ALGOMA PUBLIC HEALTH

BOARD OF HEALTH MEETING

SEPTEMBER 28, 2016

5:00 - 7:00 PM

SAULT STE MARIE ROOM, 1ST FLOOR,

294 WILLOW AVE, SAULT STE MARIE, ON

www.algomapublichealth.com

September 28, 2016 - Board of Health Meeting

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Peterborough Public Health

f. Patients First

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ii. Letter to Linda Steward alPHa from County of Lambton — Page 179

g. Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act

i. Letter to Ms. Sattler from Windsor-Essex County Health Unit — Page 188

9. Items of Information

a. Basic Income Guarantee Position Statement from Haliburton Kawartha Pine Ridge District Health Unit — Page 190

10. Addendum

11. In Committee

a. Adoption of Previous In-Committee Minutes

b. Litigation or Potential Litigation

c. Labour Relations and Employee Negotiations

12. Open Meeting

13. Resolutions Resulting From In Committees

14. Announcements

a. Board of Health Orientation - October 15, 2016

b. Board of Health Meeting - October 26, 2016

15. Adjournment

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
SEPTEMBER 28, 2016 @ 5:00 pm
SAULT STE MARIE ROOM A&B, SSM
A*G*E*N*D*A

1.0 Meeting Called to Order — Mr. Lee Mason, Board Chair

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda Items — Mr. Lee Mason, Board Chair

Resolution

THAT the agenda items dated September 21, 2016 be adopted as circulated; and
THAT the Board accepts the items on the addendum.

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

a. June 22, 2016

b. August 9, 2016

Resolution

THAT the Board of Health minutes for the meetings dated June 22, 2016 and August 9, 2016 be adopted as circulated.

4.0 Delegations/Presentations.

a. Infectious Diseases — Mr. Jonathon Bouma, Program Manager

i. PowerPoint Presentation
ii. Attachment - Reportable Communicable Diseases List

5.0 Business Arising from Minutes

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Report — Mr. Justin Pino, Acting CEO/ Chief Financial Officer

i. September 2016 MOH/CEO Report
ii. Attachment – 2016 Ontario Building Code Annual Report

Resolution

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

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

i. Committee Chair Report for September 2016
ii. Draft Financial Statements for the Period Ending July 31, 2016
iii. New Financial Statement Template

Resolution

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

THAT the Financial Statements for the Period Ending July 31, 2016 be approved as presented; and

THAT the Board of Health approves the new financial statement template as presented.

iv. Infant Development Program Reconciliation
v. Renewal of Building Automation and Security Services Contract

Resolution
THAT the Board of Health approves:
1. *Sole source procurement of HVAC control services and security services related to building card access system for its 294 Willow Ave location; and*
2. *The execution of the building automation and security services contract/lease with Siemens Canada ltd.*

vi. Approved minutes June 8, 2016 ***– for information only***

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

i. Committee Chair Report for September 2016

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

ii. Bylaw 95-1: To Regulate the Proceedings of the Board of Health
Bylaw 95-1 – Revised
Bylaw 95-1 – Clean

Resolution:
THAT the Board of Health approves the changes to Bylaw 95-1: To Regulate the Proceedings of the Board of Health as presented.

iii. Terms of Reference - Governance Standing Committee
TOR – Revised
TOR – Clean

iv. Terms of Reference - Finance and Audit Committee
TOR – Revised
TOR – Clean

Resolution:
THAT the Board of Health approves the changes to the Terms of Reference for the Governance Standing Committee and the Finance and Audit Committee as presented.

v. Monthly Meeting Evaluation – June 2016
vi. Annual Self-Evaluation – June 2016
vii. Approved Minutes June 8, 2016 – ***for information only***

7.0 New Business/General Business

a. Preparation for Fall Board Orientation – October 15, 2016 — Mr. Lee Mason, Board Chair

8.0 Correspondence — Mr. Lee Mason, Board Chair

a. Baby-Friendly Initiative

i. Letter to APH from MOHLTC dated June 22, 2016

b. Basic Income Guarantee

i. Letter to Minister Dulcos from Haliburton, Kawartha, Pine Ridge District Health Unit dated September 14, 2016

c. Food Insecurity and BIG

i. Letter to Premier Wynne from Simcoe Muskoka District Health

Unit dated June 15, 2016

d. Legalization of Cannabis in Canada

i. Letter to Prime Minister Trudeau from Count of Lambton dated July 14, 2016
ii. Letter to Prime Minister Trudeau from Wellington-Dufferin-Guelph Public Health dated June 1, 2016

e. Lyme Disease

i. Letter to Minster Philpott and Hoskins from Peterborough Public Health dated September 20, 2016

f. Patients First

i. Letter to Minster Hoskins from County of Lambton dated July 14, 2016
ii. Letter to Linda Steward alPHa from County of Lambton dated July 14, 2016

g. Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act

i. Letter to Ms. Sattler from Windsor-Essex County Health Unit dated June 23, 2016

9.0 Items for Information

a. Basic Income Guarantee Position Statement from Haliburton Kawartha Pine Ridge District Health Unit — Mr. Lee Mason, Board Chair

10.0 Addendum

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

Resolution
THAT the Board of Health goes into committee.

Agenda Items:

a. Adoption of previous in-committee minutes dated:
   i. June 22, 2016
   ii. August 8, 2016
b. Litigation or Potential Litigation
c. Labour Relations and Employee Negotiations

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

Resolution
THAT the Board of Health goes into open meeting

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

14.0 Board Meeting Monthly Evaluation — Mr. Lee Mason, Board Chair

15.0 Announcements: Mr. Lee Mason, Board Chair

Board Orientation:
October 15, 2016
Sault Ste. Marie

Next Board Meeting:
October 26, 2016 at 5:00pm
Sault Ste. Marie, Room A&B, Sault Ste. Marie

16.0 That The Meeting Adjourn Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health meeting adjourns

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Infectious Diseases

Manager, Environmental Health and Communicable Diseases
Jon Bouma MSc; CPHI(C)

Ontario Public Health Standards

- Infectious Diseases Prevention and Control
- Rabies Prevention and Control
- Sexual Health, Sexually Transmitted Infections and Blood-borne Infections (including HIV)
- Tuberculosis Prevention and Control

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Protocols

- Exposure of Emergency Service Workers to Infectious Diseases Protocol
- Infection Prevention and Control in Child Care Centres
- Infection Prevention and Control in Personal Service Settings
- Infection Prevention and Control Practices Complaint
- Infectious Diseases Protocol
- Institutional/Facility Outbreak Prevention and Control Protocol
- Tuberculosis Prevention and Control Protocol

Deliverables

- Requires APH to report infectious disease data elements (HPPA)
- Conduct surveillance and increase awareness
- Work with community partners
- Participate on committees, networks.
- Inform public
- Public health management of cases and outbreaks
- Inspect facilities

Clinical aspects

- TB skin testing
- Travel consult
- Needle exchange services

Reportable Communicable Diseases

The following suspect and confirmed Reportable Diseases (Ontario Reg. 559/91 under the Health Protection and Promotion Act) are reportable to the local Medical Officer of Health:

Report diseases listed below to the: Communicable Disease Control Program 705-759-5404 or 1-866-892-0172	Report diseases listed below to the: Environmental Health Program 705-942-4646 or 1-866-892-0172	Report diseases listed below to the: Sexual Health Program 705-541-7141 or 1-866-892-0172
Acute Flaccid Paralysis (AFP)	Amoebiasis	Acquired Immunodeficiency Syndrome (AIDS)
Chickenpox (Varicella)	**Anthrax**	Chancroid
Diphtheria	**Botulism**	Chlamydia trachomatis infections
Encephalitis, including:	**Brucellosis**	Gonorrhea
1. Primary, viral	Campylobacter enteritis	Ophthalmia neonatorum
2. Post-infectious	Cholera	Syphilis
3. Vaccine-related	Creutzfeldt-Jakob Disease, all types	
4. Subacute sclerosing panencephalitis	**Cryptosporidiosis**	
5. Unspecified	**Cyclosporiasis**	
Haemophilus influenzae b disease, invasive Hemorrhagic fevers, including:	**Food poisoning, all causes**	
1. Ebola virus disease	**Gastroenteritis, institutional outbreaks**	
2. Marburg virus disease	**Giardiasis**	
3. Other viral causes	**Hantavirus Pulmonary Syndrome**	
Hepatitis, viral	Influenza	
1. Hepatitis A	**Lassa Fever**	
2. Hepatitis B	**Legionellosis**	
3. Hepatitis C	Leprosy	
Measles	**Listeriosis**	
Meningitis, acute	Lyme Disease	
1. Bacterial	Malaria	
2. Viral	Paralytic Shellfish Poisoning (PSP)	
3. Other	Paratyphoid Fever	
Meningococcal disease, invasive	**Plague**	
Mumps	Psittacosis/Ornithosis	
Pertussis (Whooping Cough)	**Q Fever**	
Poliomyelitis, acute	**Rabies**	
Rubella	**Respiratory infection outbreaks in institutions**	
Rubella, congenital syndrome	Salmonellosis	
Severe Acute Respiratory Syndrome (SARS)	**Shigellosis**	
Smallpox	Trichinosis	
Streptococcal infections, Grp A invasive	**Tularemia**	
Streptococcal infections, Grp B neonatal	Typhoid Fever	
Streptococcus pneumoniae, invasive	**Verotoxin-producing E. coli infection indicator conditions including Hemolytic Uremic Syndrome**	
Tetanus	Yersiniosis	
Tuberculosis		
West Nile Virus illness, including:		
1. West Nile fever		
2. West Nile neurological manifestations		
Yellow Fever		

BOLDED diseases must be reported **IMMEDIATELY**. All other diseases may be reported on the next working day.

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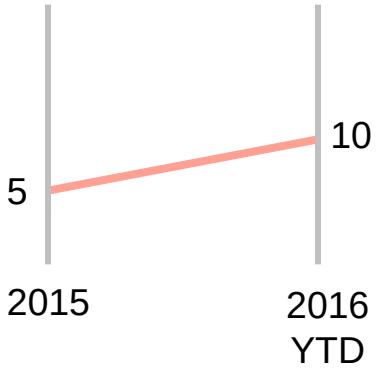
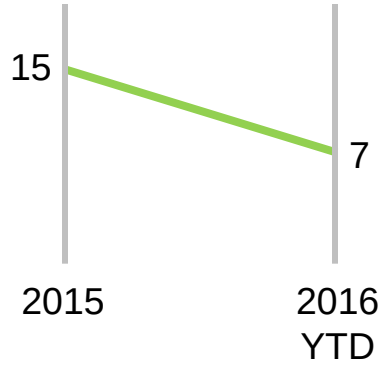
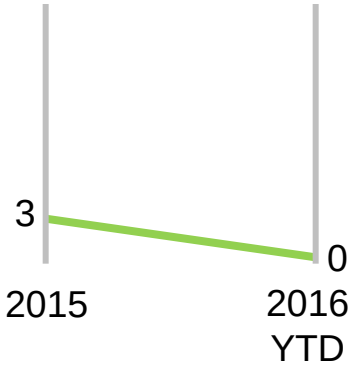
Number of Outbreaks







Gastrointestinal outbreaks

Respiratory outbreaks

Antibiotic resistant organism outbreaks

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Collaborations

- Interagency infection control committee
- IPAC education days with Regional Infection Control Network
- Individual facility support
- Support district healthcare facilities, practitioners
- Emergency service workers

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Health Protection

- Personal Service Settings (PSS) inspections
- Child Care facilities
- Infection Prevention And Control (IPAC) lapses

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MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER
BOARD REPORT
SEPTEMBER 2016

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

Members of the APH Communicable Disease Team participated in World Hepatitis Day Celebrations July 28, 2016 at the Roberta Bondar Pavilion in SSM. Over a hundred people toured the displays and there was even a place to have blood taken and tested. A highlight of the day was a Jenga trivia contest between the APH team and the Group Health Centre Hepatitis C care team. APH was able to make a great move at the end for the win. We are looking forward to defending our title next year!

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APH AT-A-GLANCE

Two Conversation Cafés were held, one in July and one in August. Topic was communication. Ideas were received from staff about improving internal communication regarding keeping front desk staff informed of daily events, schedule changes, staff moves, replacements and work plans for planned absences e.g. medical leave, more use of social media to inform public about APH events. Suggestions were also received about listing policy additions/revisions that have occurred in 2015/16, creating an Executive summary of board meeting i.e. resolutions/ motion passed related to programs or advocacy.

Dr. Hanlon did a MOH recruitment visit to the 4th and 5th year Public Health Residents at the University of Toronto Medical School. Public Health Residents from Queens, Ottawa and McMaster participated via teleconference. Dr. Sutcliffe also participated via teleconference. Our presentation spoke to the significant governance and operational policy improvements during 2015/16 as well as promoting the District of Algoma as an excellent place to live, work and play. The presentation was well received. Special thanks to Dr. Castellani, APH board member, for attending the session and showing his support.

We welcome two new Board members appointed by the Province - Dr. Patricia Avery, M.D. and Ms. Deborah Graystone N.P.

Dr. Sutcliffe and Dr. Hanlon along with management staff from APH held an introductory meeting with First Nations Health Directors/managers representing most of First Nations communities in the District of Algoma. Plans are to meet again in October to discuss building on existing collaborations and looking at new partnerships based on First Nation communities needs and available resources.

The APH Ontario Building Code (OBC) 2016 Annual Report has been posted to the APH website. APH is regulated under the Ontario Building Code Act section 1.7.1.1 General. APH is responsible for the enforcement of the Act and its Code related to sewage systems for the district and is required to publish an annual report. APH has OBC certified Public Health Inspectors work throughout the district including an inspector stationed in Elliot Lake. In 2015 APH performed 384 inspections.

We congratulate Dr. Peter Wiebe on his retirement. Peter has been the Public Health Dental Consultant for Algoma Public Health for well over 20 years. His dedication and knowledge of public health dentistry has provided guidance and support to the staff in the Oral Health program. Arrangements are being made to ensure service continues to clients with this vacancy. Laurie Zeppa, Director Promotion and Prevention, is available to provide an update.

PROGRAM HIGHLIGHTS

INFANT CHILD DEVELOPMENT PROGRAM AND PRESCHOOL SPEECH AND LANGUAGE

Director: Laurie Zeppa
Manager: Leslie Wright

Topic: Waitlist Management

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables:
Preschool Speech and Language is funded through the Ministry of Child and Youth Services (MCYS).
Infant Child Development Program (ICDP) is funded through MCYS under the Early Child Development Branch.

This report addresses the following Strategic Directions: Improve Health Equity and Collaborate Effectively

To ensure children and families receive timely, effective intervention the Ministry of Children and Youth expects that wait lists for assessment and intervention are managed and kept to a minimum.

To address local waitlists the programs have adopted approaches that provide universal services and group services to clients while they "wait" for a service provider.

Preschool Speech and Language program has a ministry target that states 50% of children will receive their initial assessment within 3 months from the date of referral. Currently, there are approximately **60** children on the waitlist. PSLS has developed two waitlist strategies to support clients who are waiting for a service provider. Clients who refer through the Parent Child Information Line will receive information about videos and resources from Markham Stouffville Hospital. The videos provide educational and home activities to families who have single needs speech and language concerns and social emotional development concerns. In addition there is access to a stuttering video from The Stuttering Foundation. These universal resources will assist families while they are waiting for a service provider and are easily accessible on the APH website. Another waitlist strategy that the PSLS offers is group sessions, Wee Talk and Toddler Talk. The group sessions are for parents and children with single speech and language needs. This strategy allows children access to assessment and intervention in a group format and parents are provided with training to help their children.

Infant Child Development Program: There is no specific target defined by the ministry for access to services. Clients are provided a quick response as early intervention is paramount with children developmental delays. There are approximately 40 on waitlist for service intervention. To address the wait list, there is an ICDP clinic that runs every Wednesday that families can access for assessment. From this clinic they can be discharged if there is no concern, remain a clinic client for monitoring or be placed on the waitlist. The ICDP program also provides Parent Coffee Break once per month in SSM and Elliot Lake as these locations usually have the largest waitlists. ICDP has also started a brief consultation program for families who refer children once they enter school. Our program relies on home base services and parent training. With children in school the amount of time we can attend at the home is limited. This brief consultation program includes one school observation and one meeting with teacher and parent in order to provide services/referrals to the family. This meeting also provides information to the teacher about services in the community that can be used for other children who may need a service.

The management and definition of waitlist has been a topic of discussion with many service providers across the province, from both the Infant and Child Development program (ICDP) and the Preschool Speech and Language (PSLS) programs. We are anticipating the new provincial Special Needs Strategy will guide consistent practice related to waitlists.

PREVENTION OF INJURY AND SUBSTANCE MISUSE

Director: Laurie Zeppa
Manager: Jennifer Flood

Topic: Alcohol and Post-Secondary

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/ Deliverables:
Requirement 2: The board of health shall work with community partners, using a comprehensive health promotion approach, to influence the development and implementation of healthy policies and programs, and the creation or enhancement of safe and supportive environments

Requirement 4: The board of health shall increase public awareness of prevention of injury and substance

This report addresses the following Strategic Directions: Collaborate Effectively

Research indicates 19-24 years olds, which make up the majority of the post-secondary population, have the highest rate of alcohol consumption and non-compliance with the Low Risk Alcohol Drinking Guidelines (LRADG). A significant proportion of post-secondary students engage in episodic heavy drinking (also referred to as 'binge drinking'). 'Binge drinking' is defined as drinking 5 or more drinks for men or 4 or more drinks for women, at least once per month. The consequences of exceeding the LRADG are serious and may contribute to the degradation of the on-campus environment, affect the quality of education, and negatively impact individuals' personal health.

The Canadian Community Health Survey 2013-2014 reveals of individuals in Algoma aged 19-24 that:

- 92.28% are current drinkers
- 68.88% drink regularly
- 54.33% are heavy drinkers

Research emphasizes collaborative and peer based approaches are best practices with regards to creating behaviour change.

In an effort to address alcohol misuse within this population, Algoma Public Health has been developing partnerships with Sault College and Algoma University. We are working on collaborative student initiatives and student awareness activities with student unions, residences and services. Many of these activities are designed to raise awareness of the LRADG in this population. Activities have included:

- The development and dissemination of an Alcohol and Post-Secondary Students infographic report targeting parents and influencers
- The development of an APH alcohol awareness website banner linking audiences to the infographic report
- The development and dissemination of social media messages for APH, Sault College, and Algoma University Facebook and Twitter accounts
- The development of branding related to alcohol awareness information #KnowYourNoAlgoma. This is used on all social media messaging and promotional items

- Collaborative interactive displays pertaining to alcohol use and the LRADG (i.e. pour challenge to raise awareness of what a standard drink size is)
- Alcohol awareness education to Residence Advisors for both Sault College and Algoma University related to standard drink size, low risk drinking guidelines and safer drinking practices
- Regular meetings with community partners, with the goal of modifying the drinking environment and helping to change the social norms of drinking

This collaboration is ongoing with plans to continue to address this priority population with regards to alcohol use and misuse.

VACCINE PREVENTABLE DISEASES

Director: Sherri Cleaves
Manager: Stephanie Blaney

Topic: Grade 7/8 Immunization Program/Universal Influenza Immunization program

This report addresses the following requirements of the Ontario Public Health Standards (2014) or Program Guidelines/Deliverables: Infectious Diseases, Vaccine Preventable Diseases requirement #7.
The board of health shall promote and provide provincially funded immunization programs to any eligible person in the health unit, including: Board of health-based clinics; School-based clinics (including, but not limited to, hepatitis B and meningococcal immunization); Community-based clinics; and Outreach clinics to priority populations.

This report addresses the following Strategic Directions: Be Accountable

Grade 7/8 Immunization Program

Nurses in the VPD program will again be providing publicly funded immunizations at elementary school-based clinics starting in late September 2016.

This year, the ministry has implemented program changes to include Grade 7 males in the publicly funded Human Papillomavirus [Gardasil (HPV)] vaccination program. The BOH passed resolution 2016-50 in May of 2016 commending the ministry for its commitment to expand this program. In the past the HPV vaccination program only targeted females.

Clinics will be offered at elementary schools in the district of Algoma for Grade 7 students (males and females) for HPV, Meningococcal ACYW-135, and Hepatitis B. Grade 8 female students will also be offered HPV at school-based clinics.

Communications have been sent to school boards to advise them of the program changes.

Universal Influenza Immunization Program

APH will again be hosting flu immunization clinics in our offices district-wide. This is the first year that we will be hosting the flu vaccine clinic in our new Elliot Lake office.

Community based clinics will also be provided in communities such as White River, Echo Bay, Desbarats, Thessalon and Iron Bridge. Clinics are expected to begin mid-October and are by appointment. Our flu appointment booking line will be open on October 3rd.

Health care providers, institutions, and pharmacies will also be able to order flu vaccine from APH to provide to their clients.

PARTNERSHIPS

Ministry of Long-Term Health
Ontario's Minister of Health Dr. Eric Hoskins launched the publicly funded Shingles Immunization Program on Thursday, September 15, 2016. This program offers free shingles vaccine to seniors 65 to 70 years of age through primary care providers and public health clinics. Until December 31, 2016, individuals born in 1945 (i.e., those who have turned or will be turning 71 years of age in 2016), will be eligible for publicly funded herpes zoster vaccine through a one-time catch-up program. This one-time catch up program will end on December 31, 2016.

Sault Ste. Marie Community Adjustment Committee
Algoma Public Health (APH) has been invited to participate on the Sault Ste. Marie Community Adjustment Committee (CAC). A number of economic events have occurred in the community which precipitated the development of this committee. "The purpose of the committee is to develop a multifunctional plan (recommendations) for the broader community as a whole". The Ministry of Advanced Education and Skills Development (MAESD) is supporting the 8 month timeline set out for CAC. On September 8th, an orientation to the community adjustment program was provided by the MAESD. This program will guide work of the committee. Preliminary discussions during the orientation day indicate that the work of this committee will focus on developing recommendations for creating a "resilient" community. Laurie Zeppa, the Director of Health Promotion and Prevention is representing APH on this committee. As the health care representative, she will bring the broad community health view and ensure other areas of the health sector are consulted through this process. In addition to APH, the members consist of various representatives from education, business, social service, culture and labour. Involvement in this committee aligns to the "Enhance Health Equity" and "Collaborate Effectively" strategic directions.

Syrian Refugees
Algoma Public Health (APH) has participated in meetings to discuss the current updates on the Syrian Refugees settling in our community (Sault Ste. Marie) this summer. We continue to work with many agencies to provide seamless service as needed for these families. Currently the Sault Community Career Center (SCCC) is the lead agency for our area.

The SCCC is taking a great leadership role and is working to help the families connect with all programs and services they may need. They have dentists and doctors that have pre-registered to be able to take on the families as clients and will hopefully help guide them to other programs and services that they may need. In addition, the SCCC has two Arabic speaking staff members and a confidential translator they can call from

Thunder Bay for medical appointments. SAH also has two Arabic speaking psychologists on staff. More information is on the local website that you can review at http://refugee705.com

It appears that the City of Sault Ste. Marie is well positioned for the settling of Syrian Refugees in the community while ensuring personal health information is kept confidential.

APH has shared information on our services with the SCCC. Recently we have been asked to provide food preparation and nutrition training session for the new families in the Sault. They will be invited to our community kitchens and our dieticians will be able to help them with the new food choices and preparing nutritious meals. In addition our Healthy Smiles Ontario program maybe another service they would be interested in receiving.

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

APH Ontario Building Code (OBC) 2016 Annual report

Submitted to: Justin Pino for the Finance Committee

Submitted on: May 13, 2016

Algoma Public Health is Regulated under the Ontario Building Code Act section 1.7.1.1 General. Algoma Public Health is named the principal authority and is one of 6 northern Health Units responsible for the enforcement of the provisions of the Act and its Code related to sewage systems. The Code and Act can be found at: https://www.ontario.ca/laws/regulation/120332 . A provision under the Code is that each principal authority is required to present an annual report; this report will meet this requirement when released in the APH Board of Health Report.

Algoma Public health inspects and approves all sewage systems in the district of Algoma that have calculated daily sewage flows under 10, 000l/day (residential applications). The program is self-funded from the issuance of Building permits and other user paid fees. The following tables highlight the financial statement/revenue for 2014 and 2015.

Total Revenue for 2014 and 2015:

Revenue: Substantial completion, performance level reviews, Permits , consents, severances and file searches	Sault Ste. Marie	Blind River	Elliot Lake	Wawa	TOTAL
2014 Land Control Total	***$119,850***	***$25,771***	***$3,700***	***$1,650***	***$150,971***
2015 Land Control Totals	***$146, 070***	***$13,975***	***$2,970***	***$6,100***	***$169, 115***

Schedule "A" To By-Law 06-01 As amended on February 18, 2015	
Class 1 - Privy (outhouse, composting toilet, etc.)	No fee
Class 2 – Grey water system (leaching pit)	$250.00
Class 3 - Cesspool System	$250.00
Class 4 - Leaching bed system (septic tank and leaching bed)	$750.00
Class 4 - Tank replacement	$300.00
Class 4 - Leaching bed replacement / alteration	$500.00
Class 5 - Holding tank system	$500.00
Sewage system demolition / decommissioning	$100.00
Transfer of Permit	$50.00
Revision of Permit (no inspection required)	$100.00
Revision of Permit (inspection required)	$250.00

Staffing for 2015

OBC certified Public Health Inspectors (PHIs) in the program work throughout the district of Algoma. We have a PHI in Elliot Lake working for the east district and a PHI in the Sault Ste. Marie office that also covers the Algoma North (Wawa) area. Additional PHIs are used for back up in the program and during the busy season. Most of the applications are within the Sault Ste. Marie area as indicated above in the revenue. In addition each district office has clerical support; both the East District Manager and Environmental Health Manager also spend some time in this program.

Program Expenses

Algoma Public Health purchased a new truck for use in the land control program; the remote construction sites, distance on rural roads and the equipment that must be carried for this program provide the need to have a dedicated vehicle. The total cost for the truck was $33,704.87

New in 2015 was the initiating of annual fees to support the designation of the Public Health Inspectors (PHIs) in the program. APH and other designated authorities are now required to pay over $100 per registered PHI to maintain their registration annually. All PHIs with the designation are required to register to ensure we have coverage across the district for this program. See table below:

Number of Certified Building Inspectors at Algoma Public Health	Cost
8	$107
Total	$ 856

Highlights:

1) In addition to enforcing the OBC for Part VIII APH is also working to comply with local by-laws and regional set back requirements. More municipalities in the Algoma district are implementing additional set back requirements around waterways and lakes. We are attempting to comply with known by-laws and mapping them across the district, however it is the municipality's responsibility to enforce their own by-law.
2) In 2015 we met with local representatives from companies that own townships and have tenant occupants. In consultation with the owners of townships and due to the difficulty managing the township applications in unincorporated areas we made changes to our internal forms requiring both the owner and tenant to sign before we will process.

   Moving Forward:
3) To be certified to work under the OBC PHIs must pass two exams, one is the technical exam and the second is legal components and this requires attending a training session followed by the exam. For efficiency of time and cost APH arranged training and certification of our uncertified PHIs to be done locally the week of May 9-13, 2016. Our agency is committed to ongoing and continued training.

Respectfully Submitted by:

Sherri Cleaves
Chief Building Officer, Part VIII OBC
Algoma Public Health
BCIN#15265

ALGOMA PUBLIC HEALTH

FINANCE AND AUDIT COMMITTEE REPORT

FOR THE SEPTEMBER 28, 2016 BOARD MEETING

Meeting held on: September 14, 2016 – Started at 4:31 pm

In attendance:

Justin Pino, Joel Merrylees, Ian Frazier, Lee Mason, Candace Martin, Dennis Thompson (via teleconference)

Secretary – Christina Luukkonen

Justin provided an overview of the financial statements for the period ending July 31, 2016. At the same time the Committee discussed the Briefing Note that was presented regarding revising the monthly presentation of the financial statements to make it easier for everyone to read. The single largest modification related to breaking out the income and related expenditures by category; that being public health, calendar based community health programs and then fiscal based community health programs. This will allow a reader to quickly see the over/under budget by these categories which can easily identify a potential financial impact to the Health Unit. The Committee greatly appreciated the efforts of Justin and Joel to review and make changes based on feedback from the Committee and agree that is a step in the right direction and will continue to be fine-tuned as we progress.

As follow-up from our June meeting regarding our Capital Reserve Fund, it was presented to the Committee that management continued to communicate with the Ministry of Community and Social Services as to when our building would have its condition assessment completed. It is firmly believed that due to perseverance our assessment was moved up the list and is scheduled to be completed on September 16. Once completed and a copy obtained we can review the building's status and hopefully set any capital reserve requirements in time for the upcoming budget.

As follow-up from our June meeting regarding the mortgage renewal process, our original mortgage was coming due at the beginning of September with Royal Bank of Canada. A RFP was issued and two submissions were received and during our June meeting the Toronto Dominion Bank was chosen once a couple of items were clarified. With the due diligence of management and our legal team the renewal was completed on time and without incident. The mortgage has been renewed for a five (5) year term with a fixed rate along with a few negative covenants but none are expected to pose an issue to the Health Unit.

For information purposes only, the Committee was presented with the Infant Development Program Reconciliation to show what is typically completed for each program.

The Committee reviewed the Briefing Note regarding the renewal of the building automation and security services contract. Due to the significant annual cost of the contract and the equipment and software specialty, management presented to the Committee for review the sole source procurement for these services. Upon review it will be the Committee's recommendation to the Board for approval of this sole sourcing of services with Siemens Canada Ltd.

Next meeting is scheduled for November 9, 2016.

Meeting was adjourned at 5:52 pm.

Chair, Finance and Audit Committee
Algoma Public Health

9/20/16
Date

Algoma Public Health
Financial Statements
For the period ending: July 31, 2016

Algoma Public Health
Statement of Operations and Fund Balances
For the period ending: **July 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	$ 2,556,269	$ 1,983,212	$ 573,057	$ 3,399,791	129%
Provincial Grants -public health	5,832,227	5,693,217	139,010	9,759,800	102%
Provincial Grants - community health	2,870,081	2,880,782	(10,701)	7,641,618	100%
Fees, other grants and recovery of expenditures	313,141	480,786	(167,645)	824,204	65%
Dental Benefits Ontario Works Recoveries	195,054	0	195,054	-	
	$ 11,766,772	$ 11,037,996	$ 728,776	$ 21,625,413	107%
Expenditures					
Public Health Programs					
Public Health	$ 7,781,819	$ 8,155,882	$ 374,063	$ 13,983,797	95%
Community Health Programs					
Healthy Babies and Children	$ 600,835	$ 623,006	$ 22,172	$ 1,068,011	96%
Child Benefits Ontario Works	13,174	14,082	908	24,135	94%
Dental Benefits Ontario Works	178,440	-	(178,440)	-	
Algoma CADAP programs	109,596	123,853	14,257	212,320	88%
Misc Calendar	0	-	-	-	
Northern Ontario Fruit & Vegetable Program	49,841	41,146	(8,695)	117,400	121%
Brighter Futures for Children	33,473	39,983	6,510	114,447	84%
Infant Development	208,703	210,645	1,942	631,935	99%
Preschool Speech and Languages	175,462	204,752	29,290	614,256	86%
Nurse Practitioner	39,596	40,951	1,355	122,853	97%
Genetics Counseling	117,730	126,269	8,539	378,806	93%
Community Mental Health	1,061,956	1,131,566	69,611	3,219,298	94%
Community Alcohol and Drug Assessment	219,126	227,386	8,260	682,157	96%
Remedial Measures	9,230	-	(9,230)	-	
Diabetes	0	14,556	14,556	131,000	
Healthy Kids Community Challenge	48,576	60,064	11,488	225,000	81%
Stay on Your Feet	25,928	33,333	7,406	100,000	78%
Misc Fiscal	7,421	-	(7,421)	-	
	$ 10,680,905	$ 11,047,474	$ 366,569	$ 21,625,416	97%
Excess of revenues over expenses - CH	166,049				
Excess of revenues over exp. - Public Health	919,818				

Algoma Public Health
Revenue Statement
For the Seven Months Ending July 31, 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	4,467,295	4,373,717	93,578	60%	7,497,800	4,379,050	4,483,060	(104,010)
MOH One Time Funding	29,579	29,575	4	58%	50,700	26,129	29,573	(3,445)
MOH Funding Haines Food Safety	14,350	14,350	0	58%	24,600	14,309	14,311	(2)
MOH Funding CINOT/Healthy Smiles	276,802	239,517	37,285	67%	410,600	249,398	239,497	9,902
MOH Funding - Social Determinants of Health	105,293	105,292	1	58%	180,500	105,257	105,261	(5)
MOH Funding Vector Bourne Disease	63,407	63,408	(1)	58%	108,700	63,354	63,357	(3)
MOH Funding Chief Nursing Officer	70,879	70,875	4	58%	121,500	70,819	70,825	(6)
MOH Funding Safe Water	40,600	40,600	0	58%	69,600	40,576	40,578	(3)
MOH Enhanced Funding Safe Water	9,042	9,042	0	58%	15,500	9,036	9,042	(6)
MOH Funding Unorganized	291,843	291,842	1	58%	500,300	254,269	254,270	(1)
MOH One Time Funding Dental Health	27,967	19,833	8,134	82%	34,000	9,843	19,688	(9,844)
MOH Funding Infection Control	182,237	182,233	4	58%	312,400	182,165	182,174	(10)
Levies Sault Ste Marie	1,772,134	1,378,327	393,807	75%	2,362,846	973,019	1,113,996	(140,976)
Levies Sault Ste Marie Capital	0	0	0	0%	0	144,742	168,866	(24,124)
Levies Vector Bourne Disease	44,575	34,669	9,906	75%	59,433	32,977	38,473	(5,496)
Levies District	739,560	570,215	169,345	76%	977,512	508,262	504,651	3,611
Levies District Capital	0	0	0	0%	0	62,032	72,371	(10,339)
Recoveries from Programs	5,873	5,869	4	58%	10,061	7,826	5,869	1,957
Program Fees	125,283	144,167	(18,884)	51%	247,143	111,636	144,167	(32,531)
Land Control Fees	63,940	93,333	(29,393)	40%	160,000	69,065	93,333	(24,268)
Program Fees Immunization	104,963	93,333	11,630	66%	160,000	116,966	93,333	23,633
HPV Vaccine Program	3,018	5,833	(2,816)	30%	10,000	867	5,833	(4,966)
Influenza Program	1,405	35,000	(33,595)	2%	60,000	760	35,000	(34,240)
Meningococcal C Program	2,849	5,833	(2,984)	28%	10,000	255	5,833	(5,578)
Interest Revenue	5,810	1,167	4,643	290%	2,000	5,952	1,167	4,785
Other Revenues	0	96,250	(96,250)	0%	165,000	19,982	96,250	(76,268)
Funding Holding		0	0	0%	0	434	0	434
Funding Ontario Tobacco Strategy	252,933	252,933	(0)	58%	433,600	252,919	243,600	9,319
Elliot Lake Office Relocation	0	0	0	0%	0	0	0	0
Panorama	0	0	0	0%	0	0	0	0
First Nations Inititative -One Time	0	0	0	0%	0	112,214	0	112,214
	$ 8,701,637	$ 8,157,213	$ 544,424		$ 13,983,795	$ 7,824,112	$ 8,134,377	$ (310,266)
Summary								
Levies	2,556,269	1,983,211	573,058	129%	3,399,791	1,721,032	1,898,357	(177,324)
Funding Grants	5,832,227	5,693,217	139,010	102%	9,759,800	5,769,337	5,755,235	14,101
Fees & Recoveries	313,141	480,786	(167,645)	65%	824,204	333,743	480,786	(147,043)
	$ 8,701,637	$ 8,157,213	544,423	107%	$ 13,983,795	$ 7,824,112	$ 8,134,377	$ (310,266)

Algoma Public Health

Expense Statement- Public Health

For the Seven Months Ending July 31, 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	$ 4,512,332	$ 4,848,357	336,025	54%	$ 8,314,147	$ 4,551,398	$ 4,771,112	$ 219,714	1
Benefits	1,131,698	1,212,089	80,392	54%	2,078,537	1,113,432	1,192,780	79,347	2
Travel - Car Allowances	0	0	-	0%		43,351	36,143	(7,207)	3
Travel - Mileage	64,281	85,390	21,108	44%	146,784	80,888	73,178	(7,711)	3
Travel - Other	33,181	55,280	22,099	35%	95,301	44,921	73,680	28,759	3
Program	407,619	327,178	(80,441)	73%	557,306	540,039	428,255	(111,784)	4
Office	73,506	53,667	(19,839)	80%	92,000	27,100	76,971	49,871	4
Computer Services	391,511	522,613	131,101	44%	895,908	343,223	442,417	99,194	4
Telephone Charges	6,918	22,750	15,832	18%	39,000	8,493	28,153	19,661	5
Telecommunications	139,277	104,365	(34,912)	77%	180,483	71,260	99,727	28,468	5
Program Promotion	50,846	124,883	74,037	24%	214,085	66,530	123,423	56,894	4
Facilities Expenses	477,865	474,789	(3,076)	59%	813,924	380,803	442,809	62,007	6
Fees & Insurance	275,942	140,703	(135,239)	114%	241,205	272,218	163,036	(109,182)	7
Debt Management	271,531	266,000	(5,531)	60%	456,000	(52,402)	(83,304)	(30,902)	8
Recoveries	(54,688)	(82,182)	(27,494)	39%	(140,883)	0	0	0	9
	$ 7,781,819	$ 8,155,882	$ 374,063		$ 13,983,797	$ 7,757,167	$ 8,134,379	$ 377,212	

	Current YTD	2015	Total	Total % Spent	Total Budget
Elliot Lake Renovations	422,304	277,890	700,194	97%	724,960

Notes to Financial Statements – July 2016

Reporting Period

The July 2016 financial reports include seven months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, Child & Dental Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting four month results from operations year ended March 2017.

