boards of Health
Ontario Medical Officers of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies

Encl.

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

February 22, 2016

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

Dear Minister Hoskins:

Subject: Environmental Health Program Funding – BOH Resolution #BOH/2016/01/13

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/13:

Whereas, *the Board of Health is responsible to oversee the implementation of the Ontario Public Health Standards (OPHS), related protocols/guidelines and Health Protection and Promotion Act (HPPA) and related regulations, and*

Whereas, *the Board of Health works towards improvement of the overall health of the population through surveillance, health promotion, disease prevention, health protection and enforcement of provincial public health policy, and legislation, and*

Whereas, *the Board of Health supports the Province of Ontario enacting new policy and legislation which will improve the health of the population, and*

Whereas, *recent changes to provincial policy and new legislation has resulted in the expansion of the Environmental Health program mandate in recent years, and*

Whereas, *in 2014 the Skin Cancer Prevention Act (Tanning Beds) went into effect and public health inspectors (PHIs) were required to complete education visits of tanning bed establishments and respond to future public complaints with these facilities, and*

Whereas, *the Recreational Water Protocol was updated by the Ministry of Health and Long-Term Care in 2014 and included a broadening of the definition of a public beach which resulted in doubling the number of municipal public beaches that require annual water sampling, and*

Whereas, *in 2015, the Ministry of Health and Long-Term Care released the new Infection Prevention and Control Lapse Disclosure Guidance document requiring the Health Unit to actively investigate public complaints related to infection prevention and control (IPAC) in regulated health care settings where previously the Health Unit was not mandated, and*

Whereas, *in 2017, the Ministry of Health and Long-Term Care advises that menu labelling requirements will come into force for certain restaurants and will require PHIs to enforce, and*

Whereas, *recent amended environmental health protocols require the disclosure of public facility inspection reports to the public on request and resulting in increased workload for Health Unit staff, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any additional resources and where current Environmental Health program staff are already at full capacity implementing existing mandated programs, and*

Whereas, *the challenge is implementing new policy and legislation that comes often without any support for staff training,*

Now Therefore Be It Resolved, *that the Board of Health for the North Bay Parry Sound District Health Unit endorse the following actions to support the Environmental Health program in implementing new provincial public health policy and legislation:*

1) *Encourage the Ontario Ministry of Health and Long-Term Care to provide dedicated, predictable recurring funding to public health units for the purpose to enhance Environmental Health program field staff and management capacity to implement new provincial public health policy and legislation;*

2) *Encourage the Ontario Ministry of Health and Long-Term Care to fund an additional 2.0 full-time equivalent (FTE) public health inspectors in the Environmental Health program;*

3) *Encourage the Ontario Ministry of Health and Long-Term Care to adopt as standard policy for providing of training to public health staff whenever new provincial public health policy and legislation is implemented; and*

4) *Encourage the Ministry of Health and Long-Term Care to develop a staffing model for health units to use to determine adequate levels of environmental health staffing which include field staff, supervisory staff and management staff necessary to fully implement provincial environmental health policy and legislation.*

Furthermore Be It Resolved, *that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, Dr. Bob Bell, Deputy Minister of Health and Long-Term Care, Roselle Martino, Assistant Deputy Minister of Health and Long-Term Care, Dr. David Williams, Interim Chief Medical Officer of Health for the Ministry of Health and Long-Term Care, the Association of Local Public Health Agencies, Ontario Medical Officers of Health, and Ontario Boards of Health, and member municipalities.*

Sincerely,

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

C: Hon. Dr. Bob Bell, Deputy Minister of Health and Long-Term Care (MOHLTC)
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division, MOHLTC
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Linda Stewart, Executive Director, Association of Local Public Health agencies
Ontario Medical Officers of Health
Ontario Boards of Health
Member Municipalities (31)

March 24, 2016

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

Dear Minister Hoskins:

Re: Herpes Zoster Vaccine

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached correspondence from Peterborough County-City Health Unit regarding the Herpes Zoster Vaccine. A motion to endorse this correspondence was passed.

Sincerely,

Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Ontario Boards of Health
Association of Local Public Health Agencies

Encl.

