Algoma
PUBLIC HEALTH
Santé publique Algoma

Board of Health Meeting

June 28, 2017 @ 5:00pm

Sault Ste. Marie Community Rooms A and B

www.algomapublichealth.com

June 28, 2017 - Board of Health Meeting Book

Algoma Public Health Board of Health Meeting Table of Contents

Ontario Act, 2016

i. Letter to Minister Hoskins from Elgin St. Thomas Public Health — Page 106

9. **Items of Information**

10. **Addendum**

11. **In Committee**

12. **Open Meeting**

13. **Resolutions Resulting From In Committees**

14. **Announcements**

    a. Next Board of Health Meeting - Date

15. **Adjournment**

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
JUNE 28, 2017 @ 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 June 28, 2017 be adopted as circulated.

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

Resolution
THAT the Board of Health minutes for the meeting dated May 24, 2017 be adopted as circulated.

4.0 Delegations/Presentations.

a. Accountability Agreement Indicators — Dr. Marlene Spruyt

5.0 Business Arising from Minutes

6.0 Reports to the Board

a. Medical Officer of Health and Chief Executive Officer Report — Dr. Marlene Spruyt MOH/CEO

Resolution
THAT the report of the Medical Officer of Health and CEO for the month of June 2017 be adopted as presented.

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

i. Committee Chair Report for June 14, 2017

ii. Draft Financial Statements for the Period Ending April 30, 2017 — Mr. Ian Frazier, Committee Chair

Resolution
THAT the Finance and Audit Committee report for the month of June 2017 be adopted as presented; and

THAT the Financial Statements for the Period Ending April 30, 2017 be approved as presented.

iii. Insurance Broker Services

Resolution
THAT the Board of Health approves providing a forum for interested brokers to present their service offerings to the Finance and Audit Committee for consideration.

iv. Proposed Ontario Building Code Fees

Resolution
THAT the Board of Health approves and directs staff to implement the recommended Ontario Building Code Fee increases for the District of Algoma Health Unit for the 2018-2020 budget years inclusive.

v. 02-05-065 – Algoma Board of Health Reserve Fund Policy

Resolution

THAT the Board of Health approve the changes to policy 02-05-065 – Algoma Board of Health Reserve Fund as presented.

vi. Approved minutes April 19, 2017 ***– for information only***

c. Governance Standing Committee Report — Ms. Deborah Graystone, Committee Chair

i. Committee Chair Report for June 2017

Resolution

THAT the Governance Standing Committee report for the month of June 2017 be adopted as presented.

ii. Bylaw Review

- Bylaw 95-1 – To Regulate the Proceedings of the Board of Health
- Bylaw 95-2 – To Provide for Banking and Finance
- Bylaw 95-3 – To Provide for the duties of the Auditor of the Board of Health
- Bylaw 06-01 – Sewage Systems Part 8 of the Ontario Building Code Act
- Bylaw 06-02 – Ontario Building Code Appointments
- Bylaw 2015-01 – To Provide for the Management of Property

Resolution

THAT the Board of Health approves the changes to the By-Laws as presented.

iii. Board Evaluation

- 02-05-055 – Board of Health Self-Evaluation Policy
- Monthly Meeting Evaluation
- Annual Self-Evaluation

Resolution

THAT the Board of Health approves the changes to policy 02-05-055 – Board of Health Self Evaluation and the monthly meeting and annual self-evaluation evaluation templates as presented.

iv. Approved Minutes April 12, 2017 – ***for information only***

7.0 New Business/General Business – N/A

8.0 Correspondence — Mr. Lee Mason, Board Chair

a. Assessment of the Healthy Menu Choices Act
   i. Letter to Minister Hoskins from Peterborough Public Health

b. Federal Opioid Strategy
   i. Letter to Minister Philpott from Peterborough

c. Low Income Adult Dental Program in Ontario
   i. Letter to Minister Hoskins from Leeds, Grenville & Lanark District Health Unit

d. Personal Service Settings
   i. Letter to Minister Hoskins from Elgin St. Thomas

e. Municipal Levy Appointment
   i. Letter to Minister Hoskins from Leeds, Grenville & Lanark District
f. Smoke-free Clauses in the Standard Lease Under the Residential Tenancies Act
   i. Letter to Minister Ballard from Middlesex-London Health Unit
g. Anti-Contraband Tobacco
   i. Letter to APH from City of Sault Ste. Marie
h. Marijuana Controls under Bill 178, Smoke Free Ontario Act, 2016
   i. Letter to Minister Hoskins from Elgin St. Thomas Public Health

9.0 Items for Information

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 May 24, 2017
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 Announcements: — Mr. Lee Mason, Board Chair

Next Board Meeting:
September 27, 2017 at 5:00pm
Sault Ste. Marie, Room A&B, Sault Ste. Marie

15.0 That The Meeting Adjourn — Mr. Lee Mason, Board Chair

Resolution
THAT the Board of Health meeting adjourns

Algoma PUBLIC HEALTH
Santé publique Algoma

Accountability Agreement Indicators

Overview and review of 2016

Dr. Marlene Spruyt
Medical Officer of Health/CEO

Performance Measurement

- Performance management involves establishing goals, monitoring progress, and making adjustments to achieve desired outcomes.
- Intended to capture, report on, and respond to the performance of boards of health and health units and the public health system

Algoma PUBLIC HEALTH
Santé publique Algoma

Accountability Agreements

- Accountability Agreements between BOH and the MOHLTC were introduced in 2011
- Initially set for a 3 year term from 2011-2013, then renewed for 2014-2016
- Set of indicators are common across all BOH in the province

Structure

- In the 1st year of an indicator, baselines are established for each indicator with each board of health.
- In subsequent years, targets for performance improvement will be established in consultation with each board of health, relative to its baseline level of achievement.

Indicator Types

- **Performance indicators**: annual targets for achievement.
- **Monitoring indicators**: do not have targets and performance is reviewed internally by the ministry to ensure expectations are met.
- **Long-term indicators**: measure population level outcomes when data becomes available.

2016 Indicator Performance

Common challenges for meeting targets

- Business owner availability
- Establishment going in and out of business
- Weather for travel to some inspection sites
- Staffing shortages – short and long term
- Data entry issues
- Cooperation of external agencies/partners
- Unrealistic targets given nature of APH's region

Indicator 1.1

% of population (19+) that exceeds the Low-Risk Alcohol Drinking Guidelines

- Not currently monitored; considered as long term indicators
- Baseline in 2013/4 was 36.8%

Indicator 1.2

Fall-related emergency visits in older adults aged 65+

- Not currently monitored; considered as long-term indicators
- Baseline in 2009 was 6,235 visits

Indicator 1.3

% of youth (ages 12-18) who have never smoked a whole cigarette

- Not currently monitored; considered as long term indicators
- Baseline in 2009/10 was 77.2%

Indicator 1.4

% of tobacco vendors in compliance with youth access legislation at the time of last inspection

Target >=90%

- 2016 = 94.2%
- 97/103

Indicator 1.5

% of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act (SFOA)

Target 100%

- 2016 year end = 100%
- 12/12

Indicator 1.6

% tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA)

Target 100%

- 2016 Year End
  - Seasonal = 100% 
  - Non-seasonal = 97.8%

Algoma PUBLIC HEALTH Santé publique Algoma

Indicator 1.7

% tobacco retailers inspected for compliance with display, handling and promotion sections of the Smoke-Free Ontario Act (SFOA)

Target 100%

- 2016 Year End = 99%
- 2015 Year End = 92.1%

Algoma PUBLIC HEALTH Santé publique Algoma

Indicator 1.8
Oral health Assessment and Surveillance

Target 100%

- % of schools screened
  - July 1 2015- June 30 2016 = 100%
  - Previous year = 98%

- % of all JK, SK and Grade 2 students screened in all publically funded schools
  - July 1 2015 – June 30 2016 = 100%
  - Previous year = 95.2%

Indicator 1.9
Implementation status of NutriSTEP Preschool Screen

- 2015 Year End Target – Intermediate stage
- 2016 achieved Advanced status Target reached

Indicator 1.10
Baby-Friendly Initiative (BFI) Status

- 2015 Year End – Designated
- Re-designation achieved April 2016

Indicator 2.1
% of high-risk food premises inspected once every 4 months while in operation

Target 100%

- 2016 Year End 331/359 = 92.2%

Indicator 2.2

% of moderate-risk food premises inspected once every 6 months while in operation

Target 98.4%

- 2016 Year End 337/388 = 96.1%

Indicator 2.3

% of Class A pools inspected while in operation

Target 100%

- 2016 Year End 7/7 = 100%
- 8/8

Indicator 2.4

% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection

Target 90%

- 2016 Year End = 90.9%
- 10/11

Indicator 2.5

% public spas inspected while in operation

Target 100%

- 2016 Year End = 100%
- 15/15

Indicator 2.6

% of restaurants with a Certified Food Handler(CFH) on site at time of inspection

- New monitoring indicator for 2017
- No data for 2016

Indicator 3.1

% of personal services settings inspected annually

Target 100%

- 2016 Year End 165/170 = 97.1%
- Previously in 2015 = 100%)

Indicator 3.2

% of suspected rabies exposures reported with investigation initiated within one day of public health unit notification

Target 100%

- 2016 Year End 239/239 = 100%
- Previously 2015 193/193 = 100%)

Indicator 3.3

% of confirmed gonorrhea cases where initiation of follow-up occurred within two business days

Target 100%

- 2016 Year End 92/94 = 97.9%
- 2015 68/68 100%

Indicator 3.4

% of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case

Target 100%

- 2016 Year End 6/6 - 100% (previous year also 100%)

Indicator 3.5

% of salmonellosis cases where one or more risk factor(s) other than "Unknown" was entered into iPHIS

Target 90%

- 2016 Year End 17/17 = 100%
- 2015 = 85.7%
- 2014 = 66.7%

Indicator 3.6

% of confirmed gonorrhea cases treated according to the recommended Ontario treatment guidelines

No target- Monitoring

- 2016 year end 67/94 = 71.3%
- 2015 year end = 73.2%

Indicator 4.1

% of HPV vaccine wasted that is stored/administered by the public health unit

Target changes based on previous years performance but generally less than 5 % initially

- September 1st 2015 – August 31st 2016 = 3.6%
- Previous year = 0.6%

Indicator 4.2

% of influenza vaccine wasted that is stored/administered by the public health unit

Target 2.3% was based on previous years performance of 2%

- September 1st 2015– August 31st 2016 = 8.0%

Indicator 4.3

% of refrigerators storing publically funded vaccines that have received a completed routine annual cold chain inspection

Target 100%

- 2016 Year End 115/115 = 100% ✓
- 2015 Year End = 97.7%

Indicator4.4

% of school-aged children who have completed immunizations for hepatitis B

Monitoring

- As of June 30, 2016 683/1009 = 67.7% (based on school year)
- 2015 724/980 = 71.5%
- 2014 = 76.1 %

Indicator 4.5

% of school-aged children who have completed immunizations for HPV

Monitoring

- As of June 30, 2016 302/502 = 60.2%
- 2015 was 285/493 = 57.8%
- 2014 was 283/498 = 56.8%

Indicator 4.6

% of school-aged children who have completed immunizations for meningococcus

Monitoring

- June 30, 2016 868/1009 = 86.0%
- June 2015 820/980 = 83.7%
- June 2014 868/1041 = 83.4%

Indicator 4.7

% of MMR vaccine wastage

New for 2016

- 482/2360 = 20.4%
  Developing baseline

Indicator 4.8

% of 7 or 8 year old students in compliance with ISPA

New for 2016

- 946/1037 = 91.2%
  Developing baseline

Indicator 4.9

% of 16 or 17 year old students in compliance with ISPA

New for 2016

- 945/1021 = 92.6%
  Monitoring

Algoma
PUBLIC HEALTH
Santé publique Algoma

MEDICAL OFFICER OF HEALTH/CHIEF EXECUTIVE OFFICER
BOARD REPORT
JUNE 2017

Prepared by Dr. Marlene Spruyt, Medical Officer of Health/CEO

And the Leadership Team

Table of Contents

APH AT-A-GLANCE

Several APH employees including myself participated in a Rural Health Hub Planning Day June 2, 2017 in Thessalon. As part of our direction to support planning for health services with the LHIN we may be asked to participate in many more of these types of meeting.

On June 9, 2017 Laurie Zeppa and I attended the launch of the Lake Superior Water Trail and the Great Lakes Waterfront Trail. This cycle trail connects the North Shore from Gros Cap to Sudbury (and is part of the larger Trans Canada Trail). The launch included a group cycle from SSM City Hall to the Machine Shop with Minister of Tourism, Recreation and Sport and SSM Mayor. Most of this entire trail is off road. Providing safe cycling trails is one way to encourage physical activity and active transportation in our communities.