Public Health – Statement of Operations (see page 1)

General Comments

As of July 31st 2016, Public Health programs are reporting a surplus of approximately $919k.

On the Revenue side, the $573 positive variance is attributable to the timing of receipts of the municipal levies from the City of Sault Ste. Marie and the District. Provincial Grants – Public Health is showing a positive variance of $139k. This is associated with 2015 approved and settled one-time funding requests related to the Interim CEO Position and New Purpose-Built Vaccine Refrigerators. Fees, Other Grants & Recoveries are indicating a negative $167k variance as a result of timing of fees recovered by APH.

There is a positive variance of $374k related to Public Health Expenses being less than budgeted. This 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. Computer Services is also contributing to this positive variance. APH's 2016 Operating Budget was approved by the Board of Health in November of 2015 and included the buy-back of IT equipment. In December of 2015, the decision was made to buy-back leased IT equipment prior to 2016. Offsetting the positive contribution of Computer Services is the increase in legal fees incurred by APH to defend a public health policy issue. APH has submitted a one-time funding request to recoup these legal costs.

Community Health programs are reporting a surplus of $166k.

Dental Benefit Ontario Works Recoveries are being offset by the corresponding Dental Benefits Ontario Works Expense, neither of which has been budgeted.

Preschool Speech and Language is showing a positive $29k variance. This is a result of the timing of payment to the Children's Rehab Center for purchased services. The Community Mental Health program is indicating a positive $69k variance. This is a result of inherent time lag to fill vacant positions.

Notes Continued...

Revenue (see page 2 for details)

Public Health funding revenues are indicating a positive variance of $544k. Driving this is a $573k positive variance related to the timing of the municipal levy receipts from the City of Sault Ste. Marie and the District.

Funding Grants are operating relatively within budget. The $139k positive variance noted is primarily attributable to 2015 one-time funding requests related to the Interim CEO Position and the New Purpose-Built Vaccine Refrigerators. These funds were received in 2016 have been settled with the Ministry.

There is a negative variance of $167k associated with Fees & Recoveries. In an effort to balance the budget, recognition of deferred revenue was planned for 2016. Management will determine if this is required as the year progresses. This is impacting the negative $96k variance related to Other Revenues. The negative $29k variance associated with Land Control Fees and the negative $33k variance related to the Influenza Program should be reduced as the year progresses. 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 $336k 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 $80k. 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 $21k variance due to timing of employee claim submissions.

Travel - Other is showing a positive $22k variance. Staff travel typically occurs between the spring and fall months.

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

Program expense is indicating a negative $80k variance. The purchased services for the Acting MOH and Associate MOH roles are driving the noted variance.

Office expense is operating relatively within budget.

Computer Services is showing a positive variance of $131k. APH's 2016 Operating Budget was approved by the Board of Health in November of 2015 and included the buy-back of IT equipment. In December of 2015, the decision was made to buy-back leased IT equipment prior to 2016. This is driving the noted positive variance.

Notes Continued...

Program Promotion is showing a positive variance of $74k due to timing of expenditures not yet incurred.

Note 5 – Telephone Charges/Telecommunications

Telephone Charges are indicating a positive variance of $15k. Telecommunications is indicating a negative variance of $35k. When netted together Telephone/Telecommunications are operating relatively within budget.

Note 6 – Facilities Expenses/Renovations

Facilities Expenses is operating relatively within budget.

Note 7 – Fees & Insurance

Fees & Insurance is indicating a negative variance of $135k. 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 $5k. 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 $27k. This is a result of recoveries being less than budgeted. Revisions to the budgeted Recoveries figure will be implemented in the 2017 APH Budget.

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 July 31st, 2016. Cash includes $.324 million in short-term investments.

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.

Long term debt of $5.625 million is held by the Royal Bank @ 2.76% for a 60 month term (amortization period of 240 months). The loan matures on September 1, 2016.

The Board of Health has awarded the refinancing of its loans (Elliot Lake leasehold improvements and Sault Ste. Marie building) to TD Bank for the next 60 month term (amortization period of 180 months) upon the upcoming maturity of the current term.

Notes Continued…

There are no material collection concerns for accounts receivable. Letters were issued by APH to three participating municipalities regarding late levy payments. APH is awaiting a response.

Algoma Public Health
Statement of Financial Position

Date: As of July 2016	July 2016	December 2015
Assets		
Current		
Cash & Investments	$ **2,202,960**	$ 2,368,709
Accounts receivable	581,567	658,510
Receivable from municipalities	**113,166**	5,134
Receivable from Province of Ontario	-	
Subtotal Current Assets	***2,897,693***	*3,032,353*
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**953,681**	1,490,132
Payable to Gov't of Ont/Municipalities	**294,966**	641,766
Deferred Revenue	**760,887**	664,615
Employee Future Benefit Obligations	**2,453,960**	2,453,960
Capital Lease Obligation	**0**	107,264
Term Loan	**6,173,490**	6,173,490
Subtotal Current Liabilities	**10,636,984**	11,531,227
Net Debt	**-7,739,291**	-8,498,874
Non-Financial Assets:		
Building Construction in Progress	**22,732,421**	22,732,421
Furniture & Fixtures	**1,914,772**	1,914,772
Leasehold Improvements	**1,169,635**	1,169,635
IT	**3,029,040**	3,029,040
Automobile	**40,113**	40,113
Accumulated Depreciation	**-6,880,999**	-6,880,999
Subtotal Non-Financial Assets	**22,004,981**	22,004,981
Accumulated Surplus	**14,265,690**	13,506,107

Algoma Public Health
Financial Statements July 31, 2016

Algoma Public Health
Statement of Operations
July 2016

	Actual YTD 2016	Budget YTD 2016	Variance Act. to Bgt. 2016	Annual Budget 2016	Variance % Act. to Bgt. 2016	YTD Actual/ YTD Budget 2016
Public Health Programs						
Revenue						
Municipal Levy - Public Health	$ 2,556,269	$ 2,549,843	$ 6,426	$ 3,399,791	0%	100%
Provincial Grants - Public Health 75% Prov. Funded	4,460,269	4,497,558	(37,289)	7,710,100	-1%	99%
Provincial Grants - Public Health 100% Prov. Funded	1,232,958	1,195,658	37,300	2,049,700	3%	103%
Fees, other grants and recovery of expenditures	313,141	480,786	(167,645)	824,204	-35%	65%
Provincial Grants - Fiscal	0		-			
Provincial Grants - Funding for Prior Yr Expenses	139,000		139,000			
Total Public Health Revenue	$ 8,701,637	$ 8,723,846	$ (22,209)	$ 13,983,795	0%	100%
Expenditures						
Public Health 75% Prov. Funded Programs	$ 6,772,748	$ 6,969,075	$ (196,327)	$ 11,934,098	-3%	97%
Public Health 100% Prov. Funded Programs	1,009,071	1,186,807	(177,736)	2,049,700	-15%	85%
Public Health Fiscal						
Total Public Health Programs Expenditures	$ 7,781,819	$ 8,155,882	$ (374,063)	$ 13,983,797	-5%	95%
Excess of Rev. over Exp. 75% Prov. Funded	$ 556,931	$ 559,113	$ (2,181)	$ (3)		
Excess of Rev. over Exp. 100% Prov. Funded	223,887	8,851	215,035	0		
Excess of Rev. over Fiscal Funded	-	-	-	-		
Provincial Grants for Prior Yr Expenses	139,000		139,000			
Total Rev. over Exp. Public Health	$ 919,818	$ 567,964	$ 351,854	$ (2)		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ 623,011	$ 623,006	$ 5	$ 1,068,011	0%	100%
Municipal, Federal, and Other Funding	165,145	137,932	17,213	236,455	12%	112%
Dental Benefits Ontario Works Recoveries	195,054		195,054			
Total Community Health Revenue	$ 973,210	$ 760,939	$ 212,272	$ 1,304,466	28%	128%
Expenditures						
Healthy Babies and Children	$ 600,835	$ 623,006	$ (22,172)	$ 1,068,011	-4%	96%
Child Benefits Ontario Works	13,174	14,082	(908)	24,135	-6%	94%
Dental Benefits Ontario Works	178,440		178,440			
Algoma CADAP programs	109,596	123,853	(14,257)	212,320	-12%	88%
Total Calendar Community Health Programs	$ 902,045	$ 760,941	$ 141,103	$ 1,304,466	19%	119%
Total Rev. over Exp. Calendar Community Health	$ 71,166	$ (3)	$ 71,169	$ 0		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 1,830,843	$ 1,874,989	$ (44,146)	$ 5,712,299	-2%	98%
Municipal, Federal, and Other Funding	249,056	244,855	4,201	800,253	2%	102%
Other Bill for Service Programs	12,026		12,026			
Total Community Health Revenue	$ 2,091,925	$ 2,119,844	$ (27,919)	$ 6,512,552	-1%	99%
Expenditures						
Northern Ontario Fruit & Vegetable Program	49,841	41,146	$ 8,695	117,400	21%	121%
Brighter Futures for Children	33,473	39,983	(6,510)	114,447	-16%	84%
Infant Development	208,703	210,645	(1,942)	631,935	-1%	99%
Preschool Speech and Languages	175,462	204,752	(29,290)	614,256	-14%	86%
Nurse Practitioner	39,596	40,951	(1,355)	122,853	-3%	97%
Genetics Counseling	117,730	126,269	(8,539)	378,806	-7%	93%
Community Mental Health	1,061,956	1,131,566	(69,610)	3,394,698	-6%	94%
Community Alcohol and Drug Assessment	219,126	227,386	(8,260)	682,157	-4%	96%
Diabetes	0	14,556	(14,556)	131,000	-100%	0%
Healthy Kids Community Challenge	48,576	60,064	(11,488)	225,000	-19%	81%
Stay on Your Feet	25,928	33,333	(7,406)	100,000	-22%	78%
Bill for Service Programs	16,652	-	16,652	-		
Misc Fiscal	0	-	-	-		
Total Fiscal Community Health Programs	$ 1,997,042	$ 2,130,651	$ (133,608)	$ 6,512,553	-6%	94%
Total Rev. over Exp. Fiscal Community Health	$ 94,883	$ (10,807)	$ 105,690	$ (0)		

Algoma Public Health
Revenue Statement
For the Seven Months Ending July 31, 2016

	Actual YTD 2016	Budget YTD 2016	Variance Act. to Bgt. 2016	Annual Budget 2016	Variance % Act. to Bgt. 2016	YTD Actual/ YTD Budget 2016	*Comparison Prior Year:* YTD Actual 2015	YTD BGT 2015	Variance 2015
Levies Sault Ste Marie	1,772,134	1,772,134	0	2,362,846	0%	75%	973,019	1,113,996	(140,976)
Levies Sault Ste Marie Capital	0	0	0	0		0%	144,742	168,866	(24,124)
Levies Vector Bourne Disease and Safe Water	44,575	44,575	0	59,433	0%	75%	32,977	38,473	(5,496)
Levies District	739,560	733,134	6,426	977,512	1%	76%	508,262	504,651	3,611
Levies District Capital	0	0	0	0		0%	62,032	72,371	(10,339)
Total Levies	**2,556,269**	**2,549,843**	**6,426**	**3,399,791**	**0%**	**75%**	**1,721,032**	**1,898,357**	**(177,324)**
MOH Public Health Funding	4,328,295	4,373,717	(45,422)	7,497,800	-1%	58%	4,379,050	4,483,060	(104,010)
MOH Funding Vector Bourne Disease	63,407	63,408	(1)	108,700	0%	58%	63,354	63,357	(3)
MOH One Time Funding Dental Health	27,967	19,833	8,134	34,000	41%	82%	9,843	19,688	(9,844)
MOH Funding Safe Water	40,600	40,600	0	69,600	0%	58%	40,576	40,578	(3)
Total Public Health 75% Prov. Funded	**4,460,269**	**4,497,558**	**(37,289)**	**7,710,100**	**-1%**	**58%**	**4,492,822**	**4,606,682**	**(113,860)**
MOH One Needle Exchange	29,579	29,575	4	50,700	0%	58%	26,129	29,573	(3,445)
MOH Funding Haines Food Safety	14,350	14,350	0	24,600	0%	58%	14,309	14,311	(2)
MOH Funding CINOT/Healthy Smiles	276,802	239,517	37,285	410,600	16%	67%	249,398	239,497	9,902
MOH Funding - Social Determinants of Health	105,293	105,292	1	180,500	0%	58%	105,257	105,261	(5)
MOH Funding Chief Nursing Officer	70,879	70,875	4	121,500	0%	58%	70,819	70,825	(6)
MOH Enhanced Funding Safe Water	9,042	9,042	0	15,500	0%	58%	9,036	9,042	(6)
MOH Funding Unorganized	291,843	291,842	1	500,300	0%	58%	254,269	254,270	(1)
MOH Funding Infection Control	182,237	182,233	4	312,400	0%	58%	182,165	182,174	(10)
Funding Ontario Tobacco Strategy	252,933	252,933	(0)	433,600	0%	58%	252,919	243,600	9,319
Total Public Health 100% Prov. Funded	**1,232,958**	**1,195,658**	**37,300**	**2,049,700**	**3%**	**60%**	**1,164,301**	**1,148,553**	**15,748**
Funding for Prior Yr Expenses	**139,000**	**0**	**139,000**						
Recoveries from Programs	5,873	5,869	4	10,061	0%	58%	7,826	5,869	1,957
Program Fees	125,283	144,167	(18,884)	247,143	-13%	51%	111,636	144,167	(32,531)
Land Control Fees	63,940	93,333	(29,393)	160,000	-31%	40%	69,065	93,333	(24,268)
Program Fees Immunization	104,963	93,333	11,630	160,000	12%	66%	116,966	93,333	23,633
HPV Vaccine Program	3,018	5,833	(2,816)	10,000	-48%	30%	867	5,833	(4,966)
Influenza Program	1,405	35,000	(33,595)	60,000	-96%	2%	760	35,000	(34,240)
Meningococcal C Program	2,849	5,833	(2,984)	10,000	-51%	28%	255	5,833	(5,578)
Interest Revenue	5,810	1,167	4,643	2,000	398%	290%	5,952	1,167	4,785
Other Revenues	0	96,250	(96,250)	165,000	-100%	0%	19,982	96,250	(76,268)
Funding Holding		0	0	0		0%	434	0	434
Total Fees, Other Grants and Recoveries	**313,141**	**480,786**	**(167,645)**	**824,204**	**-35%**	**38%**	**333,743**	**480,786**	**(147,043)**
Panorama	0	0	0	0		0%	0	0	0
First Nations Inititative -One Time	0	0	0	0		0%	112,214	0	112,214
Total Provincial Grants Fiscal	0	0	0	0		0%	112,214	0	112,214
Total Public Health Revenue	**$ 8,701,637**	**$ 8,723,845**	**$ (22,209)**	**$ 13,983,795**	**0%**	**62%**	**$ 7,824,112**	**$ 8,134,377**	**$ (310,266)**

Algoma Public Health

Expense Statement- Public Health

For the Seven Months Ending July 31, 2016

	Actual YTD 2016	Budget YTD 2016	Variance Act. to Bgt. 2016	Annual Budget 2016	Variance % Act. to Bgt. 2016	YTD Actual/ YTD Budget 2016	*Comparison Prior Year:* YTD Actual 2015	YTD BGT 2015	Variance 2015
Salaries & Wages	$ 4,512,332	$ 4,848,357	336,025	$ 8,314,147	-7%	54%	$ 4,551,398	$ 4,771,112	$ 219,714
Benefits	1,131,698	1,212,089	80,392	2,078,537	-7%	54%	1,113,432	1,192,780	79,347
Travel - Car Allowances	0	0	-			0%	43,351	36,143	(7,207)
Travel - Mileage	64,281	85,390	21,108	146,784	-25%	44%	80,888	73,178	(7,711)
Travel - Other	33,181	55,280	22,099	95,301	-40%	35%	44,921	73,680	28,759
Program	407,619	327,178	(80,441)	557,306	25%	73%	540,039	428,255	(111,784)
Office	73,506	53,667	(19,839)	92,000	37%	80%	27,100	76,971	49,871
Computer Services	391,511	522,613	131,101	895,908	-25%	44%	343,223	442,417	99,194
Telephone Charges	6,918	22,750	15,832	39,000	-70%	18%	8,493	28,153	19,661
Telecommunications	139,277	104,365	(34,912)	180,483	33%	77%	71,260	99,727	28,468
Program Promotion	50,846	124,883	74,037	214,085	-59%	24%	66,530	123,423	56,894
Facilities Expenses	477,865	474,789	(3,076)	813,924	1%	59%	380,803	442,809	62,007
Fees & Insurance	275,942	140,703	(135,239)	241,205	96%	114%	272,218	163,036	(109,182)
Debt Management	271,531	266,000	(5,531)	456,000	2%	60%	(52,402)	(83,304)	(30,902)
Recoveries	(54,688)	(82,182)	(27,494)	(140,883)	-33%	39%	0	0	0
	$ 7,781,819	$ 8,155,882	$ 374,063	$ 13,983,797	-5%	56%	$ 7,757,167	$ 8,134,379	$ 377,212

	Current YTD	*2015*	*Total*	Total Budget	*Total % Spent*
Elliot Lake Renovations	422,304	277,890	700,194	724,960	97%

Notes to Financial Statements – July 2016

Reporting Period

The July 2016 financial reports include seven months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, Child & Dental Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting four month results from operations year ended March 2017.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of July 31st 2016, Public Health programs are reporting a surplus of approximately $351k.

On the Revenue side, municipal levies are operating relatively within budget. Provincial Grants are also operating relatively within budget. Fees, Other Grants & Recoveries are indicating a negative $167k variance as a result of timing of fees recovered by APH. Provincial Grants – Funding from prior years is showing a positive variance of $139k. This is associated with 2015 approved and settled one-time funding requests related to the Interim CEO Position and New Purpose-Built Vaccine Refrigerators.

There is a positive variance of $374k related to Public Health Expenses being less than budgeted. This 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. Computer Services is also contributing to this positive variance. APH's 2016 Operating Budget was approved by the Board of Health in November of 2015 and included the buy-back of IT equipment. In December of 2015, the decision was made to buy-back leased IT equipment prior to 2016. Offsetting the positive contribution of Computer Services is the increase in legal fees incurred by APH to defend a public health policy issue. APH has submitted a one-time funding request to recoup these legal costs.

Community Health Calendar programs are reporting a surplus of $71k.

On the revenue side, $195k positive variance is associated with Dental Benefits Ontario Works as these funds are not budgeted. This is being offset by the corresponding expenses related to this program that are also not budgeted.

Community Health Fiscal programs are indicating a positive $105k variance.

On the revenue side, there is a $44k negative variance related to funding for Community Mental Health Transformational Housing. APH has yet to receive these funds however indications from the North East LHIN is that it is forthcoming.

On the Expense side, Preschool Speech and Language is showing a positive $29k variance. This is a result of the timing of payment to the Children's Rehab Center for purchased services. The Community Mental Health program is indicating a positive $69k variance. This is a result of inherent time lag to fill vacant positions.

Notes Continued...

Public Health Revenue (see page 2 for details)

Public Health funding revenues are showing a negative $22k variance.

The municipal levies are showing a positive $6k variance.

Funding Grants are operating relatively within budget.

There is a negative variance of $167k associated with Fees, Other Grants & Recoveries which is driving the overall negative variance of Public Health Revenues. In an effort to balance the budget, recognition of deferred revenue was planned for 2016. Management will determine if this is required as the year progresses. This is impacting the negative $96k variance related to Other Revenues. The negative $29k variance associated with Land Control Fees and the negative $33k variance related to the Influenza Program should be reduced as the year progresses. APH typically captures the bulk of its fees between the spring and fall months.

Public Health Expenses (see page 3)

Note1 & 2– Salaries/Benefits

The positive variance of $336k 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 $80k. 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 $21k variance due to timing of employee claim submissions.

Travel - Other is showing a positive $22k variance. Staff travel typically occurs between the spring and fall months.

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

Program expense is indicating a negative $80k variance. The purchased services for the Acting MOH and Associate MOH roles are driving the noted variance.

Office expense is operating relatively within budget.

Computer Services is showing a positive variance of $131k. APH's 2016 Operating Budget was approved by the Board of Health in November of 2015 and included the buy-back of IT equipment. In

Notes Continued...

December of 2015, the decision was made to buy-back leased IT equipment prior to 2016. This is driving the noted positive variance.

Program Promotion is showing a positive variance of $74k due to timing of expenditures not yet incurred.

Note 5 – Telephone Charges/Telecommunications

Telephone Charges are indicating a positive variance of $15k. Telecommunications is indicating a negative variance of $35k. When netted together Telephone/Telecommunications are operating relatively within budget.

Note 6 – Facilities Expenses/Renovations

Facilities Expenses is operating relatively within budget.

Note 7 – Fees & Insurance

Fees & Insurance is indicating a negative variance of $135k. 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 $5k. 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 $27k. This is a result of recoveries being less than budgeted. Revisions to the budgeted Recoveries figure will be implemented in the 2017 APH Budget.

Non Public Health Programs Revenue and Expenses (see page 1)

All Non Public Health Programs are operating without budget issues.

Notes Continued...

Financial Position - Balance Sheet (see page 7)

Our cash flow position continues to be stable and the bank has been reconciled as of July 31st, 2016. Cash includes $.324 million in short-term investments.

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.

Long term debt of $5.625 million is held by the Royal Bank @ 2.76% for a 60 month term (amortization period of 240 months). The loan matures on September 1, 2016.

The Board of Health has awarded the refinancing of its loans (Elliot Lake leasehold improvements and Sault Ste. Marie building) to TD Bank for the next 60 month term (amortization period of 180 months) upon the upcoming maturity of the current term.

There are no material collection concerns for accounts receivable. Letters were issued by APH to three participating municipalities regarding late levy payments. APH is awaiting a response.

Algoma Public Health
Statement of Financial Position

Date: As of July 2016	July 2016	December 2015
Assets		
Current		
Cash & Investments	$ **2,202,960**	$ 2,368,709
Accounts Receivable	**581,567**	658,510
Receivable from Municipalities	**113,166**	5,134
Receivable from Province of Ontario		
Subtotal Current Assets	**2,897,693**	3,032,353
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**953,681**	1,490,132
Payable to Gov't of Ont/Municipalities	**294,966**	641,766
Deferred Revenue	**760,887**	664,615
Employee Future Benefit Obligations	**2,453,960**	2,453,960
Capital Lease Obligation	**0**	107,264
Term Loan	**6,173,490**	6,173,490
Subtotal Current Liabilities	**10,636,984**	11,531,227
Net Debt	**-7,739,291**	-8,498,874
Non-Financial Assets:		
Building Construction in Progress	**22,732,421**	22,732,421
Furniture & Fixtures	**1,914,772**	1,914,772
Leasehold Improvements	**1,169,635**	1,169,635
IT	**3,029,040**	3,029,040
Automobile	**40,113**	40,113
Accumulated Depreciation	**-6,880,999**	-6,880,999
Subtotal Non-Financial Assets	**22,004,981**	22,004,981
Accumulated Surplus	**14,265,690**	13,506,107

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION I: SUMMARY, CERTIFICATION and VERIFICATION

SERVICE PROVIDER / DELIVERY AGENT: Board of Health for the District of Algoma Health Unit

FOR THE YEAR ENDED: March 31, 2016

SERVICE CONTRACT/CFSA APPROVAL NUMBER: 0

PART A: SUMMARY

LINE	SERVICES		Executive and Allotment Control	Total Eligible Expenditures (pending final Ministry review and approval)	Total Approved Ministry Funding	Summary of Revised Ministry Funding after Financial Flexibility (pending final Ministry review and approval)
100	Detail Code #	Service (Detail Code) Name				
101	A478	Infant Development	CYSEX034-AL09	$ 621,935	$ 621,935	$ 621,935
102	A771	Community Capacity Building	CYSEX032-AL02	$ 44,051	$ 44,051	$ 44,051
103	0			$ -	$ -	$ -
104	0			$ -	$ -	$ -
105	0			$ -	$ -	$ -
106	0			$ -	$ -	$ -
107	0			$ -	$ -	$ -
108	0			$ -	$ -	$ -
109	0			$ -	$ -	$ -
110	0			$ -	$ -	$ -
111	0			$ -	$ -	$ -
112	0			$ -	$ -	$ -
113	0			$ -	$ -	$ -
114	0			$ -	$ -	$ -
115	0			$ -	$ -	$ -
116	0			$ -	$ -	$ -
117	0			$ -	$ -	$ -
118	0			$ -	$ -	$ -
119	0			$ -	$ -	$ -
120	0			$ -	$ -	$ -
121	0			$ -	$ -	$ -
122	0			$ -	$ -	$ -
123	0			$ -	$ -	$ -
124	0			$ -	$ -	$ -
125	0			$ -	$ -	$ -
126	0			$ -	$ -	$ -
127	0			$ -	$ -	$ -
128	0			$ -	$ -	$ -
129	0			$ -	$ -	$ -
130	0			$ -	$ -	$ -
131	0			$ -	$ -	$ -
132	0			$ -	$ -	$ -
133	0			$ -	$ -	$ -
134	0			$ -	$ -	$ -
135	0			$ -	$ -	$ -
136	0			$ -	$ -	$ -
137	0			$ -	$ -	$ -
138	0			$ -	$ -	$ -
139	0			$ -	$ -	$ -
140	0			$ -	$ -	$ -
141	0			$ -	$ -	$ -
142	0			$ -	$ -	$ -
TOTAL				$ 665,986	$ 665,986	$ 665,986

PART B: CERTIFICATION BY SERVICE PROVIDER / DELIVERY AGENT AUTHORITY

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

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

Tony Hanlon

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

Chief Executive Officer

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

27/07/16

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

PART C: VERIFICATION BY THE BOARD OF DIRECTORS

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

the Board of Directors on the _____ day of _____, _____ **(LINE 160)**

Chairperson of the Board of Directors: _____ **(LINE 170)**

Signature

Kenneth Mason

Name of Chairperson or Designate

Board Chair

Title

TRANSFER PAYMENT ANNUAL RECONCILIATION

SECTION IV: AUDITED FINANCIAL STATEMENT RECONCILIATION

SERVICE PROVIDER / DELIVERY AGENT:	Board of Health for the District of Algoma Health Unit
FOR THE YEAR ENDED:	March 31, 2016
SERVICE CONTRACT/CFSA APPROVAL NUMBER:	0

LINE			
400	**TOTAL GROSS REVENUES PER AUDITED FINANCIAL STATEMENTS**		$ 665,986
401	**LESS: Non Funded Ministry (MCYS) Revenue (i.e. funding from other sources not related to ministry servic**		$ -
402	**Adjustments for Revenues from Ministry Funding calculation**		
403	Less: Non Retainable Revenues		
404		Specify (e.g. Expenditure Recoveries)	$ -
405		Specify (e.g. Offsetting Revenues)	$ -
406		Specify (e.g. Specific Operating Donations)	$ -
407		Specify (e.g. Inter-Agency Chargebacks)	$ -
408	Less: Amortization of Deferred Revenue		$ -
409	Less: Other (specify)_____		$ -
410	Less: Other (specify)_____		$ -
		Subtotal	$ -
411	Add: One-Time Capital Expenditures Approved & not included in Revenue		$ -
412	Add: Other (specify)_____		$ -
413	Add: Other (specify)_____		$ -
414		**Subtotal**	$ -
415	**Total Revenue Reported (Line 400 - Line401 - Line 404 to Line 410 + Line 414)**		$ 665,986
420	**Total Approved Ministry Funding (Total of LINE 223)** *(Lines 415 and 420 should equal)*		$ 665,986
440	**TOTAL GROSS EXPENDITURES PER AUDITED FINANCIAL STATEMENTS**		$ 665,986
441	**LESS: Non Funded Ministry (MCSS) Expenditures (i.e. expenditures from other services not related to ministry services)**		$ -
442	**Adjustments for Inadmissible Expenditures related to Ministry Funded Programs**		
443	Less: Accruals (Payables greater than 30 day i.e. Vacation/Sick Accrual)		$ -
444	Less: Appropriations		$ -
445	Less: Amortization on Capital Assets		$ -
446	Less: Donations to Individuals or Organizations		$ -
447	Less: Fundraising Costs		$ -
448	Less: Loans to Clients or Staff		$ -
449	Less: Retainer Fees		$ -
450	Less: Provisions for Bad Debt		$ -
451	Less: In Kind		$ -
452	Less: Other (specify)_____		$ -
453	Less: Other (specify)_____		$ -
		Subtotal	$ -
	LESS: Other Adjustments		
455	Less: Expenditure Recoveries/ Offsetting Revenues		$ -
456	Less: Other (specify)_____		$ -
457	Less: Other (specify)_____		$ -
		Subtotal	$ -
460	**ADD: Adjustments for Admissible Expenditures, attach prior approval documentation**		
461	Add: One-Time Capital Expenditures Approved & Capitalized		$ -
462	Add: Other (specify)_____		$ -
463	Add: Other (specify)_____		$ -
		Subtotal	$ -
475	**Total Ministry (MCYS) Eligible Expenditures reported in the Audited Financial Statements**		$ 665,986
480	**Total Eligible Expenditures (Total of LINE 269)**		$ 665,986
490	Variance		$ -

Variance Explanation:

491	**Retained Earning**	$ -
492	**Total Assets**	$ -
493	**Total Debt**	$ -

(Please attach additional sheets if necessary or if the space is insufficient to complete the above reconciliation)

Financial Information of

ALGOMA PUBLIC HEALTH

Infant Development Program

(unaudited)

Year ended March 31, 2016

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

REVIEW ENGAGEMENT REPORT

To the Members of the Board of the Algoma Public Health

At the request of Algoma Public Health, we have reviewed the statement of revenue and expenditures of the Infant Development Program of the Algoma Public Health for the year ended March 31, 2016. Our review was made in accordance with Canadian generally accepted standards for review engagements and accordingly consisted of primarily inquiry, analytical procedures and discussion related to information supplied to us by the management. Our review was performed to determine whether the information presented is consistent with management's financial records of the Algoma Public Health and Ministry of Community and Social Services year-end settlement form for the program.

A review does not constitute an audit and, consequently, we do not express an audit opinion on the statement of revenue and expenditures.

Based on our review, nothing has come to our attention that causes us to believe that the statement of revenue and expenditures is not, in all material respects, in accordance with the basis of presentation as required by Ministry of Children and Youth Services.

KPMG LLP

Chartered Professional Accountants, Licensed Public Accountants

July 20, 2016
Sault Ste. Marie, Canada

ALGOMA PUBLIC HEALTH

Infant Development Program

Statement of Revenue and Expenditures
(unaudited)

Year ended March 31, 2016, with comparative information for 2015

	Budget	2016	2015
Revenue:			
Provincial grants	$ 621,935	$ 621,935	$ 621,935
Community capacity building	44,051	44,051	44,051
	665,986	665,986	665,986
Expenditures:			
Salaries and benefits	508,426	508,426	507,426
Occupancy	50,354	50,534	51,014
Community capacity building costs	44,051	44,051	44,051
Travel and training	34,000	34,000	30,446
Administration	16,000	16,000	16,000
Program materials and supplies	14,255	14,004	14,061
Telephone	5,400	5,319	6,313
Equipment	–	152	1,497
Professional development	3,500	3,500	3,337
Expenses recovered	(10,000)	(10,000)	(9,887)
	665,986	665,986	664,258
Excess of revenue over expenditures	$ –	$ –	$ 1,728

See accompanying note to financial information.

ALGOMA PUBLIC HEALTH

Infant Development Program

Note to Financial Information
(unaudited)

Year ended March 31, 2016

Basis of accounting:

The statement of revenue and expenditures report has been prepared in accordance with the basis of presentation as required by Ministry of Children and Youth Services. The following principles have been applied:

- Revenue and expenses are reported on the accrual basis of accounting.
- Capital expenditures are recorded as expenses rather than being capitalized.

Algoma PUBLIC HEALTH
Santé publique Algoma

www.algomapublichealth.com

Briefing Note

To: Board of Health

From: Dr. Tony Hanlon, CEO
Justin Pino, CFO

Date: September 28, 2016

Re: Renewal of Building Automation and Security Services Contract

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Algoma Public Health's (APH) current contract with its building automation and security services provider for its 294 Willow Avenue location expired at the end of June 2016. APH extended the contract on a 3 month basis to ensure the Board of Health would have appropriate information to assess the contract prior to renewal. Specifically, Section 6.1 Contract/Leases of APH's Procurement policy states the following:

The Board of Health must approve contracts where:

a) Irregularities preclude the award of a contract to the lowest bidder in the Tendering and Request for Quotation process and the 'total acquisition costs' exceeds $50,000
b) A bid solicitation has been restricted to a single source supply and the total acquisition cost of such goods or services exceeds $50,000
c) The contract/lease is for multiple years and exceeds $50,000

Conditions b) and c) are relevant in this case, therefore require board approval.

RECOMMENDED ACTION:

It is recommended that the Finance and Audit Committee recommend approval to the Board of Health for:

1. Sole source procurement of HVAC control services and security services related to building card access system for its 294 Willow Avenue location.
2. The execution of the building automation and security services contract/lease with Siemens Canada Ltd.

BACKGROUND:

At the time of construction of the 294 Willow Avenue building in Sault Ste. Marie in 2011, the architect involved helped in drafting and securing preventive maintenance contracts between APH and critical mechanical, electrical and controls vendors. One of those contracts was with

Siemens Canada Ltd. for building automation and security services related to HVAC control services and the building card access system. Siemens is the manufacturer of the proprietary hardware and software currently installed throughout the 294 Willow Avenue building.