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

February 25, 2016

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

Dear Minister Hoskins:

The board of health for Peterborough County-City Health Unit recently received a staff report on the Herpes Zoster Vaccine, at our request. As individual board members, we are aware of both the serious complications of Herpes Zoster reactivation, or "Shingles", and the significant cost of the vaccine. We are also aware that the currently available vaccine, Zostavax II™, produced by Merck Canada Inc., appears to have a limited length of time where it is considered protective.

The burden of illness associated with Herpes Zoster reactivation is considerable, with a lifetime risk of 30%. For persons over 80 years of age, the incidence has been estimated to be 8.4/1,000. The debilitating neurogenic pain syndrome that can occur following shingles, called post-herpetic neuralgia, occurs in 20% of all cases, but increases to more than a third of octogenarians.

The Provincial Infectious Diseases Advisory Committee (PIDAC) for Ontario released a report in 2013 which examined several options for a publicly funded vaccine program for herpes zoster. PIDAC found that the vaccine was cost-effective under a wide range of assumptions, particularly for adults aged 65-70 years of age. PIDAC recommended that the provision of the vaccine for 65 year olds, as this is also the age eligibility for the pneumococcal polysaccharide vaccine. Providing the vaccine to 60 year olds, as currently recommended by the National Advisory Committee on Immunization (NACI) would be more expensive but also more equitable, as all persons for whom the vaccine is recommended by NACI would be eligible.

We understand that there is a new vaccine currently in development that may present a much more effective and longer lasting option. The availability of this promising vaccine would only enhance the economic evaluations that have already been done.

We call upon you and your government to seriously consider adding the herpes zoster vaccine to the list of publicly funded vaccines available to Ontario's adults. Immunization continues to be one of our most effective tools in the prevention of disease and promotion of health, and this remains true through-out the life cycle, including into our later years.

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

We appreciate your consideration of this important addition as you move forward with Vision 20/20, the modernization of our provincial immunization system.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at

cc: Hon. Dipika Damerla, Associate Minister of Health and Long-Term Care
Dr. David Williams, Ontario Chief Medical Officer of Health
M.P.P. Jeff Leal, Peterborough
M.P.P. Laurie Scott, Haliburton-Kawartha Lakes-Brock
Ontario Boards of Health
Association of Local Public Health Agencies

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Ministère de la Santé et des Soins de longue durée

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Ontario

April 21, 2016

To Boards of Health:

RE: Ontario's Publicly Funded Human Papillomavirus (HPV) Immunization Program

We are writing to inform you about an exciting expansion to Ontario's publicly funded Human Papillomavirus (HPV) immunization program to help protect more youth from HPV infection and related cancers.

Consistent with the *Patients First: Action Plan for Health Care* and *Immunization 2020*, Ontario's five-year plan to modernize its publicly funded immunization program, effective September 2016, the Ministry of Health and Long-Term Care will be:

- Expanding Ontario's school-based HPV immunization program to include boys; and
- Moving Ontario's school-based HPV immunization program from Grade 8 to Grade 7.

Ontario's HPV immunization program is currently available to Grade 8 girls through school-based immunization clinics administered by public health units. Starting in the 2016/17 school year, the school-based HPV immunization program will be offered to boys and girls in Grade 7. To support the transition of the program to Grade 7, female students who are beginning Grade 8 in the transitional 2016-17 school year will be eligible for publicly funded HPV vaccine through school-based clinics.

The expansion of Ontario's school-based HPV immunization program to include boys aligns with current scientific and expert recommendations. Moving the school-based HPV immunization program from Grade 8 to Grade 7 will bring Ontario in line with other jurisdictions in Canada that offer publicly funded HPV immunization programs in earlier grades.

…/2

Further information and materials to support public health units and school boards in communicating these changes to health care providers and parents will be forthcoming.

We look forward to collaborating with you to implement this important initiative. We gratefully acknowledge the hard work that goes into the delivery of Ontario's publicly funded immunization program and thank you for your continued leadership.

Yours sincerely,

Original signed by

Dr. Eric Hoskins
Minister

c. Medical Officers of Health and Associate Medical Officers of Health

alPHa
Association of Local PUBLIC HEALTH Agencies

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

April 21, 2016

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: Ontario HPV Vaccination Program Expansion

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 congratulate and thank the Government of Ontario for its commitment to expanding its HPV vaccination program to include males.