I travelled to Chatham on June 11-12, 2017 to attend the alPHa annual meeting. I attended interesting sessions on Change Management and Program Based Marginal Analysis for budgeting. And as always the opportunity to network with others in the public health community was beneficial.

Throughout the month the management team has worked to develop plans for implementation of the Modernized Standards for Public Health Programs and Services. This will involve significant reorganization in some areas which deliver public health mandatory programs. Community based client service programs such as Mental Health and Addictions, Genetics, Speech and Language and Infant Child Development are not affected , however in an organization as large as ours where different programs work together everyone will be affected by the changes. We have reassured staff that these are service reorganizations and there is no intended reduction in positions and we are discussing our process for re-alignment with both unions. We are awaiting the release of the finalized document from the Ministry (which is expected this month) before we proceed with implementation activities.

PROGRAM HIGHLIGHTS

CHRONIC DISEASE PREVENTION

Director: Laurie Zeppa
Manager: Kristy Harper

Topic: 2017 Nutritious Food Basket Results

This report addresses the OPHS Chronic Disease Prevention Requirement #2: The board of health shall monitor food affordability in accordance with the *Nutritious Food Basket Protocol* and the *Population Health Assessment and Surveillance Protocol.*

This report addresses the following Strategic Directions: Improve Health Equity

Annually during the month of May, all Ontario public health units conduct the Nutritious Food Basket (NFB) survey in accordance with the requirements under the Ontario Public Health Standards. The survey provides a measure of the cost of basic healthy eating taking into consideration current nutrition recommendations and average food purchasing patterns of Canadians. The NFB results can be used to: estimate the basic cost for an individual or household to eat healthy; compare the basic costs of healthy eating with income and other basic living expenses; and inform policy decisions. In 2017, seven grocery stores across Algoma were surveyed.

In May 2017, the estimated local monthly cost to feed a family of four was $907.09. The results of the 2017 survey indicate that the average weekly cost to feed a family of four has risen 20.6% over the past seven years. All of us have noticed that food costs are rising; however, households with limited incomes often consider food budgets to be “flexible” and redirect these funds to pay for housing, utilities and other essential “fixed” costs.

The annual NFB results bring attention to the issue of food insecurity across Algoma. Food insecurity is associated with inadequate nutrient intakes as well as an increased risk of infectious and chronic diseases. It is also more difficult to manage these diseases and conditions for people who are food insecure. Algoma Public Health (APH) Registered Dietitians work with our Health Equity Public Health Nurses and community partners, such as Algoma Food Network and the Sault Ste. Marie and North Channel Poverty Reduction Roundtables, to increase awareness of the issue of food insecurity and look for opportunities for community action to address it.

Currently, APH continues to strive to address food insecurity by:

- Providing education around poverty and food insecurity
- Monitoring and reporting on the Nutritious Food Basket data and other food insecurity indicators
- Working with community partners to address food insecurity
- Focusing on food literacy to provide families and individuals with knowledge and skills to make healthy food choices

Table 1. Average Weekly Cost for a Family of Four* to Eat a Healthy Diet in Algoma District

Year	Weekly Cost	Percent Change in Cost from Previous Year
2017	$209.49	-2.6%
2016	$214.99	+ 1.9%
2015	$211.07	+ 7.0%
2014	$197.32	+ 1.6%
2013	$194.12	+ 0.8%
2012	$192.64	+ 3.8%
2011	$185.50	+ 6.8%
2010	$173.64	-

The results of the 2017 survey indicate that average weekly cost to feed a family of four has risen over 20% over the past seven years.

* The family of four scenario is based on:
- Male 31-50
- Female 31-50
- Male 14-18
- Female 4-8

ENVIRONMENTAL HEALTH

Director: Sherri Cleaves
Manager: Chris Spooney

Topic: Recreational Water

This report addresses the OPHS Safe Water Requirement #9: the board of health shall reduce risks of public beach and recreational water facilities use in accordance with Recreational Water Protocol, 2016 (or as current)

The board of health shall report Safe Water Program data elements in accordance with the Drinking Water Protocol, 2014 (or as current) and the Recreational Water Protocol, 2016 (or as current).

This report addresses the following Strategic Directions: Be Accountable

Background:
Within Algoma District, the beach management program operates between the months of June-September. The goal of this program is to inform the general public around public beach/water health and safety. Routine bacteriological water samples are taken at each location. When samples taken exceed the bacteriological standard the beach is considered unsafe for swimming and signage is posted until repeat water samples return confirming the contamination has cleared. We also provide health promotion campaigns, interactive water mapping and educational signage at each public beach.

Public Beaches:
In the Algoma District there are 31 public beaches in total.

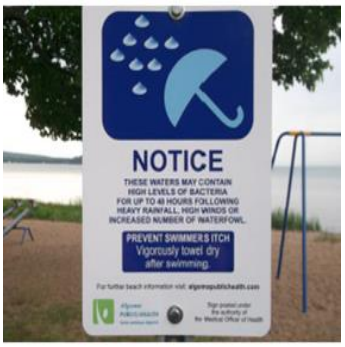
- SSM 6
- Wawa 7
- BR/EL 18

Adverse Postings:
In 2016, there were a total of 8 beaches posted due to elevated E.coli counts.

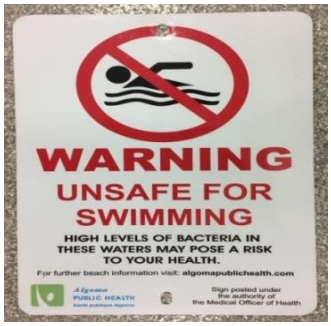
- 4 SSM
- 4 BR/EL

Educational Beach Signage vs. Posting Beach Signage:

- Educational signage is permanently located at each beach site which provides general advice to consider when bathing such as water fowl activity and weather conditions.
- The beach will be posted if the water sample collected exceeds the Provincial standard. In Algoma, beachs are not closed they are posted "Warning Unsafe for Swimming – High levels of bacteria in these waters may pose risk to your health".



Educational permanent beach sign



Beach posting sign

Factors that influence E.coli levels:

- Human Activity
- Water Temperature
- Rainfall
- Wave Height
- Topography
- Birds
- Animals

If you have any further questions or would like to learn more regarding our beach management program please visit our website at www.algomapublichealth.com/inspections-environment/recreational-water/

HEALTHY BABIES HEALTHY CHILDREN

Director: Laurie Zeppa
Manager: Leslie Wright

Topic: 48 hour Postpartum Support Services

This report addresses OPHS Child Health Requirement #9: The board of health shall provide all the components of the Healthy Babies Healthy Children Program in accordance with the Healthy Babies Healthy Children Protocol, 2008 (or as current) (Ministry of Children and Youth Services).

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

The OPHS directs that we deliver the Healthy Babies Healthy Children (HBHC) program as per the guidance document of the Ministry of Child and Youth Services (MCYS). One of the requirements under the HBHC program is Postpartum Support Services. This requirements states, 'The board of health shall provide all families who have given their consent, contact with a public health nurse within 48 hours of being discharged from a birth admission.

To initiate postpartum support services, consent is obtained from the mother while in hospital and an HBHC screening tool is completed. The HBHC screen is a validated tool that is use to determine the level of risk. The screen includes 36 questions that will assist service providers in identifying vulnerable families who would benefit from the HBHC program

In Sault Ste. Marie, a public health nurse (PHN) attends the Sault Area Hospital Monday to Friday for the purpose of completing the HBHC screen with postpartum mothers. The weekend HBHC screens are completed on the following Monday by a PHN during the 48 hour phone call. At St. Joseph's Hospital in Elliot Lake the PHN attends every Friday, as a rule, to offer support and guidance for the hospital staff in completing the HBHC screen.

According to the HBHC guideline, those families who are considered to be *identified with risk* must receive contact within 48 hours of discharge from the hospital. The current practice at Algoma Public Health is to contact all families within 48 hours *regardless of risk* to provide the opportunity to schedule a home visit. The measurement of a successful contact is one in which a PHN has spoken to a responsible family member and is able to confirm the family's willingness to continue with HBHC program.

Families who are considered 'not identified with risk' remain eligible to receive a 48 hour contact however; this practice is not a requirement according to the HBHC guidelines.

The following are some of the postpartum health issues which are assessed during contact with families:

- Infant hydration
- The presence of jaundice and other abnormalities.
- The mother's physiological recovery from childbirth
- The mother's confidence in basic baby care.
- The mother-infant interaction.
- The mother's emotional health and adjustment.
- The safety of the home environment.
- Parenting knowledge and capacity.

- Level of parenting support available.
- Family relationships and family adjustment to the new baby.
- The health and development of other young children in the home

Postpartum Support Services Statistics

Ministry Target	2016	2016 Algoma Average	2016 Provincial Average
Number of consented births	975		
Number of HBHC screens completed	886	96.2%	91.9%
Number of screens identified with risk	669	75.5%	58.5%
Number of families contact within 48 hrs	226	42.5%	48.7%
Number of families contact after 48 hrs	114	21.3%	45.5%
No contact	101	15.1%	26.8%
Accepted postpartum HV	270	50.6%	46.4%
Number of screens not identified with risk	217	24.5%	51.5%
Number of families contact within 48 hrs	120	55.3%	45.5%
Number of families contact after 48 hrs	43	19.8%	32.5%
No contact	13	6%	10.3%

Note: Reasons for 'No Contact' include referred to another agency referred to another Public Health Unit, referred to aboriginal HBHC, declined, moved, or HBHC not appropriate

The HBHC program is a universal program that supports all consenting mothers in their postpartum period to encourage attachment and healthy growth and development and it helps families build confidence in parenting skills.

PREVENTION OF INJURY

Director: Laurie Zeppa
Manager: Kristy Harper

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

This report addresses the OPHS:

- ***Requirement #2****:* the board of health shall work with community partners to influence the development and implementation of healthy policies, programs and supportive environments that address falls across the lifespan.
- ***Requirement #3****:* The board of health shall use a health promotion approach to increase capacity of priority populations to prevent injury.
- ***Requirement # 4****:* The board of health shall increase public awareness of falls prevention.

This report addresses the following Strategic Directions: Improve Health Equity

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

To reduce the rate and severity of falls, SOYF includes multiple components and approaches. The strategy is built on working with community partners and addressing the nine steps of falls prevention (be active, manage your medications, manage your health, improve balance, walk tall, care for your feet, regularly check eyesight and hearing, eat well, identify and remove hazards). The SOYF structure consists of a regional network and local SOYF coalitions.

One of the activities providing opportunities for older adults to increase physical activity, manage health and improve balance is the implementation of Stand Up!, which is a best practice falls prevention program for seniors 65+. Stand Up! is a twelve week program that consists of group exercises, home exercise and education and awareness sessions about falls prevention. This program is being delivered by a variety of community partners throughout the Algoma District.

Some medications and or combinations of medications may increase an older adults' risk for falls. Managing medication can help older adults maintain independence and prevent a fall. As part of the launch for this event The Sault Rising Stars performed musical pieces and a skit that focused on the safe use of medications by older adults

Recently, the local SOYF coalition and The Sault Rising Stars partnered with The Ontario Provincial Police, Sault Ste. Marie Police Services, Safe Communities Partnership, Batchewana Police, and Anishinabek Police to support the community wide Prescription Drug Drop off event. The goal of the event is to improve overall community safety. This partnership provided the opportunity to increase awareness about the importance of managing medication and proper disposal of medication. Green medication return bags were distributed throughout the community to individuals and community partners to encourage the safe disposal of medication. The medication clean out day occurred on May 20th at the Station Mall, police and a pharmacist were on site to collect and dispose of the medications properly. Those that could not attend are encouraged to drop off expired and unused medications to a local pharmacy.

PARTNERSHIPS

We thank SAH for inviting us to join them in their Leadership Development Series. Our management staff recently attended a workshop on LEAN and how to apply Lean practices. The core idea is to maximize customer value while minimizing waste. The lean business model means creating more value for customers with fewer resources.