Services which Siemens Canada Ltd. will provide to APH include:

- Emergency Online/Phone Response
  - ✓ System and software troubleshooting and diagnostics
- Emergency Onsite Response
  - ✓ Designed to reduce disruptions of downtime when unexpected problems occur
- Replacement & Labour Discount
  - ✓ Preferred labour pricing
- Replacement & Repair Materials Discount
  - ✓ Preferred service parts pricing
- Preventative Maintenance
  - ✓ Designed to extend equipment life, reduce energy consumption and reduce risk of breakdowns (monthly visitis)
- Data Protection & Data Recovery Services
  - ✓ Scheduled database back-ups and safe storage of information
- Software Maintenance
  - ✓ Remote service and onsite visits
- Control Loop Tuning
  - ✓ Ensures devices such as valves, dampers, actuators, etc., experience minimized overshooting behavior
- Network Maintenance
  - ✓ Proactive calibration and tuning of data network analyses variables impacting network performance
- Software Supports & Updates
  - ✓ Will provide software updates and training

A Sole Source Justification form is attached in Appendix 1.

FINANCIAL IMPLICATIONS:

The financial commitment of the building automation and security service contract is noted below. It is a 5 year Preventative Maintenance agreement.
Services include 12 visits per year (monthly) annual software upgrades and phone service support as required. Emergency call or repairs not included in the agreement.

Year 1: $51,665 + HST
Year 2: $53,215 + HST
Year 3: $54,765+ HST
Year 4: $56,355 + HST
Year 5: $58,000 + HST

TOTAL value of contract: $274,000 + HST

CONTACT:

J. Pino, Chief Financial Officer

Appendix 1

ALGOMA PUBLIC HEALTH
SOLE SOURCE PROCUREMENT JUSTIFICATION FORM

Date Submitted	June 29/16
Program	Administration – Facilities
Product/Service:	**Siemens Building Automation & Security**
Budget Code:	7120-10-190
Provider:	Siemens Canada Ltd. Building Technologies 1108 Webbwood Dr. Sudbury, ON P3C 3B7
Staff requesting	
Program Manager	Manager Building and Facilities
Program Director	CFO/Director of Operations

Situational Assessment:
Algoma Public Health's current contract with Siemens Canada Ltd. Building Technologies expired at the end of June 2016.

The services provided include building automation and security services related to HVAC control services and the building card access system. Siemens is the manufacturer of the proprietary hardware and software currently installed throughout Algoma Public Health's building located at 294 Willow Avenue in Sault Ste. Marie.

Sole Source Procurement Justification: (*Please Reference applicable conditions as per Section 5.5 of APH's Procurement Policy 02-04-030)*

- Compatibility of a purchase with existing equipment, facilities, or services is a paramount consideration
    - Siemens is the manufacturer of the building automation and security equipment currently installed at the 294 Willow Avenue offices of at APH. Siemens is the only provider of the proprietary software used. Siemens created the custom software configuration in the system and provided the application engineering for the project. Siemens is the only service provider who can program the building automation and security panels.

- Where it is most cost effective or beneficial to APH
    - A significant financial commitment was made to this equipment at the time of construction of the building in 2011.
    - If another firm tested and inspected the equipment, and any issues arose, Siemens would generally need to be called in.

- When the procurement is for technical services in connection with the assembly, installation or servicing of equipment of a highly technical or specialized nature
    - Siemens is the only provider who can provide a manufacturer's extended warranty, including free firmware upgrades.
    - Only Siemens can offer compete servicing of the Siemens equipment in APH's building.
    - Only Siemens will receive information on Siemens equipment they are attempting to service.

Staff and Management recommend that APH procure the services of Siemens Canada Ltd. Building Technologies for the building automation and security of APH's 294 Willow Avenue location.

Program Manager Signature: _____

Program Director Signature: _____

Chief Executive Officer Signature (if required) _____

Boar Chair Signature (if required): _____

ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE MEETING
JUNE 8, 2016 @4:30 p.m.
PRINCE MEETING ROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Ian Frazier	Candace Martin
	Dennis Thompson	
APH STAFF PRESENT:	Tony Hanlon, Ph.D.	Chief Executive Officer
	Justin Pino	Chief Financial Officer
	Christina Luukkonen	Recording Secretary

1) CALL TO ORDER:
Mr. Frazier called the meeting to order at 4:34pm.

2) DECLARATION OF CONFLICT OF INTEREST
Mr. Frazier called for any conflict of interests; none were reported.

3) ADOPTION OF AGENDA ITEMS

FC2016-29 Moved: L. Mason
Seconded: C. Martin

THAT the agenda items for the Finance and Audit Committee dated June 8, 2016 be adopted as circulated.
CARRIED.

4) ADOPTION OF MINUTES

FC2016-30 Moved: L. Mason
Seconded: C. Martin

THAT the minutes for the Finance and Audit Committee dated May 11, 2016 be adopted as circulated.
CARRIED.

5) FINANCIAL STATEMENTS

a. Draft Financial Statements for the Period ending April 30, 2016
Mr. Pino spoke to his report that was provided in the committee package. The gapped positions will be filled throughout the summer.

A question was asked regarding the public health community program actual number. The Board inquired if this was a data entry error as there seems to be a larger difference. Mr. Pino to follow-up with accounting and if any adjustments are required they will be reflected in the April financial statements presented to the Board on June 22 and Mr. Pino will highlight this change for the Board.

FC2016-31 Moved: D. Thompson
Seconded: L. Mason

THAT the Finance and Audit Committee recommends the draft Financial Statements for the Period ending April 30, 2016 and puts forward to the Board for approval.
CARRIED.

6) BUSINESS ARISING FROM MINUTES

a. Capital Fund Study Services

At the last committee meeting the committee directed Dr. Hanlon and Mr. Pino to conduct a reserve fund study for capital assets. Mr. Pino contacted EPOH, the architect firm that built the Sault Ste. Marie building, to see if they had any information that would help with this matter. Mr. Pino informed the committee that he discovered that our building is being included in a Building Conditions Assessment review by the Ministry of Community and Social Services. An RFP was issued through the ministry for an assessment of sites where funded services are delivered. Mr. Pino has reviewed the Building Conditions Assessment review and believes this would meet the needs of the Boards Capital Reserve Fund Study. The committee recommends waiting until more information can be received on when APH's assessment would be completed and a detailed assessment shared before deciding to move forward with our own study.

Edits were made to the draft RFP presented in case the committee decides at a later date to move forward instead of waiting for the ministry's assessment. Mr. Pino to make the edits.

Capital Reserve Fund Study to come back to the next committee meeting in September. Mr. Pino to provide an update on the ministry timelines.

b. Long-Term Debut Renewal RFP Opening and Evaluation of Submissions

Ms. Luukkonen reported that two submissions were received.

1. Royal Bank of Canada
2. TD Northern Ontario Commercial Banking Group

Mr. Pino provided evaluation and scoring tools for the committee to use while evaluating each submission.

After reviewing both submissions the Finance and Audit Committee found TD to be the successful bidder pending clarifications required from TD. Mr. Pino will follow up and report back to the full Board on June 22, 2016 for final approval. Staff were directed to follow-up on the following items:

- Legal cost payments
- GSA/LOC impact
- Follow-up on references
- Negative covenants with RFQ

7) NEW BUSINESS/GENERAL BUSINESS - None

8) IN-COMMITTEE - Deferred

Due to time concerns the committee decided to defer the approval of the minutes from the April 19, 2016 in-committee meeting.

9) OPEN MEETING - Deferred

10) ADDENDUM - None

11) NEXT MEETING: September 14, 2016

12) THAT THE MEETING ADJOURN: 5:54pm

FC2016-32 Moved: L. Mason
Seconded: D. Thompson

THAT the meeting of the Finance and Audit Committee adjourns at 5:54pm.
CARRIED.

ALGOMA PUBLIC HEALTH

GOVERNANCE COMMITTEE REPORT

FOR THE SEPTEMBER 28, 2016 BOARD MEETING

Meeting held on: September 14, 2016 – Started at 5:57 pm

In attendance:

Justin Pino, Antoniette Tomie, Sherri Cleaves, Laurie Zeppa, Ian Frazier, Candace Martin, Lee Mason,

Absent: Sue Jensen (with regrets)

Secretary – Christina Luukkonen

As part of the continued follow-up regarding communication with the Municipalities, the Committee was presented with a draft pamphlet that contains relevant information regarding the Health Unit and the District that the Board and Staff can utilize. A few minor modifications were suggested. It is anticipated that after the modifications are made that the pamphlet will be issued and distributed. The second stage will be to follow-up with municipal visits.

Due to additional changes required, in June the Board requested the Governance Committee to revisit the Committees Terms of Reference and the related Bylaw 95-1 to ensure they are cohesive. Management presented to the Committee both marked up and clean versions of all three. Some concern was raised where someone that is elected as a Vice Chair will also be a Committee Chair. The concern is based on work load and responsibilities and that holding two positions may not interest a prospective Board Member because they may only have an interest in filling one position. It was decided that the Committee will put forth the Terms of Reference and Bylaw 95-1 with recommendation for approval but will discuss this point.

It was noted that Bylaw 95-1 could contain additional procedural items regarding meeting protocols, etc. and the Committee decided to create an ad hoc Committee to review and present additional changes for the November Committee meeting. Candace will Chair this Committee.

A Briefing Note was presented to the Committee regarding supporting the Health Unit's involvement in setting standards and protocols as the Government continues with their directive to legalize the use of cannabis. After much debate on the subject as a whole, the Committee was reminded that the resolution being presented tonight with the Committee's support is not in support of legalizing cannabis, but as the process of legalizing cannabis occurs, the Health Unit is involved in setting up rules and protocols similarly as they have been for tobacco.

The Committee was reminded that Board Orientation will take place on October 15, 2016.

The Committee went into closed session. Nothing was to come out of the closed session.

Next meeting is scheduled for November 9, 2016.

Meeting was adjourned at 7:45 pm.

Chair, Governance Committee
Algoma Public Health

9/20/16
Date

APPROVED BY:	Board of Health	**BY-LAW #:**	95-1
DATE:	O: December 13, 1995 Revised: September 28 ~~June 22~~, 2016	**SECTION:**	Board
PAGE:	1 of 9	**SUBJECT:**	To Regulate the Proceedings of the Board of Health

The Board enacts as follows:

Interpretation

1. In this By-law:

a) "Act" means the Health Protection and Promotion Act. ~~S.D. Ontario 1983, Chapter 10~~ R.S.O. 1990, Chapter H.7 as amended;

b) "Board" means THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT, as prescribed;

c) "Chair" means the person presiding at the meeting of the Board;

d) "Chair of the Board" means the Chair elected under Section 5~~7~~6 of the Act which reads:

i) A Board of Health shall hold its first meeting of each year not later than the 1st day of February
ii) At the first meeting of the Board of Health in each year, the members of the Board shall elect one of the members to be Chairman and one to be Vice-chairman of the Board for the year;

e) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

f) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

g) "Meeting" means a meeting of the Board;

h) "Member" means a member of the Board;

i) "Quorum" means a majority of the current members of the Board (MOHLTC interpretation) and that there must be at least five current members of the Board

j) "Secretary" means the Secretary of the Board of Health;

k) Words that indicate singular masculine gender only shall include plural and/or feminine gender.

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General

2. The Board shall hold the first meeting of each year not later than the first day of February. At the first meeting of the Board in each year, members of the Board shall elect one member to be Chair~~-~~, one member to be First Vice- chair and one member to be Second Vice-chair of the Board for the year. The First Vice-chair shall chair the Finance and Audit Committee and the Second Vice-chair shall chair the Governance Committee. ~~at least one of the standing committees of the Board~~.

3. The Board shall consist of the members as prescribed under the Act;

    a) Where a vacancy occurs in the Board by death, disqualification, resignation or removal of a member, the person or body that appointed the member shall appoint a person forthwith to fill the vacancy for the remainder of the term of the member.

4. In all the proceedings at or taken by this Board, the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committee (s) thereof.

5. Except as herein provided, *Robert's Rules of Order* shall be followed for governing the proceedings of the Board and the conduct of its members.

6. A person who is not a member of the Board shall not be permitted to address the Board except upon invitation of the Chair subject to written request to the Secretary at least two weeks prior to the scheduled meeting.

7. In unusual circumstances persons who have not requested in writing to address the Board may address the Board provided two-thirds of the Board's members are ~~are~~ in agreement.

Meetings

8. Regular Meetings:

    a) The regular meetings shall be held at a date and time as stated in the Board's Activity Plan determined by the Board annually at its June meeting. ~~first regular meeting of the year~~;

    b) The Board may, by resolution, alter the time, day or place of any meeting;

    c) It is expected that commitments to regularly scheduled Board meetings be honoured by the Board members;

    d) Three consecutive absences from regular Board meetings by a member of the Board will be reviewed by the Chair of the Board with the member in question; following which, notification may be forwarded to the appropriate municipality, council or the province.

9. Special Meetings:

    a) A special meeting of the Board shall not be called for a time which conflicts with a regular meeting previously called of (participating) council(s) or municipality(s).

b) A special meeting may be called by the Chair of the Board of Health.

c) The Secretary shall call a special meeting upon receipt of a petition signed by the majority of Board members, for the purpose and at the time mentioned in the petition.

10. Notice of Meetings:

a) The Secretary shall give notice of each regular and special meeting of the Board and of each committee to the members thereof and to the heads of departments concerned with such meeting.

b) The notice shall be accompanied by the agenda and any other matter, so far as is known, to be brought before such meeting.

c) The notice for a regular meeting shall be delivered or sent by electronic means or courier to the residence or place of business of each member so as to be received not later than three working days prior to the day of the meeting.

d) The notice for a special meeting may be sent by telephone or by electronic means with the Secretary confirming receipt.

e) No errors or omissions in giving such notice for the meeting shall invalidate it or any action taken.

f) The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

11. Preparation of the Agenda:

a) The Secretary shall have prepared for the use of members at the regular meetings, the Agenda as follows:

i. Call to Order
ii. Declaration of Conflict of Interest
iii. Adoption of Agenda
iv. Adoption of Minutes of Previous Meeting
v. Business Arising from Minutes
vi. Delegations/Presentations
vii. Reports of Committees
viii. Reports of Officers/Program Managers
ix. Correspondence/Items for Information
x. Addendum
xi. Announcements
xii. New Business/General Business
xiii. In-Committee Session
xiv. Return to Open Meeting
xv. Adjournment

b) For special meetings, the Agenda shall be prepared when and as the Chair of the Board may direct or, in default of such direction, as provided in the last preceding section so far as is applicable.

c) The business for each meeting shall be taken up in the order in which it stands upon the Agenda, unless otherwise decided by the Board.

12. Commencement of Meetings:

a) As soon as there is a quorum after the hour fixed for the meeting, the Chair of the Board or First Vice-chair of the Board, if the Chair is not present or the Second Vice-chair if the First Vice-chair is not present shall take the chair and call the members to order.

b) If the Chair or Vice-chairs are~~is~~ not present, or their duly appointed representative, but a quorum is otherwise achieved, the Secretary shall call the members to order and a presiding officer shall be appointed by the Secretary to preside during the meeting or until the arrival of the person who ought to preside.

c) If there is no quorum within 15 minutes after the time appointed for the meeting, the Secretary shall call the roll and take down the names of the members then present. If an absence of an expected Quorum occurs due to a health emergency or to weather conditions and business must be expedited, the Board shall have the privilege of designating items of business as essential to be expedited at that meeting. Under these conditions the Board shall have the privilege of conducting the necessary items of business but such items shall be confirmed at the next meeting of the Board

Rules of Debate and Conduct of Members of the Board

13. The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on point of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

14. Each deputation will be allowed a maximum of one speaker for a maximum of 10 minutes, but a member of the Board may introduce a deputation in addition to the speaker or speakers. Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

a) The Board shall render its decision in each case within five (5) working days after deputations have been heard.

15. If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall ~~call on~~ vacate the chair to one of the Vice-chairs during the debate ~~another member,~~ prior to the beginning of the debate, to fill his place until he resumes the chair.

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

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

18. A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

19. A motion for introducing new matter shall not be presented without notice unless the Board, without debate, dispenses with such notice by a majority vote and no report requiring action of the Board shall be introduced to the Board unless a copy has been placed in the hands of the members at least one day prior to the meeting, except by a majority vote, taken without debate.

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

21. Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

22. When a matter is under debate, no motion shall be received other than a motion:

    a) to adopt,
    b) to amend,
    c) to defer action,
    d) to refer,
    e) to receive,
    f) to adjourn the meeting, or
    g) that the vote be now taken.

23. a) A motion to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.
    b) A motion to refer shall require direction as to the body to which it is being referred and is not debatable.
    c) A motion to defer must include a reason and a time period for the deferral and is not debatable.

24. When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

25. Any member, including the Chair, may propose or second a motion and all members including the Chair shall vote on all motions except when disqualified by reasons of interest or otherwise; a tie vote shall be considered lost. When the Chair proposes a motion, he shall vacate the chair to one of the ~~the~~ Vice-chairs during debate on the motion and reassume the chair following the vote.

Duties of the Secretary for the Board

26. It shall be the duty of the Secretary:

    a) to attend or cause an assistant to attend all meetings of the Board;

    b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of By-laws and Resolutions passed by it; and

    c) to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same.

    d) to give all notices required to be given to the members.

Appointment and Organization of Committees

27. At the first meeting in any year, the Board shall appoint the members required by the Board to standing committees(s) (Finance and Audit Committee, Governance Committee). When a new member(s) join the Board after the first meeting of the year the Board shall appoint the new member(s) to one of the standing committees.

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

Conduct of Business in Committees

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

30. It shall be the duty of the Committee:

    a) to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

    b) to report to the Board the number of meetings called during a year, at which a quorum was present, and the number of meetings attended by each member of the Committee; and

    c) to forward to the incoming Committee for the following year any matter undisposed of.

Procedures of the Board Covered by other By-laws

31. The procedures of the Board with respect to:

    a) incurring of liabilities and paying of accounts;

b) authority for expenditures;
c) audits;
d) budgets and settlements;

Shall be in accordance with the By-laws #95-2 and #95-3.

Corporate Seal

32. The corporate seal of the Board shall be in the form impressed hereon and shall be kept by the Chief Executive Officer/Chief Administrative Officer- or the Chief Financial Officer.

Short Name

33. The Board will use the short name Algoma Public Health for signage, communications and promotional messaging and other matters as warranted.

Execution of Documents

34. The Board may at any time and from time to time, direct the manner in which and the person or persons who may sign on behalf of the Board and when required affix the corporate seal to any particular contract, arrangement, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, conveyances, mortgages, obligations or documents.

35. In general, unless changed by a resolution of the Board under clause 34 of this By-law, the following applies:

a) Budgets and Settlement Forms will be signed by the combination of Board member(s) and staff of the agency as required by Ministry specifications;

b) Leases for real estate, mortgages or other loan documents -will be signed by the Chair of the Board and by the Medical Officer of Health or Chief Executive Officer/Chief Administrative Officer;

c) Leases or purchase agreements for vehicles, as approved in budgets, will be signed by the Director/Chief Financial Officer and/or the Medical Officer of Health or Chief Executive Officer /Chief Administrative Officer (should two signatures be necessary);

d) Purchase of service agreements with service providers for programs will be signed by the Medical Officer of Health or/CEO/CAO and by the appropriate program Director.

e) Purchase of service agreements with service providers for financial, building and corporate services will be signed by the Medical Officer of Health or Chief Executive Officer/ Chief Administrative Officer and by the appropriate administrative manager or Director/Chief Financial Officer.

Duties of Officers

36. The Chair of the Board shall:

a) preside at all meetings of the Board;

b) represent the Board at public or official functions or designate another Board member to do so;

c) be ex-officio a member of all Committees to which he has not been named a member;

d) complete an annual performance appraisal of the Medical Officer of Health/CEO/CAO using input from the Medical Officer of Health/CEO/CAO as well as the members of the Board, with the results of this appraisal being shared with the Board members in camera;

e) perform such other duties as may from time to time be determined by the Board.

37. The First Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of the Chair of the Board, together with such powers and duties, if any, as may be from time to time assigned by the Board. The Second Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of both the Chair of the Board and the First Vice-chair, together with such powers and duties, if any, as may be from time to time assigned by the Board.

Amendments

38. Any provision contained herein may be repealed, amended or varied, and additions may be made to this By-law by a majority vote of members present at the meeting at which such motion is considered to give effect to any recommendation contained in a Report to the Board and such report has been transmitted to members of the Board prior to the meeting at which the report is to be considered. No motion for that purpose may be considered, unless notice thereof has been received by the Secretary two weeks before a Board meeting and such notice may not be waived and in any event no bill to amend this By-law shall be introduced at the same meeting as that at which such report or motion is considered.

Dismissal of Medical Officer(s) of Health/CEO/CAO

39. A decision by the Board of Health to dismiss a Medical Officer of Health/CEO/CAO from office is not effective unless:

a) the decision is carried by the vote of two-thirds of the members of the Board; and

b) in situations where the Medical Officer of Health is a separate position from the CEO/CAO position the Minister consents in writing to the dismissal of the MOH.

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

a) reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;

b) a written statement of the reason for the proposal to dismiss the Medical Officer of Health/CEO/CAO; and

c) an opportunity to attend and to make representation to the Board at the meeting.

Reporting of Medical Officer of Health to the Board of Health/CEO/CAO

1. The Medical Officer of Health/CEO/CAO of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other Act. The Medical Officer of Health of a board of health is responsible to the board for the management of the public health programs and services under this or any other Act. (HPPA, s.67(1) and (3))

2. The Medical Officer of Health/CEO/CAO of a board of health is entitled to notice of and to attend each meeting of the Board and every committee of the Board, but the Board may require the Medical Officer of Health/CEO/CAO to withdraw from any part of a meeting at which the Board or a Committee of the Board intends to consider a matter related to the remuneration or the performance of the duties of the Medical Officer of Health/CEO/CAO. (HPPA, s70)

Enacted and passed by the Algoma Health Unit Board this 13th day of December, 1995.

Original signed by
I. Lawson, Chair
G. Caputo, Vice-chair

Revised and passed by the Algoma Health Unit Board this 18th day of November 1998
Revised and passed by the Algoma Public Health Board February 2011
Revised and passed by the Algoma Public Health Board on this 28th day of October 2015
Revised and passed by the Algoma Public Health Board on this 28th day of September 2016

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APPROVED BY:	Board of Health	**BY-LAW #:**	95-1
DATE:	O: December 13, 1995 Revised: September 28 , 2016	**SECTION:**	Board
PAGE:	1 of 9	**SUBJECT:**	To Regulate the Proceedings of the Board of Health

---

The Board enacts as follows:

Interpretation

1. In this By-law:

   a) "Act" means the Health Protection and Promotion Act. R.S.O. 1990, Chapter H.7 as amended;

   b) "Board" means THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT, as prescribed;

   c) "Chair" means the person presiding at the meeting of the Board;

   d) "Chair of the Board" means the Chair elected under Section 57 of the Act which reads:

      i) A Board of Health shall hold its first meeting of each year not later than the 1st day of February
      ii) At the first meeting of the Board of Health in each year, the members of the Board shall elect one of the members to be Chairman and one to be Vice-chairman of the Board for the year;

   e) "Committee" means a committee of the Board, but does not include the Committee of the Whole;

   f) "Committee of the Whole" means all the members present at a meeting of the Board sitting in Committee;

   g) "Meeting" means a meeting of the Board;

   h) "Member" means a member of the Board;

   i) "Quorum" means a majority of the voting positions on the Board with no less than five of the positions being filled;(models alPHa by-law amendment)

   j) or " Quorum means a majority of the current members of the Board (MOHLTC interpretation) and that there must be at least five current members of the Board

   k) "Secretary" means the Secretary of the Board of Health;

   l) Words that indicate singular masculine gender only shall include plural and/or feminine gender.

General

2. The Board shall hold the first meeting of each year not later than the first day of February. At the first meeting of the Board in each year, members of the Board shall elect one member to be Chair, one member to be First Vice- chair and one member to be Second Vice-chair of the Board for the year. The First Vice-chair shall chair the Finance and Audit Committee and the Second Vice-chair shall chair the Governance Committee. .

3. The Board shall consist of the members as prescribed under the Act;

    a) Where a vacancy occurs in the Board by death, disqualification, resignation or removal of a member, the person or body that appointed the member shall appoint a person forthwith to fill the vacancy for the remainder of the term of the member.

4. In all the proceedings at or taken by this Board, the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committee (s) thereof.

5. Except as herein provided, *Robert's Rules of Order* shall be followed for governing the proceedings of the Board and the conduct of its members.

6. A person who is not a member of the Board shall not be permitted to address the Board except upon invitation of the Chair subject to written request to the Secretary at least two weeks prior to the scheduled meeting.

7. In unusual circumstances persons who have not requested in writing to address the Board may address the Board provided two-thirds of the Board's members arein agreement.

Meetings

8. Regular Meetings:

    a) The regular meetings shall be held at a date and time as stated in the Board's Activity Plan determined by the Board annually at its June meeting.;

    b) The Board may, by resolution, alter the time, day or place of any meeting;

    c) It is expected that commitments to regularly scheduled Board meetings be honoured by the Board members;

    d) Three consecutive absences from regular Board meetings by a member of the Board will be reviewed by the Chair of the Board with the member in question; following which, notification may be forwarded to the appropriate municipality, council or the province.

9. Special Meetings:

    a) A special meeting of the Board shall not be called for a time which conflicts with a regular meeting previously called of (participating) council(s) or municipality(s).

    b) A special meeting may be called by the Chair of the Board of Health.

c) The Secretary shall call a special meeting upon receipt of a petition signed by the majority of Board members, for the purpose and at the time mentioned in the petition.

10. Notice of Meetings:

a) The Secretary shall give notice of each regular and special meeting of the Board and of each committee to the members thereof and to the heads of departments concerned with such meeting.

b) The notice shall be accompanied by the agenda and any other matter, so far as is known, to be brought before such meeting.

c) The notice for a regular meeting shall be delivered or sent by electronic means or courier to the residence or place of business of each member so as to be received not later than three working days prior to the day of the meeting.

d) The notice for a special meeting may be sent by telephone or by electronic means with the Secretary confirming receipt.

e) No errors or omissions in giving such notice for the meeting shall invalidate it or any action taken.

f) The notice calling a special meeting of the Board shall state the business to be considered at the special meeting and no business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

11. Preparation of the Agenda:

a) The Secretary shall have prepared for the use of members at the regular meetings, the Agenda as follows:

i. Call to Order
ii. Declaration of Conflict of Interest
iii. Adoption of Agenda
iv. Adoption of Minutes of Previous Meeting
v. Business Arising from Minutes
vi. Delegations/Presentations
vii. Reports of Committees
viii. Reports of Officers/Program Managers
ix. Correspondence/Items for Information
x. Addendum
xi. Announcements
xii. New Business/General Business
xiii. In-Committee Session
xiv. Return to Open Meeting
xv. Adjournment

b) For special meetings, the Agenda shall be prepared when and as the Chair of the Board may direct or, in default of such direction, as provided in the last preceding section so far as is applicable.

c) The business for each meeting shall be taken up in the order in which it stands upon the Agenda, unless otherwise decided by the Board.

12. Commencement of Meetings:

a) As soon as there is a quorum after the hour fixed for the meeting, the Chair of the Board or First Vice-chair of the Board, if the Chair is not present or the Second Vice-chair if the First Vice-chair is not present shall take the chair and call the members to order.

b) If the Chair or Vice-chairs are not present, or their duly appointed representative, but a quorum is otherwise achieved, the Secretary shall call the members to order and a presiding officer shall be appointed by the Secretary to preside during the meeting or until the arrival of the person who ought to preside.

c) If there is no quorum within 15 minutes after the time appointed for the meeting, the Secretary shall call the roll and take down the names of the members then present. If an absence of an expected Quorum occurs due to a health emergency or to weather conditions and business must be expedited, the Board shall have the privilege of designating items of business as essential to be expedited at that meeting. Under these conditions the Board shall have the privilege of conducting the necessary items of business but such items shall be confirmed at the next meeting of the Board

Rules of Debate and Conduct of Members of the Board

13. The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on point of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

14. Each deputation will be allowed a maximum of one speaker for a maximum of 10 minutes, but a member of the Board may introduce a deputation in addition to the speaker or speakers. Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

a) The Board shall render its decision in each case within five (5) working days after deputations have been heard.

15. If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall vacate the chair to one of the Vice-chairs during the debate prior to the beginning of the debate, to fill his place until he resumes the chair.

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

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

18. A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

19. A motion for introducing new matter shall not be presented without notice unless the Board, without debate, dispenses with such notice by a majority vote and no report requiring action of the Board shall be introduced to the Board unless a copy has been placed in the hands of the members at least one day prior to the meeting, except by a majority vote, taken without debate.

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

21. Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

22. When a matter is under debate, no motion shall be received other than a motion:

    a) to adopt,
    b) to amend,
    c) to defer action,
    d) to refer,
    e) to receive,
    f) to adjourn the meeting, or
    g) that the vote be now taken.

23. a) A motion to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.
    b) A motion to refer shall require direction as to the body to which it is being referred and is not debatable.
    c) A motion to defer must include a reason and a time period for the deferral and is not debatable.

24. When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and, if carried by a majority vote of the members present, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

25. Any member, including the Chair, may propose or second a motion and all members including the Chair shall vote on all motions except when disqualified by reasons of interest or otherwise; a tie vote shall be considered lost. When the Chair proposes a motion, he shall vacate the chair to one of the Vice-chairs during debate on the motion and reassume the chair following the vote.

Duties of the Secretary for the Board

26. It shall be the duty of the Secretary:

    a) to attend or cause an assistant to attend all meetings of the Board;

    b) to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of By-laws and Resolutions passed by it; and

    c) to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same.

    d) to give all notices required to be given to the members.

Appointment and Organization of Committees

27. At the first meeting in any year, the Board shall appoint the members required by the Board to standing committees(s) (Finance and Audit Committee, Governance Committee). When a new member(s) join the Board after the first meeting of the year the Board shall appoint the new member(s) to one of the standing committees.

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

Conduct of Business in Committees

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

30. It shall be the duty of the Committee:

    a) to report to the Board on all matters referred to them and to recommend such action as they deem necessary;

    b) to report to the Board the number of meetings called during a year, at which a quorum was present, and the number of meetings attended by each member of the Committee; and

    c) to forward to the incoming Committee for the following year any matter undisposed of.

Procedures of the Board Covered by other By-laws

31. The procedures of the Board with respect to:

    a) incurring of liabilities and paying of accounts;
    b) authority for expenditures;
    c) audits;

d) budgets and settlements;

Shall be in accordance with the By-laws #95-2 and #95-3.

Corporate Seal

32. The corporate seal of the Board shall be in the form impressed hereon and shall be kept by the Chief Executive Officer/Chief Administrative Officer or the Chief Financial Officer.

Short Name

33. The Board will use the short name Algoma Public Health for signage, communications and promotional messaging and other matters as warranted.

Execution of Documents

34. The Board may at any time and from time to time, direct the manner in which and the person or persons who may sign on behalf of the Board and when required affix the corporate seal to any particular contract, arrangement, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, conveyances, mortgages, obligations or documents.

35. In general, unless changed by a resolution of the Board under clause 34 of this By-law, the following applies:

a) Budgets and Settlement Forms will be signed by the combination of Board member(s) and staff of the agency as required by Ministry specifications;

b) Leases for real estate, mortgages or other loan documents will be signed by the Chair of the Board and by the Medical Officer of Health or Chief Executive Officer/Chief Administrative Officer;

c) Leases or purchase agreements for vehicles, as approved in budgets, will be signed by the Director/Chief Financial Officer and/or the Medical Officer of Health or Chief Executive Officer /Chief Administrative Officer (should two signatures be necessary);

d) Purchase of service agreements with service providers for programs will be signed by the Medical Officer of Health orCEO/CAO and by the appropriate program Director.

e) Purchase of service agreements with service providers for financial, building and corporate services will be signed by the Medical Officer of Health or Chief Executive Officer/ Chief Administrative Officer and by the appropriate administrative manager or Director/Chief Financial Officer.

Duties of Officers

36. The Chair of the Board shall:

    a) preside at all meetings of the Board;

    b) represent the Board at public or official functions or designate another Board member to do so;

    c) be ex-officio a member of all Committees to which he has not been named a member;

    d) complete an annual performance appraisal of the Medical Officer of Health/CEO/CAO using input from the Medical Officer of Health/CEO/CAO as well as the members of the Board, with the results of this appraisal being shared with the Board members in camera;

    e) perform such other duties as may from time to time be determined by the Board.

37. The First Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of the Chair of the Board, together with such powers and duties, if any, as may be from time to time assigned by the Board. The Second Vice-chair shall have all the powers and perform all the duties of the Chair of the Board in the absence or disability of both the Chair of the Board and the First Vice-chair, together with such powers and duties, if any, as may be from time to time assigned by the Board.

Amendments

38. Any provision contained herein may be repealed, amended or varied, and additions may be made to this By-law by a majority vote of members present at the meeting at which such motion is considered to give effect to any recommendation contained in a Report to the Board and such report has been transmitted to members of the Board prior to the meeting at which the report is to be considered. No motion for that purpose may be considered, unless notice thereof has been received by the Secretary two weeks before a Board meeting and such notice may not be waived and in any event no bill to amend this By-law shall be introduced at the same meeting as that at which such report or motion is considered.

Dismissal of Medical Officer(s) of Health/CEO/CAO

39. A decision by the Board of Health to dismiss a Medical Officer of Health/CEO/CAO from office is not effective unless:

    a) the decision is carried by the vote of two-thirds of the members of the Board; and

    b) in situations where the Medical Officer of Health is a separate position from the CEO/CAO position the Minister consents in writing to the dismissal of the MOH.

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

    a) reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;

    b) a written statement of the reason for the proposal to dismiss the Medical Officer of Health/CEO/CAO; and

    c) an opportunity to attend and to make representation to the Board at the meeting.

Reporting of Medical Officer of Health to the Board of Health/CEO/CAO

1. The Medical Officer of Health/CEO/CAO of a board of health reports directly to the board of health on issues relating to public health concerns and to public health programs and services under this or any other Act. The Medical Officer of Health of a board of health is responsible to the board for the management of the public health programs and services under this or any other Act. (HPPA, s.67(1) and (3))

2. The Medical Officer of Health/CEO/CAO of a board of health is entitled to notice of and to attend each meeting of the Board and every committee of the Board, but the Board may require the Medical Officer of Health/CEO/CAO to withdraw from any part of a meeting at which the Board or a Committee of the Board intends to consider a matter related to the remuneration or the performance of the duties of the Medical Officer of Health/CEO/CAO. (HPPA, s70)

Enacted and passed by the Algoma Health Unit Board this 13th day of December, 1995.

Original signed by
I. Lawson, Chair
G. Caputo, Vice-chair

Revised and passed by the Algoma Health Unit Board this 18th day of November 1998
Revised and passed by the Algoma Public Health Board February 2011
Revised and passed by the Algoma Public Health Board on this 28th day of October 2015
Revised and passed by the Algoma Public Health Board on this 28th day of September 2016

BOARD OF HEALTH FOR ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE
TERMS OF REFERENCE

O: September 22, 2015

R: September 28, 2016

The following Terms of Reference are in accordance with By-Law No. 95-1. The Committee is advisory to the Board unless the Board expressly delegates authority to the Committee on a particular matter.