We have already expressed our appreciation for your commitment to providing HPV vaccinations to Grade 8 girls with a provision for catch-up in grades 9 through 12. This is an important health protection initiative that will only be strengthened by expanding eligibility to Ontario's boys.

As you know, the National Advisory Committee on Immunization (NACI) has recommended HPV vaccination for both males and females between the ages of 9 and 26 years and alPHa Resolution A12-10 (attached) was passed in support of that recommendation. We are very pleased that coverage for boys will now be provided, and that you have confirmed that eligible youth who are unable to begin or complete the HPV vaccine series in Grade 7 will remain eligible to catch-up on missed doses until the end of Grade 12.

With this announcement, Ontarians can be proud that theirs will be the fifth Canadian province to provide this cancer-preventing vaccine to males as part of its own school-based program.

Again, we sincerely congratulate you for further expanding this important health protection program and will be pleased to assist by working in our communities with schools and other local partners to ensure maximum uptake of this life-saving vaccine.

Sincerely,

V Jaeger

Valerie Jaeger,
President

Copy: Hon. Kathleen Wynne, Premier of Ontario; Hon. Liz Sandals, Minister of Education; Hon. Charles Sousa, Minister of Finance; Dr. David Williams, Chief Medical Officer of Health ; Roselle Martino, Assistant Deputy Minister, Public Health Division, MOHLTC

Attach.

alPHa Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A12-1

TITLE: **HPV Immunization of All Students**

WHEREAS infection with HPV types 6 and 11 causes anogenital warts and with HPV types 16 and 18 is associated with cancers of the penis, anus, mouth, and oropharynx in males; and

WHEREAS more than 70% of sexually active men and women are infected with HPV at least once in their lifetime; and

WHEREAS HPV infection is a associated with a significant burden of anogenital warts and anogenital and head & neck cancer; and

WHEREAS in Canada, of the ~150 men and ~200 women who are diagnosed with anal cancer every year, 80 to 90% case are HPV positive; and

WHEREAS in February 2010, a quadrivalent HPV vaccine (Gardasil®) was authorized by Health Canada to expand its indications to include males 9 to 26 years of age for the prevention of infection caused by HPV types 6, 11, 16, and 18 and for genital warts caused by HPV types 6 and 11; and

WHEREAS in May 2011, Gardasil® was indicated in females and males 9 through 26 years of age for the prevention of anal cancer caused by HPV types 16 and 18 and anal intraepithelial neoplasia grades 1, 2, and 3 caused by HPV types 6, 11, 16, and 18; and

WHEREAS in January 2012, the National Advisory Committee on Immunization (NACI) advised that Gardasil® be recommended for use in males between 9 and 26 years of age for the prevention of anal intraepithelial neoplasia grades 1, 2, and 3, anal cancer, and anogenital warts (NACI Grade A Recommendation); and

WHEREAS NACI also advised that Gardasil® be recommended in males between 9 and 26 years of age for the prevention of penile, perianal, and perineal intraepithelial neoplasia and associated cancers (NACI Grade B Recommendation); and

WHEREAS all grade 8 female students are eligible to receive 3 publicly funded doses of Gardasil® through public health school-based immunization clinics";

NOW THEREFORE BE IT RESOLVED that alPHa urges the Ontario government to expand Ontario's Publicly Funded Immunization Schedule to make Gardasil® available to male students through public health school-based immunization clinics;

AND FURTHER that the Premier of Ontario, Ministers of Children and Youth Services, Education, Finance and Health and Long-Term Care, Chief Medical Officer of Health, Chief Public Health Officer of Canada, AMO and all Ontario boards of health are so advised.

AND FURTHER that all students who are eligible for immunization against HPV maintain their eligibility throughout high school.

AND FURTHER that alPHa recommends a review to be conducted of the program to enhance uptake in girls including moving the program to grade 7 and implementing a catch-up program.