PERFORMANCE INDICATORS

2017 Health Protection Indicators		First Quarter (January – March)					Second Quarter (April–May *only*)					YTD - TOTAL
		Wawa	SSM	BR	EL	Total	Wawa	SSM	BR	EL	Total	
Safe Water	Private Wells – Adverse DW	0	3	0	0	**3**	0	0	2	0	**2**	**5**
	Regulated Premise – ADW (O.reg.319)	0	1	0	0	**1**	0	0	1	0	**1**	**2**
	BWA issued	0	0	1	1	**2**	0	0	0	2	**2**	**4**
	DWA issued	0	0	0	0	**0**	0	0	0	0	**0**	**0**
	Beach closures	N/A	N/A	N/A	N/A	**0**	N/A	N/A	N/A	N/A	**0**	**0**
Rabies	#Rabies risk Investigations Initiated	0	31	8	5	**44**	0	22	3	5	**30**	**74**
Food Safety	Special Event Permits issued	0	26	5	7	**38**	0	10	8	5	**23**	**61**
	Food Handler Training (#persons)	0	98	21	0	**119**	0	60	1	8	**69**	**188**
	Farmer's Market Approvals	0	30	0	0	**30**	0	20	30	0	**50**	**80**
Health Hazard	Complaint/Investigations all types	0	60	7	0	**67**	0	34	5	0	**39**	**106**
Land Control – OBC	Applications/Permits – Class IV	0	3	0	0	**3**	1	23	8	0	**32**	**35**
Communicable Disease Control	#Institutional outbreaks	1	8	4	2	**15**	0	0	1	1	**2**	**17**
	Total outbreak days in quarter	50	137	38	21	**246**	0	0	11	0	**11**	**257**
	Gonorrhea*June 13	0	17	0	0	**17**	0	6	0	0	**6**	**23**
	Chlamydia*June 13 (6 cases-location not identified)	5	61	1	7	**79**	0	43	1	7	**52**	**131**
	BBI (Hep B, C, HIV)	N/A	N/A	N/A	N/A	**31**	N/A	N/A	N/A	N/A	**16**	**47**
	Other Reportable Diseases	4	19	1	5	**29**	0	8	2	0	**10**	**39**
	Confirmed influenza cases	2	29	22	4	**57**	3	9	3	11	**26**	**83**
	#sharps picked up	N/A	125	N/A	N/A	**125**	N/A	83	N/A	N/A	**83**	**208**
	#sharps picked up at bins (est from City and APH)	N/A	9000	N/A	N/A	**9000**	N/A	9000	N/A	N/A	**9000**	**18000**

Respectfully submitted,

Dr. Marlene Spruyt

Algoma Public Health
(Unaudited) Financial Statements April 30, 2017

Algoma Public Health
Statement of Operations
April 2017
(Unaudited)

	Actual YTD 2017	Budget YTD 2017	Variance Act. to Bgt. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017
Public Health Programs						
Revenue						
Municipal Levy - Public Health	$ 1,746,279	$ 1,742,393	$ 3,886	$ 3,484,786	0%	100%
Provincial Grants - Public Health 75% Prov. Funded	2,436,399	2,436,400	(1)	7,309,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	857,938	857,933	5	2,691,200	0%	100%
Fees, other grants and recovery of expenditures	170,357	206,325	(35,969)	670,476	-17%	83%
Provincial Grants - Funding for Prior Yr Expenses	0	0	-	-		
Total Public Health Revenue	$ 5,210,972	$ 5,243,052	$ (32,079)	$ 14,155,662	-1%	99%
Expenditures						
Public Health 75% Prov. Funded Programs	$ 3,459,571	$ 3,856,985	$ 397,414	$ 11,464,463	-10%	90%
Public Health 100% Prov. Funded Programs	768,148	863,757	95,609	2,691,200	-11%	89%
Total Public Health Programs Expenditures	$ 4,227,719	$ 4,720,742	$ 493,023	$ 14,155,662	-10%	90%
Excess of Rev. over Exp. 75% Prov. Funded	$ 893,463	$ 528,133	$ 365,330	$ (1)		
Excess of Rev. over Exp. 100% Prov. Funded	89,790	(5,824)	95,613	1		
Provincial Grants for Prior Yr Expenses	-	-	-	-		
Total Rev. over Exp. Public Health	$ 983,253	$ 522,309	$ 460,944	$ (0)		
Public Health Programs - Fiscal 16/17						
Provincial Grants and Recoveries	$ -	-	-	-		
Expenditures	-	-	-	-		
Excess of Rev. over Fiscal Funded	-	-	-	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ 367,237	$ 356,004	$ 11,234	$ 1,068,011	3%	103%
Municipal, Federal, and Other Funding	126,694	112,773	13,921	338,455	12%	112%
Total Community Health Revenue	$ 493,931	$ 468,777	$ 25,154	$ 1,406,466	5%	105%
Expenditures						
Healthy Babies and Children	$ 365,876	$ 356,004	$ (9,872)	$ 1,068,011	3%	103%
Child Benefits Ontario Works	5,810	8,044	2,234	24,135	-28%	72%
Algoma CADAP programs	92,448	100,773	8,325	302,319	-8%	92%
One-Time Funding programs	10,996	12,000	1,004	12,000	-8%	92%
Total Calendar Community Health Programs	$ 475,130	$ 476,821	$ 1,691	$ 1,406,465	0%	100%
Total Rev. over Exp. Calendar Community Health	$ 18,801	$ (8,044)	$ 26,845	$ 1		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 450,311	$ 455,508	$ (5,197)	$ 5,566,099	-1%	99%
Municipal, Federal, and Other Funding	34,251	58,012	(23,762)	728,603	-41%	59%
Other Bill for Service Programs	1,431		1,431			
Total Community Health Revenue	$ 485,993	$ 513,520	$ (27,527)	$ 6,294,702	-5%	95%
Expenditures						
Brighter Futures for Children	4,895	9,121	4,225	109,447	-46%	54%
Infant Development	49,904	53,370	3,465	640,434	-6%	94%
Preschool Speech and Languages	52,839	51,188	(1,651)	614,256	3%	103%
Nurse Practitioner	9,982	10,646	664	127,753	-6%	94%
Genetics Counseling	36,560	30,626	(5,935)	367,806	19%	119%
Community Mental Health	252,945	287,192	34,246	3,449,498	-12%	88%
Community Alcohol and Drug Assessment	56,173	60,346	4,173	724,157	-7%	93%
Healthy Kids Community Challenge	10,399	17,449	7,050	161,350	-40%	60%
Stay on Your Feet	7,641	8,333	692	100,000	-8%	92%
Bill for Service Programs	4,144	-	(4,144)	-		
Misc Fiscal	-	-	-	-		
Total Fiscal Community Health Programs	$ 485,484	$ 528,270	$ 42,786	$ 6,294,701	-8%	92%
Total Rev. over Exp. Fiscal Community Health	$ 509	$ (14,750)	$ 15,259	$ 1		

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

Algoma Public Health
Revenue Statement
For the Four Months Ending April 30, 2017
(Unaudited)

	Actual YTD 2017	Budget YTD 2017	Variance Bgt. to Act. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017	Comparison Prior Year: YTD Actual 2016	YTD BGT 2016	Variance 2016
Levies Sault Ste Marie	1,211,486	1,211,486	0	2,422,972	0%	50%	1,202,522	787,615	414,907
Levies Vector Bourne Disease and Safe Water	29,717	29,717	0	59,433	0%	50%		19,811	(19,811)
Levies District	505,076	501,190	3,886	1,002,381	1%	50%	501,903	325,837	176,066
Total Levies	**1,746,279**	**1,742,393**	**3,886**	**3,484,786**	**0%**	**50%**	**1,704,425**	**1,133,264**	**571,161**
MOH Public Health Funding	2,376,966	2,376,967	(1)	7,130,900	0%	33%	2,477,604	2,499,267	(21,663)
MOH Funding Vector Bourne Disease	36,233	36,233	(0)	108,700	0%	33%	36,233	36,233	(0)
MOH One Time Funding Dental Health	0	0	0	0		0%	27,967	11,333	16,634
MOH Funding Safe Water	23,200	23,200	0	69,600	0%	33%	23,200	23,200	0
Total Public Health 75% Prov. Funded	**2,436,399**	**2,436,400**	**(1)**	**7,309,200**	**0%**	**33%**	**2,565,004**	**2,570,033**	**(5,029)**
MOH One Needle Exchange	16,901	16,900	1	50,700	0%	33%	16,901	16,900	1
MOH Funding Haines Food Safety	8,200	8,200	0	24,600	0%	33%	8,200	8,200	0
MOH Funding CINOT/Healthy Smiles	256,634	256,633	1	769,900	0%	33%	146,188	136,867	9,321
MOH Funding - Social Determinants of Health	60,167	60,167	0	180,500	0%	33%	60,167	60,167	0
MOH Funding Chief Nursing Officer	40,501	40,500	1	121,500	0%	33%	40,501	40,500	1
MOH Enhanced Funding Safe Water	5,167	5,167	0	15,500	0%	33%	5,167	5,167	0
MOH Funding Unorganized	171,701	171,700	1	515,100	0%	33%	166,767	166,767	0
MOH Funding Infection Control	104,134	104,133	1	312,400	0%	33%	104,134	104,133	1
MOH Funding Diabetes	50,000	50,000	0	150,000	0%	33%			
MOH Funding Northern Ontario Fruits & Veg.	0	0	0	117,400		0%			
Funding Ontario Tobacco Strategy	144,533	144,533	0	433,600	0%	33%	164,439	147,033	17,406
One Time Funding	0	0	0	0					
Total Public Health 100% Prov. Funded	**857,938**	**857,933**	**5**	**2,691,200**	**0%**	**32%**	**712,464**	**685,733**	**26,731**
Funding for Prior Yr Expenses	**0**	**0**	**0**	**0**		**0%**			
Recoveries from Programs	3,354	3,354	(0)	10,061	0%	33%	3,825	3,354	471
Program Fees	80,460	83,248	(2,788)	249,743	-3%	32%	74,117	82,381	(8,264)
Land Control Fees	18,900	53,333	(34,433)	160,000	-65%	12%	13,385	53,333	(39,948)
Program Fees Immunization	60,885	59,833	1,052	179,500	2%	34%	61,346	53,333	8,013
HPV Vaccine Program	289	1,300	(1,011)	12,500	0%	2%	306	3,333	(3,027)
Influenza Program	1,490	1,100	390	40,000	35%	4%	1,285	20,000	(18,715)
Meningococcal C Program	842	600	242	8,000	0%	11%	289	3,333	(3,044)
Interest Revenue	4,138	3,557	580	10,672	16%	39%	2,921	667	2,254
Other Revenues	0	0	0	0	0%	0%	0	55,000	(55,000)
Total Fees, Other Grants and Recoveries	**170,357**	**206,325**	**(35,969)**	**670,476**	**-17%**	**25%**	**157,473**	**274,735**	**(117,261)**
Total Public Health Revenue Annual	**$ 5,210,972**	**$ 5,243,052**	**$ (32,079)**	**$ 14,155,662**	**-1%**	**37%**	**$ 5,139,366**	**$ 4,663,765**	**$ 475,601**
Public Health Fiscal									
Panorama			0			0%	0	0	0
Rabies Software			0			0%			
Smoke Free Ontario NRT			0			0%			
Practicum			0			0%			
Total Provincial Grants Fiscal	**$ -**	**$ -**	**$ -**	**$ -**		**0%**	**$ -**	**$ -**	**$ -**

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

Algoma Public Health

Expense Statement- Public Health

For the Four Months Ending April 30, 2017

(Unaudited)

	Actual YTD 2017	Budget YTD 2017	Variance Act. to Bgt. 2017	Annual Budget 2017	Variance % Act. to Bgt. 2017	YTD Actual/ YTD Budget 2017	*Comparison Prior Year:* YTD Actual 2016	YTD BGT 2016	Variance 2016
Salaries & Wages	$ 2,500,049	$ 2,809,794	$ 309,745	$ 8,454,202	-11%	30%	$ 2,573,252	$ 2,768,882	$ 195,631
Benefits	643,855	661,753	17,899	1,993,632	-3%	32%	582,658	692,221	109,562
Travel - Mileage	18,299	42,620	24,321	127,861	-57%	14%	23,899	48,553	24,654
Travel - Other	16,525	25,981	9,456	77,942	-36%	21%	14,876	31,267	16,391
Program	163,275	221,828	58,553	735,528	-26%	22%	239,518	188,602	(50,916)
Office	36,060	44,750	8,690	135,250	-19%	27%	27,998	30,667	2,669
Computer Services	188,443	233,173	44,730	699,518	-19%	27%	248,489	298,636	50,147
Telecommunications	82,813	82,265	(548)	325,994	1%	25%	57,061	73,494	16,433
Program Promotion	17,744	56,932	39,188	170,797	-69%	10%	34,255	71,362	37,107
Facilities Expenses	275,127	266,783	(8,344)	800,350	3%	34%	285,460	271,308	(14,152)
Fees & Insurance	164,059	144,032	(20,027)	242,096	14%	68%	179,106	80,402	(98,704)
Debt Management	153,633	153,633	0	460,900	0%	33%	154,744	152,000	(2,744)
Recoveries	(32,161)	(22,803)	9,359	(68,408)	41%	47%	(40,342)	(46,961)	(6,619)
	$ 4,227,720	$ 4,720,742	$ 493,023	$ 14,155,662	-10%	30%	$ 4,380,974	$ 4,660,432	$ 279,458

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

Notes to Financial Statements – April 2017

Reporting Period

The April 2017 financial reports include four months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, Child Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting one month result from operations year ended March 31st, 2018.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of April 30th 2017, Public Health programs are reporting a $461k positive variance.