Name:	Board of Health Governance Standing Committee
~~Purpose/Goal~~Mandate:	To ~~fulfill the following functions on behalf of the Board:~~assist the Board in meeting its responsibilities, The Governance Standing Committee (the "Committee") shall: • Act in an advisory capacity to the Board; and • ~~Governance – To~~ Ssupport the Board in fulfilling its commitment to and responsibility for sound and effective governance of Algoma Public Health (subject to the requirements of the Health Protection and Promotion Act and Provincial Public Appointments Process) • ~~–~~ • ~~Nominations – To manage the process to identify potential provincial nominees for the Board to recommend for appointment to the Board (subject to the requirements of the Health Protection and Promotion Act and Provincial Public Appointments Process)~~ • From time to time the Board may instruct the Committee to act on its behalf. In such cases, a motion by the Board must be passed stating the specifics of the assignment, the timeframe under which the Committee will carry out the assignment and a requirement to report back its actions and decisions to the board at its earliest possible convenience. • • ~~Orientation and Education – To support the Board by ensuring that new Directors receive adequate and appropriate orientation and that all Directors are provided ongoing education to assist them in fulfilling their duties effectively.~~ Ensure the adequacy and effectiveness of the Board policies and procedures. • ~~Performance accountability – To s~~Support the Board in overseeing key elements required to ~~achieve its vision and mission.~~ ensure accountability, transparency and effective performance.
Roles & Responsibilities:	These Governance functions are fulfilled through the following roles and responsibilities: • Enable the Board to meet its fiduciary obligations by defining APH's approach to governance and supporting processes and practices that promote a leading-edge governance culture; • Recommend, where appropriate, changes to the mandate of the Board of Directors and each of its Committees based on the needs of APH and evolving governance standards (subject to requirements of the HPPA and Municipal Acts) • Recommend, where appropriate, the development and oversee the

Form # 00002 (2005/01)

	implementation of new governance structures, processes and protocols that enable the Board to fulfill its governance role effectively; • Support the Board of Directors in fostering a positive relationship with its key stakeholders; • Support a high standard of Board conduct and performance • Review Board policies on a regular basis, and at a minimum of every two years, and make recommendations to the Board to ensure currency and relevancy • Recommend and oversee the implementation of a governance review/ evaluation process regarding the performance of the Board, the Board Chair, committee chairs, committees and individual Directors; • Recommend procedures for the ongoing assessment of Board and Committee meeting effectiveness; • Recommend changes to address effectiveness issues arising out of these evaluations; • Assess the adequacy of the quality and timeliness of information provided to the Board of Directors and its Committees and make recommendations to the Board of Directors for change where appropriate. • Approve and monitor various measures of performance accountability on a regular basis. • Support the Chair of the Board of Health with MOH/CEO/CAO review as requested; • Oversee succession planning for the MOH/CEO/CAO, including development of a clear and transparent process to recruit and select a future MOH/CEO/CAO. • Ensure that there is an appropriate orientation and education program for new Directors and continuing education for all Directors including making recommendations on methods to improve Directors' knowledge of Algoma Public Health and their responsibilities as Directors; • Oversee the implementation of orientation and education programs for Directors to ensure these are undertaken effectively. • The Committee shall study and make recommendations to the Board on any matter as directed by the Board. • Complete tasks as stated in the Board's Annual Activity Plan
Chair:	The Chair of the Committee shall be elected annually by the Board and shall serve no longer than three terms. The Chair of the Governance Standing Committee will also serve as the 2nd Vice-Chair of the Board of Health. ~~The Governance Standing Committee shall elect a chair amongst them. The Board Vice-Chair may be appointed as Committee chair.~~ The Committee chair is responsible in consultation with MOH/CEO/CAO for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO/CAO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The committee may elect a vice-chair.on an annual basis. ~~The Committee chair may be appointed for a term that is not longer than his or her term as a Director and may be reappointed for as many terms as the Board determines.~~

Recorder:	The secretary to the Board will act as recorder for the Governance Standing Committee.
~~Delegation of Authority from the Board:~~	~~No authority is delegated by the Board through these terms of reference. However, the Board may from time to time delegate specific responsibilities to the Committee by resolution of the Board.~~
Reporting and Accountability to the Board:	The Committee will keep brief decision minutes of its meetings in which shall be recorded all matters considered at each meeting. These minutes will be circulated to the full Board once approved by the Committee. The Committee chair will report to the Board on recommendations from the Committee, including a brief outline of the issue, the options considered, the conclusions and recommendations arrived at and the implications and risks associated with the recommendations. In the absence of the Committee chair, this responsibility may be delegated to the Vice-chair or another Director member of the Committee or to staff.
Committee Performance:	The performance and effectiveness of the Committee shall be assessed annually as part of the Board's evaluation process. The evaluation will be based on the Committee fulfilling its Mandate.
Membership:	The Governance Standing Committee shall be comprised of: • Up to six (6)~~five (5)~~ members of the Board of Health plus the Board Chair and no less than three (3) voting members; • ~~Board Chair as an ex-officio, non-voting member~~ • MOH/CEO/CAO of Algoma Public Health, resource • Director of HR and Corporate Services – resource • Director of Promotion and Prevention~~Community Services~~ – resource • Director of Protection and Prevention~~Clinical Services~~ – resource member ~~The Committee shall have a minimum of three and a maximum of five members, all of whom shall be Directors. The Board Vice-Chair normally shall be a member of the Committee. The Board Chair may member of the Committee. Chairs of other standing committees normally would not be appointed as members of the Committee.~~ Board Committee members will be appointed annually by the Board ~~for a term not exceeding their term as a Director and may be reappointed at the discretion of the Board~~
~~Reporting to:~~	~~Algoma Public Health Board of Health~~
Frequency:	A minimum of four (4) meetings will be held annually as outlined in the Board's annual activity plan.~~workplan~~. Additional meetings can be held at the call of the Chair or at the request of the Board. The location of the meetings will be at APH's main office unless otherwise agreed upon by the Committee. ~~The Committee will meet at least four times a year. Meetings may be more frequent in the first year.~~ ~~The Committee may meet on other occasions at the call of the Committee chair or at the request of the Board.~~
Term:	The Committee shall be appointed annually by the Board.
Committee Operations:	Quorum for Committee meetings is a majority of the voting members of the Committee. The Committee shall operate in accordance with the procedures for Board meetings as set out in By-Law No. 95-1

Form # 00002 (2005/01)

	The Committee may, with the approval of the Board, establish sub-committees.
Amendments:	The Committee will review the Terms of Reference on an annual basis and make recommendations for any amendments to the Board for its review and decision re: approval.
Distribution of Minutes:	Minutes shall be provided to the committee members and the Board of Health.~~Distribute to committee members and the Board of Health members.~~

Signature of Board of Health Chair

Date

Form # 00002 (2005/01)

TERMS OF REFERENCE MEMBERSHIP

	Name	Position
1	Ian Frazier	~~Board Member~~Committee Chair
2	~~Lee Mason~~Candace Martin	~~Board Chair~~Committe Vice-Chair
3	~~Candace Martin~~Sue Jensen	Board Member
4	~~Sue Jensen~~Vacant	Board Member
5	Vacant	Board Member
6	Vacant~~Ex- Officio~~	Board member
6	Lee Mason	Board Chair
~~5~~7	~~Ex-Officio~~Resource Tony Hanlon or CA0	CEO or CAO
~~6~~8	Antoniette Tomie	Director of Human Resources and Corporate Services
9	Laurie Zeppa	Director of Promotion and prevention~~Community Services~~
10	Sherri Cleaves	Director of Protection and Prevention ~~Clinic Services~~
~~7~~11	Christina Luukkonen	Recording Secretary
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Guide for Completing Terms of Reference

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

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

BOARD OF HEALTH FOR ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE
TERMS OF REFERENCE

O: September 22, 2015
R: September 28, 2016

The following Terms of Reference are in accordance with By-Law No. 95-1. The Committee is advisory to the Board unless the Board expressly delegates authority to the Committee on a particular matter.

Name:	Board of Health Governance Standing Committee
Mandate:	To assist the Board in meeting its responsibilities, The Governance Standing Committee (the "Committee") shall: • Act in an advisory capacity to the Board; and • Support the Board in fulfilling its commitment to and responsibility for sound and effective governance of Algoma Public Health (subject to the requirements of the Health Protection and Promotion Act and Provincial Public Appointments Process) • From time to time the Board may instruct the Committee to act on its behalf. In such cases, a motion by the Board must be passed stating the specifics of the assignment, the timeframe under which the Committee will carry out the assignment and a requirement to report back its actions and decisions to the board at its earliest possible convenience. • Ensure the adequacy and effectiveness of the Board policies and procedures. Support the Board in overseeing key elements required to ensure accountability, transparency and effective performance.
Roles & Responsibilities:	These Governance functions are fulfilled through the following roles and responsibilities: • Enable the Board to meet its fiduciary obligations by defining APH's approach to governance and supporting processes and practices that promote a leading-edge governance culture; • Recommend, where appropriate, changes to the mandate of the Board of Directors and each of its Committees based on the needs of APH and evolving governance standards (subject to requirements of the HPPA and Municipal Acts) • Recommend, where appropriate, the development and oversee the implementation of new governance structures, processes and protocols that enable the Board to fulfill its governance role effectively; • Support the Board of Directors in fostering a positive relationship with its key stakeholders; • Support a high standard of Board conduct and performance • Review Board policies on a regular basis, and at a minimum of every two years, and make recommendations to the Board to ensure currency and relevancy • Recommend and oversee the implementation of a governance review/ evaluation process regarding the performance of the Board, the Board Chair, committee chairs, committees and individual Directors; • Recommend procedures for the ongoing assessment of Board and Committee meeting effectiveness; • Recommend changes to address effectiveness issues arising out of these evaluations;

	• Assess the adequacy of the quality and timeliness of information provided to the Board of Directors and its Committees and make recommendations to the Board of Directors for change where appropriate. • Approve and monitor various measures of performance accountability on a regular basis. • Support the Chair of the Board of Health with MOH/CEO/CAO review as requested; • Oversee succession planning for the MOH/CEO/CAO, including development of a clear and transparent process to recruit and select a future MOH/CEO/CAO. • Ensure that there is an appropriate orientation and education program for new Directors and continuing education for all Directors including making recommendations on methods to improve Directors' knowledge of Algoma Public Health and their responsibilities as Directors; • Oversee the implementation of orientation and education programs for Directors to ensure these are undertaken effectively. • The Committee shall study and make recommendations to the Board on any matter as directed by the Board. • Complete tasks as stated in the Board's Annual Activity Plan
Chair:	The Chair of the Committee shall be elected annually by the Board and shall serve no longer than three terms. The Chair of the Governance Standing Committee will also serve as the 2nd Vice-Chair of the Board of Health. The Committee chair is responsible in consultation with MOH/CEO/CAO for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO/CAO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The committee may elect a vice-chair on an annual basis.
Recorder:	The secretary to the Board will act as recorder for the Governance Standing Committee.
Reporting and Accountability to the Board:	The Committee will keep brief decision minutes of its meetings in which shall be recorded all matters considered at each meeting. These minutes will be circulated to the full Board once approved by the Committee. The Committee chair will report to the Board on recommendations from the Committee, including a brief outline of the issue, the options considered, the conclusions and recommendations arrived at and the implications and risks associated with the recommendations. In the absence of the Committee chair, this responsibility may be delegated to the Vice-chair or another Director member of the Committee or to staff.
Committee Performance:	The performance and effectiveness of the Committee shall be assessed annually as part of the Board's evaluation process. The evaluation will be based on the Committee fulfilling its Mandate.
Membership:	The Governance Standing Committee shall be comprised of: • Up to six (6) members of the Board of Health plus the Board Chair and no less than three (3) voting members; • MOH/CEO/CAO of Algoma Public Health, resource • Director of HR and Corporate Services – resource • Director of Promotion and Prevention – resource • Director of Protection and Prevention – resource member Board Committee members will be appointed annually by the Board.

Frequency:	A minimum of four (4) meetings will be held annually as outlined in the Board's annual activity plan. Additional meetings can be held at the call of the Chair or at the request of the Board. The location of the meetings will be at APH's main office unless otherwise agreed upon by the Committee.
Term:	The Committee shall be appointed annually by the Board.
Committee Operations:	Quorum for Committee meetings is a majority of the voting members of the Committee. The Committee shall operate in accordance with the procedures for Board meetings as set out in By-Law No. 95-1 The Committee may, with the approval of the Board, establish sub-committees.
Amendments:	The Committee will review the Terms of Reference on an annual basis and make recommendations for any amendments to the Board for its review and decision re: approval.
Distribution of Minutes:	Minutes shall be provided to the committee members and the Board of Health.

Signature of Board of Health Chair _____ Date _____

TERMS OF REFERENCE MEMBERSHIP

	Name	**Position**
1	Ian Frazier	Committee Chair
2	Candace Martin	Committee Vice-Chair
3	Sue Jensen	Board Member
4	Vacant	Board Member
5	Vacant	Board Member
6	Vacant	Board member
7	Lee Mason	Board Chair
	Resource Members	
8	Tony Hanlon or CA0	CEO or CAO
9	Antoniette Tomie	Director of HR and Corporate Services
10	Laurie Zeppa	Director of Promotion and prevention
11	Sherri Cleaves	Director of Protection and Prevention
12	Christina Luukkonen	Recording Secretary
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Guide for Completing Terms of Reference

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- None of the sections should be blank.
- Ensure a copy of the previous TOR accompanies the newly edited TOR with the changes highlighted.

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

BOARD OF HEALTH FOR ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE
TERMS OF REFERENCE

O: May 22, 2015

R: September 28, 2016

The following Terms of Reference are in accordance with By-Law No. 95-1. The Committee is advisory to the Board unless the Board expressly delegates authority to the Committee on a particular matter.

Name:	Finance and Audit Committee
Mandate:	To assist the Board in meeting its responsibilities, the Finance and Audit Committee (the "Committee") shall: • Act in an advisory capacity to the Board; and • Ensure the adequacy and effectiveness of financial reporting by reviewing and recommending approval to the Board of ~~all~~ financial statements, accounting policies, internal and external audits, internal controls, management plans and information. ~~The Committee shall assist with fulfillment of the Board's mandate and those specific responsibilities and duties assigned to the Committee; however, unless specifically stated otherwise, the Committee shall act in advisory capacity only, recommending decisions to the Board for approval.~~From time to time the Board may instruct the Committee to act on its behalf. In such cases, a motion by the Board must be passed stating the specifics of the assignment, the timeframe under which the Committee will carry out the assignment and a requirement to report back its actions and decisions to the board at its earliest possible convenience.
~~Scope/Duties:~~Roles and Responsibilities	These Finance and Audit Committee functions are fulfilled through the following roles and responsibilities: ~~shall have the following specific functions, duties and responsibilities and where necessary recommend for approval to the Board:~~ Review and make recommendations to the Board regarding monthly financial statements and other monthly/quarterly financial reporting being presented to the Board; • Review and make recommendations to the Board regarding the annual Operating and Capital Plan; • Review and make recommendations to the Board regarding the annual audited financial statements; • Review and recommend the annual audit plan, audit fees, and scope of audit services (engagement letter); • Meet with external auditors to review the findings of the audit including but not limited to the auditor's Management Letter, any weaknesses in internal controls and the Executive Management's response to such letter;

	• Review and report to the Board any changes in accounting policies or significant transactions which impact the financial statements in a significant manner as per the annual financial statements; • Periodically review the need for an internal audit and if required make such recommendation to the Board; • Monitor the internal audit process, ensure all items from the internal auditor's reports are resolved and assess the internal audit performance; • Monitor the effectiveness of internal controls to ensure compliance with Board policies and standard accounting principles; • Review and ensure that all risk management is complete with respect to all insurance coverage for the Board; • Review and make recommendations to the Board regarding long-term financial goals and long-term revenue and expense projections; • Review and make recommendation to the Board concerning any material asset acquisitions; • Review and make recommendations to the Board regarding financial, Investing and banking transactions, providers and signing officers; and • Review other projects or developments as directed by the Board. • Complete tasks as stated in the Board's Annual Activity Plan~~Develop an Committee Annual Work Plan for approval by the Board.~~
Chair:	The Chair of the Committee shall be elected annually by the Board and shall serve no longer than three terms. The Chair of the Finance and Audit Committee will also serve as the 1st Vice-Chair of the Board of Health. The Committee chair in consultation with the MOH/CEO/CAO is responsible for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO/CAO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The Committee may elect a vice-chair on an annual basis.
Recorder:	The secretary to the Board will act as recorder for the Finance and Audit Committee.
Reporting and Accountability to the Board:~~Reporting Relationship:~~	~~Finance and Audit Committee shall report on significant issues and year end progress of the Annual Work Plan through the Committee Chair or other Committee Designate to the Board.~~ The Committee will keep brief decision minutes of its meetings in which shall be recorded all matters considered at each meeting. These minutes will be circulated to the full Board once approved by the Committee. The Committee chair will report to the Board on recommendations from the Committee, including a brief outline of the issue, the options considered, the conclusions and recommendations arrived at and the implications and risks associated with the recommendations. In the absence of the Committee chair, this responsibility may be delegated to the Vice-Chair or another Director member of the Committee or to staff.

Committee Performance:	The performance and effectiveness of the Committee shall be assessed annually as part of the Board's evaluation process. The evaluation will be based on the Committee fulfilling its Mandate.
Membership:	The Finance and Audit Committee shall be comprised of: • Up to six (6) ~~five (5)~~ members of the Board of Health plus the Board Chair and no less than three (3) voting members; • ~~Board Chair as an ex-officio, non-voting member~~ • MOH/CEO/CAO of Algoma Public Health, non-voting members • ~~•~~ CFO or designate of Algoma Public Health, non-voting member
Frequency:	A minimum of four (4) meetings will be held annually as outlined in the Board's annual activity ~~work~~plan. Additional meetings can be held at the call of the Chair or at the request of the Board. The location of the meetings will be at APH's main office unless otherwise agreed upon by the Committee.
Term:	The Committee shall be appointed annually by the Board.
Committee Operations:~~Quorum:~~	Quorum for Committee meetings is a majority of the voting members of the Committee. The Committee shall operate in accordance with the procedures for Board meetings as set out in By-Law No. 95-1 The Committee may, with the approval of the Board, establish sub-committees. ~~A Quorum shall be the majority of the members on the committee~~
Amendments:	The Committee will review the Terms of Reference on an annual basis and make recommendation~~(s)~~ for any amendments~~. Any amendments are made by the Board.~~ to the Board for its review and decision re: approval.
Distribution of Minutes:~~Minutes:~~	Minutes shall be provided to the committee members and the Board of Health.

Signature of Board of Health Chair _____ Date _____

TERMS OF REFERENCE MEMBERSHIP

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

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

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

BOARD OF HEALTH FOR ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE
TERMS OF REFERENCE

O: May 22, 2015

R: September 28, 2016

The following Terms of Reference are in accordance with By-Law No. 95-1. The Committee is advisory to the Board unless the Board expressly delegates authority to the Committee on a particular matter.

Name:	Finance and Audit Committee
Mandate:	To assist the Board in meeting its responsibilities, the Finance and Audit Committee (the "Committee") shall: • Act in an advisory capacity to the Board; and • Ensure the adequacy and effectiveness of financial reporting by reviewing and recommending approval to the Board of financial statements, accounting policies, internal and external audits, internal controls, management plans and information. From time to time the Board may instruct the Committee to act on its behalf. In such cases, a motion by the Board must be passed stating the specifics of the assignment, the timeframe under which the Committee will carry out the assignment and a requirement to report back its actions and decisions to the board at its earliest possible convenience.
Roles and Responsibilities	These Finance and Audit Committee functions are fulfilled through the following roles and responsibilities: Review and make recommendations to the Board regarding monthly financial statements and other monthly/quarterly financial reporting being presented to the Board; • Review and make recommendations to the Board regarding the annual Operating and Capital Plan; • Review and make recommendations to the Board regarding the annual audited financial statements; • Review and recommend the annual audit plan, audit fees, and scope of audit services (engagement letter); • Meet with external auditors to review the findings of the audit including but not limited to the auditor's Management Letter, any weaknesses in internal controls and the Executive Management's response to such letter; • Review and report to the Board any changes in accounting policies or significant transactions which impact the financial statements in a significant manner as per the annual financial statements; • Periodically review the need for an internal audit and if required make such recommendation to the Board; • Monitor the internal audit process, ensure all items from the internal auditor's reports are resolved and assess the internal audit performance;

	• Monitor the effectiveness of internal controls to ensure compliance with Board policies and standard accounting principles; • Review and ensure that all risk management is complete with respect to all insurance coverage for the Board; • Review and make recommendations to the Board regarding long-term financial goals and long-term revenue and expense projections; • Review and make recommendation to the Board concerning any material asset acquisitions; • Review and make recommendations to the Board regarding financial, Investing and banking transactions, providers and signing officers; and • Review other projects or developments as directed by the Board. • Complete tasks as stated in the Board's Annual Activity Plan
Chair:	The Chair of the Committee shall be elected annually by the Board and shall serve no longer than three terms. The Chair of the Finance and Audit Committee will also serve as the 1st Vice-Chair of the Board of Health. The Committee chair in consultation with the MOH/CEO/CAO is responsible for: establishing Committee agendas; conducting the meetings; liaison with the Board Chair, the Board and the MOH/CEO/CAO; reporting to the Board on the activities of the Committee and presenting Committee recommendations to the Board. The Committee may elect a vice-chair on an annual basis.
Recorder:	The secretary to the Board will act as recorder for the Finance and Audit Committee.
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	agreed upon by the Committee.
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Amendments:	The Committee will review the Terms of Reference on an annual basis and make recommendations for any amendments to the Board for its review and decision re: approval.
Distribution of Minutes:	Minutes shall be provided to the committee members and the Board of Health.

Signature of Board of Health Chair Date

TERMS OF REFERENCE MEMBERSHIP

	Name	Position
1	Ian Frazier	Committee Chair
2	Dennis Thompson	Committee Vice-Chair
3	Candace Martin	Board Member
4	Vacant	Board Member
5	Vacant	Board Member
6	Vacant	Board Member
7	Lee Mason	Board Chair
	Resource Members	
7	Tony Hanlon or CAO	Chief Executive Officer or CAO
8	Justin Pino	Chief Financial Officer
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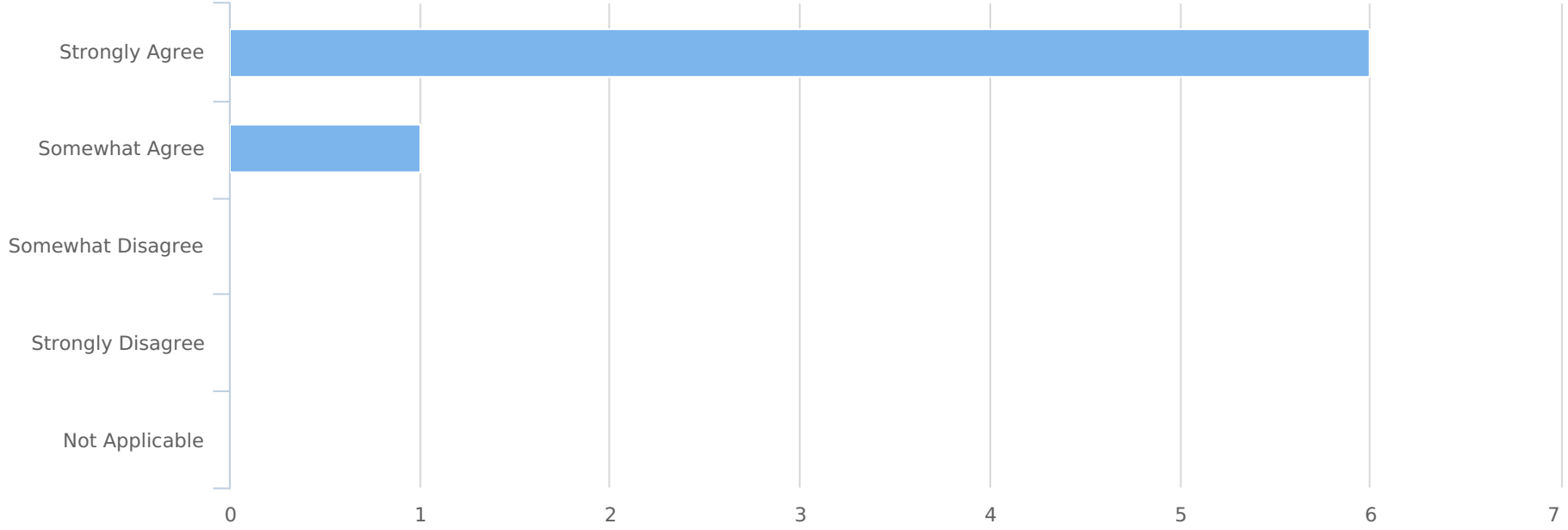
June 25, 2016 - BoH Monthly Meeting Evaluation

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

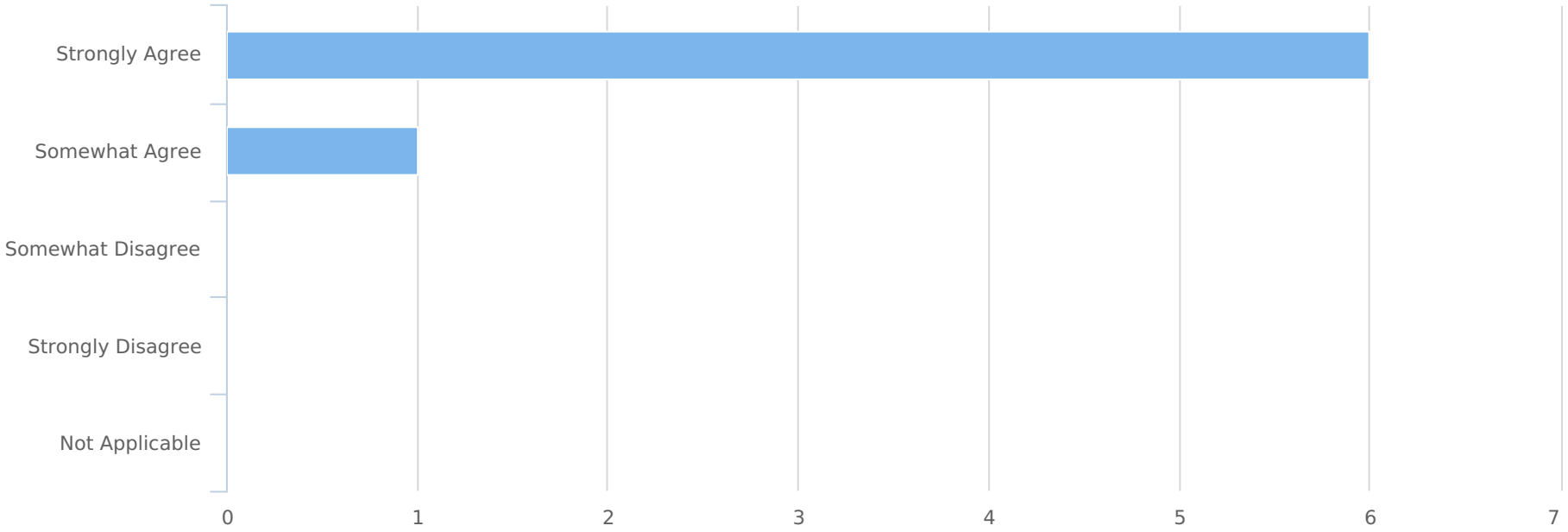
Total Invited to Survey: 7
Total Finished Survey: 7

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



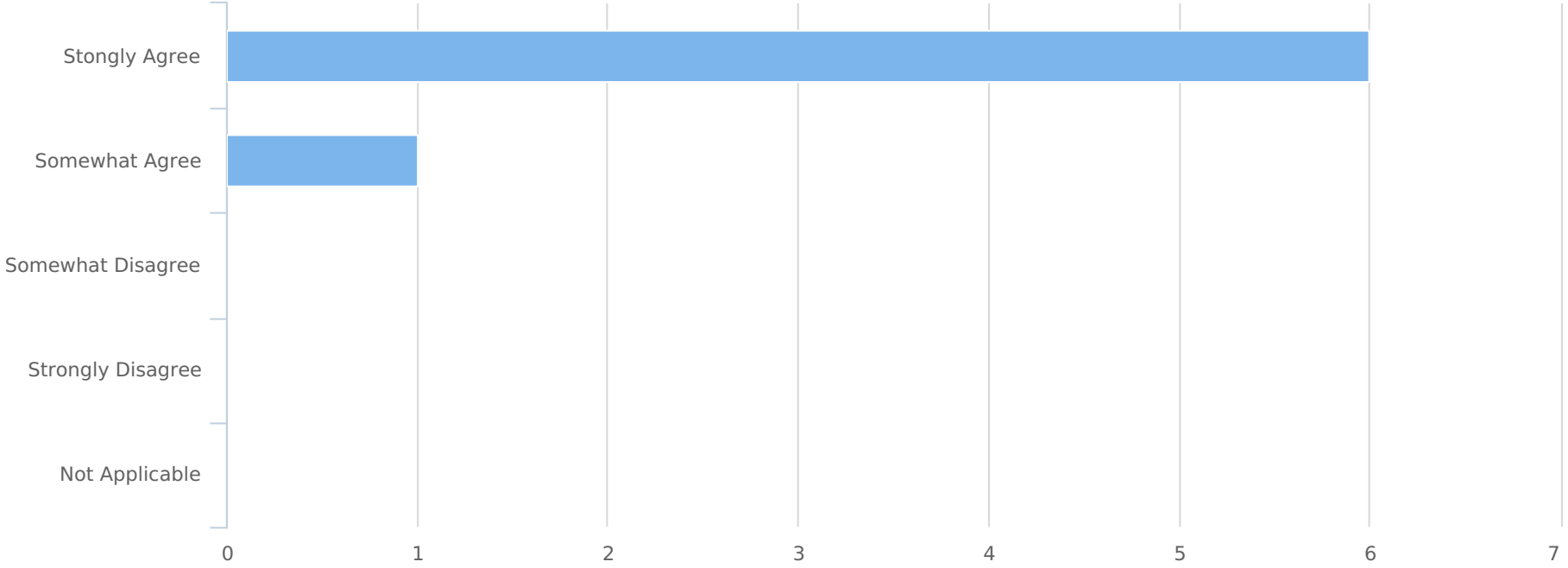
Answered Question: **7**, Skipped Question: **0, Not Yet Answered: 0**

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



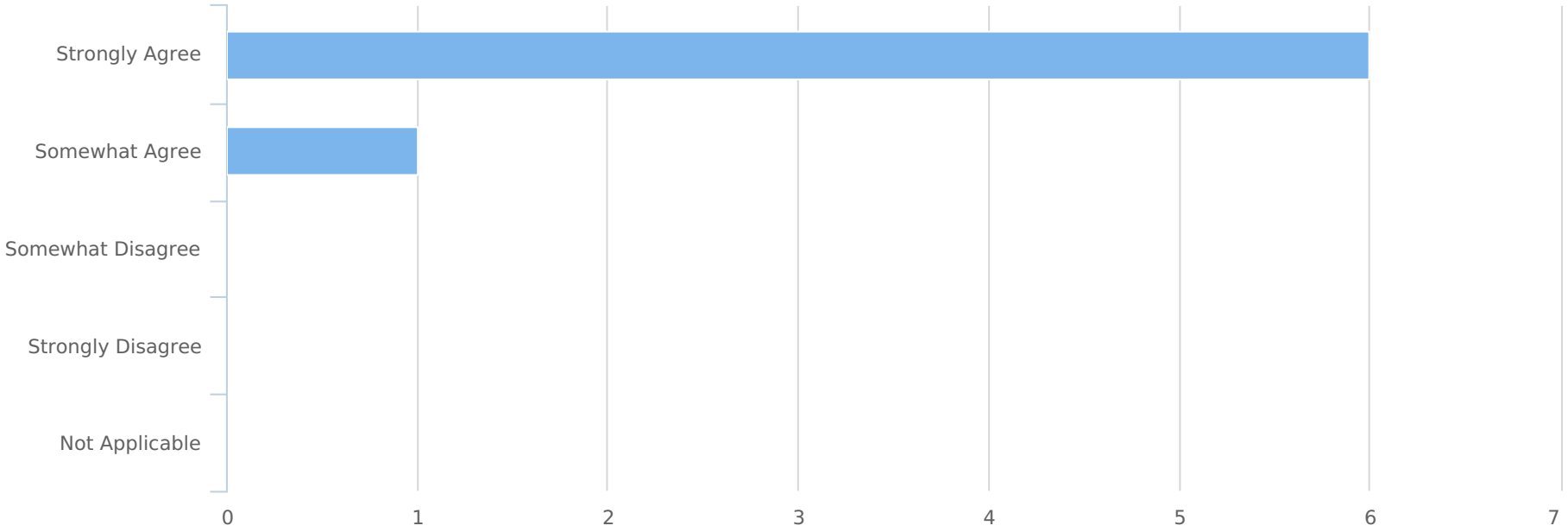
Answered Question: **7**, Skipped Question: **0, Not Yet Answered: 0**

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



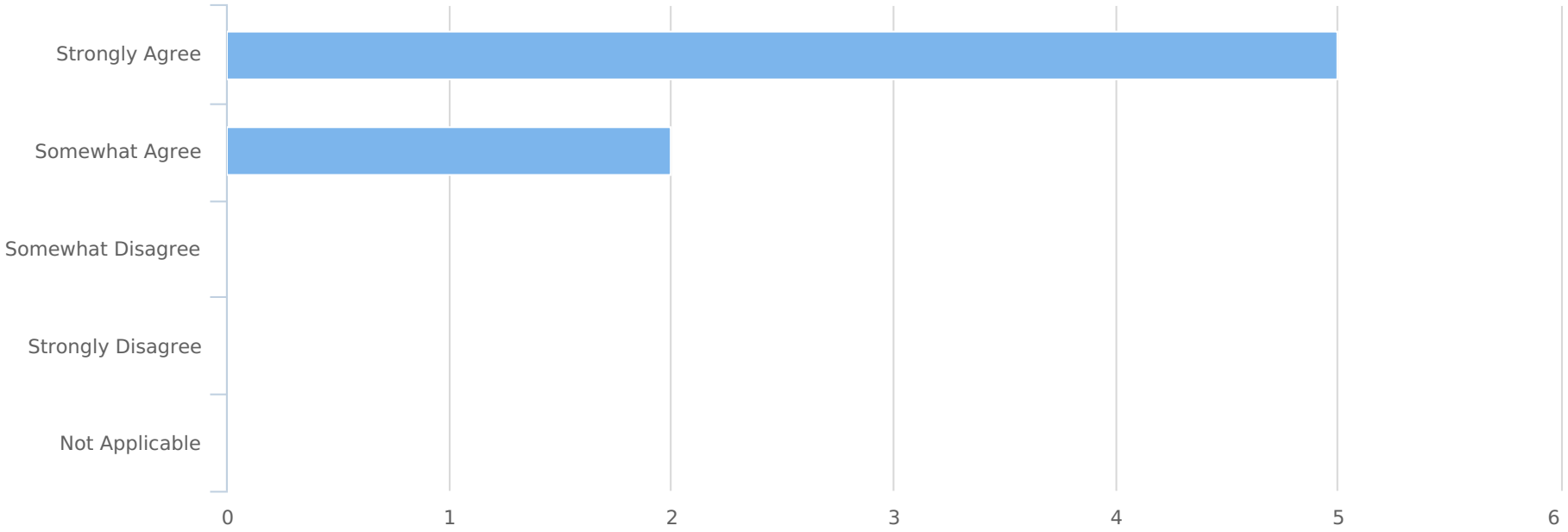
Answered Question: **7**, Skipped Question: **0, Not Yet Answered: 0**

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



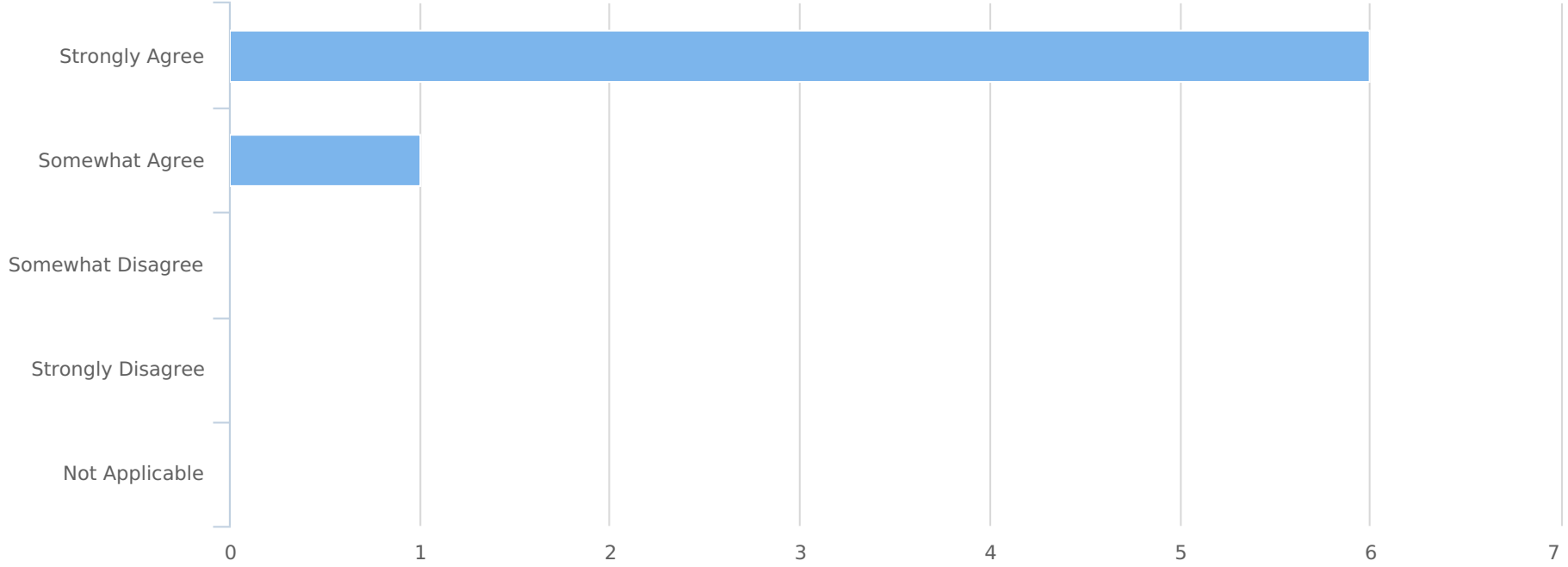
Answered Question: **7**, Skipped Question: **0, Not Yet Answered: 0**

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



Answered Question: **7**, Skipped Question: **0, Not Yet Answered: 0**

Board members' conduct was professional, cordial and respectful.