March 31, 2016

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

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

Dear Premier Wynne and Minister Hoskins

Re: Patients First Discussion Paper

At its meeting held on March 9, 2016, the Board of Health for the Peterborough County-City Health Unit passed the following resolution:

> "WHEREAS the discussion paper Patients First: A Proposal to Strengthen Patient-Centred Care in Ontario conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care, by establishing links between LHINs and public health which can occur through identifying new roles and responsibilities that do not require changes in the funding or governance of public health in Ontario; and
>
> WHEREAS the wider problem of improving and supporting the health and health equity of Ontarians is mandated to the public health system, through the Health Protection and Promotion Act that has created local boards of health and has made them accountable for the delivery of public health programs and services as required by the Ontario Public Health Standards and the Ontario Public Health Organizational Standards, and
>
> WHEREAS the direct relationship with the province ensures that the same principles and standards are upheld and implemented for all boards of health, further ensuring that all Ontarians benefit equitably from the public health system; and

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WHEREAS municipal and First Nation representation on boards of health ensure valuable connections with decision makers and staff to support local healthy public policy; and

WHEREAS evidence from other jurisdictions where public health funding has been integrated regionally with funding for the rest of the health care system shows that opportunities for system improvement is often not realized and unintended risks to public health have arisen:

BE IT THEREFORE RESOLVED that the board of health for the Peterborough County-City Health Unit calls upon the province of Ontario to ensure a continued strong role for public health in keeping people healthy by

- maintaining independent governance of the public health sector by local boards of health; and
- maintain its direct and transparent funding of local boards of health; and
- continue to directly negotiate Provincial Public Health Funding and Accountability Agreements (PHFAA) with local boards of health.

Local municipal and First Nation Councils are called upon to endorse this motion and advise Premier Kathleen Wynne, Minister of Health and Long Term Care, the Honourable Eric Hoskins, and local MPPs, Minister of Agriculture and Rural Affairs Jeff Leal, and Laurie Scott, in writing."

Moved:	Mr. Andy Sharpe
Seconded:	Chief Phyllis Williams
Motion carried.	(M-2016-032)

On behalf of our communities, the Board of Health would like to thank you for the opportunity to provide input on the discussion paper. Our concerns echo those of other public health units, it is our hope that the Province will consider these recommendations.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at

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

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

March 24, 2016

Dear Dr Hoskins,

The Board of Health for the Perth District Health Unit received *Patient's First Report: A proposal to strengthen patient-centred health care in Ontario* on December 22, 2015, and further considered the proposal on January 20, 2016 and March 16, 2016.

During its board meeting on March 16, the board unanimously moved to support the alPHa response to the Patients First Report, and urges the Ministry of Health and Long-Term Care to include the alPHa recommendations in any implementation of Patients First.

Sincerely,

Ms. Teresa Barresi
Board Chair

Attachments:
PDHU Staff Report: Patients First Report (January 20, 2016)
alPHa Response to Patients First Report (February 29, 2016)

Links:
Ministry of Health and Long-Term Care. (2015). Patients First: A proposal to strengthen patient-centred health care in Ontario. Discussion Paper. Retrieved from: http://www.health.gov.on.ca/en/news/bulletin/2015/hb_20151217.aspx

MK/mr

cc.
Association of Local Public Health Agencies
Council of Medical Officers of Health
Ontario Public Health Association
36 Boards of Health of Ontario
Dr David Williams, Chief Medical Officer of Health
Member municipalities (City of Stratford, Town of St. Marys, Perth County)

Staff Report

Date: January 20, 2016

To: Board of Health

From: Miriam Klassen, Medical Officer of Health

Subject: **PATIENTS FIRST REPORT**

PURPOSE:
To provide an update to the Board of Health (BOH) regarding significant health system changes that could impact the health unit.

FINANCIAL IMPLICATIONS AND IMPACT STATEMENT:
The implications for funding and programming are difficult to predict but could be significant.

RECOMMENDATIONS:
It is recommended that:
- The report *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario* (link) be received
- That the Medical Officer of Health (MOH) work with the Association of Local Public Health Agencies (alPHa) to develop and communicate a response
- That the BOH work with the Association of Municipalities of Ontario (AMO) as appropriate to promote strong, evidence-based public health programming.

BACKGROUND:
The *Patients First* discussion paper was released by the Ministry of Health and Long-Term Care (MOHLTC) on December 17, 2015; it includes several proposals to strengthen patient-centred health care in Ontario. Specifically, Local Health Integration Networks (LHINs) would assume responsibility for home and community care and system integration, and have greater involvement with primary care, and improved linkages with population health planning.