Total Public Health Revenues are indicating a negative $32k variance. This is a result a result of Fees, Other Grants & Recoveries being less than budgeted. Land Control Fees are driving this negative variance. APH typically captures the bulk of its fees between the spring and fall months.

There is a positive variance of $493k related to Total Public Health Expenses being less than budgeted. The $310k positive variance associated with Salary & Wages expense is driving this positive variance. The 2017 Public Health Operating Budget included the new positions of Associate Medical Officer of Health (AMOH) and Human Resource (HR) Manager. As of April 30th, the HR Manager position has been filled while the AMOH position is scheduled to start at the end of August 2017. The inherent time lag in filling positions within the agency is also contributing to this variance. Program expenses, Computer Services expenses and Program Promotion expenses are also contributing to the positive variance. As APH is relatively early in its budget year, many expenditures related to Programs and Computer services have yet to be incurred.

Community Health Calendar programs are reporting a $27k positive variance. This is primarily a result of timing of funding receipts.

APH's Community Health Fiscal Programs are only one month into the fiscal year.

On the revenue side, $24k negative variance is associated with Municipal, Federal, and Other Funding. This is due to timing of receipt of funding.

Community Mental Health Program expenses operated with a positive variance of $34k. This is a result of the inherent time lag in filling positions.

Notes Continued…

Public Health Revenue (see page 2 for details)

Public Health funding revenues are showing a negative $32k variance.

The municipal levies are within budget.

Provincial Grants are within budget.

There is a negative variance of $36k associated with Fees, Other Grants & Recoveries. This is a result of Land Control Fees being less than budgeted. APH typically captures the bulk of its fees between the spring and fall months.

Public Health Expenses (see page 3)

Salary & Wages
Salary & Wages expense is indicating a positive variance of $310k. The 2017 Public Health Operating Budget included the position of the AMOH and the HR Manager. As of April 30th, the HR Manager position has been filled while the AMOH position is scheduled to start at the end of August 2017. The inherent time lag in filling positions within the agency is also contributing to this variance.

Travel - Mileage
Travel – Mileage expense is indicating a positive variance of $24k. Staff travel typically occurs between the spring and fall months.

Program
Program expense is indicating a positive variance of $59k variance. This is a result of allocating in-kind expenses to the Community Health Program Brighter Futures for Children from Public Health. APH also received a credit from a supplier related to vaccine purchases. In addition, the timing of expenditures not yet incurred is contributing to the noted variance.

Computer Services
Computer Services expense is showing a positive variance of $45k. The noted variance is a result of timing as general IT equipment purchases that have yet to be made. Furthermore, the annual Microsoft License renewal has yet to be purchased.

Program Promotion
Program promotion expense is indicating a positive$39k variance which is due to timing of expenditures not yet incurred. Specifically, staff professional development typically occurs between the spring and fall months.

Notes Continued...

Financial Position - Balance Sheet (see page 7)

APH's cash flow position continues to be stable and the bank has been reconciled as of April 30th, 2017. Cash includes $325k in short-term investments.

Long-term debt of $5.79 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $335k of the loan relates to the financing of the Elliot Lake office renovations with the balance related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie.

There are no material collection concerns for accounts receivable. Letters were issued by APH to four municipalities regarding past due levy payments.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of April 2017	**April 2017**	December 2016
Assets		
Current		
Cash & Investments	**$ 2,483,716**	$ 2,146,361
Accounts Receivable	**570,605**	509,998
Receivable from Municipalities	**266,358**	9,159
Receivable from Province of Ontario		
Subtotal Current Assets	**3,320,679**	2,665,518
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,446,424**	1,587,880
Payable to Gov't of Ont/Municipalities	**61,854**	321,402
Deferred Revenue	**514,413**	494,864
Employee Future Benefit Obligations	**2,550,458**	2,550,458
Term Loan	**5,903,861**	5,903,861
Subtotal Current Liabilities	**10,477,010**	10,858,466
Net Debt	**-7,156,332**	-8,192,947
Non-Financial Assets:		
Building	**22,732,421**	22,732,421
Furniture & Fixtures	**1,914,772**	1,914,772
Leasehold Improvements	**1,572,807**	1,572,807
IT	**3,244,030**	3,244,030
Automobile	**40,113**	40,113
Accumulated Depreciation	**-7,690,685**	-7,690,685
Subtotal Non-Financial Assets	**21,813,456**	21,813,456
Accumulated Surplus	**14,657,125**	13,620,509

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: Algoma Public Health Board of Health

From: Dr. Marlene Spruyt, MOH/CEO
Justin Pino, CFO

Date: June 28th, 2017

Re: Procurement Process for Insurance Broker Services

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Algoma Public Health's (APH) has used the same insurance broker services for years. It should be noted that there have been no reported issues with the level of service of this broker. Furthermore, the price that a broker charges for their respective services is fixed based on the level of coverage and the insurer provided. APH uses Frank Cowan Company as its insurer. The Frank Cowan Company is a leader in providing specialized insurance programs, including risk management and claims services to municipalities, healthcare, education, community, and children's and social services organizations across Canada. In 2015, a survey went out to the other public health units within the province asking what insurer they use. Approximately half reported using the Frank Cowan Company. While it is not recommended to changes insurers, the issue of broker services has surfaced. Specifically, another broker has shown interest in providing these services to APH and would like the forum to make a presentation to APH's Finance & Audit Committee to sell their services. The only differentiating factor between one broker and another is the service offering they could provide, as any broker providing Frank Cowan Company insurance coverage must charge the same price for the same coverage. As such, the Finance & Audit Committee may want to consider a process to ensure an opportunity for other insurance brokers to present their service offerings over a certain number-of-year cycle. This would ensure APH's insurance procurement process is fair to the public.

RECOMMENDED ACTION:

It is recommended that the Finance & Audit Committee provide the forum for interested brokers to present their services offerings. Once the Finance & Audit Committee choses a broker based on the presentation, the broker service commitment would be for a five-year cycle. Once that five-year cycle has elapsed, any broker to show interest would

have the forum to present to the Finance & Audit Committee at that time. This cycle would be repeated.

BACKGROUND:

Choosing an insurance broker is an important decision in the purchase of insurance. The role of the insurance broker varies but includes the proper disclosure of material information to the insurer, coverage levels and wordings, the provision of advice and assistance throughout the duration of the relationship and providing assistance to the buyer in the event of a claim. The broker should offer advice on the existing program and suggest to the buyer coverage options that are available that would add value to the buyer. The broker would require a full understanding of the buyer's organization and industry, its current performance and ongoing plans to ensure adequate and relevant coverage is in place.

Over the past few years, an insurance broker firm has inquired about APH's insurance broker business. They have asked for a forum to present their respective service offerings as a means of potentially garnering APH's business. While APH has no obligation to react to every request, APH's Procurement Policy 02-04-030 sets out the following purpose:

a) Ensure that the Board of Health for the District of Algoma Health Unit utilizes fair, reasonable and efficient methods to procure quality goods and services required to execute the Board's programs and services.
b) Ensure APH aims to be accountable and transparent when procuring goods and services while safeguarding the assets of the agency.
c) Protect the financial interest of APH while meeting the needs of its programs and services it offers within the District of Algoma.
d) Promote and ensure integrity of the procurement process to ensure the necessary controls are present for a public institution.

As insurance broker services have not been explored for some time, it may be an appropriate opportunity for APH to develop a process where a broker would provide APH with services for a period of time. Once that time has elapsed, any broker who expresses interest in presenting their services would have an opportunity for APH's business. This would ensure APH is "utilizing fair, reasonable and efficient methods" of procurement as noted in APH's Procurement Policy 02-04-30.

FINANCIAL IMPLICATIONS:

There is no financial commitment for APH to offer the forum for interested brokers to present to APH the services they can offer.

CONTACT:

J. Pino, Chief Financial Officer

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: Algoma Public Health Board of Health

From: Dr. Marlene Spruyt, MOH/CEO
Justin Pino, CFO
Sherri Cleaves, Chief Building Officer

Date: June 28th, 2017

Re: 2018-2020 Proposed Land Control Fees Increase

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Under Part VIII of the Ontario Building Code, Algoma Public Health is responsible for issuing permits for the construction and use of sewage treatment systems within the District of Algoma. Under the Planning Act, APH is requested by local Municipalities in organized territories and the Ontario Ministry of Municipal Affairs and Housing in the unorganized territories to comment on proposed severances, subdivisions, minor variances, zoning amendments and official plans from an in-ground sewage treatment and dispersal viewpoint. As such, APH is responsible for the enforcement of the provisions of the Act and its Codes related to sewage systems. Specifically, APH is required to inspect and approve all sewage system applications within the District of Algoma that have a calculated daily sewage flows under 10,000/day. The Land Control program is funded only through the fees generated. As such, APH must ensure it is at least covering the costs incurred to administer the program. Management has reviewed programs statistics in addition to fees charged by other northern Health Units. The goal is to ensure APH's fee structure is adequate for the service being provided and that fees are comparable with other neighboring areas.

RECOMMENDED ACTION:

It is recommended that the Finance and Audit Committee of the Board of Health recommend to the Board of Health the approval of the noted fee increases for the 2018-2020 budget years inclusive.

BACKGROUND:

The following is a summary of the total revenues of APH's Land Control program over the past three years:

Total Land Control Revenues 2014-2016

Year	Sault Ste. Marie	Blind River	Elliot Lake	Wawa	TOTAL
2014	*$119,850*	*$25,771*	*$3,700*	*$1,650*	*$150,971*
2015	*$146,070*	*$13,975*	*$2,970*	*$6,100*	*$169, 115*
2016	*$102,575*	*$23,350*	*$3,100*	*$1,625*	*$130,650*

Total Land Control Expenses 2016

APH Land Control program expenses in 2016 were:

Salary and Benefits expenses: $129,892
Program operating expenses: $11,663
Total Program expenses: $141,555

In 2016, revenues declined resulting in the Land Control program operating in a deficit position of $10,095.

As such, a review of the fees administered by other northern health units and service providers was conducted. The results are below:

2017 Review of Fee Schedules in Northern Ontario for Septic Systems						
APH: Schedule "A" To By-Law 06-01 As amended on February 18, 2015	**Algoma Public Health**	**Thunder Bay District Health Unit**	**Sudbury & District Health Unit**	**Porcupine Health Unit**	**Timiskaming Health Unit**	**North Bay-Mattawa Conservation Authority**
Class 2 - Greywater system (leaching pit)	$250	$225	$350	$300	$254	
Class 3 - Cesspool System	$250	$225	$350	$300	$254	$510
Class 4 - Leaching bed system (septic tank and leaching bed)	$750	$850	$825	$800	$952	$860
Class 4 - Tank replacement	$300	$450	$325	$300	$317	$375
Class 4 - Leaching bed replacement/alteration	$500	$750	$500	$500	$952	
Class 5 - Holding tank system	$500	$750	$825	$800	$317	
Sewage system demolition/ decommissioning	$100		$250	$400	$254	$150
Transfer of Permit	$50		$100	$100	$63	$100
Revision of Permit (no inspection required)	$100	$75				
Revision of Permit (inspection required)	$250	$350	$350	$400	$190	
File Request (copy of permit on file) ▪ **> 5 days' notice** ▪ **< 5 days' notice**	 $75.00 $150.00		$65	$50	$127	$80

Management is proposing the below fee increases for the next three years.

PROPOSED FEE CHANGES	2016 Volumes	2017 Rate	2018 Rate (Proposed)	2019 Rate (Proposed)	2020 Rate (Proposed)
Class 2 - Greywater system (leaching pit)	6	$250	$250	$275	$300
Class 3 - Cesspool System	0	$250	$250	$275	$300
Class 4 - Leaching bed system (septic tank and leaching bed)	129	$750	$850	$900	$950
Class 4 - Tank replacement	7	$300	$325	$350	$375
Class 4 - Leaching bed replacement/alteration	12	$500	$550	$600	$650
Class 5 - Holding tank system	2	$500	$800	$850	$900
Sewage system demolition/decommissioning	N/A	$100	$125	$150	$150
Transfer of Permit	N/A	$50	$75	$100	$100
Revision of Permit (no inspection required)	N/A	$100	$100	$125	$150
Revision of Permit (inspection required)	N/A	$250	$300	$325	$350
File Request (copy of permit on file)					
▪ **Greater than 5 days' notice**	82	$75	$100	$125	$125
▪ **Less than 5 days' notice**	13	$150	$175	$200	$200

Note: Class 4 – Leaching bed system (septic tank and leaching bed) constitutes the highest volume and highest fees for APH. By increasing the fee by $100 for 2018, this would have covered the deficit noted in 2016 and ensure APH's fees are more comparable with its Northern Ontario Public Health Unit peers.

FINANCIAL IMPLICATIONS:

By approving the proposed increase in Land Control fees, the Board of Health will better position the program to operate within budget and have a fee structure that is more aligned with other Northern Ontario Public Health Units.