Answered Question: **7**, Skipped Question: **0, Not Yet Answered: 0**

2016 - Board Member Annual Self-Evaluation

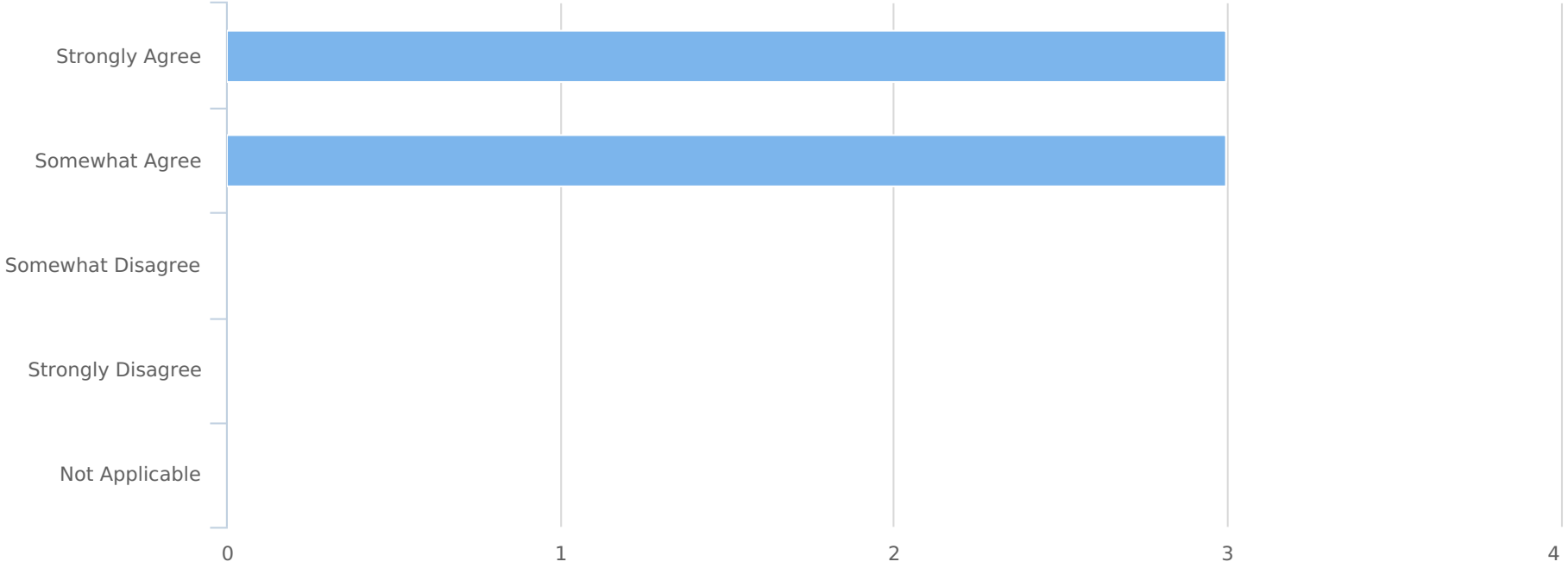
As part of this Board’s commitment to good governance, continuous quality improvement, compliance with the Ontario Public Health Organizational Standards, and in accordance with 02-05-000 and 02-05-055 of the Board of Health Manual, all Board members are encouraged to individually complete this Self-Evaluation of Performance. All responses will be presented through aggregated results.

Please complete prior to June 30. Time will be allocated for Board members to complete the survey during the June Board meeting.

Total Invited to Survey: 7
Total Finished Survey: 6

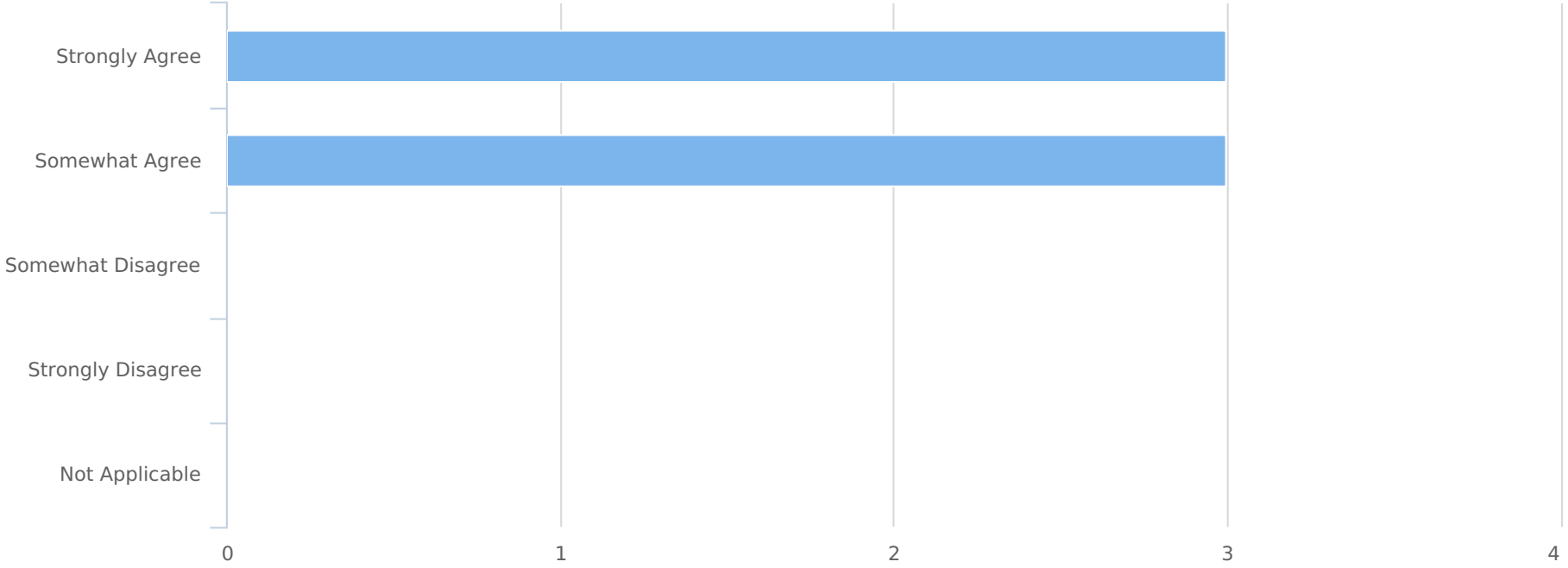
Part 1: Individual Performance

As a BoH member, I am satisfied with my attendance at meetings.



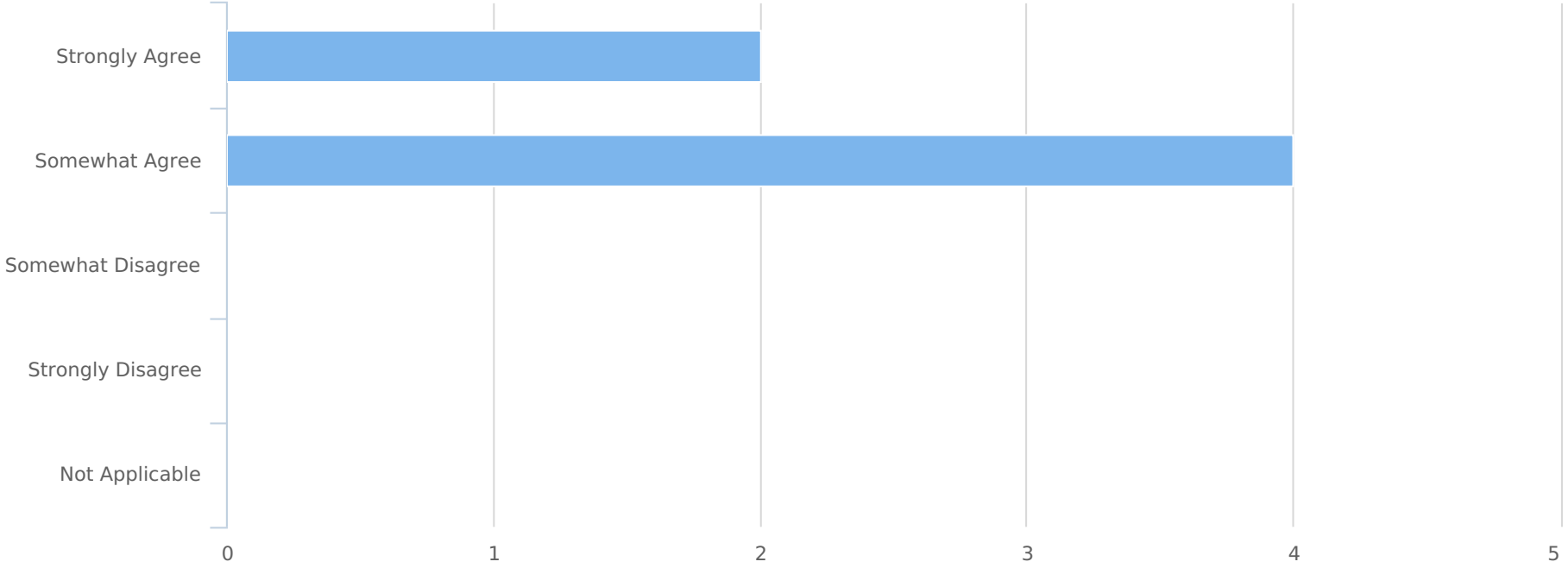
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

As a BoH member, I am satisfied with my preparation for meetings.



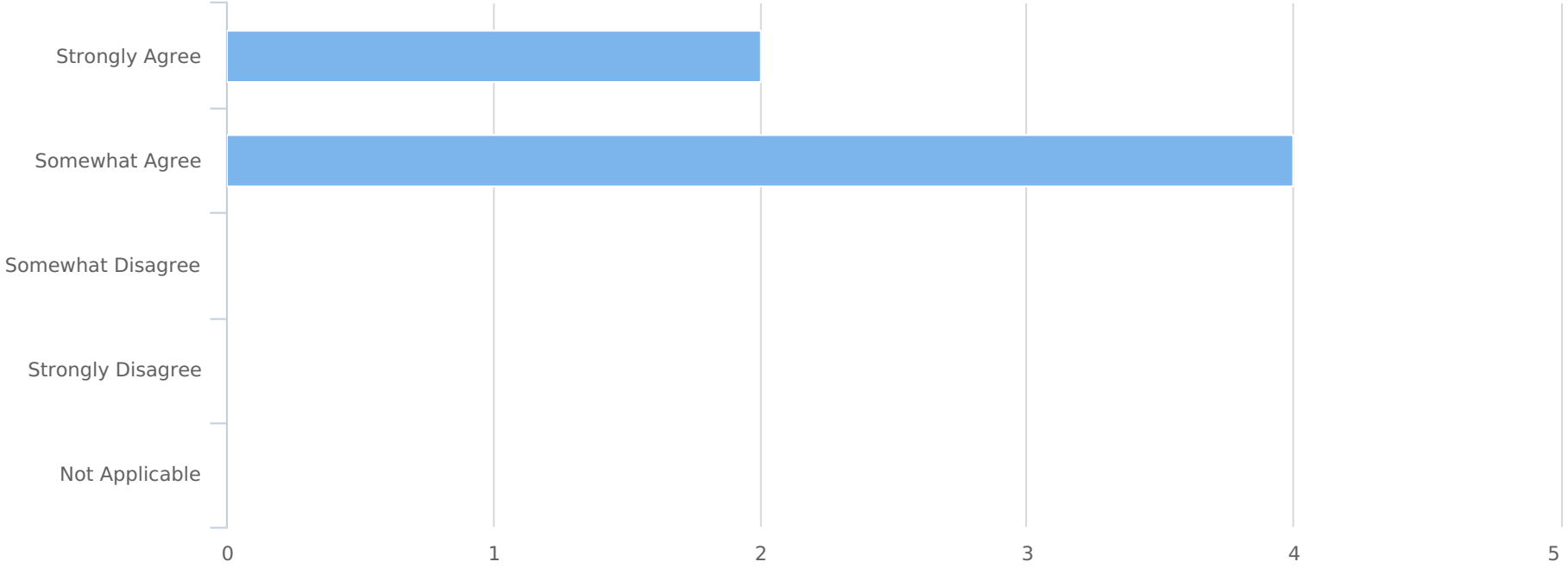
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

As a BoH member, I am satisfied with my participation in meetings.



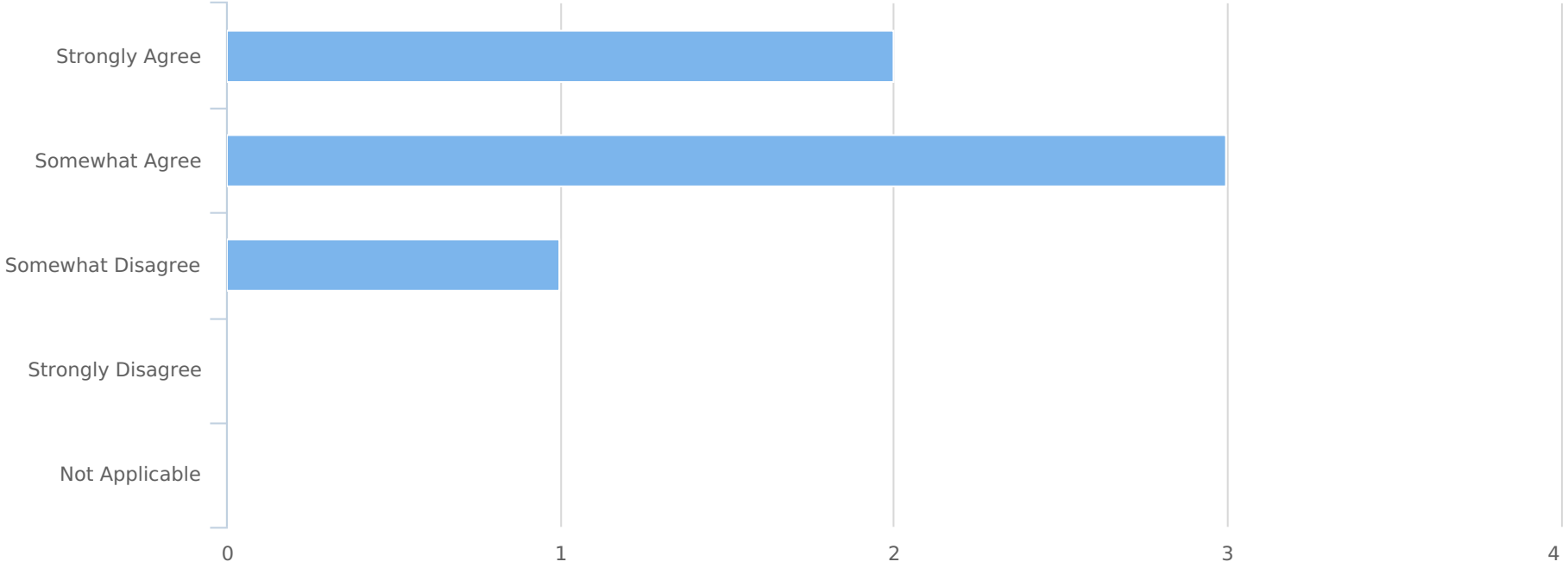
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

As a BoH member, I understand my roles and responsibilities.



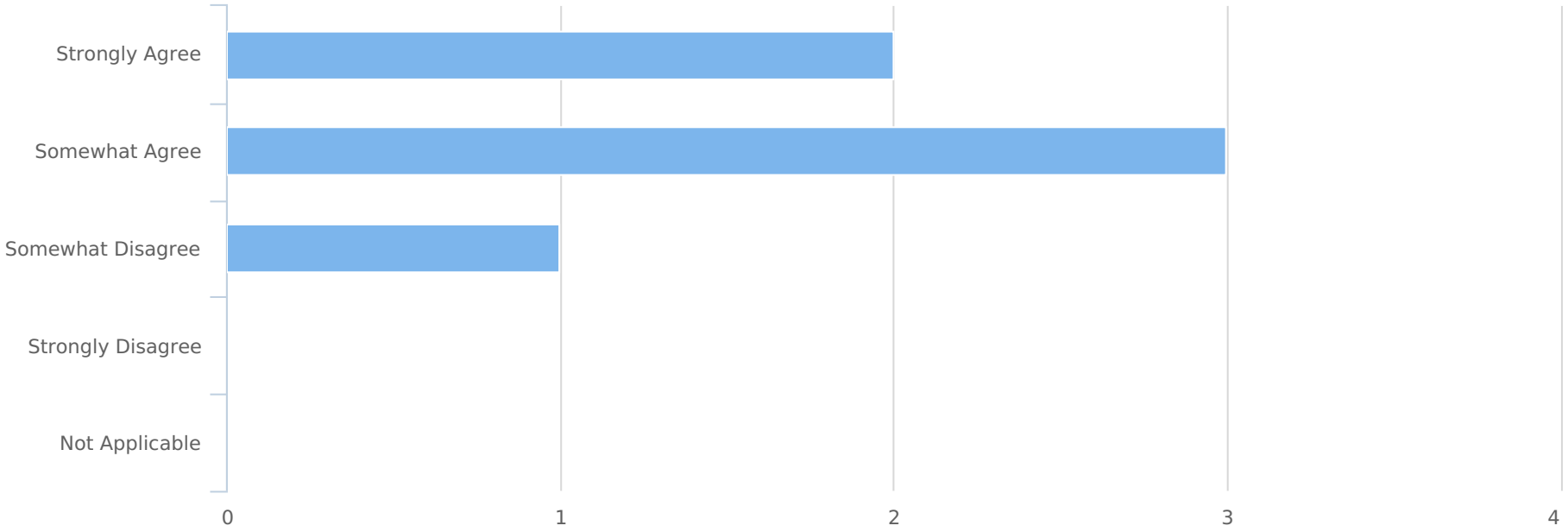
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

As a BoH member, I understand current public health issues.



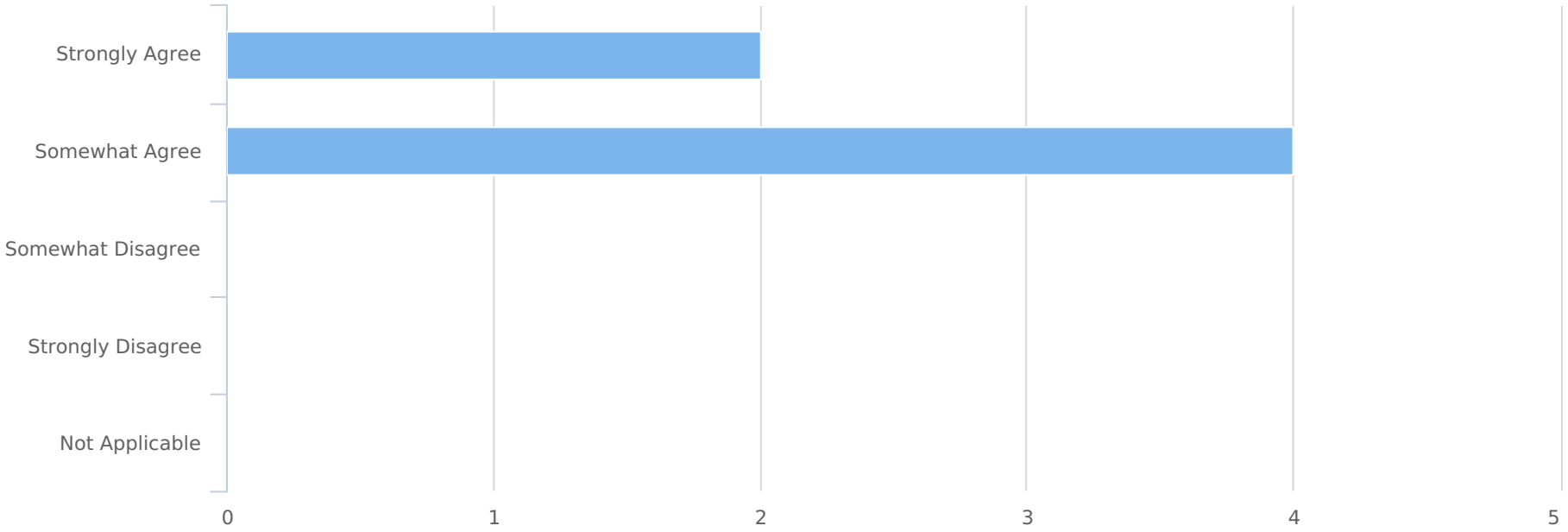
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

As a BoH member, I have input into the vision, mission and strategic direction of the organization.



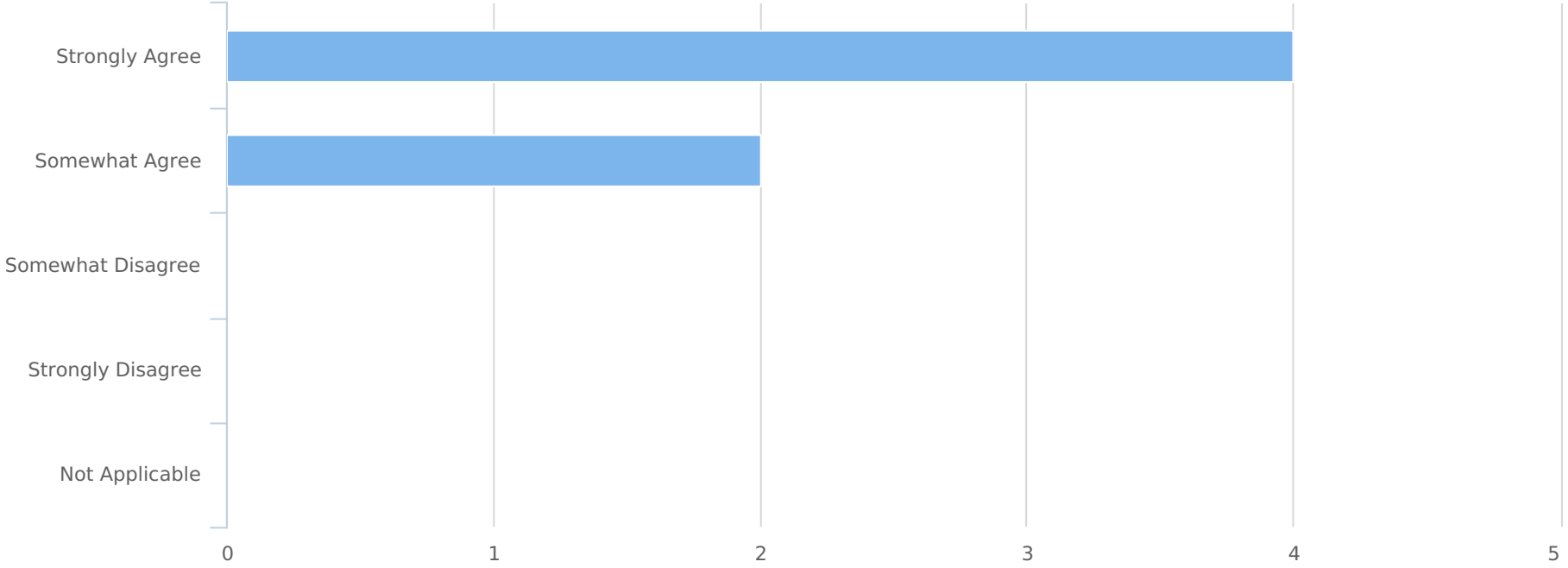
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

As a BoH member, I am aware and represent community perspective during board meetings.



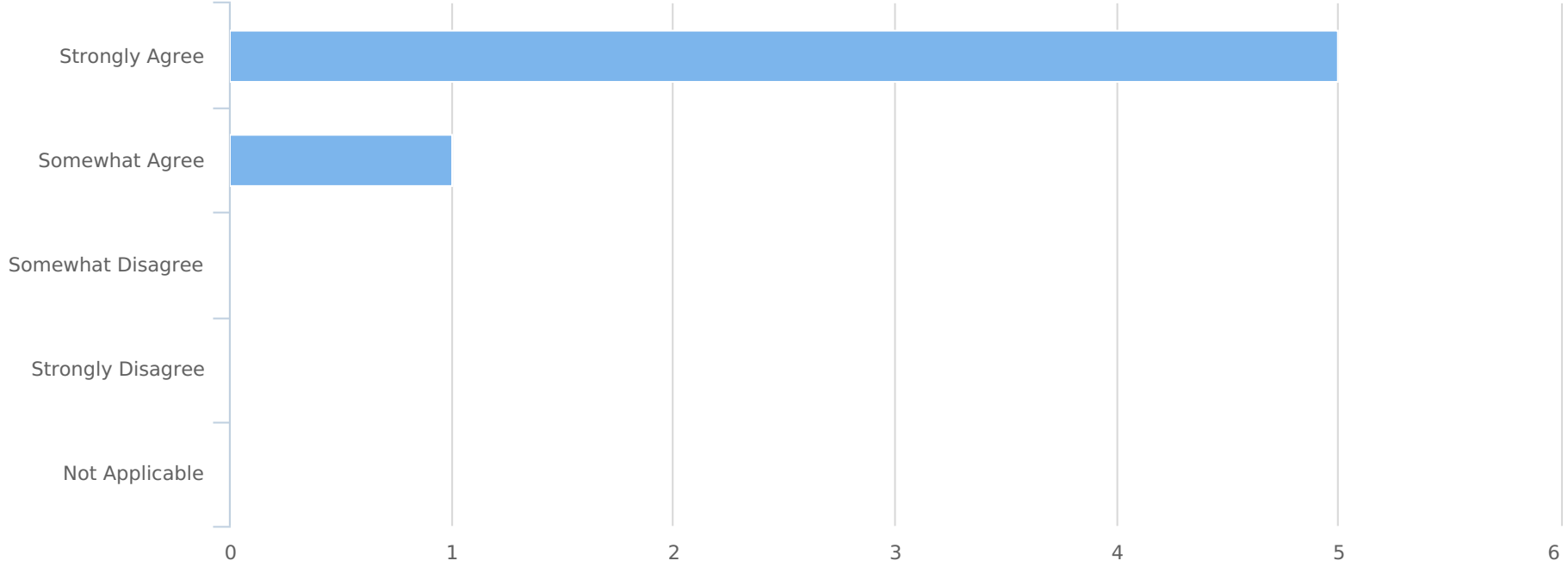
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

As a BoH member, I provide input into policy development and decision-making.



Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

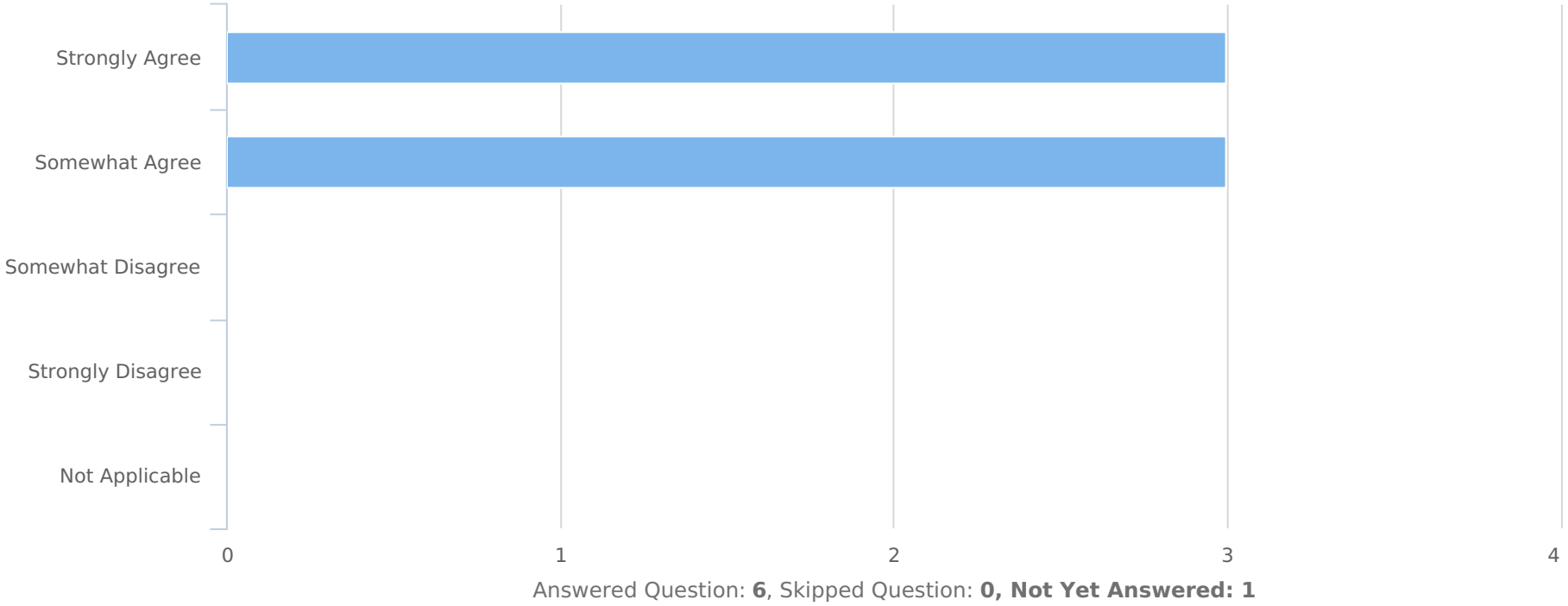
As a BoH member, I represent the interests of the organization at all times.



Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

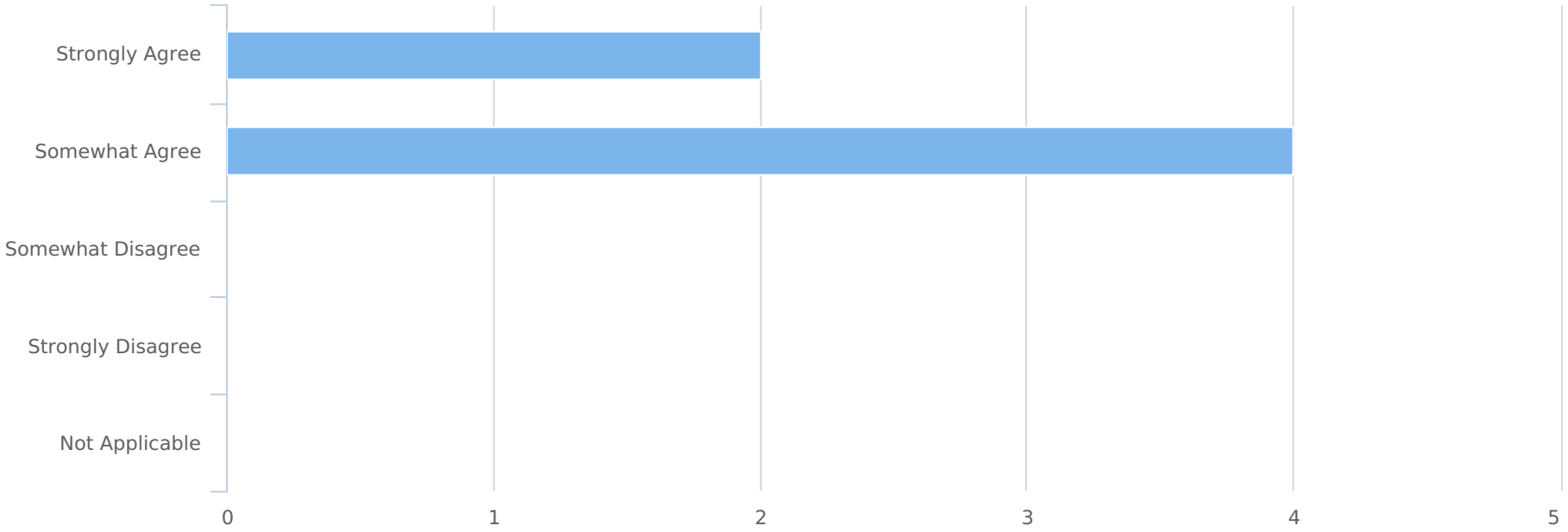
Part 2: Board of Health Processes

The BoH is compliant with all applicable legislation and regulations.



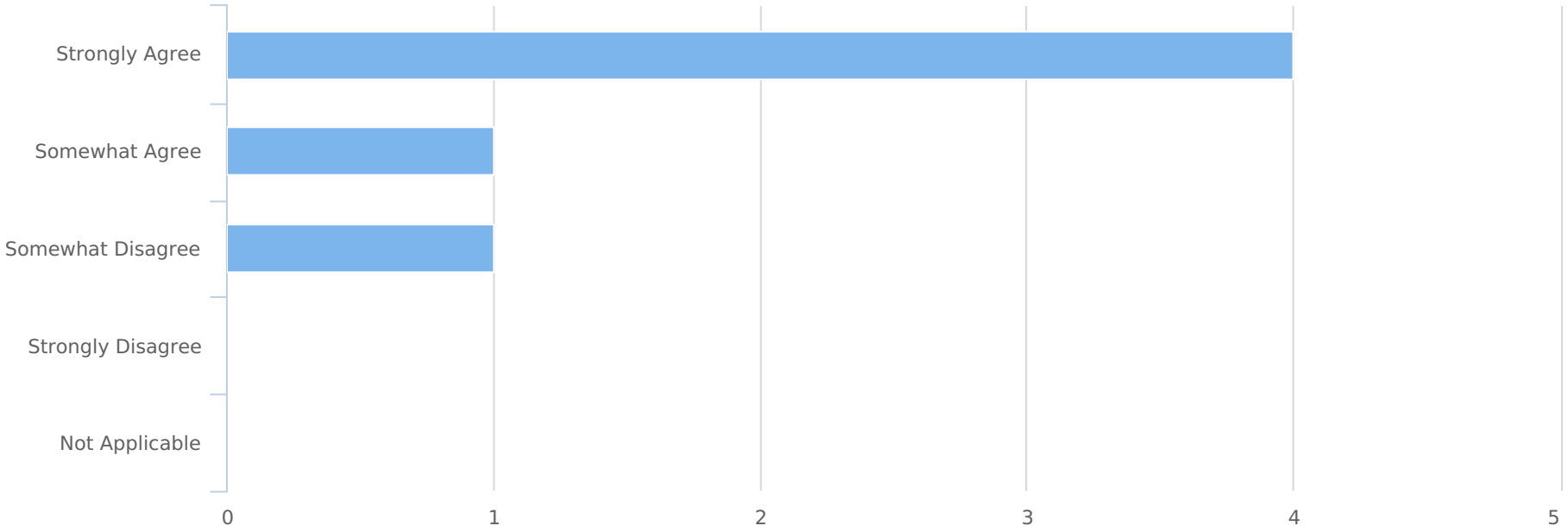
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

The BoH ensures members are aware of their roles and responsibilities through orientation of new members.