With regard to Public Health, the paper proposes that LHINs and Public health Units (PHUs) align their work and ensure that population and public health priorities inform health planning, funding and delivery.
To support this new structure:
- the MOHLTC would create a formal relationship between MOHs and each LHIN
- the MOHLTC would transfer the dedicated provincial funding for PHUs to the LHINs for allocation to PHUs
- the LHINs would assume responsibility for the accountability agreements with PHUs
- local BOHs would continue to set budgets, and the BOH would continue to be managed at the municipal level.

The discussion paper notes that changes to legislation are being considered for the spring of 2016. These could include the following: the *Local Health System Integration Act*; the *Community Care Access Corporations Act*; the *Home Care and Community Services Act*; and the *Health Protection and Promotion Act*.

The ministry plans to 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.

As part of a separate initiative, the MOHLTC has initiated a 'modernization' of the Ontario Public Health Standards (OPHS) and Organizational Standards (OPHOS). The results of this review are expected by the end of 2016 and may have further significant impact on the services that local public health is mandated to deliver.

COMMENTS:
There are benefits to strengthening the relationship/alignment between LHINs and PHUs including but not limited to:

- Public health skills and knowledge can inform health system planning
- There may be increased opportunities to advance public health priorities through these connections.

However, there are risks associated with transferring funding and accountability to the LHINs including but not limited to:

- The proposed role for public health in supporting LHIN planning is in addition to existing work; it is unlikely that additional funding will be available
- The LHIN is being asked to provide oversite to public health work such as small drinking water, tobacco and restaurant inspections and school health programs; work that is outside of the health care system and outside of their expertise
- Scare resources currently allocated to public health may be at risk of reallocation to address issues within acute care, negatively impacting our ability to promote and protect population health
- The ability of BOHs to influence local priority setting and resource allocation could be impacted
- System integration could lead to the discontinuation of the provision of some public health clinical services such as Sexual Health and Travel Health.

alPHa is taking the lead on developing a response for the public health field:

- alPHa staff attended an announcement pre-meeting on December 17th, as well as the announcement itself
- alPHa has surveyed members regarding the main proposals in the paper for public health units as a first step in formulating a response
- alPHa's Executive Director met with Minister Hoskin's policy advisor responsible for the public health file, Alyson Rowe, on January 11 to initiate a discussion about the paper
- alPHa staff have been in discussion with AMO
- Council of Ontario Medical Officers of Health (COMOH) Executive has had an initial discussion about the content of the paper, and is working closely with alPHa on the response

Other steps include:

- Toronto Public Health is preparing a full report that will be available to other health units; this will include additional information about public health structure and organization in other jurisdictions
- alPHa will be putting forward names to represent public health on the Expert Panel
- COMOH representatives have been appointed to the Executive Steering Committee (ESC) and Practice and Evidence Program Standards Advisory Committee (PEPSAC) as part of the review of the OPHS and OPHOS
- Dr Williams (Acting Chief Medical Officer of Health) has indicated he is planning a meeting for COMOH to meet with himself and Deputy Minister Dr Bell in the coming weeks.

CONCLUSIONS:
Public health staff and the Board of Health will work to ensure that public health practice remains evidence-based, and focused on population health through health promotion, health protection and disease prevention, by engaging in system transformation and providing input into the review of the OPHS and OPHOS, and into the proposed *Patients First* proposal.

CONTACT:
Miriam Klassen
MOH and CEO
Perth District Health Unit
☎ 519-271-7600 ext. 255
🖷 519-271-2195

LIST OF ATTACHMENTS:
http://www.health.gov.on.ca/en/news/bulletin/2015/docs/discussion_paper_20151217.pdf

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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February 29, 2016

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

Dear Minister Hoskins:

On behalf of member Medical Officers of Health, Boards of Health and Affiliate organizations, the Association of Local Public Health Agencies (alPHa) is pleased to provide comment on the Ministry of Health and Long-Term Care discussion paper, *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*. We received and reviewed the paper with much interest and anticipation. There is much to consider from a local public health perspective. We offer our preliminary comments herein and will be very pleased to engage further as the government's work progresses to strengthen patient-centred health care in Ontario.

We note the fact that how a "problem" is defined will greatly inform the solutions that are considered.