The proposed $100 increase in fees associated with Class 4 – Leaching bed systems for 2018 would generate an additional $12,900 in revenues based on 2016 volumes.

CONTACT:

J. Pino, Chief Financial Officer

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-065
DATE:	O: June 17, 2015 Revised: June 24, 2017	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	Algoma Board of Health Reserve Fund

Purpose

To provide guidance on the establishment, maintenance, and use of a reserve fund.

Policy

The Board of Health for the Algoma Public Health has established reserves as follows:

Background:

The Health Protection and Promotion Act (the "Act") requires, in section 72(1), that the expenses incurred by or on behalf of a Board of Health and the Medical Officer of Health/Chief Executive Officer (MOH/CEO) in the performance of their functions and duties under the Act or any other act shall be borne and paid by the Municipalities in the health unit served by the Board of Health.

Section 72(5) (1) of the Act requires the Board of Health to cause the preparation of an annual estimate of expenses for the next year. Such estimate of expenses may from time to time be too high or too low resulting in an excess or a shortfall respectively of funds paid by the Municipalities.

The Board of Health considers it prudent and expedient to establish reserve funds, which include reserves, into which, inter alia, any excess funds received in any year be paid to be applied to cover any shortfall of funds in future years.

Section 417(1) of the Municipal Act empowers the Board of Health in each year to provide in its estimate of expenses for the establishment or maintenance of a reserve fund for any purpose for which it has authority to expend funds.

Section 417(2) of the Municipal Act only requires the approval of the Councils of the majority of the Municipalities in a health unit for the establishment and maintenance of a reserve fund if the Board of Health is required to obtain such approval for capital expenditures.

Section 52(4) of the Act only requires the Board of Health to seek the approval of the Councils of the majority of Municipalities in a health unit for capital expenditures made to acquire and hold real property.

To obviate the need to seek the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit to establish and maintain a reserve fund, the reserve fund will contain a restriction that the funds therein shall not be used for capital expenditures to acquire real property without first obtaining the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit as required by section 52(4) of the Act.

Motion: 2015-91 ALGOMA BOARD OF HEALTH UNIT RESERVE FUNDS

THEREFORE BE IT RESOLVED THAT

1) The Board of Health forthwith establish and maintain reserve funds for Working Capital, Land Control, Human Resources Management, Public Health Initiatives and Response, Corporate Contingencies, and Facility and Equipment Repairs and Maintenance; and,
2) The reserve funds shall be used and applied only to pay for expenses incurred by or on behalf of the Board of Health and the Medical Officer of Health in the performance of their functions and duties under the Health Protection and Promotion Act or any other Act; and,
3) None of the reserve funds shall be used or applied for capital expenditures to acquire and hold real property unless the approval of the Councils of the majority of the Municipalities in the Algoma Health Unit have been first obtained pursuant to section 52(4) of the Act; and,
4) The Board of Health in each year may provide in its estimates for a reasonable amount to be paid into the reserve funds provided that no amount shall be included in the estimates which is to be paid into the reserve funds when the cumulative balance of all the reserve funds in the given year exceeds 15 percent of the regular operating revenues for the Board of Health approved budget for the mandatory cost shared programs and services; and,
5) All lease revenues, received by the Board of Health under leases of part of its premises, in excess of the actual operating costs attributable to the leased premises, shall be paid annually into the reserve funds; and,
6) Any over-expenditures in any year shall be paid firstly from the reserve funds and only when the reserve funds shall have been exhausted will the Board of Health seek additional funds from the Municipalities to pay for such over-expenditures; and,
7) Any excess revenues in any year resulting from an over estimate of expenses shall be paid into the reserve funds; and,
8) The MOH/CEO ~~Medical Officer of Health/Chief Executive Officer~~ shall, will Board approval, in each year direct the allocation of excess funds to such reserve fund or funds as the MOH/CEO ~~Medical Officer of Health~~ shall decide; and,
9) The MOH/CEO ~~Medical Officer of Health/Chief Executive Officer~~ shall be entitled to transfer funds from one reserve fund to another reserve fund at any time and from time to time.

The MOH/CEO ~~Medical Officer of Health/Chief Executive Officer~~ shall be responsible for the management of the reserves in accordance with respective Board of Health motions and Board By-law 2015-1.

The approval of the Board of Health shall be required for any transfers from the Board's reserves that constitute part of the annual budget approval process or that are in excess of $50,000 per transaction.

ALGOMA PUBLIC HEALTH
FINANCE AND AUDIT COMMITTEE MEETING
APRIL 19, 2017
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Ian Frazier	Dennis Thompson
REGRETS:	Lee Mason	Christina Luukkonen
APH STAFF PRESENT:	Marlene Spruyt	Medical Officer of Health
	Justin Pino	Chief Financial Officer
	Joel Merrylees	Manager of Accounting and Budgeting
	Mary Henry	Executive Assistant
GUESTS:	Mike Marinovich, KPMG	

1) CALL TO ORDER:
Mr. Frazier called the meeting to order at 4:13pm

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

3) ADOPTION OF AGENDA ITEMS
Agenda items to be adjusted to accommodate presentations to the committee.

FC2017-09 Moved: D. Thompson
Seconded:

THAT the agenda items for the Finance and Audit Committee dated April 19, 2017 be adopted as circulated.
CARRIED.

4) ADOPTION OF MINUTES

FC2017-10 Moved: D. Thompson
Seconded:

THAT the minutes for the Finance and Audit Committee dated February 8, 2017 be adopted as circulated.
CARRIED.

5) IN-COMMITTEE

FC2017-11 Moved: D. Thompson
Seconded:

THAT the Finance and Audit Committee goes in-committee at 4:17p.m.
Agenda items:

a. Adoption of in-committee minutes: February 8, 2017
b. Security of Property of the Municipality or Local Board

CARRIED.

6) OPEN MEETING

FC2017-14 Moved: D. Thompson
Seconded:

THAT the Finance and Audit Committee goes into open meeting at 5:11 p.m.
CARRIED.

7) FINANCIAL STATEMENTS

a. Financial Statements for the Period ending February 28, 2017
J. Pino spoke to the draft financial statements provided in the committee package. J. Pino explained why there is a positive variance, due to staffing. J. Pino explained that Health Units will receive money from the Ministry which will go directly to the school board for fruit and veggies.

After discussion, it was agreed that predictable expenses will be provided for the next meeting.

FC2017-15 Moved: D. Thompson
Seconded:

THAT the Finance and Audit Committee recommends and puts forward to the Board of Health the draft Financial Statements for the Period ending February 28, 2017 for approval.
CARRIED.

8) NEW BUSINESS/GENERAL BUSINESS - None

9) Addendum

10) NEXT MEETING: Wednesday, June 14, 2017 @ 4:30pm

11) THAT THE MEETING ADJOURN:

FC2017-16 Moved: D. Thompson
Seconded:

THAT the meeting of the Finance and Audit Committee adjourns at 5:33pm.
CARRIED.

Algoma Public Health

Governance Standing Committee Meeting Report

June 15, 2017

By-Law Review and amendments were made with discussion and further amendments to finalize for Board approval:

- **By-Law 95-1** - To Regulate the Proceedings of the Board;
- **By-Law 95-3** - To provide for the Duties of the Auditor of the Board;
- **By-Law 06-01** - Construction, Demolition and Change of the Use of Permits and Inspections;
- **By-Law 06-02 -** To Appoint a CBO and Inspectors and to Establish a Code of Conduct for the CBO and Inspectors

The following By-Laws were reviewed with no amendments:

- **By-Law 95-2** - To Provide for Banking and Finance
- **By-Law 2015-01 –** To Provide for the Management of Property

The first draft of a Dashboard for reporting quantitative data with Health Protection Indicators was developed by Dr. Spruyt. The committee reviewed, discussed and made amendments and suggestions for the current draft. It was also recommended to develop a second page similarly containing data regarding Health Promotion Indicators.

Annual and monthly board Evaluation Templates were reviewed and amended. Discussion regarding the need for monthly evaluations resulted in a decision to trial the revised monthly template with numerical assignments for the fall and then re-evaluate.

The process for new board member orientation was discussed and will be reviewed at our next meeting.

Deborah Graystone
Chair, Governance Standing Committee

APPROVED BY:	Board of Health	**BY-LAW #:**	95-1
DATE:	O: December 13, 1995 Revised: September 28 , 2016 Revised: June 28, 2017	**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 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.

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 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.~~the minister consents in writing to the dismissal. R.S.O. 1990 c.H7, s.66(1)

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. R.S.O 1990, c.H7, S.66(2)

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
Revised and passed by the Algoma Public Health Board on this 28th day of June 2017

APPROVED BY:	Board of Health	**BY-LAW #:**	95-2
DATE:	O: December 13, 1995 Revised: June 17, 2015 Reviewed: June 28, 2017	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	To Provide for Banking and Finance

The Board enacts as follows:

1. In this By-law:

a) "Act" means the Health Protection and Promotion Act, S.O. Ontario 1983, Chapter 10 as amended.

b) "Board" means the THE BOARD OF HEALTH FOR THE DISTRICT OF ALGOMA HEALTH UNIT.

2. Signing Authorities:

a) The Board will maintain a formal list of names, titles and signatures of those individuals who have signing authority.

b) Signing authorities for all accounts shall be restricted to:
   i) the Chair of the Board of Health
   ii) one other Board member, designated by Resolution
   iii) the Medical Officer of Health/Chief Executive Officer
   iv) the Chief Financial Officer

c) All cheques issued shall have two signatures from the list above in 2b).

3. Budgets and Accounts:

a) The Medical Officer of Health/Chief Executive Officer shall:

   i) ensure that all annual budgets are prepared and presented to the Board in accordance with all Board and Ministries guidelines;

   ii) have over-all responsibility for the control of expenditures as authorized by Board and Ministry approvals of the individual annual budgets under the jurisdiction of the Board;

   iii) ensure the security of all funds, grants and monies received in the course of provision of service by the programs under the jurisdiction of the Board; and

   iv) ensure that all reports are prepared and distributed to the appropriate bodies, in accordance with established Board and Ministry(ies) guidelines.

b) The Chief Financial Officer shall:

i) prepare, or ensure the preparation of, all annual budgets under the jurisdiction of the Board for submission to the Board;

ii) control, or ensure control of, expenditures as authorized by Board and Ministry approvals of the individual annual budgets under the jurisdiction of the Board;

iii) secure, or ensure the security of, all funds, grants and monies received in the course of provision of service by the programs under the jurisdiction of the Board;

iv) prepare, or ensure the preparation of, financial and operating statements for the Board and for the appropriate Ministries or agencies, in accordance with established Ministry policies, indicating the financial position of the Board with respect to the current operations of all programs under the jurisdiction of the Board;

v) maintain and secure, or ensure the maintenance and security of, the books of account and accounting records of the Board required to be kept by the laws of the Province;

vi) arrange, or ensure the arrangement, for an annual audit of all accounting books and records, in conjunction with the Auditor;

vii) Register the Health Unit as a charitable organization and follow the legal requirements associated therewith,

viii) report to the Board on all financial and banking matters initiated by the Chief Executive Officer;

ix) reconcile all balances with the appropriate Ministries upon receipt of final year end settlements; and

x) enter into an agreement with a recognized chartered bank or trust company which will provide the following services"
    1. Current accounts
    2. provision of monthly bank statements
    3. payment of interested or surplus funds held at the institution
    4. payroll services, as needed
    5. lending of money to the Board, as required

xi) perform other duties as the Board may direct.

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 Board of Health for Algoma Public Health this 17th day of June 2015
Reviewed and passed by the Board of Health for Algoma Public Health this 28th day of June 2017

APPROVED BY:	Board of Health	**BY-LAW #:**	95-3
DATE:	O: December 13, 1995 Revised: June 17, 2015 Revised: June 28, 2017	**SECTION:**	Board
PAGE:	1 of 1	**SUBJECT:**	To Provide for the Duties of the Auditor of the Board of Health

---

The Board of Health for the District of Algoma Health Unit enacts as follows:

1. In accordance with the Health Protection and Promotion Act and the Municipal Act, the Board shall, appoint an Auditor who shall not be a member of the Board and shall be licensed under the Public Accountancy Act.

As per the Municipal Act 2001
296 Joint boards

~~1.~~2. (10) If a local board is a local board of more than one municipality, only the auditor of the municipality that is responsible for the largest share of the expenses of the local board in the year is required to audit the local board in that year. 2009, c. 18, Sched. 18, s. 5.