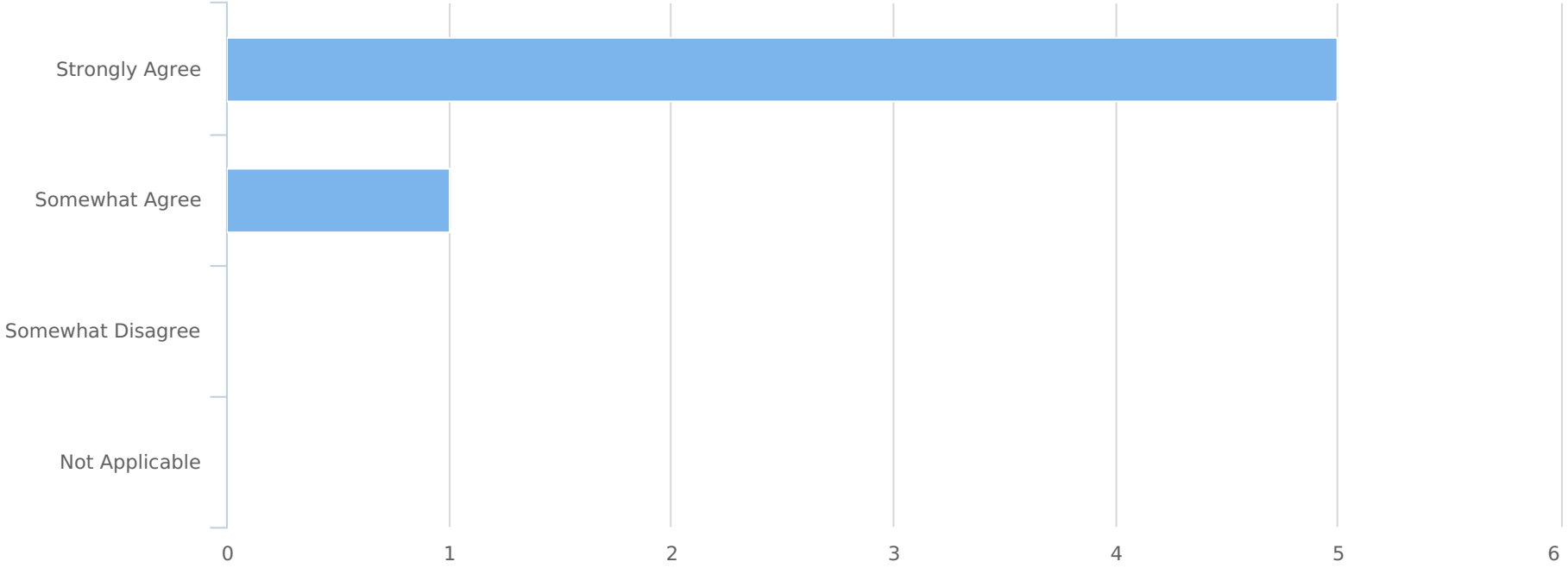
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

The BoH is appropriately informed about financial management, procurement policies and practice, risk management and human resources issues.



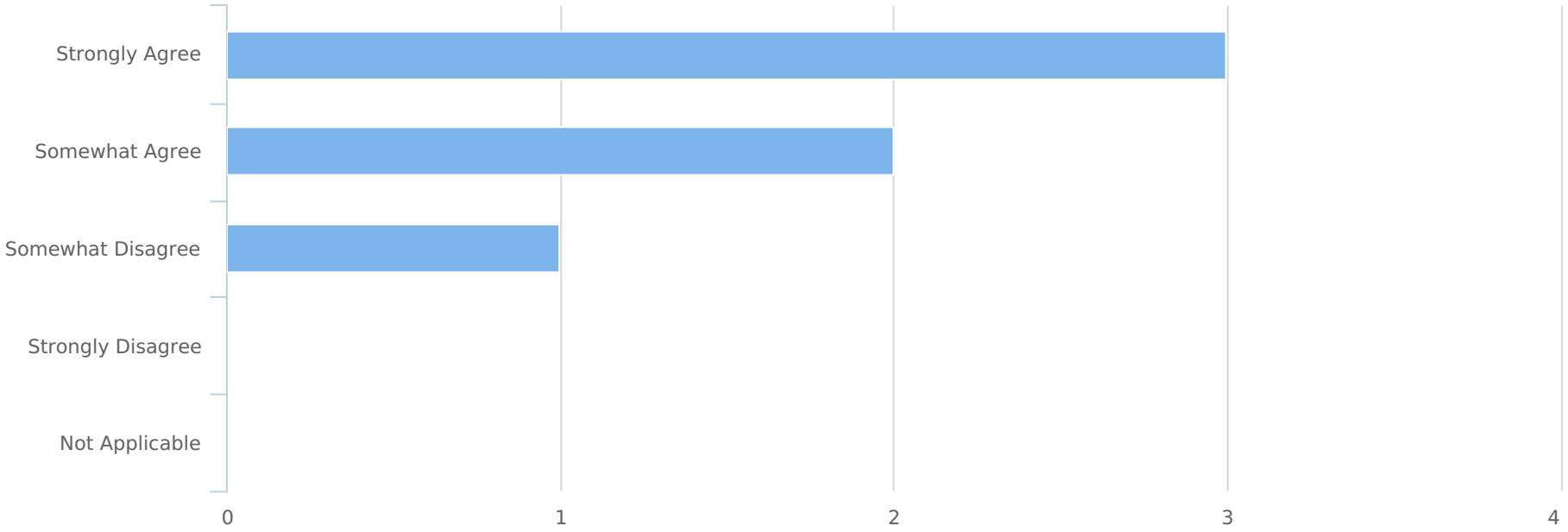
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

The BoH holds meetings frequently enough to ensure timely decision-making.



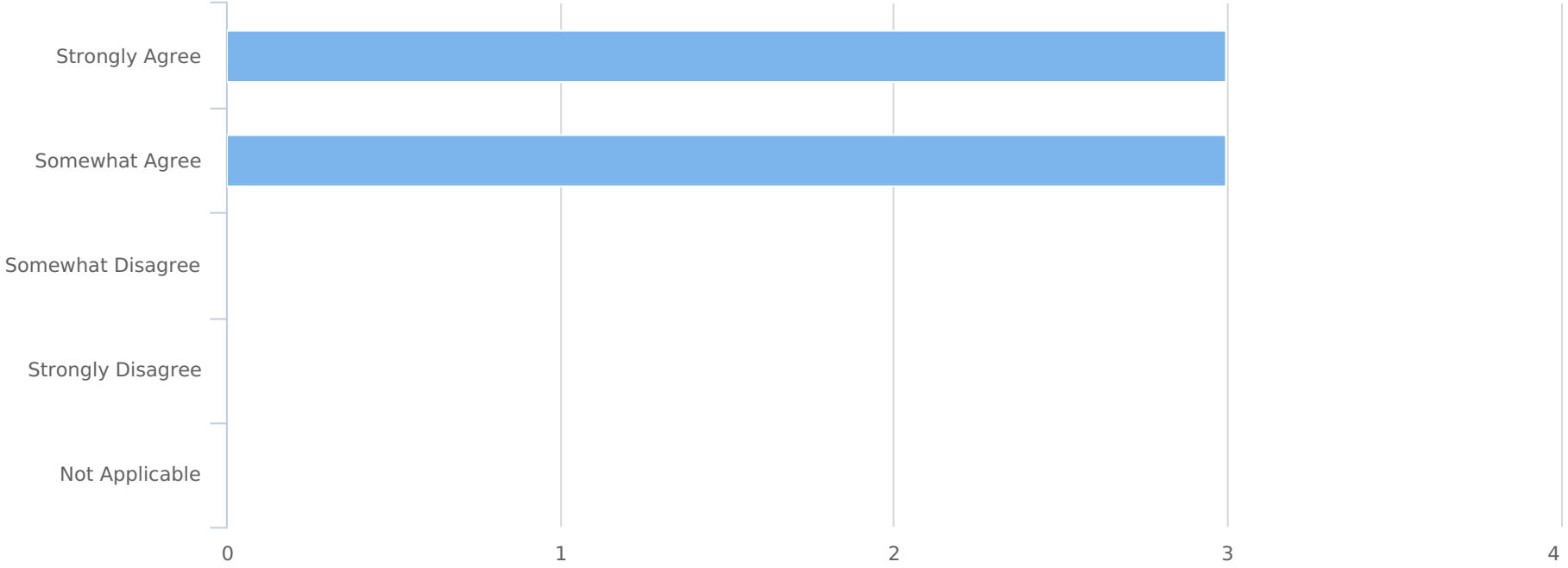
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

The BoH bases decision making on access to appropriate information with sufficient time for deliberations.



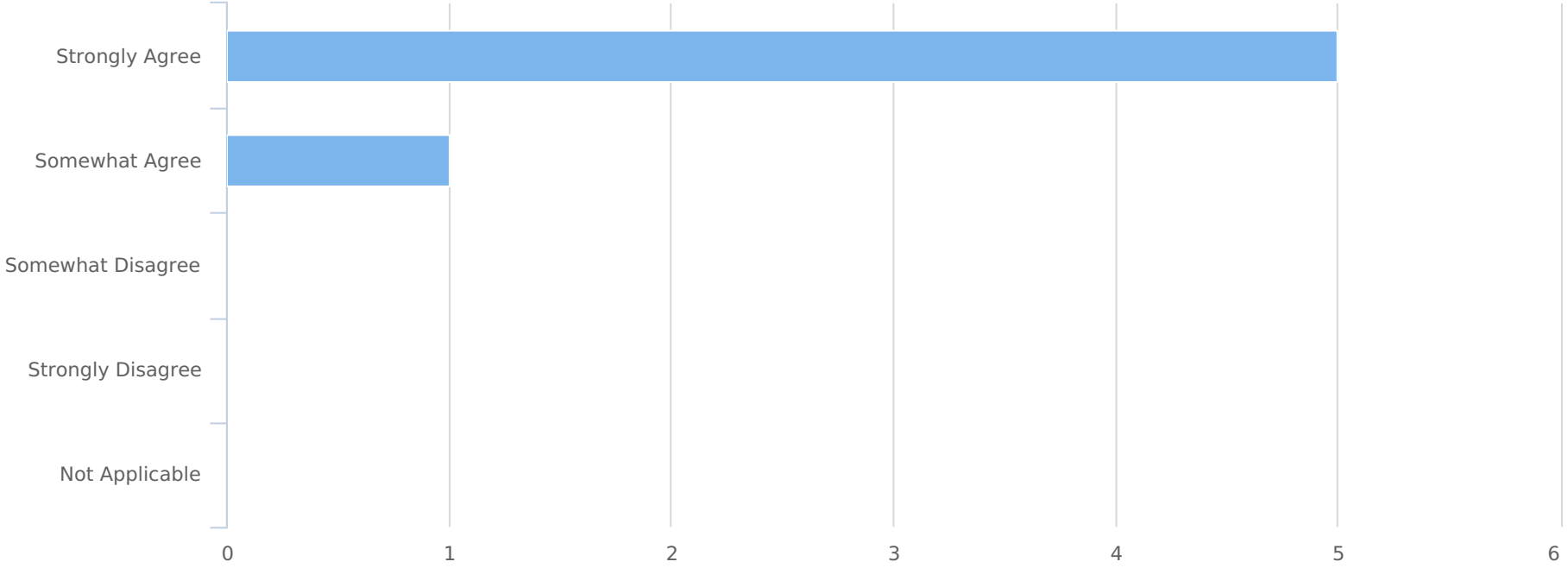
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

The BoH is kept apprised of public health issues in a timely and effective manner.



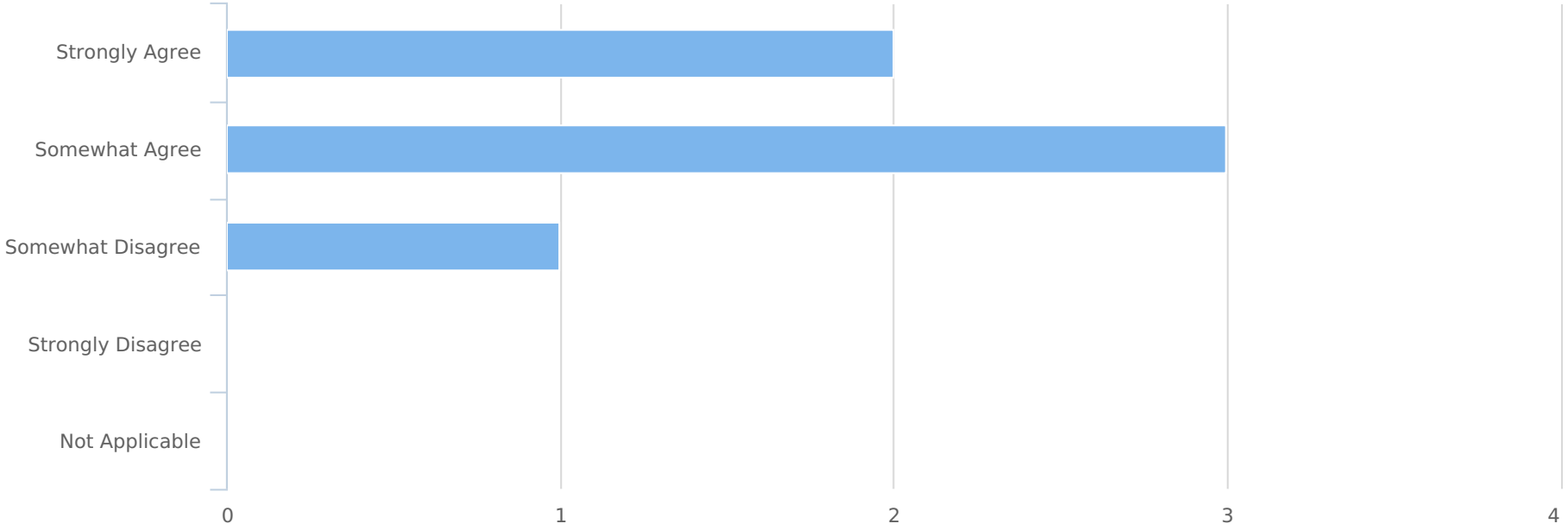
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

The BoH sets bylaws and governance policies.



Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

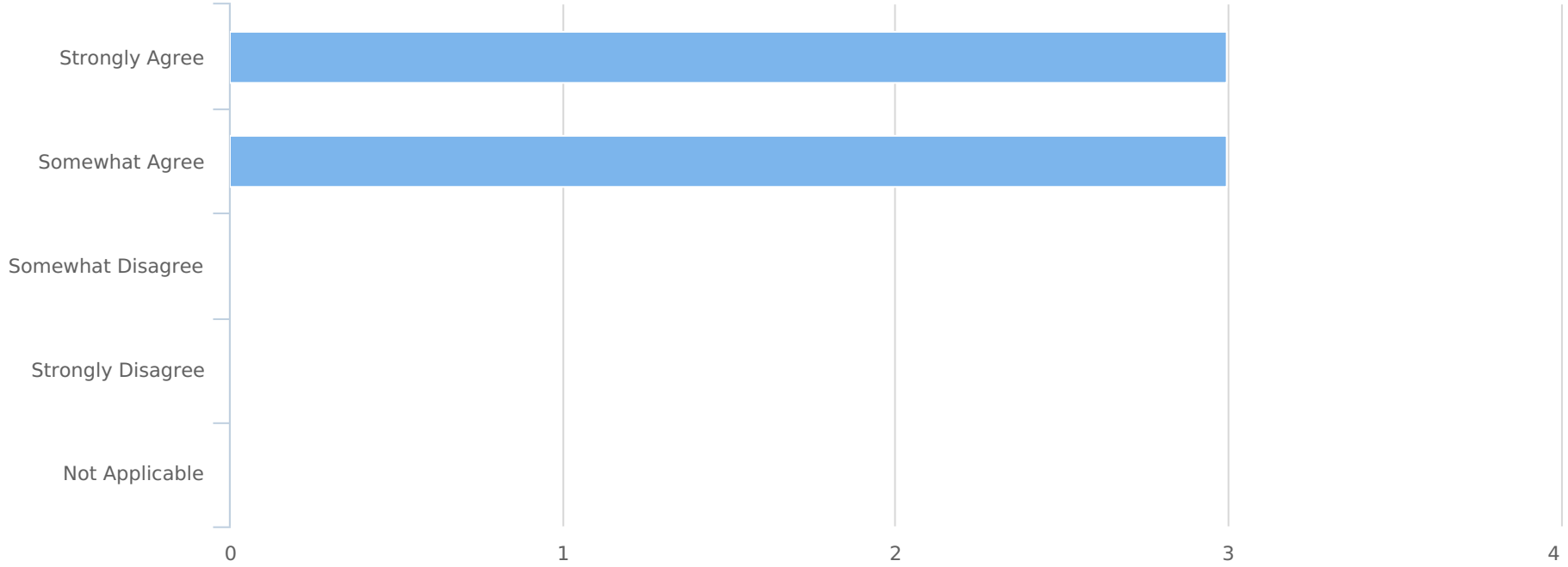
The BoH remains informed with issues pertaining to organizational effectiveness through performance monitoring and strategic planning.



Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

Part 3: Overall Performance of the Board of Health

The BoH contributes to high governance and leadership performance.



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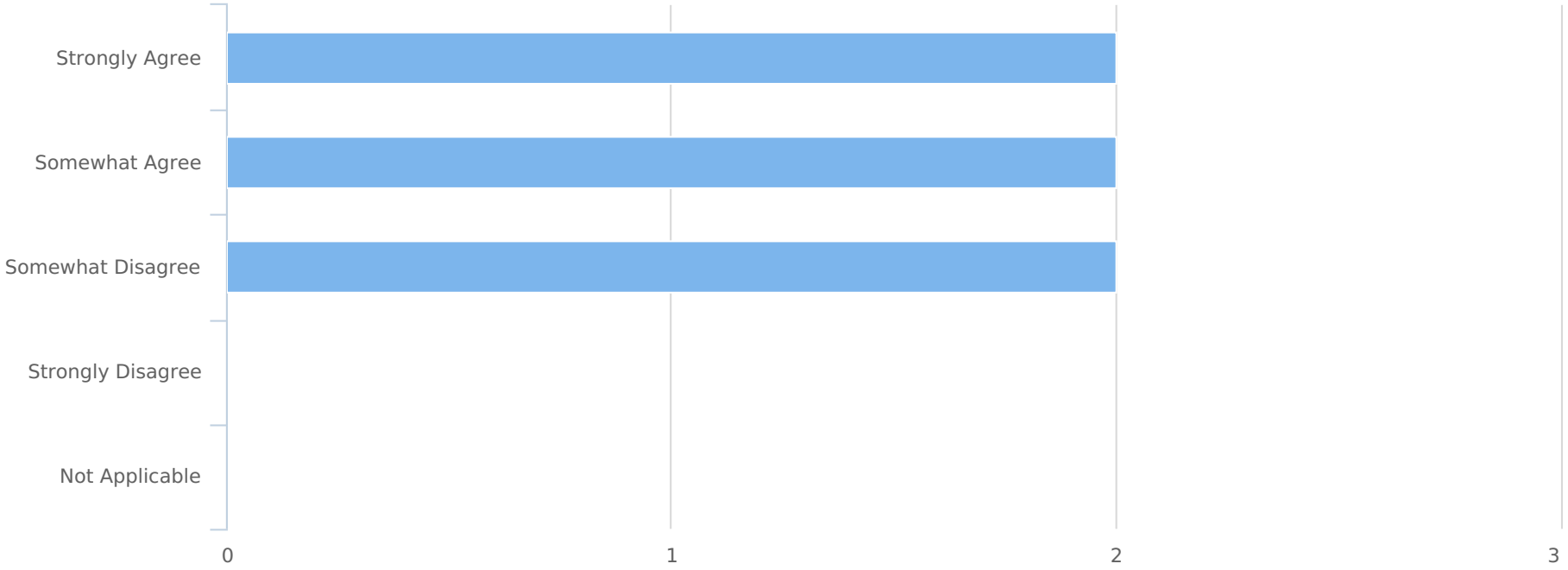
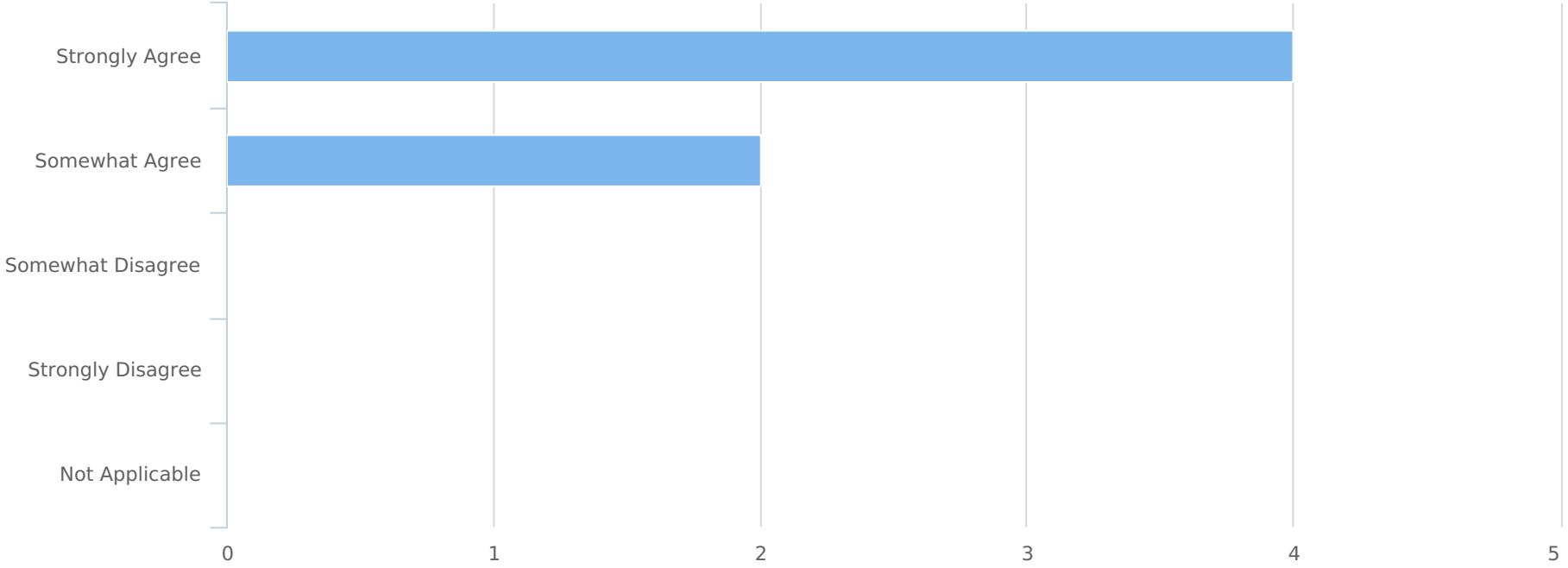
The BoH oversees the development of the strategic plan.



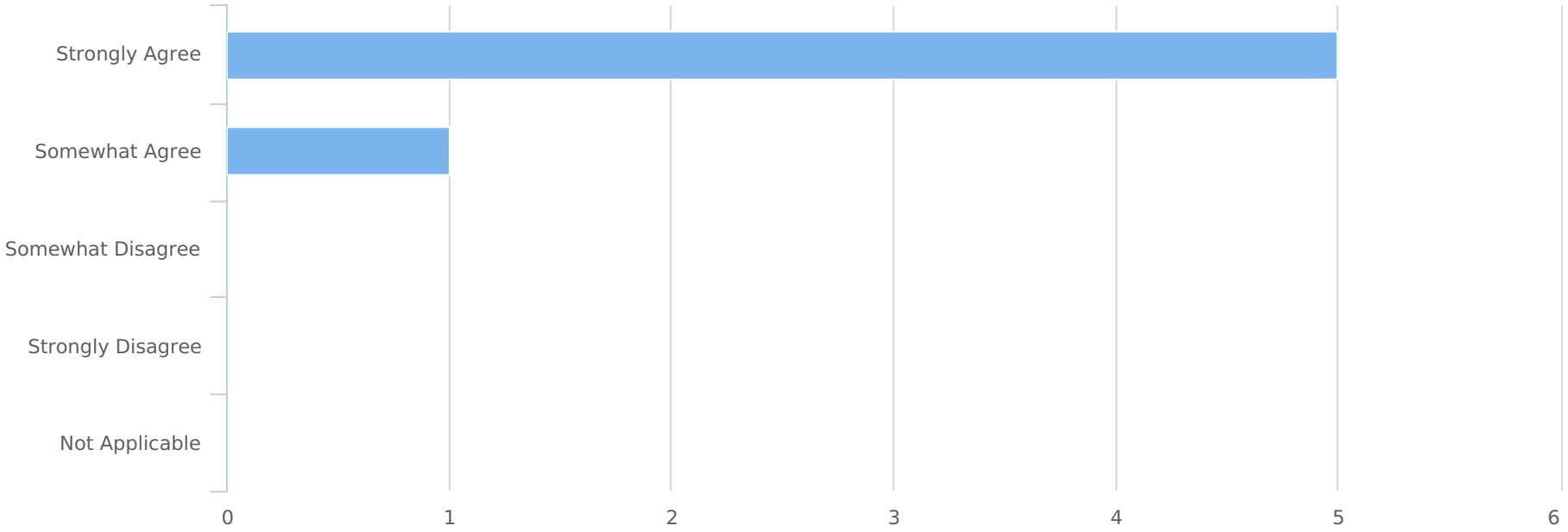
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

The BoH ensures planning processes consider stakeholder and community needs.



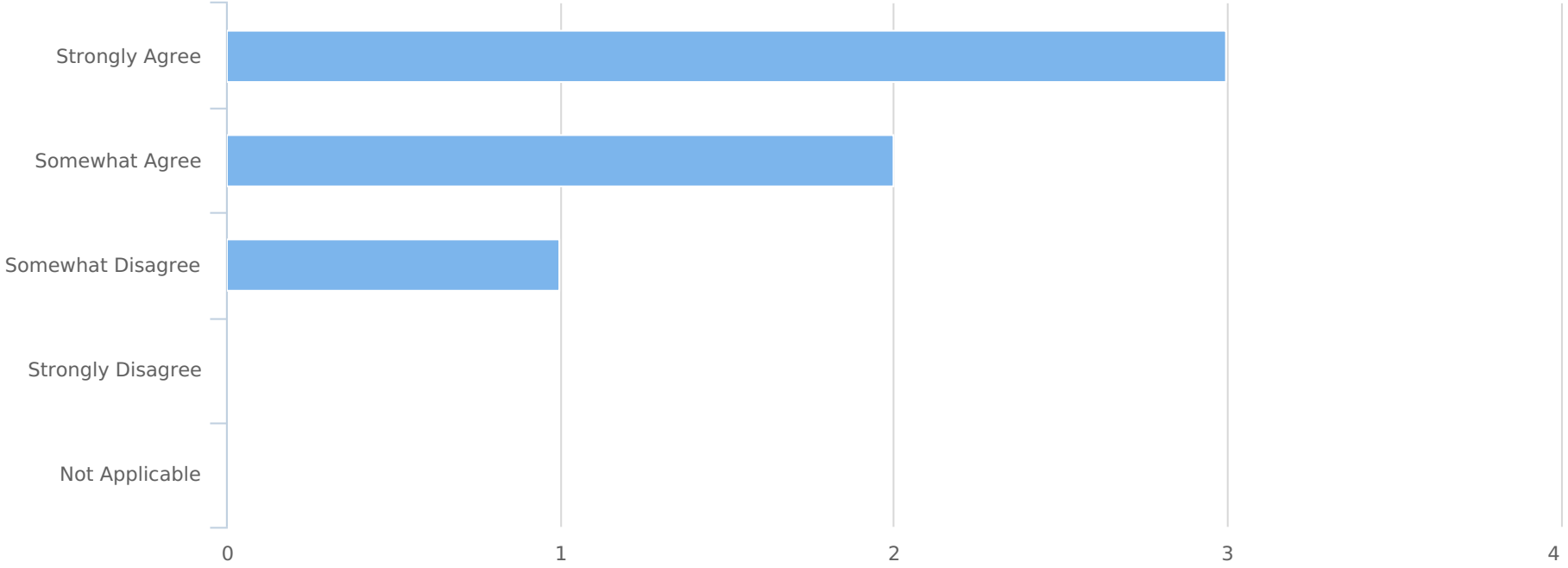
Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

The BoH ensures a climate of mutual trust and respect between themselves and the Medical Officer of Health (MOH/CEO).



Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

5. The BoH as a governing body is achieving its strategic outcomes.



Answered Question: **6**, Skipped Question: **0, Not Yet Answered: 1**

ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE MEETING
JUNE 8, 2016 @ 5:30 PM
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Ian Frazier	Candace Martin	Lee Mason
TELECONFERENCE:	Sue Jensen		
APH STAFF PRESENT:	Tony Hanlon, Ph.D.	Chief Executive Officer	
	Antoniette Tomie	Director of HR and Corporate Services	
	Laurie Zeppa	Director of Community Services	
	Sherri Cleaves	Director of Clinical Services	
	Christina Luukkonen	Recording Secretary	

1) CALL TO ORDER:
Mr. Frazier called the meeting to order at 5:58pm

2) DECLARATION OF CONFLICT OF INTEREST
Mr. Frazier called for any conflict of interests; none were reported.

3) ADOPTION OF AGENDA ITEMS

GC2016-34 Moved: C. Martin
Seconded: L. Mason
THAT the agenda items for the Governance Standing Committee dated June 8, 2016 be adopted as amended.
CARRIED.

4) ADOPTION OF MINUTES

GC2016-35 Moved: L. Mason
Seconded: S. Jensen
THAT the minutes for the Governance Standing Committee dated May 11, 2016 be adopted as amended.
CARRIED.

5) BUSINESS ARISING FROM MINUTES

a. Communication with Municipalities
The committee has requested this become a standing item for the fall. Dr. Hanlon informed the committee that the CAO for City of Sault Ste. Marie has invited APH to present on our budget in the fall to city council. APH will present to city council on APH programs and services date to still to be decided.

Key messages for municipalities will be completed by the fall.

b. Revised Performance Monitoring Plan

Dr. Hanlon presented a revised performance monitoring plan. Copies were provided in the committee's package. Currently the Board is already receiving program updates as part of the MOH/CEO monthly board report so this would be a duplication of information. Dr. Hanlon is proposing moving to one qualitative report and one quantitative report.

GC2016-36 Moved: L. Mason
Seconded: C. Martin

THAT the Governance Standing Committee recommends the draft changes to the APH Performance Monitoring Plan as amended and put forth to the Board for approval.
CARRIED.

6) NEW BUSINESS/GENERAL BUSINESS

a. Terms of Reference Review

Revised copies of the Governance Standing Committee and Finance and Audit Committee were provided as part of the meeting packages. Changes were made to the template and format so both Terms Of Reference (TOR) match. Other proposed changes are on the process for appointing the chairs of the committees. The new TOR would see two vice-chairs being elected at the beginning of the year and the vice-chairs would then each be a chair on a committee. Bylaw 95-1 would need to be revised prior to approval of the new TOR. Dr. Hanlon to revise Bylaw 95-1 and put forth to the Board for approval on June 22, 2016.

Dr. Hanlon to make the requested changes to the TOR in the amendment section and adding back in language on the working with communities and the province on appointing new Board members.

GC2016-37 Moved: L. Mason
Seconded: S. Jensen

THAT the Governance Standing Committee recommends the draft changes to the Terms of Reference for the Finance and Audit Committee and the Governance Standing Committee as amended and put forth to the Board for approval.
CARRIED.

b. 2016-2017 APH Board Annual Work Plan – Draft

Dr. Hanlon presented a draft APH Board work plan for 2016-2017. Only major items are identified for board and committee meetings. Other items can be added as they come up. The committee decided to change the name to APH Board Annual Activity Plan. Also a schedule of program budgets to be added to the activity plan.

GC2016-38 Moved: L. Mason
Seconded: C. Martin

THAT the Governance Standing Committee recommends the 2016-2017 APH Board Annual Activity Plan as presented as put forth to the Board for approval.
CARRIED.

c. Board of Health Evaluations

Dr. Hanlon presented revised policy 02-05-055 – Board of Health Monthly Meeting and Self-Evaluation. The changes reflect the new process for evaluations with the use of the BoardEffect survey tool. Monthly board evaluations will become a standing item on the board agenda. Board

members will be required to complete the evaluation before the meeting adjourns. The monthly evaluations for April and May were provided for information.

GC2016-39 Moved: L. Mason
Seconded: C. Martin

THAT the Governance Standing Committee recommends the draft changes to 02-05-055 Board of Health Monthly Meeting and Self-Evaluation policy as presented and put forth to the Board for approval.

CARRIED.

7) ADDENDUM – N/A

8) IN COMMITTEE

GC2016-40 Moved: L. Mason
Seconded: S. Jensen

THAT the Governance Standing Committee goes in-committee at 6:59pm.

Agenda items:

a. Adoption of Minutes dated May 11, 2016
b. Labour Relations or Employee Negotiations
c. Litigation or Potential Litigation

CARRIED.

9) OPEN MEETING

GC2016-42 Moved: L. Mason
Seconded: C. Martin

THAT the Governance Standing Committee goes into open meeting at 7:51pm.

CARRIED.

10) NEXT MEETING: Wednesday, September 14, 2016

11) THAT THE MEETING ADJOURN:

GC2016-43 Moved: L. Mason
Seconded: S. Jensen

THAT the Governance Standing Committee meeting adjourns at 7:53pm.

CARRIED.

Ministry of Health and Long-Term Care

Health Promotion Implementation Branch

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Fax: 416-314-5497
TTY: 416-327-4282
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Ministère de la Santé et des Soins de longue durée

Direction de la mise en œuvre de la promotion de la santé

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ATS sans frais: 1-800-387-5559
www.health.gov.on.ca

Ontario

June 22, 2016

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

Dear Dr. Sutcliffe,

The ministry is pleased to learn your health unit has successfully achieved Baby-Friendly Initiative (BFI) Redesignation.

Congratulations to you, your leadership team and your staff on this milestone achievement for Algoma Public Health! No doubt your Board of Health is pleased to hear of this significant performance achievement which benefits parents and babies in Algoma.

As early adopters of BFI, Algoma has a long history of breastfeeding promotion. Your health unit has supported and inspired your local community, and other public health units. Most importantly, Algoma Public Health builds continued supports for the health of babies and their parents within your jurisdiction.

We thank you for so willingly sharing your successes and lessons learned on your journey to BFI designation and redesignation with the ministry, BFI Ontario, other public health units and health care facilities.

Sincerely,

Laura A. Pisko
Director, Health Promotion Implementation Branch

c. Roselle Martino, ADM, Population and Public Health Division
David Sit, Manager (A), Health Promotion Performance and Accountability Unit
Dr David Williams, Chief Medical Officer of Health
Laurie Zeppa, Chief Nursing Officer/Director of Community Services, Algoma Public Health
Hannele Dionisi, Manager of Reproductive Health/ Oral Health/Child Health, Algoma Public Health

HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT
HEALTH UNIT

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

September 14, 2016

The Honourable Jean-Yves Duclos
Minister of Families, Children and Social Development
House of Commons
Ottawa, Ontario K1A 06A

Dear Minister Dulcos

Re: Basic Income Guarantee

I am writing to advise you that the Haliburton Kawartha Pine Ridge District Health Unit Board of Health has endorsed a position statement supporting the concept of a basic income guarantee as one component of a multi-pronged strategy to reduce poverty and eliminate health inequities.