Patients First conceptualizes the problem as that of reducing gaps and inequities in care and strengthening patient-centred care. One solution to this problem is to better integrate population health within the health system, specifically through establishing closer linkages between LHINs and public health units. We are aware of recent work exploring the use of the population health approach in health system planning (CIHI 2014) and appreciate the merits of this work in contributing to health system sustainability. Further, we believe that local public health has valuable expertise to offer in this area. Indeed this approach is one of the five actions for health promotion as set out in the 1986 Ottawa Charter for Health Promotion.

A wider problem is improving and supporting the health and health equity of Ontarians which is effectively the mandate of the Ontario public health system. A solution to this problem would be to support and strengthen the public health system which works on all five Ottawa Charter actions for health promotion. The public health system understands that although access to a quality health care system is a determinant of individual and population health, it is a relatively minor determinant as compared with social and economic circumstances that create opportunities for health, mediated by factors such as education, food security, physical activity opportunities, social networks, effective coping strategies, etc. The public health system is that part of the overall health system that is specifically mandated to work with both health and non-health sector partners to act on these determinants and create opportunities for health for all.

We are concerned that some of the *Patients First* proposals regarding public health may have the unintended consequence of eroding the capacity of the public health system to improve the health of Ontarians through our intersectoral work on the determinants of health.

At the same time, we firmly hold that public health can assist in reorienting the health care system and see this as a valuable contribution of public health to the problems of health care system sustainability as set out in *Patients First*. We also hold that health care system sustainability is achieved by ensuring a strong public health system that can stem the tide of need; focusing on healthy people first.

In the recommendations that follow, we list and briefly describe what we present are the conditions necessary to achieve both. That is, to ensure that public health is able to contribute to the reorientation of the health care system so that population and public health priorities inform health care planning, funding and delivery, while at the same time protecting public health's ability to work upstream to promote and protect the health of all Ontarians.

Recommendations

1. **Funding and Accountability** – Provincial Public Health Funding and Accountability Agreements (PHFAA) must continue to be directly negotiated between local boards of health and the MOHLTC.
   a. A direct relationship mitigates against the threat of resource reallocation (financial and functional) to the acute care system as has been evidenced in the experience of other regions with integrated health systems.
   b. The direct relationship ensures that common Ministry principles and standards are upheld and implemented for all boards, further ensuring that all Ontarians benefit equitably from the public health system.
   c. The direct relationship with the Ministry is needed to maintain the independent voice of public health at LHIN tables; otherwise public health would be advising on health resource allocation and also be a resource recipient.

2. **Independent Voice of Boards of Health –** Boards of health must be maintained as defined in the Health Protection and Promotion Act, directly accountable to the Minister of Health.
   a. Boards of health must continue as entities with an independent voice with roles and responsibilities as set out in statute, standards and accountability agreements.
   b. Municipal representation on boards of health ensures invaluable connections with decision makers and staff in non-health sectors where there is scope of authority over key determinants of health (e.g. bylaws, built environment, social services, child care, planning, long term care, drinking water, recreational facilities, first responders, etc.).
   c. For certain boards of health (e.g. single tier and regional boards), local government is the de facto board of health, creating governance issues if required to report to an appointed LHIN board.
   d. Ways to strengthen boards of health should be explored; this should form part of the work of the Expert Panel following the report of the Institute on Governance (IOG).

3. **Integration of Local Population and Public Health Planning with Other Health Services –** The Ontario Public Health Standards and Ontario Organizational Standards, as required, should be modified to require boards of health to align their work and ensure that population and public health priorities inform LHIN health planning, funding and delivery. Reciprocal amendments should be made to the LHIN legislation (or other mandate documents as appropriate) to require LHIN boards to ensure that population and public health priorities inform LHIN health planning, funding and delivery. alPHa looks forward to participating in the following activities.
    a. Identification of the enabling policies and structures to ensure an effective relationship between the medical officer of health and LHIN leadership.
    b. The identification of the resources and funding required for public health to effectively engage in this work.