~~2.~~3. The Auditor shall:

a) audit the accounts and transactions of the Board;

b) perform such duties as are prescribed for the Auditor by the Health Protection and Promotion Act; by the Ministry of Municipal Affairs with respect to local Boards under the Municipal Act and the Municipal Affairs Act;

c) perform such other duties as may be required by the Board;;

d) have the right of access at all reasonable hours to all books, records (with signed consent, if consent is required under the Municipal Freedom of Information and Protection of Privacy Act), documents, accounts and vouchers of the Board; the auditor is entitled to require from the members of the Board and from the Officers of the Board such information and explanation as in his or her opinion may be necessary to enable him to carry out such duties as are prescribed under the Health Protection and Promotion Act;

e) be entitled to attend any meeting of members of the Board that concerns ~~him or her~~the ~~as~~ auditor and to receive all notices relating to any such meeting that any member is entitled to receive and to be heard at any such meeting that he or she attends. .

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

Original signed by
I Lawson, Chair

Original signed by
G. Caputo, Vice-chair

Reviewed and passed by the Board of Health for Algoma Public Health this 17th day of June, 2015
Revised and passed by the Board of Health for Algoma Public Health this 28th day of June 2017

APPROVED BY:	Board of Health	**BY-LAW #:**	2015-01
DATE:	O: June 17, 2015 Reviewed: June 28, 2017	**SECTION:**	Board
PAGE:	1 of 2	**SUBJECT:**	To Provide the Management of Property of the Board of Health

---

The Board of Health for the District of Algoma Health Unit enacts as follows:

1. The Board shall acquire and hold title to any real property acquired by the by the Board for the purpose of carrying out the functions of the Board and may sell, exchange, lease, mortgage or otherwise charge or dispose of real property owned by it in accordance with the Act [Health Protection and Promotion Act R.S.O. 1990, c.H.7, s.52(3)].

2. Clause 1 is subject to the requirement that the Board of Health first obtain the consent of the councils of the majority of the municipalities within the Health Unit served by the Board of Health [Health Protection and Promotion Act R.S.O. 1990, c.H.7,s 52(4);2002, c. 18, Sched I.s.9(8)].

3. Prior to the sale of any real property owned by the Board of Health, the Board shall,

    a. By by-law or resolution passed at a meeting open to the public, declare the real property to be surplus;
    b. Obtain not more than one(1) year before the date of sale at least one appraisal of the fair market value of the real property from such person as the Medical Officer of Health/Chief Executive Office considers qualified

4. Notice to the public of a proposed sale of real property owned by the Board of Health shall be given prior to the date of the sale by publication in a newspaper that is of sufficiently general paid or unpaid circulation within the Health Unit area to give the public reasonable notice of the proposed sale.

5. Despite the requirement of clause 3(b) of the by-law, and subject to the requirements of clause 2, the Board of Health may sell any real property owned by it to any one of the following classes of public bodies without first obtaining an appraisal:

    a. Any municipality within the Health Unit served by the Board of Health;
    b. A local board as defined in the Health Protection and Promotion Act.
    c. The Crown In Right of Ontario or of Canada and their agencies.

6. The Medical Officer of Health/Chief Executive Officer shall establish and maintain a public register listing and describing all real property owned or leased by the Board and which should, to the extent that is reasonable possible, include the following information:
    a. A brief legal description of the property
    b. The assessment roll number of the property;
    c. The municipal address or the real property, if available;
    d. The date of purchase;

e. The name of the person to whom the property was purchased;
f. The instrument number of the transfer or deed by which title was transferred to the municipality;
g. The purchase price of the real property;
h. A brief description of improvements, if any, on the real property;
i. The date of the sale of the property;
j. The name of the person to whom the property was sold;
k. The sale price of the real property.

7. The CFO/Director of Operations through the Medical Officer of Health/Chief Executive Officer shall be responsible for the care and maintenance of all properties required by the Board

8. Such responsibility shall include, but shall not be limited to, the following:
   a. The replacement of , or major repairs to, capital items such as heating, cooling and ventilation systems; roof and structural work; plumbing; lighting and wiring;
   b. The maintenance and repair of the parking areas and the exterior of the building;
   c. The care and upkeep of the grounds of the property;
   d. The cleaning, maintaining, decorating and repairing the interior of the building;
   e. The maintenance of up-to-date fire and liability insurance coverage.

9. The Board shall ensure that all such properties comply with applicable statutory requirements contained in either local, provincial or federal legislation (e.g. building and fire code).

Read a first and second time this 17th day of June 2015.

Originally signed by
L. Mason, Chair
I. Frazier, Vice-Chair

Reviewed and passed by the Algoma Public Health Board on this 28th day of June 2017

APPROVED BY:	Board of Health	**BY-LAW #:**	06-01
DATE:	O: April 19, 2006 Revised: February 18, 2015 Revised: June 28, 2017	**SECTION:**	Board
PAGE:	1 of 9	**SUBJECT:**	Sewage Systems Pat 8 of the Ontario Building Code Act

A By-law respecting construction, demolition and all components of the Ontario Building Code Part 8, including inspections and fees related to sewage systems for all private sewage systems, less than 10, 000 litres per day.

WHEREAS the Board of Health of Algoma Pubic Health is responsible for the enforcement of the Building Code Act and Regulations related to sewage systems, as defined in section 3.1 of the Act, for the area of jurisdiction defined in Table 1.7.1.1, section 1.7.1.1 of Division C, Part 1 of the Ontario Building Code.

AND WHEREAS the Board of Health of Algoma Public Health is empowered pursuant to Section 7 of the Building Code Act, C23, as amended, Statutes of Ontario, 1992, to make By-laws respecting sewage systems;

NOW THEREFORE THE BOARD OF HEALTH OF ALGOMA PUBLIC HEALTH HEREBY ENACTS AS FOLLOWS:

PERMITS AND FEES

The Chief Building Official (CBO) as appointed will create applications forms and templates for the public to use and complete to apply for inspection and approvals related to sewage systems.
Fees for a required permit are due and payable upon submission of an application.
Classes of permits required for sewage systems including construction, demolition, and permit fees for other services, related to sewage systems are set forth in Schedule "A" attached hereto and forms part of this By-law.

DATE OF EFFECT

That this By-law shall come into force and take effect on the 28th day of June, 2017.

READ AND PASSED IN OPEN MEETING THIS 28th DAY OF JUNE, 2017.

_____

L. Mason, Chair

_____

I. Frazier, 1st Vice-Chair

SCHEDULE "A" TO BY-LAW 06-01
As amended on June 24, 2017
SEWAGE SYSTEM PERMIT APPLICATION FEES

PROPOSED FEE CHANGES	2016 Volumes	2017 Rate	2018 Rate (Proposed)	2019 Rate (Proposed)	2020 Rate (Proposed)
Class 2 - Greywater system (leaching pit)	6	$250	$250	$275	$300
Class 3 - Cesspool System	0	$250	$250	$275	$300
Class 4 - Leaching bed system (septic tank and leaching bed)	129	$750	$850	$900	$950
Class 4 - Tank replacement	7	$300	$325	$350	$375
Class 4 - Leaching bed replacement/alteration	12	$500	$550	$600	$650
Class 5 - Holding tank system	2	$500	$800	$850	$900
Sewage system demolition/decommissioning	N/A	$100	$125	$150	$150
Transfer of Permit	N/A	$50	$75	$100	$100
Revision of Permit (no inspection required)	N/A	$100	$100	$125	$150
Revision of Permit (inspection required)	N/A	$250	$300	$325	$350
File Request (copy of permit on file)					
▪ **Greater than 5 days' notice**	82	$75	$100	$125	$125
▪ **Less than 5 days' notice**	13	$150	$175	$200	$200

Exemptions for Severance Applications:

Unless exempted below, each application for consent, severance, minor variance, zoning amendment, will require as listed in the above fee schedule.

Lot fees are exempt under the following conditions:

1. The property is served by a sewage works designed for a daily sewage flow in excess of 10,000 litres per day, which has been, or requires approval by the Ministry of Environment under the Ontario Water Resources Act.
2. Any lot municipally serviced (sewer and water), with a letter stating services are available from the municipality.
3. Any parcel which comprises, or will comprise part of a public highway.
4. Any lot or property transfer which is for the purposes of an easement, unless the easement is for the purpose of permitting the installation of a sewage system, <10,000 litres per day.
5. An application for a re-zoning or minor variance on a parcel for which a consent to sever fee had been collected during the same construction year.

Enacted and passed by the Algoma Health Unit Board on this 16th day of April 2006

Original signed by
G. Caputo, Chair
A. Northan, MOH

Revised and passed by the Algoma Public Health Board on this 17th day of March 2010
Revised and passed by the Algoma Public Health Board on this 18th day of February 2015
Revised and passed by the Algoma Public Health Board on this 28th day of June 2017

APPROVED BY:	Board of Health	**REFERENCE #:**	02-05-055
DATE:	O: May 20, 2015 R: June 22, 2016 Reviewed: June 27, 2017	**SECTION:**	Board of Health
PAGE:	1 of 2	**SUBJECT:**	Board of Health Monthly Meeting and Self-Evaluation Policy

POLICY:

The Board of Health shall have an annual self-evaluation process of its governance practices and outcomes that is implemented every year and may result in recommendations for improvements in leadership excellence, board effectiveness, engagement and performance. The Board may also supplement its evaluation tools seeking evaluation by key partners and/or stakeholders and/or governance consultants when issues are identified in its self-evaluation that requires further investigation,

Annual self-evaluation

The self-evaluation process shall include consideration of whether:

- Decision-making is based on access to appropriate information with sufficient time for deliberations Compliance with all federal and provincial regulatory requirements is achieved;
- Any material notice of wrongdoing or irregularities is responded to in a timely manner;
- Reporting systems provide the Board with information that is timely and complete;
- Members remain abreast of major developments in governance and public health best practices, including emerging practices among peers; and
- The Board members are actively engaged in discussing agenda items that focus on strategic results, policy issues and solutions rather than on day-to-day operational issues
- The Board monitors fiscal and program and services performance

Monthly Board meeting Evaluation

The Board of Health shall have meeting evaluation process that results in improved Board of Health meeting effectiveness. Meeting evaluation will be a standing agenda item on the Board Agenda, and evaluation forms including board member name will be completed before the meeting is adjourned and be collected by the recording secretary. Meeting evaluation results will be reviewed 4 times per year by the Governance Committee as noted in the Board's annual workplan.

The Board of Health will maintain a record of its members' attendance. The summary will be reviewed by the Board of Health on an annual basis as noted in the Board's annual work plan.

PROCEDURES:

Annual Self-Evaluation

Board of Health Member	1. Complete the Board of Health Self-Evaluation Survey including board member name ~~-~~at ~~-~~the June Board meeting.
	2. The completed evaluations will be collected and the results compiled by the board secretary and forwarded to the Board Chair
Board Secretary	3. Will compile evaluations into a report and present at the September Board meeting as noted in the Board's annual work plan.

Monthly Board Meeting Evaluation

Board of Health Member	1. Complete the Board of Health Meeting Evaluation Survey after each regularly scheduled Board meeting.
	2. The completed evaluations will be collected and the results compiled by the board secretary.
Board Secretary	3. Will compile evaluations and forward to the ~~MOH/CEO~~Board Chair to review.
	4. Results will be reported back to the Board in the Board package the following month.

KNOWLEDGE

Board Member Self-Evaluation of Performance Template

Board Monthly Meeting Evaluation Template

Meeting Evaluation
Algoma Public Health Board of Health

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.

1. Select the month of the Board of Health meeting:

- ☐ January
- ☑ February
- ☐ March
- ☐ April
- ☐ May
- ☐ Other:
- ☐ June
- ☐ September
- ☐ October
- ☐ November
- ☐ December

Please select one response for each question in the following grid. If the question is not relevant please select "not applicable".					
	Strongly Agree 4	**Somewhat Agree 3**	**Somewhat Disagree 2**	**Strongly Disagree 1**	**Not Applicable 0**
1. The Board agenda package contained appropriate information to support the Board in carrying out its governance leadership role.					
2. The delegation/presentation was an opportunity for me to improve my knowledge and understanding of an important public health subject.					
3. The MOH/CEO report was informative, timely and relevant to my governance role.					
4. Overall, the Board meeting was conducted in an active~~, informative,~~ and responsible manner ~~with decisions made that advance the APH vision and mission[1].~~ which allowed me to seek information and provide input.					
5. ~~There is alignment with items that were included in the Board agenda package and the APH's 2015-2020 Strategic Plan[2].~~					
6. ~~Board members' conduct was~~					

[1] ~~**APH Vision** : Together, we create and sustain health communities; **APH Mission** : Together with our communities, Algoma Public Health is a leader in promoting and protecting health and well-being~~

[2] ~~***2015–2020 Strategic Planning Priorities***~~

1. ~~*Improve Health Equity*~~
2. ~~*Collaborate Effectively*~~
3. ~~*Be Accountable*~~
4. ~~*Enhance Employee Engagement*~~

Adapted with permission from Sudbury & District Health Unit

~~professional, cordial and respectful.~~					

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

_____

_____

_____

Thank you for your valuable feedback.