Income is identified as the most important determinant of health. Research shows that as income increases, health outcomes improve. Since people with lower incomes are at greater risk of having poor physical and mental health and live shorter lives, improving income is an effective public health strategy to improve health and social outcomes.

Basic income guarantee as a policy option to reduce poverty has been debated for many years. The Mincome Pilot Project in Dauphin Manitoba in the 1970's demonstrated improved health and educational outcomes. Similarly the guaranteed income supplement programs already existing in Canada for seniors and children including the Old Age Security (OAS), Guaranteed Income Supplement (GIS), and the Canadian Child Tax Benefit (CCTB), have shown that income security measures have contributed to improved health and well-being in these populations.

There has been recent support for basic income guarantee from several health and social service sectors, citizen groups, economists and politicians. Most recently the Province of Ontario announced plans to move forward with a Pilot.

Since one of the Haliburton Kawartha Pine Ridge District Health Unit's strategic priorities is to address the social determinants of health and health equity, we are requesting that the Government of Canada work with the Government of Ontario in developing and implementing poverty reduction strategies. In addition to addressing early childhood development, education, employment, economic and workforce development, and affordable housing, consideration and investigation of basic income guarantee as a policy option to reduce poverty and income insecurity must be included to improve health and social outcomes.

Sincerely

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

Mark Lovshin, Chair, Board of Health

Attachments: Haliburton, Kawartha, Pine Ridge District Health Unit Basic Income Guarantee Position Statement and Resolution

HALIBURTON KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT
BASIC INCOME GUARANTEE

Position Statement

It is the position of the Haliburton Kawartha Pine Ridge District Health Unit that eliminating poverty is an urgent health, human rights and social justice issue that requires action on the part of the municipal, provincial and federal governments. Basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, is an essential component of a strategy to effectively eliminate poverty, ensure all Canadians have a sufficient income to meet their basic needs, and live with dignity and to eliminate health inequities.

Backgrounder

Income has been identified as the most important determinant of health as it influences living conditions, physical and mental health and health-related behaviours including the quality of one's diet, extent of physical activity and tobacco use[1]. People living in poverty are more likely to experience poorer health, have two or more chronic conditions, have more injuries, be more likely to have a disability, use health care services more frequently and live shorter lives.

Based on the Low-Income Measure After Tax (LIM-AT), the incidence of low-income in 2013 was 13.5% for the Canadian population.[2] More specifically, 16.5% of children aged 17 and under lived in low income families and for children living in lone-parent families headed by a woman, the incidence rose to 42.6%.

Locally in the Haliburton Kawartha Pine Ridge District Health Unit, in 2010, 12.7% of the population lived in low-income situations based on LIM-AT.[3] In terms of children under the age of 6 years, 21.8 % lived in low income families. [4]

Currently, households that rely on Ontario Works or Ontario Disability Support Programs as their primary source of income have income levels that are inadequate to meet core basic needs such as housing and food. According to a report on household food insecurity in Canada

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[1] In Focus The Social Determinants of Health, Epidemiology and Evaluation Services, Fall 2014 available from http://www.hkpr.on.ca/Portals/0/PDF%20Files/PDF%20-%20Epi/InFocus14-Web.pdf

[2] Statistics Canada Canadian Income Survey 2013 available from http://www.statcan.gc.ca/daily-quotidien/150708/dq150708b-eng.htm

[3] 2011 National Household Survey, Statistics Canada available from https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=HR&Code1=3535&Data=Count&SearchText=Haliburton,%20Kawartha,%20Pine%20Ridge%20District%20Health%20Unit&SearchType=Begins&SearchPR=01&A1=All&B1=All&GeoLevel=PR&GeoCode=3535&TABID=1

[4] Ibid

in 2012, 70% of households whose primary source of income was social assistance were food insecure.[5]

Over the past 20 years there have been tremendous changes in technology and globalization, which impacts job stability and security. Almost half of working adults are employed in precarious employment, which is part-time, seasonal or contract work that has little or no benefits and often pays low wages. Research shows that 70% of Canadians living in poverty are considered to be the working poor, which means they are employed but do not earn enough to make ends meet. [6]

Basic Income Guarantee

The causes of poverty are complex and a multipronged approach is required to eliminate poverty and to improve health and social equity for all. One component of a poverty reduction strategy is to provide a basic income guarantee (BIG). It is an unconditional income transfer from the government to individuals and families that is not tied to labour market participation. [7] The objective of a basic income guarantee is to provide a minimum annual income at a level that is sufficient to meet basic needs and allows individuals and families to live with dignity, regardless of work status.[8] Since research shows that basic income guarantee could have health promoting effects and reduce health and social inequities, it is considered to have merits as an effective policy option.

A basic income guarantee was piloted in Dauphin Manitoba from 1974-1979 to study the impact of a guaranteed income supplement. Research showed a number of substantial benefits including a decrease in hospitalization rates, which were 8.5% less when compared to the control group. There were fewer incidents of work-related injuries, fewer visits to the emergency department from motor vehicle accidents and domestic violence and there was a reduction in the rates of psychiatric hospitalizations and the number of mental illness consultations with health care professionals. The research also showed that teenagers and new mothers were the only populations to significantly work less. The study showed that more teenagers completed high school and new mothers extended their maternity leaves. Once the

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[5] Tarasuk, V., Mitchell, A., Dachner, N.,(2014) Household food insecurity in Canada, 2012 available from http://nutritionalsciences.lamp.utoronto.ca/wp-content/uploads/2014/05/Household_Food_Insecurity_in_Canada-2012_ENG.pdf

[6] Lewchuk, W. et al. It's More than Poverty: Employment Precarity and Household Well-being United Way Toronto-McMaster University Social Sciences, 2013. www.pepso.ca

[7] Pasma, C., and Mulvale, J. Income Security for all Canadians Understanding Guaranteed Income. Ottawa: Basic Income Earth Network Canada; 2009. Available from http://www.cpj.ca/files/docs/Income_Security_for_All_Canadians.pdf

[8] Ibid

pilot finished and the cash transfers stopped, the number of teens not graduating from high school rose, returning to the previous rate that existed before the pilot.[9]

Currently in Canada, Old Age Security (OAS) and Guaranteed Income Supplements (GIS) are forms of guaranteed income supplement programs, which are income tested cash transfers for seniors at age 65 and older. Since their implementation, the incidence of poverty in seniors dropped substantially from 21.4% in 1980 to 5.2% in 2011. As a result, Canada has one of the lowest rates of seniors living in poverty in the world and the incidence of food insecurity is 50% less for those age 65 to 69 than for those age 60-64.[10]Similarly, other programs such as the Canadian Child Tax Benefit and National Child Benefit Supplement (which are tax free monthly payments for eligible families with children) have shown benefits in terms of improved math and reading skills and improved mental and physical health measures.[11]

Cost Considerations for a Basic Income Guarantee Program

It is widely agreed upon that the costs of poverty are very high. The total cost of poverty in Ontario is approximately $32.2-$38.3 billion dollars.[12] It is estimated that between $10.1 billion and $13.1 billion is spent on the social costs of poverty related to social assistance, housing and justice programs and health care costs associated with the effects of poverty. Lost opportunities for income tax revenue are estimated to be $4- $6.1 billion dollars and an additional $21.8-25.2 billion is attributed to lost productivity and revenue and intergenerational poverty low-income cycles.

Given the magnitude of the social and economic costs of poverty and the resources being spent on countering the negative effects of poverty, it is more prudent to spend those resources on prevention.

The costs of a basic income guarantee program in contrast to the costs of social and private costs of poverty have yet to be extensively researched. Estimates from Queen's University and the University of Manitoba identify that the amount for a basic income guarantee program for all of Canada would cost between $40 and $58 billion. Considering the total costs of poverty for just Ontario, a basic income guarantee would be very achievable.[13]

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[9] Forget, E. **The Town with No Poverty: Using Health Administration Data to Revisit Outcomes of a Canadian Guaranteed Annual Income Field Experiment 2011** available from http://nccdh.ca/images/uploads/comments/forget-cea_(2).pdf

[10] Hyndman, B., and Simon, I., Basic Income Guarantee Backgrounder October 2015 aIPHA and OPHA available from ww.opha.on.ca/getmedia/bf22640d-120c-46db-ac69-315fb9aa3c7c/aIPHa-OPHA-HEWG-Basic-Income-Backgrounder-Final-Oct-2015.pdf.aspx?ext=.pdf

[11] Ibid

[12] Laurie, N. **The cost of poverty: an analysis of the economic cost of poverty in Ontario.** Toronto Ontario Association of Food Banks, 2008. http://www.oafb.ca/assets/pdfs/CostofPoverty.pdf

[13] Roos, N., and Forget, E. **"The time for a guaranteed annual income might finally have come."** The Globe and Mail, August 4, 2015. Available at http://www.theglobeandmail.com/report-on-business/rob-commentary/the-time-for-a-guaranteed-annual-income-might-finally-have-come/article25819266/

Provincial and National Support for a Basic Income Guarantee Program

Support for the basic income guarantee program exists across the political spectrum including politicians from several provinces and municipalities, economists and the health and social service sectors. Many large associations have given formal expressions of support such as The Canadian Medical Association, the Association of Local Public Health Agencies and the Ontario Public Health Association, the Ontario Society of Nutrition Professionals in Public Health, the Canadian Association of Mental Health, the Canadian Association of Social Workers and many health units in Ontario. Citizen groups in communities across Canada have also been forming to express their support for this initiative.

This past winter the Ontario provincial government embraced the opportunity to engage in the needed research to provide a clearer understanding of the implications and outcomes of the basic income guarantee program. By conducting a pilot study of the program, evidence will be gathered to determine if this is a more efficient manner of delivering income support, if it strengthens engagement in the labour force and if savings are achieved in areas such as the health care and justice systems. In 2016, the Ontario provincial government will work with researchers, communities and stakeholders to develop and implement a basic income guarantee pilot study.

HALIBURTON KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT
RESOLUTION ON BASIC INCOME GUARANTEE

WHEREAS addressing the social determinants of health and reducing health inequities are fundamental to the work of public health in Ontario; and

WHEREAS the Haliburton Kawartha Pine Ridge District Health Unit's strategic direction is to address the social determinants of health and health equity; and

WHEREAS income is recognized as the most important determinant of health and health inequities; and

WHEREAS 12.7% of the population in the Haliburton Kawartha Pine Ridge District live in low income circumstances based on the Low-Income After-Tax (2011 National Household Survey, Statistics Canada); and

WHEREAS low income and income inequality have well-established, strong relationships with a wide range of adverse health and social outcomes as well as lower life expectancy; and

WHEREAS income insecurity continues to rise in Ontario and Canada as a result of an increase in precarious employment and an increasing number of working-age adults who rely on employment that pays low wages; and

WHEREAS existing federal and provincial income security programs are insufficient to ensure that all Canadians have adequate and equitable access to the social determinants of health (e.g., food, shelter, education); and

WHEREAS a basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, has the potential to ensure all Canadians have a sufficient income to meet basic needs and to live with dignity; and

WHEREAS a basic income guarantee resembles existing income security supplements currently in place for Canadian seniors and children, which have contributed to improved health status and quality of life in these age groups; and

WHEREAS a pilot project of basic income for working age adults conducted in Dauphin Manitoba in the 1970s, indicates that the provision of a basic income guarantee can reduce poverty and income insecurity, improve physical and mental health and educational outcomes, and enable people to pursue educational and occupational opportunities relevant to them and their families; and

WHEREAS the concept of a basic income guarantee has received support from the health and social sectors including the Canadian Public Health Association (CPHA), the Canadian Medical Association (CMA), the Canadian Association of Social Workers, the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA), the Ontario Society of Nutritional Professionals in Public Health and the Ontario Mental Health and Addictions Alliance as a means to alleviate poverty and improve health outcomes of low income Canadians; and

WHEREAS there is growing support from economists, political affiliations and other sectors across Canada for a basic income guarantee;

NOW THEREFORE BE IT RESOLVED THAT the Haliburton Kawartha Pine Ridge District Health Unit Board of Health endorse a position statement of a basic income guarantee;

AND FURTHER that the Haliburton Kawartha Pine Ridge District Health Unit Board of Health join alPHa and OPHA in requesting that the federal Ministers of Employment, Workforce Development and Labour, Families, Children and Social Development, Finance and Health, as well as the Ontario Ministers Responsible for the Poverty Reduction Strategy, Community and Social Services, Children and Youth Services, Finance and Health and Long-Term Care, prioritize joint federal-provincial consideration and investigation into a basic income guarantee as a policy option for reducing poverty and income insecurity;

AND FURTHER that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer, the Chief Medical Officer of Health for Ontario, the Ontario Public Health Association, the Canadian Public Health Association, the Association of Local Public Health Agencies, the Ontario

Boards of Health, the Federation of Canadian Municipalities, the Association of Municipalities of Ontario, MP Kim Rudd, MP Jamie Schmale, MPP Lou Rinaldi and MPP Laurie Scott as well as the City of Kawartha Lakes, the County of Haliburton and Northumberland County be so advised.

simcoe muskoka
DISTRICT HEALTH UNIT

June 15, 2016

The Honourable Kathleen Wynne
Premier of Ontario
Room 281, Legislative Building
Queen's Park
Toronto, Ontario M7A 1A1

Dear Premier Wynne:

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I would like to commend you for the inclusion of a basic income pilot in the 2016 provincial budget. We appreciate that the voices of public health and many other stakeholders have been heard on this issue. We are very pleased to see that your government is examining the potential role of basic income in addressing key issues such as poverty reduction, the changing labour market, and cost savings in health care and elsewhere. We were also encouraged to read your government's plans to work with communities, researchers and other stakeholders in 2016 to design and implement a basic income pilot.

The health rationale for a basic income is strong, given the powerful impact of poverty and income inequality on a wide range of population health outcomes. We'd like to draw attention, in particular, to the clear evidence of a direct link between poverty, poor health and food insecurity. Children and youth who experience hunger at any time in their lives are more likely to have poorer mental and physical health, including likelihood of chronic conditions. Food insecure adults are more likely to have poorer physical and mental health, and social well-being, and suffer from multiple chronic conditions including depression, diabetes, heart disease and hypertension. Inadequate income is the most significant barrier to a nutritious diet, and the lower the household income the greater the prevalence of food insecurity.

Like other health units across the Province, the Simcoe Muskoka District Health Unit has been conducting the Nutritious Food Basket survey (NFB) for many years. Annually, the local cost of the NFB plus rent are compared with household income from social assistance or minimum wage work to assess whether income from these sources is adequate to cover the cost of these basic necessities. Unfortunately, year after year NFB survey results indicate that a healthy diet is beyond the reach of many individuals and families of low income. For example, a reference family of two adults and two children with income from one full-time minimum wage job ($11.00/hour) would require 68% (Muskoka) or 72% (Simcoe) of their total income to pay for food and rent alone (NFB, 2015). If this same family of four was receiving Ontario Works, almost their entire income (89% for Muskoka, 94% for Simcoe) would be needed for food and rent alone. It should be noted that, as grim as these income/expense scenarios are, they do not factor in the cost of other essentials such as transportation, phone, clothing, and household

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and personal care products. It is also troubling that the cost of the Nutritious Food Basket in Simcoe Muskoka has risen substantially over the last five years. The cost for a family of four was $170.86 more per month in May 2015 than in May 2010, which would amount to $2,050.00 more per year than five years ago. Under these circumstances, low income households may have no choice but to look at food dollars as “flexible” and redirect this money to pay for rent, utilities and other necessities.

Recognizing the troubling nature of such circumstances and the strong link between poverty and food insecurity, the Board of Health for the Simcoe Muskoka District Health Unit, at its meeting on June 15, 2016, endorsed the Ontario Society of Nutrition Professionals in Public Health Position Statement on Responses to Food Insecurity (attached). This position statement urges the provincial and federal governments to jointly prioritize and investigate a basic income guarantee as a policy option for reducing poverty and food insecurity among people of low income. The Simcoe Muskoka District Health Unit Board of Health urges the Province of Ontario, in collaboration with the Government of Canada, to move forward on the recommendations contained in the OSNPPH Position Statement. Specifically, we encourage you to act without delay on the design and implementation of the basic income pilot your government committed to in the 2016 budget.

In May of 2015, the SMDHU Board of Health sent the attached letter to several of your Ministers, requesting an investigation into this promising policy approach. We also had the opportunity to meet with Minister Jaczek regarding basic income at a 2015 meeting of the Association of Municipalities of Ontario. A request for exploration of basic income was subsequently made by the Association of Local Public Health Agencies and the Ontario Public Health Association. The current version of the 2015 backgrounder on basic income prepared for these public health organizations is linked here for your information and use as a resource: http://www.opha.on.ca/Advocacy-and-Policy/Position-Paper,-Resolutions-and-Motions.aspx.

We look forward to hearing more from your government on engagement opportunities surrounding the pilot. Once again, our congratulations for your government’s inspiring leadership on this issue and for your courage to consider a different path forward. Combined with continued investment in other key aspects of poverty reduction such as early childhood development and affordable housing, a basic income guarantee may well be necessary to address some of the most complex, impactful and largely preventable health and social issues facing Ontarians.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward
Chair, Board of Health

Attachments (2):
- OSNPPH Position Statement on Responses to Food Insecurity
- May 28, 2015 Letter from SMDHU Board of Health to Minister Poilievre, Minister Leitch, Minister Ambrose, Minister Flynn, Minister Hoskins, Minister MacCharles, and Minister Mathews

c. Ontario Boards of Health
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Evelyn Vaccari, Chair, Ontario Society of Nutrition Professionals in Public Health
Simcoe Muskoka Members of Provincial Parliament
Simcoe Muskoka Members of Parliament
Simcoe Muskoka Upper and Lower Tier Municipalities
North Simcoe Muskoka and Central Local Health Integration Networks
Chair, Child, Youth and Family Services Coalition of Simcoe County
Chair, Poverty Reduction of Muskoka Planning Table (PROMPT)
Chair, Simcoe County Alliance to End Homelessness

Ontario Society of Nutrition Professionals in Public Health

La société ontarienne des professionnel(le)s de la nutrition en santé publique

www.osnpph.on.ca
@RDsPubHealthON

Position Statement on Responses to Food Insecurity

November 2015

Background

Food insecurity – inadequate or insecure access to food because of financial constraints – is a serious social and public health problem in Ontario. In 2013, 624,200 Ontario households (12.5%) experienced food insecurity.[1] This translates into 1,598,200 people, of which 485,700 were under the age of 18 (Valerie Tarasuk, PhD, email communication, August 27, 2015).

The root cause of food insecurity is poverty.[2] The magnitude of poverty in the country contravenes Canada's commitment to ensure the basic human right to food for all citizens.[3] The majority (57.5%) of Ontario families struggling to put food on the table are part of the labour force but trapped in low-paying or unstable jobs.[1] Food insecurity affected 64.5% of Ontario households reliant on social assistance in 2012.[4]

It is the position of the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) that food insecurity is an urgent human rights and social justice issue for local, provincial and federal public policy agendas. Food charity is an ineffective and counterproductive response to food insecurity because it does not address the root cause which is poverty. An income response is required to effectively address food insecurity.

The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) is the independent and official voice of over 200 Registered Dietitians working in Ontario's public health system. OSNPPH provides leadership in public health nutrition by promoting and supporting member collaboration to improve the health of Ontario residents through the implementation of the Ontario Public Health Standards.

Adults in food insecure households have poorer self-rated health, poorer mental and physical health, poorer oral health, greater stress, and are more likely to suffer from chronic conditions such as diabetes, high blood pressure, and anxiety.[5] Food insecurity also makes it difficult to manage chronic diseases and conditions through diet. Household food insecurity increases the risk of mental health problems in children and puts teenagers at greater risk of depression, social anxiety and suicide.[6] Being food insecure is strongly associated with becoming a high-cost user of health care.[7,8]

While the terms 'food insecurity' and 'hunger' may be used interchangeably, they are not the same thing. Food insecurity has been defined as, "household-level economic and social condition of limited or uncertain access to adequate food," while hunger has been defined as, "an individual-level physiological condition that may result from food insecurity."[9]

The Food Charity Response

Food charity is not new, and in most cultures offering food to hungry people is considered the right thing to do. Currently, food charity in Canada includes a variety of ad-hoc community-based programs, including food banks and meal programs.

Food banks are the primary community response to household food insecurity. They were originally intended as temporary food relief operations necessitated by the recession in the early 1980s; however, demands for charitable food assistance did not diminish as the economy improved and numbers using food banks continued to expand.[10] Over the past 30+ years, food banks have become a well-established part of the fabric of many communities across Ontario and Canada. Food banking has grown and evolved into an extensive charity-based secondary food distribution system specifically for impoverished people.

The growth of food charity has been linked to a reduction in social programs, as governments abandon previously held responsibilities for the well-being of citizens and rely on community-based charities to fill the gap.[10,11,12] People in need of food are routinely directed to charitable food programs by government websites, case workers and health care providers.

In March of 2014, Ontario food banks were visited by 374,698 adults and children.[13] The number of households accessing food banks for the very first time increased by 20%, from 14,206 in 2013 to 17,182 households in March 2014.[13] Although a considerable number of people go to food banks, they represent only a small proportion – about 25% – of those who experience food insecurity.[14,15] For this reason, food bank usage statistics are not a valid measure of food insecurity.[16]

Food banks operate under many constraints, relying on volunteers and inconsistent food and monetary donations from the public and corporate sponsors.[10,17] Demand for food always exceeds the supply. Balance between supply and demand is achieved only when the amount of food provided per visit and/or the frequency of visits is restricted.[17] Because of

supply limitations, food banks are typically not able to meet the preferences, religious restrictions, nutritional or health-related dietary needs of clients.[10,15,18,19] Access can be challenging with limited operating hours, long line-ups, and lack of transportation to get to a food bank.[15] Despite the best intentions of volunteers and staff, the experience of accessing food banks undermines people's dignity.[11,15] All of these limitations and challenges may explain, at least in part, why only a minority of people who experience food insecurity access food banks. In summary, food banks are an ineffective response to food insecurity.

The government plays a supportive role in the charitable food model by permitting and encouraging donations while absolving donors of liability for the safety of donated food.[20] Food Banks Canada has lobbied the federal government to provide tax credits to corporate donors but this proposal has not been adopted.[11] However, Ontario's Local Food Act, introduced in 2013, includes tax credits for farmers who donate agricultural produce to community food programs.[21]

Corporations exert significant control and influence over charitable food programs in many ways, while reaping the benefits of participating in corporate social responsibility initiatives. Corporations participate as board members for food charity organizations at the provincial and national levels[22,23] and provide significant food and monetary donations.[19,22,24] Corporations directly benefit from supporting food charity, as market research has shown that companies who contribute to a good cause build brand loyalty, attract new customers, drive word of mouth advertising and grow revenue.[25] They also benefit from donating unsaleable food by avoiding landfill disposal fees.[24] Corporate self-promotion of their food charity efforts and associated media coverage further promote the public perception that food charity is an acceptable and appropriate response to food insecurity.[12,22]

The media perpetuate a positive illusion of the benefits of food charity.[12,22] Actively drawing attention to fund-raising and food drive efforts enables people to 'feel good' when they contribute. However, the media rarely acknowledge the inadequacies of food charity or that the underlying problem of persistent poverty is the root cause of food insecurity. Well-intentioned people are persuaded to believe that those who don't have enough food are in the good hands of charity.[22]

By contributing to the institutionalization of food charity and feeding the public perception that food insecurity is a matter for charity, the media and corporations have become a major obstacle in advancing public policy to address poverty and food insecurity.[22] The current charitable food model absolves governments of their responsibility to ensure the basic right to food security for all.[12]

The Income Response

Current evidence indicates the need for targeted and sustainable approaches to address the root causes of food insecurity.[26] Implementation of a basic income guarantee (also known as guaranteed annual income) would ensure income at an adequate level to meet basic needs and for people to live with dignity, regardless of work status.[27]

A basic income guarantee has the potential to eliminate poverty and spending on its consequences. The Guaranteed Income Supplement (GIS), a form of guaranteed income for Canadians 65 years and older, has resulted in a substantial decline in seniors living below the poverty line and one of the lowest rates of elder poverty in the world.[26] The rate of Canadians experiencing food insecurity has been found to be fifty percent less among low income people aged 65 to 69 compared to those aged 60 to 64, and self-reported rates of physical and mental health improved significantly after moving from low-wage, insecure employment to a guaranteed income at the age of 65.[28] Implementing a guaranteed income program for those of working age would reduce steep income inequalities and contribute to better health and fewer societal problems, leading to long-term savings in health care and other public services.[29]

Guaranteed income is a simpler and more transparent approach to social assistance than the current system. Furthermore, it would extend protection to those who are currently not covered or poorly covered by social assistance programs.[30]

The cost of implementing a basic income program would involve substantial government spending.[31] However, even conservative estimates of the indirect costs of poverty (e.g., health care, remedial education, crime, and social assistance programs) are far higher than the costs of actually lifting people out of poverty.[32]

Position

It is the position of the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) that food insecurity is an urgent human rights and social justice issue for local, provincial and federal public policy agendas. Food charity is an ineffective and counterproductive response to food insecurity because it does not address the root cause which is poverty. An income response is required to effectively address food insecurity.

OSNPPH calls on:

- Ontario Public Health Units to promote and support implementation of the “Income Security - the effective response to food insecurity”campaign.
- Ontario Boards of Health to officially endorse OSNPPH’s Position Statement on Responses to Food Insecurity
- Municipal governments to urge provincial and federal governments to prioritize and investigate a basic income guarantee.
- Individuals to contact or meet with local politicians at all levels about their concerns with the food charity response to food insecurity and the potential benefits of a basic income guarantee.
- Schools, faith-based organizations, emergency services, local businesses, and community organizations to become aware of and promote income security as the effective response to food insecurity.
- Media to support campaigns for adequate income security, affordable social housing and child care, enhanced mental health services, together with an integrated national food policy, instead of food drives.
- Federal and provincial governments to consider and investigate a basic income guarantee as a policy option for reducing poverty and income insecurity and for providing opportunities for people with a low income.

Additional Information

“Food insecurity is a serious public health problem” infographic http://www.osnpph.on.ca/

Income-Related Policy Recommendations to Address Food Insecurity. Ontario Society of Nutrition Professionals in Public Health, September 2015. http://www.osnpph.on.ca/

Public Health Support for a Basic Income Guarantee. Association of Local Public Health Agencies Resolutions, June 2015. http://www.alphaweb.org/?page=alPHa_Resolutions click on: Resolutions passed at the most recent AGM

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Basic Income Canada Network http://www.basicincomecanada.org/

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Graphic design provided by City of Hamilton Public Health Services.

simcoe muskoka
DISTRICT HEALTH UNIT

May 28, 2015

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

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

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

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

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

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

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

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

Re: Public health support for a basic income guarantee

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

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

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

Basic income is a concept that has been examined and debated for decades, including through pilot projects in the United States, Canada, and other countries more recently.[4,5] As you may be aware, Mincome, in particular, was an encouraging pilot project of basic income for working age adults conducted jointly by the Government of Manitoba and the Government of Canada in the 1970s, which demonstrated several improved health and educational outcomes.[4] Basic income also resembles income guarantees currently provided in Canada for seniors and children, which have contributed to health and social improvements in those age groups. [6,7]

In addition to providing an effective policy response to poverty and inequality, a basic income guarantee would be a key societal support in the face of rising precarious employment in Canada. Given the trend towards fewer opportunities for secure, permanent jobs, providing living wages and benefits, a basic income guarantee could help buffer the effects of precarious employment by providing a form of 'disaster insurance' that protects people from slipping into poverty during challenging times.[6]

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

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

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

Sincerely,

ORIGINAL SIGNED BY

Barry Ward
Chair, Board of Health

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

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July 14, 2016

The Right Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

Dear Prime Minister:

Re: A Public Health Approach to the Legalization of Cannabis in Canada

At its meeting of June 1, 2016, the County of Lambton Board of Health considered the attached correspondence from Barry Ward, Board of Health Chair, Simcoe Muskoka District Health Unit dated April 20, 2016 regarding a public health approach to the legalization of cannabis in Canada.

The County of Lambton Board of Health passed the following motion:

> *#3: McGugan/Gillis: That correspondence PH 06-06-16 be supported by the Board of Health.*
>
> *Carried.*

Substance misuse is an important public health issue that has a profound effect on many local individuals, families and our health system. In 2011/12, 43% of Lambton County residents, ages 15 years and older, reported using cannabis at least once in their lifetime. Approximately 12% reported using cannabis in the past year. Marijuana use was highest among those between 15 and 29 years of age, with 31% of Lambton residents within this age group reporting cannabis use in the past year. This was higher than the provincial percentage (23%).

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in its field. CAMH recommends that legalization of cannabis can only be effective within a comprehensive system that considers the following factors:

- Establishment of a minimum age for cannabis purchase and consumption to protect youth.
- Development of a framework to address and prevent cannabis-impaired driving.
- Investment in education and prevention, and expanded access to treatment options.

The County of Lambton Board of Health supports a comprehensive public health approach to the regulation and legalization of cannabis in Canada. In the event the government proceeds with cannabis legislation, we encourage you to adopt this approach.

Thank you for your consideration. Please do not hesitate to contact me should you wish to discuss further.

Sincerely,

Warden Bev MacDougall
Chair, County of Lambton Board of Health

cc: Marilyn Gladu, M.P., Sarnia-Lambton
Bev Shipley, M.P., Lambton-Kent-Middlesex
Bob Bailey, M.P.P., Sarnia-Lambton
Monte McNaughton, M.P.P., Lambton-Kent-Middlesex
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Dr. Sudit Ranade, Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services Division

simcoe muskoka
DISTRICT HEALTH UNIT

April 20, 2016

The Right Honourable Justin Trudeau, P.C., M.P.
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street
Ottawa, ON K1A 0A2

Dear Prime Minister:

Re: A Public Health Approach to the Legalization of Cannabis in Canada

The Simcoe Muskoka District Health Unit (SMDHU) is mandated by the Ministry of Health and Long-Term Care (MOHLTC) under the Ontario Public Health Standards (2008) to address the prevention of the "adverse health outcomes associated with substance use". Prevention efforts include the delayed use of substances, such as cannabis, as well as incorporating harm reduction strategies in the delivery of health unit services. We are pleased that you are aware of the need for a well-regulated system for cannabis access which promotes public health and safety, reduces the harms associated with the use of marijuana, and helps to restrict access to youth.

In May of 2014, The Canadian Public Health Association (CPHA) identified the need for a public health approach in the management of psychoactive substances that is "based on the principles of social justice, attention to human rights and equity, evidenced informed policy and practice, and addressing the underlying determinants of health". [5] The SMDHU Board of Health has similarly passed a resolution today strongly urging you to adopt a public health approach regarding the legalizing of cannabis, with strict regulation of its use, production, distribution, product promotion, and sale.

Despite prohibition, cannabis is the most commonly used illegal drug in Canada, with youth and young adults having the highest rates of use. Research shows that cannabis use is associated with adverse health consequences, most notably for those who begin use at an early age and use it frequently. The evidence suggests that cannabis use — particularly chronic use — can have negative impacts on mental and physical health, brain function (memory, attention and thinking), driving performance and dependence. In addition, women who use cannabis during pregnancy can negatively affect the development and behaviour of their future children. [1, 2, 3, 4]

While cannabis use has the potential for many health harms, it is also important to consider the disproportionate social harms stemming from its prohibition. In addition to being ineffective and costly, prohibition has led to a series of harmful consequences including the criminalization and marginalization of users while hindering the ability of health and education professionals to effectively prevent and address problematic use. [1, 5] We are aware that you are familiar with the

Centre for Addiction and Mental Health (CAMH) Cannabis Policy Framework (October 2015) and strongly recommend that a public health approach to legalizing cannabis should include some or all of the following evidence informed guidelines for a regulatory framework as proposed by CAMH:

- **Establish a government monopoly on sales.** Control board entities with a social responsibility mandate provide an effective means of controlling consumption and reducing harm.
- **Set a minimum age for cannabis purchase and consumption.** Sales or supply of cannabis products to underage individuals should be penalized.
- **Limit availability.** Place caps on retail density and limits on hours of sale.
- **Curb demand through pricing.** Pricing policy should curb demand for cannabis while minimizing the opportunity for continuation of lucrative black markets. It should also encourage use of lower-harm products over higher-harm products.
- **Curtail higher-risk products and formulations.** This would include higher-potency formulations and products designed to appeal to youth.
- **Prohibit marketing, advertising, and sponsorship.** Products should be sold in plain packaging with warnings about risks of use.
- **Clearly display product information**. In particular, products should be tested and labelled for Tetrahydrocannabinol (THC) and Cannabidiol (CBD) content.
- **Develop a comprehensive framework to address and prevent cannabis-impaired driving.** Such a framework should include prevention, education, and enforcement.
- **Enhance access to treatment and expand treatment options.** Include a spectrum of options from brief interventions for at-risk users to more intensive interventions.
- **Invest in education and prevention.** Both general (e.g. to promote lower-risk cannabis use guidelines) and targeted (e.g. to raise awareness of the risks to specific groups, such as adolescents or people with a personal or family history of mental illness) initiatives are needed. (1)

When implementing these critical policy changes we strongly encourage your government to take sufficient time to develop and build capacity to implement these regulations and to ensure systems are in place to monitor patterns of use and health outcomes. In addition, we recommend that you develop evidence based prevention and harm reduction messaging for broad dissemination across the country. (1)

Thank you for considering a comprehensive public health approach to cannabis policy in Canada. Please do not hesitate to contact me should you wish to discuss further.

Sincerely,

ORIGINAL SIGNED BY

Barry Ward, Board of Health Chair
Simcoe Muskoka District Health Unit

c. Bill Blair, MP (Scarborough Southwest)
Dr. Kellie Leitch, MP (Simcoe-Grey)
The Honourable Tony Clement, MP (Parry Sound–Muskoka)
Patrick Brown, MPP (Simcoe North)
Ann Hoggarth, MPP (Barrie)
Norm Miller, MPP (Parry Sound-Muskoka)
Julia Munro, MPP (York-Simcoe)
Jim Wilson, MPP (Simcoe-Grey)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Boards of Health in Ontario

References:

1. Crépault J-F. Cannabis Policy Framework. [Report online]. Toronto: Centre for Addiction and Mental Health; 2014 [Last accessed 2016/03/03]. Available from: http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHCannabisPolicyFramework.pdf

2. Canadian Centre on Substance Abuse. Substance Abuse in Canada: The Effects of Cannabis Use during Adolescence. [Report online]. Ottawa: Canadian Centre on Substance Abuse, 2015 [Last accessed 2016/03/03]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Effects-of-Cannabis-Use-during-Adolescence-Report-2015-en.pdf

3. Porath-Waller AJ, Beirness, DJ, Diplock J, Kalant H. Clearing the Smoke on Cannabis: Highlights [Report online]. Canadian Centre on Substance Abuse (CCSA), 2015 [Last accessed 2016/03/03]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Clearing-Smoke-on-Cannabis-Highlights-2015-en.pdf

4. Beirness D, Porath-Waller A. Clearing the Smoke on Cannabis: Cannabis Use and Driving-An Update. [Report online]. Ottawa: Canadian Centre on Substance Abuse; 2015 [Last accessed 2016/03/03]. Available from: http://www.ccsa.ca/Resource%20Library/CCSA-Cannabis-Use-and-Driving-Report-2015-en.pdf

5. Canadian Public Health Association. A New Approach to Managing Illegal Psychoactive Substances in Canada. [Discussion paper online]. Ottawa: Canadian Public Health Association, 2014 [Last accessed 2016/03/03]. Available from: http://www.cpha.ca/uploads/policy/ips_2014-05-15_e.pdf

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

June 1, 2016

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

Dear Prime Minister,

Re: Proposed Introduction of Cannabis Legislation in Canada – Spring 2017

The Board of Health (BOH) for Wellington-Dufferin-Guelph Public Health (WDGPH) recognizes that cannabis is a commonly used illicit drug that can have significant health and social harms. The recent announcement by Jane Philpott, Federal Health Minister, stated that Canada would introduce cannabis legislation in the spring of 2017. If the federal government is in fact proposing cannabis legalization, the WDGPH BOH strongly urges the government to take a public health approach. This would include educating the public on the potential health effects of cannabis use and highlighting the need for a public health policy approach that includes strict regulations to ensure that the new regulatory system promotes health and safety, reduces harms, and prevents youth uptake.