4. **Process for Determining Respective Roles –** The respective roles of local public health and LHINs (and other system players involved with population and public health including the Population and Public Health Division, MOHLTC, the Capacity Planning and LHIN Support, Health Analytics Branch, MOHLTC and Public Health Ontario) must be determined through a transparent, inclusive and deliberative process that is informed by evidence. We maintain that this is a key role of the proposed Expert Panel.
    a. It must be recognized that the work for public health as described in *Patients First* is additional to public health's core functions and mandate and the related resources must be identified to accommodate this work to ensure that public health capacity to promote and protect health and improve health equity is not eroded.
    b. There is an important distinction between providing population health information and translating this information into planning, funding and delivery decisions for acute care and other downstream services. It should not be assumed that the latter is a public health competency.

5. **Geographic Boundaries –** LHIN boundaries should be re-configured to align with municipal, local public health, education and social service boundaries to support their relationships with local public health and population health and health care system planning.

Local public health appreciates that a population health approach to health system planning is an emerging paradigm that may contribute to the sustainability of the health care system. Local public health also agrees with the *Patients First* discussion document that the public health system has expertise that may support such a reorientation of the health care system. Simply put, however, we must ensure that this "fix" to the health care system does not "break" the public health system.

We are committed to engaging in a thoughtful change management process with you that minimizes system disruption, mitigates risks associated with system instability and fosters balance between the systems intended to treat illness and the systems intended to prevent disease and promote health. To this end, we look forward to ongoing dialogue with government on the issues addressed in this letter. We trust that this will take place in many ways, including our participation in the proposed Expert Panel. We remain available for further consultation and are eager to pursue next steps.

In closing, I would reiterate that we are committed to finding win-wins so that Ontarians can continue to benefit from a strong and effective public health system while knowing that a quality health care system is there for them when they need it.

Sincerely,

Dr. Valerie Jaeger,
President

Copy: Dr. David Williams, Chief Medical Officer of Health
Dr. Bob Bell, Deputy Minister of Health and Long-Term Care
Sharon Lee Smith, Associate Deputy Minister of Health and Long-Term Care
Nancy Naylor, Associate Deputy Minister of Health and Long-Term Care
Roselle Martino, Assistant Deputy Minister, Population and Public Health Division
Board of Health Chairs
Medical Officers of Health

Ministry of Health and Long-Term Care

Office of the Minister

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Ministère de la Santé et des Soins de longue durée

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Ontario

HLTC2976IT-2016-61

April 20, 2016

To: Boards of Health and Medical Officers of Health

Ontario is committed to developing a health-care system that puts patients first. This includes keeping people healthy and reducing inequities in health.

As Minister of Health and Long-Term Care and as a public health doctor, I know the integral role that public health units (PHUs) play in protecting and promoting the health of Ontarians. My priority is to elevate this role and ensure that your expertise in population health and prevention is incorporated into planning across our health-care system, end-to-end.

Over the past decade, Ontario's health-care system has improved significantly. 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. But we can do more to put patients first.

When we established our Local Health Integration Networks (LHINs) a decade ago, they brought planning and decision-making to the local community moving these functions which had been centralized in the ministry for years. But primary care and public health, two parts of the system most critical to keeping people healthy, were left out. Accordingly, in December I introduced proposals to truly integrate the health-care system, using a population health and health equity approach to health system planning and service delivery across the continuum of care so that Ontarians have access to the services they need, no matter where they live.

This integration can facilitate and support better health and wellness outcomes for all Ontarians and thereby improve the quality and sustainability of the health-care system. However, to achieve the full potential of the integration it will require the expertise of the public health sector.

The formal linkages we propose between PHUs and LHINs will ensure that Medical Officers of Health (MOHs) and other public health professionals are part of planning and decision making at the local level and that local population and public health priorities inform health-care system planning, funding and delivery. My intent and focus of establishing formal linkages between our LHINs and PHUs is this: to further empower and engage our public health professionals - our experts in the social determinants of health, in health equity and in population health - to positively influence and help guide our planning and delivery of services across the health care system. We need this expertise and influence to build a better health care system.

The Discussion Paper has generated significant commentary and feedback. I have also heard the concerns raised that emphasize the importance that funds for public health be protected and dedicated exclusively for use by our public health units. I want to assure you that my ministry and I fully agree on this point.

I am pleased that the Association of Local Public Health Agencies (alPHa) has recognized the opportunity presented by our proposals as indicated in its press release of December 17, 2015. There is a strong role for local public health included in our proposals, and the essential leadership provided by you with regards to population health and health equity will be an important element in supporting the extension of this approach across the rest of the health system.