Adapted with permission from Sudbury and District Health Unit

~~2015~~ Algoma Public Health Board of Health
Member Self-Evaluation of Performance

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. Your participation is voluntary. Your responses will be kept anonymous and all responses will be presented through aggregated results.

Please complete prior to June 17, 2015, in confidence to the attention of Christina Luukkonen by mail, by email at cluukkonen@algomapublichealth.com or by fax at (705) 759-2540. Time will be allocated for Board members to complete the survey during the June Board meeting.

Part 1: Individual Performance **Compliance with Individual Roles and Responsibilities as a Board of Health Member.**					
	Strongly Agree **4**	**Agree** **3**	**Disagree** **2**	**Strongly Disagree** **1**	**Not Applicable** **0**
1. As a BOH member, I am satisfied with my attendance at meetings.					
2. As a BOH member, I am satisfied with my preparation for meetings.					
3. As a BOH member, I am satisfied with my participation in meetings.					
4. As a BOH member, I understand my roles and responsibilities.					
5. As a BOH member, I understand current public health issues.					
6. As a BOH member, I have input into the vision, mission and strategic direction of the organization.					
7. As a BOH member, I am aware and ~~represent~~ respect community perspectives during board meetings.					
8. As a BOH member, I provide input into policy development and decision-making.					
9. As a BOH member, I represent the interests of the organization at all times.					

Do you have any other comments or suggestions pertaining to your role as a Board of Health member?

_____

_____

_____

Adapted with permission from Sudbury and District Health Unit

Part 2: Board of Health Processes Effectiveness of policy and process	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
1. The BOH is compliant with all applicable legislation and regulations.					
2. The BOH ensures members are aware of their roles and responsibilities through orientation of new members.					
3. The BOH is appropriately informed about financial management, procurement policies and practice, risk management and human resources issues.					
4. The BOH holds meetings frequently enough to ensure timely decision-making.					
5. The BOH bases decision making on access to appropriate information with sufficient time for deliberations.					
6. The BOH is kept apprised of public health issues in a timely and effective manner.					
7. The BOH sets bylaws and governance policies.					
8. The BOH remains informed with issues pertaining to organizational effectiveness through performance monitoring and strategic planning.					

Do you have any other comments or suggestions pertaining to Board of Health policy and process?

_____

_____

_____

Adapted with permission from Sudbury and District Health Unit

Part 3: Overall Performance of the Board of Health					
	Strongly Agree 4	Agree 3	Disagree 2	Strongly Disagree 1	Not Applicable 0
1. The BOH contributes to high governance and leadership performance					
~~2.~~ The BOH ~~oversees the development of the strategic plan~~considers the strategic plan in its decision making.					
~~3.~~2. The BOH ensures planning processes consider stakeholder and community needs.					
~~4.~~3. The BOH ensures a climate of mutual trust and respect between themselves and the Medical Officer of Health (MOH/CEO).					
~~5. The BOH as a governing body is achieving its strategic outcomes.~~					

Do you have any other comments or suggestions pertaining to overall performance of the Board of Health?

_____

_____

_____

Adapted with permission from Sudbury and District Health Unit

ALGOMA PUBLIC HEALTH
GOVERNANCE STANDING COMMITTEE MEETING
APRIL 12, 2017 @ 5:00 PM
PRINCE MEETINGROOM, 3RD FLOOR, SSM
MINUTES

COMMITTEE MEMBERS PRESENT:	Ian Frazier	Deborah Graystone
	Lee Mason	
APH STAFF PRESENT:	Marlene Spruyt	MOH/CEO
	Christina Luukkonen	Recording Secretary
REGRETS:	Heather O'Brien	

1) CALL TO ORDER:
Ms. Graystone called the meeting to order at 5:00pm

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

3) ADOPTION OF AGENDA ITEMS

GC2017-07 Moved: I. Frazier
Seconded: L. Mason

THAT the agenda items for the Governance Standing Committee April 12, 2017 be adopted as circulated.
CARRIED.

4) ADOPTION OF MINUTES

GC2017-08 Moved: L. Mason
Seconded: I. Frazier

THAT the minutes for the Governance Standing Committee dated November 9, 2016 be adopted as amended.
CARRIED.

5) BUSINESS ARISING FROM MINUTES

a. By-law Review
Governance Committee reviewed all current by-laws. Minor changes to by-laws 95-1 and 95-3 and no changes to by-laws 95-2 and 2015-01. Dr. Spruyt to review and revise By-laws 06-01 and 06-02 regarding Chief Building Inspector and bring forth at the June 14, 2017 meeting. Revised by-laws will then be presented to the Board for approval.

b. Medical Officer of Health Reporting Template
The Governance Committee reviewed MOH reports from other health units and discussed the creation of a dashboard to be included in the MOH reporting.

Dr. Spruyt to provide a template at the next meeting on June 14, 2017.

c. Elections and Selection Process for Board Chair and Committees
Mr. Mason provided a draft policy for consideration. Mr. Mason to make suggested edits and bring

back to the next meeting on June 14, 2017.

d. Board of Health Composition
   Mrs. Luukkonen will post revised composition to the BoardEffect platform for reference.
e. Board of Health Evaluations
   Changes approved to the monthly evaluation. Annual evaluation to be revised to reflect feedback from committee. Mrs. Luukkonen to make the requested changes and send to Committee members. Final version to be brought back to committee for approval.

6) NEW BUSINESS/GENERAL BUSINESS

a. Ontario Public Health Organizational Standards By-law and Policy Requirements
   Item was deferred until the implementation of the new standards.

7) ADDENDUM

8) IN COMMITTEE: N/A

9) OPEN MEETING: N/A

10) NEXT MEETING: Wednesday, June 14, 2017 at 5:30 pm

11) THAT THE MEETING ADJOURN:

GC2017-09 Moved: L. Mason
Seconded: I. Frazier

THAT the Governance Standing Committee meeting adjourns at 6:55pm.
CARRIED.

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

June 7, 2017

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

Dear Minister Hoskins:

Re: Assessment of the Healthy Menu Choices Act

On behalf of our Board of Health, I am writing to you in support of the Leeds, Grenville and Lanark District Health Unit's call for transparency regarding the indicators of success of the newly implemented Healthy Menu Choices Act. Our Board believes that it is important to equip consumers to make informed food choices. Given the significant investment of resources it takes to implement the Healthy Menu Choices Act at a local level, we request that the provincial government communicate to all stakeholders how the impact of the Act will be assessed.

In addition to indicators of success of the newly implemented act, our board requests transparency regarding the evaluation of related promotional activities and campaigns led by the Ministry of Health and Long-Term Care. Possible considerations to evaluate include:

- the effectiveness of emphasizing calories (rather than a whole foods approach, emphasizing the importance of a variety of nutrients, from minimally processed foods);
- the effects of the marketing campaign comparing equally unhealthy choices, and use of messages with sexual overtones (e.g., food items stripping);
- short and long term effectiveness of act on choices made by Ontarians;
- possible adverse effects of labelling of calories alone in relation to disordered eating patterns and promoting healthy relationships with food; and
- accuracy of calories displayed on menus compared to what consumers are purchasing.

Our board of health is committed to protecting and promoting the health and well-being of our residents. We are supportive of evidence based interventions that accomplish health goals and would welcome information regarding the evaluation of both the Healthy Menu Choices Act, and the approach taken to promote Ministry-led awareness activities that support our local efforts.

Yours in health,

Mayor Mary Smith
Chair, Board of Health

/ag
Encl.

cc: Local MPPs
Dr. David Williams, Chief Medical Officer of Health, MOHLTC
Association of Local Public Health Agencies
Ontario Boards of Health

March 22, 2017

VIA EMAIL

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

Dear Minister Hoskins:

The Leeds, Grenville and Lanark Board of Health is very concerned about two recent initiatives of the Ministry of Health and Long-Term Care – the Expert Panel on Public Health and the Healthy Menu Choices Act.

With respect to the Expert Panel on Public Health, you stated in your letter of January 18, 2017:

> "The work of the Panel will include a review of various operational models for the integration of public health into the broader health system and the development of options and recommendations that will best align with the principles of health system transformation, enhance relationships between public health, LHINs and other public sector entities and improve public health capacity and delivery."

We have learned that the work of the Expert Panel will be done in confidence and will not include consultation with local public health units. This is in contrast to the Liberal government's commitment to transparency in its work. The Expert Panel will be making recommendations that could have a profound impact on how we do business, and yet we won't have any opportunity to provide input into the discussion or the options being considered. To rectify this concern, the Board requests that all recommendations from the Expert Panel be made public, and that a formal consultation process be undertaken with all Ontario public health units before any decisions are made about the integration of public health into the broader health system.

The implementation of the Healthy Menu Choices Act requires a significant investment of resources at the local level and among the food premise industry. Concerns have been raised by other organizations about the effectiveness of this measure. Has the Ministry of Health and Long-Term Care identified indicators of success that will assess if this investment is justified; and are these indicators being tracked? The Liberal government has publicly stated a commitment to accountability. The Board of Health requests that the Minister respect this commitment and notify all parties how the impact of the Healthy Menu Choices Act will be assessed.

Sincerely,

Anne Warren, Chair
Board of Directors
Leeds, Grenville and Lanark District Health Unit

AW/hb

cc: Steve Clark, MPP Leeds-Grenville
Randy Hillier, MPP Lanark-Frontenac-Lennox and Addington
Jack MacLaren, MPP Carleton-Mississippi Mills
Ontario Boards of Health

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

June 7, 2017

The Honourable Dr. Jane Philpott
Minister of Health
Government of Canada
House of Commons
Ottawa, ON K1A 0A6
Hon.Jane.Philpott@Canada.ca

Dear Minister Philpott:

Re: Moving forward on the Federal Opioid Strategy

On behalf of our Board of Health, I am writing to express our support of moving the Federal Opioid Strategy forward and to further develop the recommendations within the federal document entitled "Action on Opioid Misuse".

Our Board believes that a fulsome federal opioid strategy, with targets, timelines and deliverables will support the work happening both locally and provincially to decrease opioid-related harm and commend the commitments you have made as part of the federal action on opioids. Building on the recommendation made by the Simcoe Muskoka District Health Unit Board of Health, our Board also strongly urges the federal government to encourage the Ontario Ministry of Health & Long-Term Care to follow suit with setting targets, timelines and deliverables on their commitment as part of the Joint Statement of Action to address the Opioid Crisis. This includes allocating appropriate resources to Ontario's Strategy to Prevent Opioid Addiction and Overdose to ensure there is reasonable capacity to respond and implement these recommendations, especially for front-line harm reduction workers.

Additionally, we were encouraged to learn of the Alberta Minister of Health's creation of an Opioid Emergency Response Commission, from a media announcement released on May 31, 2017. With a mandate of urgent and coordinated action to respond to the opioid crisis, the inclusion of a diverse group of representatives with strong expertise in evidence and experience, and dedicated funding, this Opioid Emergency Response Commission is a positive step forward to saving lives now, and a step we urge the federal government to encourage other provinces, including Ontario, to do the same.

Given the significant harms associated with opioid use, we appreciate the leadership and action you have taken to date at a federal level, and look forward to your continued leadership in supporting the provinces to move this work forward in alignment with federal efforts.

Yours in health,

Original signed by

Mayor Mary Smith
Chair, Board of Health

/ag
Encl

cc: Local MPs
Local MPPs
Dr. Theresa Tam, Interim Chief Public Health Officer
Association of Local Public Health Agencies
Ontario Boards of Health

simcoe muskoka
DISTRICT HEALTH UNIT

April 19, 2017

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

Dear Minister Philpot:

Re: Moving forward on the Federal Opioid Strategy

On behalf of the Simcoe Muskoka District Health Unit (SMDHU) Board of Health, I would like to take this opportunity to commend you, and the Ministry of Health, in releasing Health Canada's Action on Opioid Misuse [1] in response to the issue of opioid use and its devastating effects throughout Canada.

Ontario has one of the highest provincial opioid prescription rates and has experienced thirteen years of increasing and record-setting opioid overdose fatalities, which now rank as the third leading cause of accidental death, and more than double the number of people killed in motor vehicle collisions. More than 5000 Ontarians have died of an opioid overdose since 2000, the vast majority unintentionally.[2]

The opioid issue is of particular concern to us locally, as the opioid poisoning emergency visit rates in Simcoe Muskoka have been increasing since 2003, and have been significantly higher than the provincial rates since 2004.[3] SMDHU staff have been involved in a number of activities to date to help address opioid related harms in Simcoe Muskoka including promotion of fentanyl patch for patch programs, coordination of local drug strategy coalitions and provision of naloxone kits and training to people who use opioids and their friends and family. In addition, SMDHU is co-hosting an inaugural meeting of key stakeholders for the purpose of creating a Simcoe Muskoka Opioid Strategy on May 25, 2017, along with the North Simcoe Muskoka Local Health Integration Network and the Simcoe Muskoka Alcohol and Other Drug Strategy Working Group.