Cannabis is the most widely used illicit drug in Canada, with approximately 11% of Canadians and 14% of Ontarians reporting past year use. The Wellington Dufferin Guelph Youth Survey indicates that 22% of grade 10 students reported past year cannabis use, and there are no significant differences between genders or geographic areas.

Research has shown that cannabis use is associated with adverse health effects including impairments in learning, attention, memory, and psychomotor function, and mental, respiratory, and reproductive health issues. While the health effects of cannabis use are mostly concentrated among heavy (daily or near daily) users and individuals that initiate use during adolescence, there are also risks associated with short-term use.

Recognizing the potential health and social harms of cannabis use, the Centre for Addiction and Mental Health released a *Cannabis Policy Framework* document, which proposes ten (10) evidence-informed guidelines for a regulatory framework, as follows:

1. Establish a government monopoly on sales.
2. Set a minimum age for cannabis purchase and consumption.
3. Limit availability.

.../2

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

4. Curb demand through pricing.
5. Curtail higher risk products and formulations.
6. Prohibit marketing, advertising and sponsorship.
7. Clearly display product information.
8. Develop a comprehensive framework to address and prevent cannabis impaired driving.
9. Enhance access to treatment and expand treatment options.
10. Invest in education and prevention.

The WDGPH BOH discussed this important issue at its meeting of June 1, 2016 and, in the event the government proceeds with the cannabis legislation, the WDGPH BOH urges the government to consider the points outlined in its Board motion attached hereto as Appendix "A".

Thank you for your consideration to a comprehensive public health approach to cannabis policy in Canada.

Please do not hesitate to contact me should you wish to discuss further.

Sincerely,

Doug Auld,
Chair, WDGPH Board of Health

cc:
The Honourable Jane Philpott, P.C., M.P. Minister of Health
Mr. Bill Blair, M.P. Parliamentary Secretary to the Minister of Justice and Attorney General of Canada (Scarborough Southwest)
The Honourable Michael Chong, P.C., M.P. (Wellington – Halton Hills)
Mr. John Nater, M.P. (Perth – Wellington)
Mr. Lloyd Longfield, M.P. (Guelph)
Mr. David Tilson, M.P. (Dufferin – Caledon)
The Honourable Kathleen Wynne, M.P.P., Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care – via e-mail
Iaṇ Culbert, Executive Director, Canadian Public Health Association
Pegeen Walsh, Executive Director, Ontario Public Health Association
Linda Stewart, Executive Director, Association of Local Public Health Agencies – via e-mail
All Ontario Boards of Health – via e-mail

APPENDIX "A"

On June 1, 2016, the Board of Health for Wellington-Dufferin-Guelph Public Health passed the following Motion:

That the Board of Health send a letter to the federal government requesting consideration of the following recommendations, in the event that the federal government moves forward with the proposed introduction of cannabis legalization/legislation:

(i) To adopt a public health approach to the proposed legalization of non-medical cannabis that includes strict regulations around production, distribution, promotion and sale;
(ii) To allow sufficient time to develop and build capacity to implement a policy that includes strict regulation;
(iii) To establish baseline data and mechanisms to monitor the local use of cannabis and related health and societal outcomes; and
(iv) To develop evidence-based prevention and harm reduction messaging for broad and continuous dissemination across the country."

Peterborough Public Health

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

September 20, 2016

The Honourable Dr. Jane Philpott
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9

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

Dear Honourable Ministers:

Re: Lyme Disease

At its meeting held on September 14, 2016, the Board of Health for Peterborough Public Health considered correspondence from Grey Bruce Health Unit and Niagara Region regarding the above noted matter.

In the past few years, Lyme disease (LD) has surpassed West Nile virus as the predominant vector-borne disease of concern in the province of Ontario. In the past six years, in Peterborough County and City, we have seen an increase in the number of tick submissions, with a corresponding increase in ticks that have tested positive for LD.

However, the current financial and human resources to continue with the increased public consultations on tick submissions are inadequate, and therefore, we are requesting that the Government of Canada and the Province of Ontario increase funding in the areas of research, treatment, surveillance and education for LD. For this reason, our board has endorsed the attached motions from our Ontario board of health colleagues.

The Board appreciates your attention to this important public health issue.

Yours in health,

Original signed by

Scott McDonald
Chair, Board of Health

/at
Encl.

cc: Hon. Kathleen Wynne, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health, MOHLTC

Maryam Monsef, MP, Peterborough-Kawartha
Kim Rudd, MP, Northumberland-Peterborough South
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
Jeff Leal, MPP, Peterborough
Laurie Scott, MPP, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

June 2, 2016

The Honourable Dr. Jane Philpotts
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9

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

Dear Ministers:

Re: Lyme Disease

On May 27, 2016, the Board of Health for the Grey Bruce Health Unit passed the following resolution.

Resolution No: 2016-52

Moved by: Gary Levine **Seconded by: David Shearman**

WHEREAS, the blacklegged tick, Ixodes scapularis, is expanding into new areas of Ontario, and can carry the bacteria, Borrelia bugdorferi, which causes Lyme disease; and

WHEREAS, people who are infected with Borrelia burgdorferi, may develop Lyme disease which can cause long-term consequences if not treated properly;

NOW THEREFORE BE IT RESOLVED THAT the Board of Health for the Grey Bruce Health Unit requests the Province of Ontario to increase funding to enhance environmental surveillance for the tick;

AND FURTHER THAT the Province of Ontario monitor the pattern of spread of the tick and the rate of tick infection in various areas of the province;

AND FURTHER THAT the Province of Ontario develop control measures for the tick;

AND FURTHER THAT the Province of Ontario increase the education to the population regarding personal protection, property management, testing and treatment.

Carried

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: Hon, Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada
Hon. Jane Philpott, Minister of Health
Hon. Kathleen Wynne, Premier of Ontario
Hon, Madeleine Meilleur, Attorney General for Canada
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
Dr. David Williams, Chief Medical Officer of Health (Interim)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Dr. Catherine Zahn, President and CEO, Centre for Addiction and Mental Health
All Ontario Boards of Health

Encl.

Administration
Office of the Regional Clerk
1815 Sir Isaac Brock Way, PO Box 1042, Thorold, ON L2V 4T7
Telephone: 905-685-4225 Toll-free: 1-800-263-7215 Fax: 905-687-4977
www.niagararegion.ca

May 9, 2016

The Honourable Dr. Jane Philpotts
Health Canada
70 Colombine Driveway
Tunney's Pasture
Ottawa, ON K1A 0K9

Sent via email:
hon.jane.philpott@canada.ca

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

Sent via email:
ehoskins.mpp@liberal.ola.org

RE: Lyme Disease
Minute Item 9.3, CL 6-2016, April 28, 2016

Dear Ministers:

Regional Council at its meeting held on April 28, 2016, passed the following resolution:

> Whereas the number of cases of ticks positive for Lyme disease is increasing throughout Ontario and specifically in Niagara Region;
>
> Whereas the laboratory testing for and diagnosis of Lyme disease is sub-optimal; and
>
> Whereas there are chronic sufferers of long term consequences of this disease.
>
> NOW THEREFORE BE IT RESOLVED:
>
> 1. That Niagara Region **REQUEST** the Province of Ontario to increase funding for research aimed to enhance the testing for Lyme disease;
>
> 2. That Niagara Region **REQUEST** the Government of Canada to increase funding for research aimed to enhance the testing for Lyme disease and determine better treatment for long term outcomes of Lyme disease;
>
> 3. That this resolution **BE FORWARDED** to all Municipalities in Ontario for their endorsement; and
>
> 4. That this resolution **BE FORWARDED** to the Premier of Ontario, the Minister of Health and local Members of Provincial Parliament.

…/2

Please do not hesitate to contact me should you have any questions.

Yours truly,

Ralph Walton
Regional Clerk

cc: The Honourable K. Wynne, Premier of Ontario *Sent via email:* kwynne.mpp@liberal.ola.org
W. Gates, MPP (Niagara Falls) *Sent via email:* wgates-co@ndp.on.ca
The Honourable R. Nicholson, MP (Niagara Falls) *Sent via email:* rob.nicholson@parl.gc.ca
T. Hudak, MPP (Niagara West) *Sent via email:* tim.hudakco@pc.ola.org
D. Allison, MP (Niagara West) *Sent via email:* dean.allison@parl.gc.ca
The Honourable J. Bradley, MPP (St. Catharines) *Sent via email:* jbradley.mpp.co@liberal.ola.org
C. Bittle, MP (St. Catharines) *Sent via email:* chris.bittle@parl.gc.ca
C. Forster, MPP (Welland) Sent via email: cforster-op@ndp.on.ca
V. Badawey, MP (Niagara Centre) *Sent via email:* vance.badawey@parl.gc.ca
All Ontario Municipalities *Sent via email*

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Wyoming, ON N0N 1T0

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Fax: 519-845-3160

July 14, 2016

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

Dear Minister Hoskins:

Re: Patients First Discussion Paper

At its meeting of June 1, 2016, the County of Lambton Board of Health considered the attached correspondence from Dr. Valerie Jaeger, President, Association of Local Public Health Agencies (alPHa) dated February 29, 2016, a response from Dr. Eric Hoskins dated April 20, 2016 and a further response from Dr. Valerie Jaeger dated April 28, 2016 regarding *Patients First: A Proposal to Strengthen Patient-Centred Health Care in Ontario*.

The County of Lambton Board of Health passed the following motion:

> *#3: McGugan/Gillis: That correspondence PH 06-14-16 be supported by the Board of Health.*
>
> *Carried.*

The Board of Health supports the recommendations from alPHa as outlined in the attached letter dated February 29, 2016. The Board requests the Ministry of Health and Long-Term Care to include the alPHa recommendations in any implementation of the *Patients First* proposal.

Thank you for your consideration.

Sincerely,

Warden Bev MacDougall
Chair, County of Lambton Board of Health

cc: Bob Bailey, MPP, Sarnia-Lambton
Monte McNaughton, MPP, Lambton-Kent-Middlesex
Linda Stewart, Executive Direction, Association of Local Public Health Agencies
Ontario Boards of Health
Dr. Sudit Ranade, Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services Division

alPHa
Association of Local PUBLIC HEALTH Agencies

2 Carlton Street, Suite 1306
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Tel: (416) 595-0006
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E-mail: info@alphaweb.org

April 28, 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:

Thank you for your letter dated April 20, 2016. I am pleased to note that we are in agreement about the positive contributions local public health units can make in working with Local Health Integration Networks (LHINs) to facilitate and support better health and wellness outcomes for all Ontarians.

From a public health perspective, we appreciate the direction to expand the focus of LHIN planning to include population health. However, as we noted in our letter to you dated February 29, 2016, LHINs are one of the many partners with whom public health works to keep people healthy. In the absence of more detailed information, we remain concerned about the form that "integration" and "formal linkages" may take.

We wish to reiterate that alPHa's member Medical Officers of Health, Boards of Health and Affiliate organizations are concerned that some of the *Patients First* proposals regarding local public health may have unintended consequences. These consequences include an erosion of the public health system's capacity to improve the health of Ontarians through our intersectoral work on the determinants of health. We also reiterate alPHa's position, based on experience in jurisdictions elsewhere that the aims of public health are best served by Boards of Health that are truly independent, with funding and accountability flowing directly from the Ministry. alPHa's concerns are more fully expressed in our attached letter and your office has received numerous letters and resolutions from individual Boards of Health expressing similar concerns.

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,

V Jaeger

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
Ontario MPPs

Attachment

Ministry of Health and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
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Ministère de la Santé et des Soins de longue durée

Bureau du ministre

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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

alPHa
Association of Local
PUBLIC HEALTH
Agencies

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

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,

Jaeger

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
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July 14, 2016

Linda Stewart, Executive Director
Association of Local Public Health Agencies
2 Charlton Street, Suite 1306
Toronto, ON M5B 1J3

Dear Ms. Stewart:

Re: Grey Bruce Health Unit Brief in Response to Patients First Discussion Paper

At its meeting of June 1, 2016, the County of Lambton Board of Health passed a motion supporting a letter from Dr. Hazel Lynn, Medical Officer of Health, Grey Bruce Health Unit dated March 7, 2016 endorsing the *Grey Bruce Health Unit Brief in Response to the Patients First Discussion Paper*. The paper specifically addresses Section 4 in the *Patients First* proposal titled "Stronger Links Between Public Health and Other Health Services".

The County of Lambton Board of Health supports many of the key points, as public health's role is different from the health care focus on the sickness care system. Our role remains "upstream" aimed at prevention of disease and injury, promoting and protecting health and advocating for healthy public policy.

Similar to Grey Bruce Health Unit, we have established extensive connections and partnerships with community agencies, health care, primary care and a wide range of health professionals, lower-tier municipalities, First Nations communities and educational institutions. Through these networks, public health is well positioned to help populations or communities to take steps to improve their own health and well-being.

In addition to Grey Bruce Health Unit's response to *Patients First*, our Board also acknowledges the leadership and advocacy provided through alPHa and many Ontario Boards of Health on this important public health issue.

Sincerely,

Warden Bev MacDougall
Chair, County of Lambton Board of Health

cc: Bob Bailey, M.P.P., Sarnia-Lambton
Monte McNaughton, M.P.P., Lambton-Kent-Middlesex
Ontario Boards of Health
Dr. Sudit Ranade, Medical Officer of Health
Andrew Taylor, General Manager, Public Health Services Division

March 7, 2016

Association of Local Public Health Agencies
Suite 1306
2 Carlton Street
TORONTO, ON M5B 1J3

Dear Ontario Boards of Health:

Re: Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

On February 26, 2016 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached 'Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document'. The following motion was passed:

Motion No: 2016-19

Moved by: David Shearman Seconded by: Laurie Laporte

"That the Grey Bruce Board of Health does endorse the Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document."

Carried.

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: 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

Encl.

Working together for a healthier future for all.
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519-376-9420 1-800-263-3456 Fax 519-376-0605

Grey Bruce Health Unit Brief in Response to *Patients First* Discussion Document

February 2016

For More Information:
Drew Ferguson
Public/Media Relations Coordinator
Grey Bruce Health Unit
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Grey Bruce Health Unit Brief in Response to Patients First Discussion Document

This brief specifically addresses Section Four of the *Patients First* discussion document, titled *Stronger Links Between Public Health and Other Health Services.*

This brief is comprised of two components. The first looks at the population health approach taken by Public Health and issues that arise. The second section provides a Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

THE ISSUE

The initial statement ***Public health has historically been relatively disconnected from the rest of the health care system*** is at the core of this discussion.

The focus of the LHIN-based health care is on individual patient care, service provision and costs. In essence, it is sickness care.

Public Health has a different role than the sickness care system. Our **focus is "upstream"** through prevention of disease and illness, staying well.

Public **Health's population health** approach aims to improve the health of the entire population. It considers the things that influence our health both inside and outside the health care system. It recognizes that at every stage of life, our health is affected by complex interwoven fabric of factors referred to as 'determinants of health'. These include Housing; Income; Social Status; Social Support Networks; Education and Literacy; Employment/Working Conditions; Social Environments; Physical Environments; Personal Health Practices and Coping Skills; Healthy Child Development; Biology and Genetics; Health Services; Gender; and Culture. These factors do not exist in isolation. Rather, the combined influence of these factors determines our health.

This is profoundly different from the health care system's view of population health. The health care system's approach to population health is to provide interventions to specific, identifiable groups whose needs are greatest and it is taken that, by extension, this will improve overall population health.

A Public Health-based, population health strategy addresses the factors contributing to dis-ease in the population as a whole. That goes beyond behaviour and lifestyle approaches. Working at the population health level does not translate well to the individual. Using alcohol misuse as an example, greater societal gain is achieved from a small change within the larger population than by addressing the problem on an individual basis. **Referred to as the 'prevention paradox';** preventive measures, through strategies such as policy development, that address health equity or social determinants of health, that bring benefit at the population level, offers little to the individual. Public Health is virtually invisible to the public. In the population health model, success is marked by a non-event.

Public Health is the ounce of prevention. In terms of health funding, Public Health is small potatoes accounting for about 1.4 per cent of the province's over-all health budget. When limited funding for population health initiatives is balanced again individual care, the scale invariable tips to individual care. Referred to as the, "tyranny of the acute", when limited resources are in play, the demands of sick person will always take precedent over the need to better the health of the larger population. The public have a preoccupation with acute and medical care, as that affects them directly.

In identifying the current situation, Section Four states that ***Many aspects of the health care system are not able to properly benefit from public health expertise, including issues related to health equity, population health and the social determinants of health.***

Given that reality, it would be unrealistic to expect a relatively small Public Health sector to have much influence on the larger and more powerful set of illness care-oriented priorities. As seen in other jurisdictions, the larger culture of illness care will steer Public Health to a more clinical orientation and away from population health. As a result, the already scarce Public Health resources are diverted to acute, primary and long-term care issues (e.g., emergency room diversion strategies).

The role with respect to the regulatory functions performed by Public Health is not addressed in the *Patients First* discussion. These roles do not align well with health care and speak to the "disconnect from the rest of the health care system" as. Areas including safe drinking water, beach water testing, food premise inspections, personal service setting inspections (aesthetic/tattoo etc.), tobacco by-law enforcement, environmental hazards, and emergency preparedness are all significant components of the Public Heath portfolio. The transfer and monitoring of accountability and performance in these regulatory areas is a substantial undertaking for LHINs. Additionally, it would seem redundant to require 14 independent LHINs to provide universal regulatory and performance oversight in these non-healthcare areas.

Further to this discussion of accountability and performance, it should be noted that population health does not lend itself easily to quick measurements as compared to acute care. It is easy to count ER visits, but as we have seen with the shift towards tobacco de-normalization, results are often incremental and can take decades.

The LHINs are defined by health-care referral patterns where the patient goes. Owen Sound patients go to London, Blue Mountains patients go to Collingwood and Barrie, Dundalk patients go to Shelburne and Orangeville. Public Health is defined by municipal boundaries. The two do not align. The current proposal puts the Grey Bruce Health Unit in three LHINs; the majority in the South West LHIN, Southgate in the Waterloo Wellington LHIN and Town of Blue Mountains the North Simcoe Muskoka LHIN. The implications of these over-lapping alignments require clarification.

QUESTIONS FOR DISCUSSION

The following provides the Grey Bruce Health Unit perspective to the specific question for discussion contained within Section Four.

How can public health be better integrated with the rest of the health system?

Should it be? As described, the healthcare system is sickness care, the system comes into play once you become ill; Public Health is all about maintain and extending wellness. That question could well be reversed to ask how the rest of the health system can better integrate with Public Health. This would have the health care system acknowledge and adopt a population health approach as fundamental to all significant health issues. By necessity, this is a long-term approach re-directing the focus towards health and not just health care.

What connections does public health in your community already have?

Grey Bruce Health Unit has filaments that thread throughout our community. The list is extensive; these connections can be characterized as being with:

- upper and lower tier municipal partnerships and working groups. We perform regulatory roles but also focus on planning and policy for healthy communities
- health care, primary care/health care and a wide range of health professionals, providing materials, knowledge and resources
- community and community groups supporting capacity in the community around specific issues
- school boards, from frontline services such as dental screening and immunization, to issue specific initiatives such as youth mental health, to broader healthy school initiatives
- post-secondary institutions
- First Nations communities
- Plains Communities, also known as Amish and Mennonite communities
- federal and provincial ministries
- agriculture and veterinary, producer and consumer groups, industry, and
- the community at large.

What additional connections would be valuable?

Many of the areas of public health involvement, including the provision of clinical services, reflect ongoing or historic gaps on a population-wide basis. This has been particularly true for the more vulnerable populations. One of the emerging roles for the Grey Bruce Health Unit is to

identify capacity within a community and seek out the resources and links that can help empower populations or communities to take steps to improve their own health and wellbeing. These types of partnerships may provide examples of collaborative models between primary care and Public Health.

As noted, health inequities and the broader social determinants of health are often outside the immediate scope of healthcare services. In this regard, LHINs not only need to work with Public Health but they should also develop formal relationships with the municipal, social services, housing, education, and voluntary sectors to support service integration. As the Ottawa Charter for Health Promotion suggests, health services should be expanded to include building healthy public policy, creating supportive environments, strengthening community action and supporting development of personal skills.

What should the role of the Medical Officers of Health be in informing or influencing decisions across the health care system?

The Ministry plan would ***create a formal relationship between the Medical Officers of Health and each LHIN, empowering the Medical Officers of Health to work with LHIN leadership to plan population health services.***

A direct role by the Medical Officers of Health in informing or influencing decisions would provide a public health link to healthcare systems. Offering the potential to bring a population health view to health issues and the planning of healthcare services. This can only be achieved with the Medical Officer of Health's routine participation in the executive management team and at the Board level. Experience from other jurisdiction has shown that success requires a strong and interested health sector leadership combined with strong public health leadership and epidemiological capacity. Public health's involvement in providing a population health perspective can only be achieved by design and cannot be left to the discretion of individual LHINs or their Boards.

Without a formal or direct influence on budgets, programs and staffing, it might fall to the Medical Officers of Health to be the lone voice for Public Health. The challenge being to mitigate adverse impacts on Public Health including loss of funding, fragmentation of capacity, diversion of staff through re-orientation to clinical issues, and barriers to engagement with community and municipal partners.

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

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June 23, 2016

The Honourable Peggy Sattler
Main Legislative Building, Room 359
Queen's Park, Toronto, ON
M7A 1A5

Dear Ms. Sattler:

Re: Proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act

At its June 16, 2016 meeting, the Windsor-Essex County Board of Health reviewed correspondence from the Middlesex-London Board of Health and Toronto Public Health, passing the following motion.

It was moved that the Windsor-Essex County Board of Health support letters from Middlesex-London Board of Health and Toronto Public Health re: the proposed Domestic and Sexual Violence Workplace Leave, Accommodation and Training Act and, furthermore, that a similar letter of support be sent on behalf of the Windsor-Essex County Board of Health.

The Windsor-Essex County Board of Health supports legislation that assists victims of domestic and sexual violence in the workplace.

Sincerely,

Gary McNamara
Chair, Windsor-Essex County Board of Health

F:\Administration\Committees\Board\Resolutions and Recommendations\2016\WECHU BOH Support Letter Domestic and Sexual Violence Workplace Leave Accommodation and Training Act June 23 2016-v3.docx

cc: Dr. Gary Kirk, Medical Officer of Health, Windsor-Essex County Health Unit
Cheryl Hardcastle, MP Windsor-Tecumseh
Brian Masse, MP Windsor-West
Tracy Ramsey, MP Essex
Dave Van Kesteren, MP Chatham-Kent — Leamington
Hon. Kathleen Wynne, Premier of Ontario

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Rick Nicholls, MPP, Chatham-Kent-Essex
Lisa Gretzky, MPP, Windsor-West
Percy Hatfield, MPP, Windsor-Tecumseh
Taras Natyshak, MPP, Essex
Monika Turner, Director of Policy, AMO
Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Kevin Daniel Flynn, Ministry of Labour
Hon. Tracy MacCharles, Minister Responsible for Women's Issues
Hon Michael Coteau, Minister for Children and Youth Services
Dr. David Williams, Chief Medical Officer of Health
Pegeen Walsh, Executive Director, Ontario Public Health Association
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Erie-St. Clair LHIN
Ontario Women's Directorate
Canadian Women's Foundation
Dr. Catherine Zahn, President and CEO, Centre for Addiction and Mental Health
Claudia Den Boer Grima, CEO, Canadian Mental Health Association, Windsor
Dr. Glenn Bartlett, Executive Director, Windsor-Essex Community Health Centre
Mark Ferrari, Windsor Family Health Team
David Musyj, CEO, Windsor Regional Hospital
Terry Shields, CEO, Leamington District Memorial Hospital
Al Frederick, Chief, Windsor Police Services
Ontario Boards of Health
All Windsor-Essex municipalities

HALIBURTON KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT
BASIC INCOME GUARANTEE

Position Statement

It is the position of the Haliburton Kawartha Pine Ridge District Health Unit that eliminating poverty is an urgent health, human rights and social justice issue that requires action on the part of the municipal, provincial and federal governments. Basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, is an essential component of a strategy to effectively eliminate poverty, ensure all Canadians have a sufficient income to meet their basic needs, and live with dignity and to eliminate health inequities.

Backgrounder

Income has been identified as the most important determinant of health as it influences living conditions, physical and mental health and health-related behaviours including the quality of one's diet, extent of physical activity and tobacco use[1]. People living in poverty are more likely to experience poorer health, have two or more chronic conditions, have more injuries, be more likely to have a disability, use health care services more frequently and live shorter lives.

Based on the Low-Income After Tax (LIM-AT), the incidence of low-income in 2013 was 13.5% for the Canadian population.[2] More specifically, 16.5% of children aged 17 and under lived in low income families and for children living in lone-parent families headed by a woman, the incidence rose to 42.6%.

Locally in the Haliburton Kawartha Pine Ridge District Health Unit, in 2010, 12.7% of the population lived in low-income situations based on LIM-AT.[3] In terms of children under the age of 6 years, 21.8 % lived in low income families. [4]

Currently, households that rely on Ontario Works or Ontario Disability Support Programs as their primary source of income have income levels that are inadequate to meet core basic needs such as housing and food. According to a report on household food insecurity in Canada

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[1] In Focus The Social Determinants of Health, Epidemiology and Evaluation Services, Fall 2014 available from http://www.hkpr.on.ca/Portals/0/PDF%20Files/PDF%20-%20Epi/InFocus14-Web.pdf

[2] Statistics Canada Canadian Income Survey 2013 available from http://www.statcan.gc.ca/daily-quotidien/150708/dq150708b-eng.htm

[3] 2011 National Household Survey, Statistics Canada available from https://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=HR&Code1=3535&Data=Count&SearchText=Haliburton,%20Kawartha,%20Pine%20Ridge%20District%20Health%20Unit&SearchType=Begins&SearchPR=01&A1=All&B1=All&GeoLevel=PR&GeoCode=3535&TABID=1

[4] Ibid

in 2012, 70% of households whose primary source of income was social assistance were food insecure.[5]

Over the past 20 years there have been tremendous changes in technology and globalization, which impacts job stability and security. Almost half of working adults are employed in precarious employment, which is part-time, seasonal or contract work that has little or no benefits and often pays low wages. Research shows that 70% of Canadians living in poverty are considered to be the working poor, which means they are employed but do not earn enough to make ends meet. [6]

Basic Income Guarantee

The causes of poverty are complex and a multipronged approach is required to eliminate poverty and to improve health and social equity for all. One component of a poverty reduction strategy is to provide a basic income guarantee (BIG). It is an unconditional income transfer from the government to individuals and families that is not tied to labour market participation. [7] The objective of a basic income guarantee is to provide a minimum annual income at a level that is sufficient to meet basic needs and allows individuals and families to live with dignity, regardless of work status.[8] Since research shows that basic income guarantee could have health promoting effects and reduce health and social inequities, it is considered to have merits as an effective policy option.

A basic income guarantee was piloted in Dauphin Manitoba from 1974-1979 to study the impact of a guaranteed income supplement. Research showed a number of substantial benefits including a decrease in hospitalization rates, which were 8.5% less when compared to the control group. There were fewer incidents of work-related injuries, fewer visits to the emergency department from motor vehicle accidents and domestic violence and there was a reduction in the rates of psychiatric hospitalizations and the number of mental illness consultations with health care professionals. The research also showed that teenagers and new mothers were the only populations to significantly work less. The study showed that more teenagers completed high school and new mothers extended their maternity leaves. Once the

[5] Tarasuk, V., Mitchell, A., Dachner, N.,(2014) Household food insecurity in Canada, 2012 available from http://nutritionalsciences.lamp.utoronto.ca/wp-content/uploads/2014/05/Household_Food_Insecurity_in_Canada-2012_ENG.pdf

[6] Lewchuk, W. et al. It's More than Poverty: Employment Precarity and Household Well-being United Way Toronto-McMaster University Social Sciences, 2013. www.pepso.ca

[7] Pasma, C., and Mulvale, J. Income Security for all Canadians Understanding Guaranteed Income. Ottawa: Basic Income Earth Network Canada; 2009. Available from http://www.cpj.ca/files/docs/Income_Security_for_All_Canadians.pdf

[8] Ibid

pilot finished and the cash transfers stopped, the number of teens not graduating from high school rose, returning to the previous rate that existed before the pilot.[9]

Currently in Canada, Old Age Security (OAS) and Guaranteed Income Supplements (GIS) are forms of guaranteed income supplement programs, which are income tested cash transfers for seniors at age 65 and older. Since their implementation, the incidence of poverty in seniors dropped substantially from 21.4% in 1980 to 5.2% in 2011. As a result, Canada has one of the lowest rates of seniors living in poverty in the world and the incidence of food insecurity is 50% less for those age 65 to 69 than for those age 60-64.[10]Similarly, other programs such as the Canadian Child Tax Benefit and National Child Benefit Supplement (which are tax free monthly payments for eligible families with children) have shown benefits in terms of improved math and reading skills and improved mental and physical health measures.[11]

Cost Considerations for a Basic Income Guarantee Program

It is widely agreed upon that the costs of poverty are very high. The total cost of poverty in Ontario is approximately $32.2-$38.3 billion dollars.[12] It is estimated that between $10.1 billion and $13.1 billion is spent on the social costs of poverty related to social assistance, housing and justice programs and health care costs associated with the effects of poverty. Lost opportunities for income tax revenue are estimated to be $4- $6.1 billion dollars and an additional $21.8-25.2 billion is attributed to lost productivity and revenue and intergenerational poverty low-income cycles.

Given the magnitude of the social and economic costs of poverty and the resources being spent on countering the negative effects of poverty, it is more prudent to spend those resources on prevention.

The costs of a basic income guarantee program in contrast to the costs of social and private costs of poverty have yet to be extensively researched. Estimates from Queen's University and the University of Manitoba identify that the amount for a basic income guarantee program for all of Canada would cost between $40 and $58 billion. Considering the total costs of poverty for just Ontario, a basic income guarantee would be very achievable.[13]

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[9] Forget, E. **The Town with No Poverty: Using Health Administration Data to Revisit Outcomes of a Canadian Guaranteed Annual Income Field Experiment 2011** available from http://nccdh.ca/images/uploads/comments/forget-cea_(2).pdf

[10] Hyndman, B., and Simon, l., Basic Income Guarantee Backgrounder October 2015 alPHA and OPHA available from ww.opha.on.ca/getmedia/bf22640d-120c-46db-ac69-315fb9aa3c7c/alPHa-OPHA-HEWG-Basic-Income-Backgrounder-Final-Oct-2015.pdf.aspx?ext=.pdf

[11] Ibid

[12] Laurie, N. **The cost of poverty: an analysis of the economic cost of poverty in Ontario.** Toronto Ontario Association of Food Banks, 2008. http://www.oafb.ca/assets/pdfs/CostofPoverty.pdf

[13] Roos, N., and Forget, E. **"The time for a guaranteed annual income might finally have come."** The Globe and Mail, August 4, 2015. Available at http://www.theglobeandmail.com/report-on-business/rob-commentary/the-time-for-a-guaranteed-annual-income-might-finally-have-come/article25819266/

Provincial and National Support for a Basic Income Guarantee Program

Support for the basic income guarantee program exists across the political spectrum including politicians from several provinces and municipalities, economists and the health and social service sectors. Many large associations have given formal expressions of support such as The Canadian Medical Association, the Association of Local Public Health Agencies and the Ontario Public Health Association, the Ontario Society of Nutrition Professionals in Public Health, the Canadian Association of Mental Health, the Canadian Association of Social Workers and many health units in Ontario. Citizen groups in communities across Canada have also been forming to express their support for this initiative.

This past winter the Ontario provincial government embraced the opportunity to engage in the needed research to provide a clearer understanding of the implications and outcomes of the basic income guarantee program. By conducting a pilot study of the program, evidence will be gathered to determine if this is a more efficient manner of delivering income support, if it strengthens engagement in the labour force and if savings are achieved in areas such as the health care and justice systems. In 2016, the Ontario provincial government will work with researchers, communities and stakeholders to develop and implement a basic income guarantee pilot study.

HALIBURTON KAWARTHA PINE RIDGE DISTRICT HEALTH UNIT
RESOLUTION ON BASIC INCOME GUARANTEE

WHEREAS addressing the social determinants of health and reducing health inequities are fundamental to the work of public health in Ontario; and

WHEREAS the Haliburton Kawartha Pine Ridge District Health Unit's strategic direction is to address the social determinants of health and health equity; and

WHEREAS income is recognized as the most important determinant of health and health inequities; and

WHEREAS 12.7% of the population in the Haliburton Kawartha Pine Ridge District live in low income circumstances based on the Low-Income After-Tax (2011 National Household Survey, Statistics Canada); and

WHEREAS low income and income inequality have well-established, strong relationships with a wide range of adverse health and social outcomes as well as lower life expectancy; and

WHEREAS income insecurity continues to rise in Ontario and Canada as a result of an increase in precarious employment and an increasing number of working-age adults who rely on employment that pays low wages; and

WHEREAS existing federal and provincial income security programs are insufficient to ensure that all Canadians have adequate and equitable access to the social determinants of health (e.g., food, shelter, education); and

WHEREAS a basic income guarantee, which is an unconditional cash transfer from the government to citizens to provide a minimum annual income and is not tied to labour market participation, has the potential to ensure all Canadians have a sufficient income to meet basic needs and to live with dignity; and

WHEREAS a basic income guarantee resembles existing income security supplements currently in place for Canadian seniors and children, which have contributed to improved health status and quality of life in these age groups; and

WHEREAS a pilot project of basic income for working age adults conducted in Dauphin Manitoba in the 1970s, indicates that the provision of a basic income guarantee can reduce poverty and income insecurity, improve physical and mental health and educational outcomes, and enable people to pursue educational and occupational opportunities relevant to them and their families; and

WHEREAS the concept of a basic income guarantee has received support from the health and social sectors including the Canadian Public Health Association (CPHA), the Canadian Medical Association (CMA), the Canadian Association of Social Workers, the Association of Local Public Health Agencies (alPHa) and the Ontario Association of Public Health Agencies (OPHA), the Ontario Society of Nutritional Professionals in Public Health and the Ontario Mental Health and Addictions Alliance as a means to alleviate poverty and improve health outcomes of low income Canadians; and

WHEREAS there is growing support from economists, political affiliations and other sectors across Canada for a basic income guarantee;

NOW THEREFORE BE IT RESOLVED THAT the Haliburton Kawartha Pine Ridge District Health Unit Board of Health endorse a position statement of a basic income guarantee;

AND FURTHER that the Haliburton Kawartha Pine Ridge District Health Unit Board of Health join alPHA and OPHA in requesting that the federal Ministers of Employment, Workforce Development and Labour, Families, Children and Social Development, Finance and Health, as well as the Ontario Ministers Responsible for the Poverty Reduction Strategy, Community and Social Services, Children and Youth Services, Finance and Health and Long-Term Care, prioritize joint federal-provincial consideration and investigation into a basic income guarantee as a policy option for reducing poverty and income insecurity;

AND FURTHER that the Prime Minister, the Premier of Ontario, the Chief Public Health Officer, the Chief Medical Officer of Health for Ontario, the Canadian Public Health Association, the

Association of Local Public Health Agencies, the Ontario Boards of Health, the Federation of Canadian Municipalities, the Association of Municipalities of Ontario, MP Kim Rudd, MP Jamie Schmale, MPP Lou Rinaldi and MPP Laurie Scott as well as the City of Kawartha Lakes, the County of Haliburton and Northumberland County be so advised.