I look forward to the continued participation of the public health sector in our exciting system transformation.

Yours sincerely,

Original signed by

Dr. Eric Hoskins
Minister

March 24, 2016

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

Dear Minister Hoskins:

Re: Bill 139: Smoke-Free Schools Act

On March 18, 2016 at a regular meeting of the Board of Health for the Grey Bruce Health Unit, the Board considered the attached resolution #BOH/2016/01/11 from North Bay Parry Sound District Health Unit regarding Bill 139: Smoke-Free Schools Act. A motion to endorse this resolution was passed.

Sincerely,

Hazel Lynn, M.D., FCFP, MHSc
Medical Officer of Health

Cc: Hon. Kathleen Wynne, Premier of Ontario
Larry Miller, MP Bruce-Grey-Owen Sound
Benn Lobb, MP Huron-Bruce
Kellie Leitch, MP Simcoe-Grey
Bill Walker, MPP Bruce-Grey-Owen Sound
Lisa Thompson, MPP Huron-Bruce
Jim Wilson, MPP Simcoe-Grey
Ontario Boards of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies

Encl.

North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound

in your community . . . here for your health

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70 Joseph Street, Unit 302, Parry Sound, ON P2A 2G5 TEL 705.746.5801 FAX 705.746.2711
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February 22, 2016

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

Dear Minister Hoskins:

Subject: Bill 139: Smoke-Free Schools Act – BOH Resolution #BOH/2016/01/11

On January 27, 2016, at a regular meeting of the Board of Health for the North Bay Parry Sound District Health Unit, the Board unanimously approved the following motion #BOH/2016/01/11:

***Whereas**, tobacco use is the leading cause of preventable death and disability in Canada (Ministry of Health and Long-Term Care, 2010), and*

***Whereas**, the number of daily and occasional cigarette smokers in the North Bay Parry Sound District Health Unit is 7% higher than the provincial average (25.8% vs. 18.7%; NBPSDHU, 2014), and*

***Whereas**, Bill 139: Smoke-Free Schools Act introduced by MPP Todd Smith is slated for third reading in the Ontario Legislature this year, and*

***Whereas**, Bill 139: Smoke-Free Schools Act includes a prohibition on the sale of any tobacco products in schools, increased fines for offenders caught selling illegal tobacco, and increased suspension periods of driver's licenses for people convicted of using a vehicle for unauthorized delivery/transportation of illegal tobacco, sharing the proceeds of disposition of forfeited property with police forces if they were involved in the investigation, a requirement that the Government establish a public education program about the health risks associated with the use of tobacco, and*

***Whereas**, the illegal sale of contraband cigarettes undermines public health's efforts to reduce smoking rates and protect children and youth from the dangers of smoking, and*

***Whereas**, higher tobacco taxes have been identified as the most effective strategy to reduce smoking prevalence and Ontario has one of the lowest tobacco tax rates in Canada (Smoke-Free Ontario Scientific Advisory Committee, 2010; Ontario Tobacco Research Unit, 2015), and*

***Whereas**, plain and standardized packaging is an effective counter measure to the tobacco industry's use of packaging as an important part of tobacco promotion, and*

***Whereas**, Bill 139: Smoke-Free Schools Act has been endorsed by the Canadian Cancer Society, the Heart & Stroke Foundation, and the Ontario Campaign Against Tobacco (OCAT),*

***Now Therefore Be It Resolved**, that the Board of Health for the North Bay Parry Sound District Health Unit support Bill 139: Smoke-Free Schools Act and that legislation for plain and standardized cigarette packaging and higher tobacco taxes be considered by all levels of government, and*

***Furthermore Be It Resolved,** that a copy of this resolution be forwarded to the Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care, the Association of Local Public Health Agencies (alpha), MPP Todd Smith (Prince Edward-Hastings), MPP Victor Fedeli (Nipissing), MPP Norm Miller (Parry Sound-Muskoka), Premier Kathleen Wynne, and Ontario Boards of Health.*

Sincerely,

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

C: Todd Smith, MPP, Prince Edward-Hastings
Victor Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
Hon. Kathleen Wynne, Premier of Ontario
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health