In response to the significant harms associated with both prescription and illicit opioid use in Simcoe Muskoka, the SMDHU Board of Health strongly urges the Federal Ministry of Health to further develop the recommendations within the federal document entitled Action on Opioid Misuse, with targets, timelines and deliverables, and to communicate developments with key stakeholders in a timely way. This will support efforts occurring locally and provincially to address the issue, and will have the greatest opportunity to realize decreases in opioid related harm. Given the pressing nature of this continually evolving issue, we strongly urge the federal government to move quickly in mitigating further harms.

❑ **Barrie:** 15 Sperling Drive, Barrie, ON, L4M 6K9, 705-721-7520, FAX: 705-721-1495
❑ **Collingwood:** 280 Pretty River Pkwy., Collingwood, ON, L9Y 4J5, 705-445-0804, FAX: 705-445-6498
❑ **Cookstown:** 2-25 King Street S., Cookstown, ON, L0L 1L0, 705-458-1103, FAX: 705-458-0105
❑ **Gravenhurst:** 2-5 Pineridge Gate, Gravenhurst, ON, P1P 1Z3, 705-684-9090, FAX: 705-684-9887
❑ **Huntsville:** 34 Chaffey St., Huntsville, ON, P1H 1K1, 705-789-8813, FAX: 705-789-7245
❑ **Midland:** B-865 Hugel Ave., Midland, ON, L4R 1X8, 705-526-9324, FAX: 705-526-1513
❑ **Orillia:** 120-169 Front St. S., Orillia, ON, L3V 4S8, 705-325-9565, FAX: 705-325-2091

Leadership and action at all levels of government and across sectors are urgently needed. We appreciate your actions to date and look forward to your continued leadership in addressing the morbidity and mortality associated with opioid use, misuse, and addictions.

Sincerely,

ORIGINAL SIGNED BY

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

BW:CG:mk

c. Association of Local Public Health Agencies
Boards of Health in Ontario
North Simcoe Muskoka LHIN
Central LHIN
Simcoe Muskoka Alcohol and Other Drug Strategy
Dr. Kellie Leitch, MP
Tony Clement, MP
Alex Nuttall, MP
John Brassard, MP
Bruce Stanton, MP
Peter Van Loan, MP

References:

1. http://healthycanadians.gc.ca/healthy-living-vie-saine/substance-abuse-toxicomanie/misuse-plan-abus-index-eng.php
2. http://www.drugstrategy.ca/uploads/5/3/6/2/53627897/prescription_for_life_june_1_2015.pdf
3. Ambulatory Visits & Population Estimates (2003-2015). Ontario Ministry of Health and Long-term Car, IntelliHEALTH, Ontario, Date Extracted: (Jan13, 2017. ICD-10codes(Any Dx):T400-T404;T406: Age standardized using the 20011 Canadian Standard Population.

June 7, 2017

VIA EMAIL

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

Dear Minister Hoskins:

RE: LGL Board of Health Letter in Support of Low Income Adult Dental Program in Ontario

In Ontario, there is no provincial dental program for low-income working adults and seniors. Despite the well documented importance of good oral healthcare, it is not covered by our provincial healthcare system. In 2014, the Ontario government promised to extend dental programs to low-income adults by 2025. This gap in our healthcare system cannot wait.

Untreated oral disease not only affects an individual's health, well-being, and self-esteem, but has significant cost implications on our health care system as well. Poor oral health is linked to diabetes, cardiovascular disease, respiratory diseases, adverse pregnancy outcomes, and poor nutrition. When tooth decay and periodontal disease are left untreated, chronic pain and/or infection may result.

In Ontario, an estimated 2-3 million people cannot afford to see a dentist (Ontario Oral Health Alliance, 2017). Limited dental coverage is available for adults in receipt of OW or ODSP benefits, but low-income working adults and seniors must pay for dental care. If they cannot afford to see a dentist, they may visit a hospital emergency department or family doctor for relief of pain.

- In 2015, there were almost 61,000 visits to hospital emergency rooms across Ontario for oral health problems. The most common complaints were abscesses and pain. At a minimum cost of $513 per visit, the estimated cost was at least $31 million (Ontario Oral Health Alliance, 2017).

- In 2014, there were approximately 222,000 visits to physicians for similar oral health problems. At a minimum cost of $33.70 per visit, the estimated cost was at least $7.5 million (Ontario Oral Health Alliance, 2017).

Many of these locations are not staffed or equipped to deal with oral health concerns. Patients are provided with a "band-aid" solution of antibiotics and/or pain killers, referred to a dentist for treatment, and sent home. Still without the means to pay for dental treatment, the cycle begins again – the patient's only option is to live in pain or return to the emergency room or doctor's office for a short-term solution. Approximately $38 million provincial health dollars, at minimum, are spent annually to address oral health problems, but not to treat them.

A commitment to a sustainable dental program that appropriately addresses the dental problems of those in need would deliver better value for the people and for the province. We recommend redirecting the funds currently spent in emergency rooms and physician's offices to preventive care and dental treatment.

The Leeds, Grenville and Lanark District Board of Health looks forward to hearing from you regarding this important issue.

Sincerely,

Anne Warren, Chair
Board of Directors
Leeds, Grenville and Lanark District Health Unit

AW/hb

cc: Steve Clark, MPP Leeds-Grenville
Randy Hillier, MPP Lanark-Frontenac-Lennox and Addington
Jack MacLaren, MPP Carleton-Mississippi Mills
Ontario Boards of Health
Linda Stewart, Executive Director, alPHa

ELGIN ST. THOMAS PUBLIC HEALTH

1230 Talbot Street, St. Thomas, ON N5P 1G9
p: 519.631.9900 | **f:** 519.633.0468
elginhealth.on.ca

June 5, 2017

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:

Re: Requesting Support for Enactment of Legislation under the HPPA to Allow for the Inspection and Enforcement Activities of Personal Service Settings

On May 10th, 2017, at a regular meeting of the Board of Health at Elgin St. Thomas Public Health, a letter was brought forward from Wellington-Dufferin-Guelph Public Health asking provincial health units to support enactment of legislation under the *Health Protection and Promotion Act* to allow for inspection of, and enforcement activities in, personal service settings. According to the letter, six provinces and territories currently have specific legislation for the regulation of personal service settings which greatly increases the effectiveness of their public health interventions. The Elgin St. Thomas Board of Health supports the position of Wellington-Dufferin-Guelph Public Health recommending enactment of legislation that increases the enforcement abilities of public health staff and provides incentives for operators to comply with infection prevention and control best practices.

While education is considered an essential and first step in gaining operator compliance, experience has shown that enforcement activities are, at times, the only means of gaining compliance with minimum requirements in order to ensure public safety. In those provinces or territories where regulations exist for personal service settings, no-compliance with the regulations can result in a conviction and/or strict monetary fines, without requiring public health staff to prove the existence of a health hazard. This approach is similar to that used by public health when inspecting and enforcing food premises.

This proposed legislation presents a chance for health units to achieve the goal of reducing the burden of infectious diseases of public health importance.

Thank you,

Dr. Joyce Lock, MD, CCFP (EM), FRCP(C)
Medical Officer of Health

Cynthia St. John, MBA
Executive Director

c. Chief Medical Officer of Health of Ontario
Association of Local Public Health Agencies
Jeff Yurek, MPP Elgin-Middlesex-London
Ontario Boards of Health

June 1, 2017

VIA EMAIL

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

Dear Minister Hoskins:

RE: Municipal Levy Apportionment

The Health Protection and Promotion Act (appended) stipulates that municipalities must decide how to apportion the municipal component of the expenses of the Board of Health among obligated municipalities. All of the obligated municipalities will have to agree with this change before it can be implemented according to the Health Protection and Promotion Act, and Ontario Regulation 489/97 (*See Appendix #1*). The regulations state that the default is to use the Ontario Population Report of the Municipal Property Assessment Corporation (MPAC) which is the current method being used to apportion the levy.

Recently, the Board of Health for the Leeds, Grenville and Lanark District Health Unit received information from the Municipal Property Assessment Corporation (MPAC) (*See Appendix #2*) that stated:

> "The Ontario Population Report (OPR) is based on information contained in MPAC's Names Database and is produced upon conclusion of each municipal enumeration which correlates with the timing of regular municipal and school board elections that now occur every 4 years. The Report is distributed to all municipalities, certain provincial ministries and other stakeholders.
>
> "The OPR figures are developed from information gathered for assessment and enumeration purposes. These figures should not be confused with population data published by Statistics Canada that are produced from dedicated population counting and estimating processes conducted every 5 years."
>
> "The most accurate municipal population numbers are produced by Statistics Canada based on the most recent census."

Given MPAC states that the population numbers produced by Statistics Canada are more accurate than those produced by MPAC, the Board requests that Ontario Regulation 489/97 Allocation of Board of Health expenses be amended as follows:

> **1.** (1) If the obligated municipalities in a health unit fail to agree on the proportion of the expenses referred to in subsection 72 (1) of the Act to be paid by each of them, each obligated municipality in the health unit shall pay the proportion of the expenses that is determined by dividing its population by the sum of the populations of all the obligated municipalities in the health unit. O. Reg. 489/97, s. 1 (1).
>
> (2) In this section,
>
> "population" means, with respect to an obligated municipality, the population of the obligated municipality as determined from the most recent Census conducted by Statistics Canada.

The Board of Health looks forward to hearing from you regarding this important issue.

Sincerely,

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

AW/hb

cc: Steve Clark, MPP Leeds-Grenville
Randy Hillier, MPP Lanark-Frontenac-Lennox and Addington
John MacLaren, MPP Carleton-Mississippi Mills
Ontario Boards of Health

HEALTH PROTECTION AND PROMOTION ACT

Payment by obligated municipalities

72. (1) The obligated municipalities in a health unit shall pay,

(a) the expenses incurred by or on behalf of the board of health of the health unit in the performance of its functions and duties under this or any other Act; and

(b) the expenses incurred by or on behalf of the medical officer of health of the board of health in the performance of his or her functions and duties under this or any other Act. 1997, c. 30, Sched. D, s. 8.

Agreement

(3) The obligated municipalities in a health unit shall pay the expenses referred to in subsection (1) in such proportion as is agreed upon among them. 1997, c. 30, Sched. D, s. 8.

If no agreement

(4) If the obligated municipalities in a health unit fail to agree on the proportion of the expenses referred to in subsection (1) to be paid by each of them, each obligated municipality in the health unit shall pay the proportion of such expenses that is determined in accordance with the regulations. 1997, c. 30, Sched. D, s. 8.

ONTARIO REGULATION 489/97

ALLOCATION OF BOARD OF HEALTH EXPENSES

Consolidation Period: From April 1, 2005 to the e-Laws currency date.

1. (1) If the obligated municipalities in a health unit fail to agree on the proportion of the expenses referred to in subsection 72 (1) of the Act to be paid by each of them, each obligated municipality in the health unit shall pay the proportion of the expenses that is determined by dividing its population by the sum of the populations of all the obligated municipalities in the health unit. O. Reg. 489/97, s. 1 (1).

(2) In this section,

"population" means, with respect to an obligated municipality, the population of the obligated municipality as determined from the most recent enumeration conducted under section 15 of the *Assessment Act*. O. Reg. 489/97, s. 1 (2).

(3) In this section,

"assessment", with respect to real property, means the assessment for the real property made under the *Assessment Act* according to the last returned assessment roll;

"population" means population as determined from the most recent enumeration conducted under section 15 of the *Assessment Act*. O. Reg. 142/05, s. 1.

Appendix #2

MUNICIPAL PROPERTY ASSESSMENT CORPORATION

ONTARIO POPULATION REPORT

What is the OPR?

The Ontario Population Report (OPR) is based on information contained in MPAC's Names Database and is produced upon conclusion of each municipal enumeration which correlates with the timing of regular municipal and school board elections that now occur every 4 years. The Report is distributed to all municipalities, certain provincial ministries and other stakeholders. The OPR is not an 'estimate'. The OPR (and any adhoc population count done between enumeration years and/or obtained through the Population Report option provided via Municipal Connect™) is based on actual point-in time counts of current names in MPAC's database.

Note: *The OPR figures are developed from information gathered for assessment and enumeration purposes. These figures should not be confused with population data published by Statistics Canada that are produced from dedicated population counting and estimating processes conducted every 5 years (see* Factors Affecting Population Counts *below).*

Information Sources and Collection Methods

The primary source of **owner names** is the land transfer process. This results in a high degree of accuracy and currency for owner information but does not include other family members. The primary source of **tenant names** has traditionally been through the Tenant Information Program (TIP) where landlords with seven or more residential units are obliged to annually supply MPAC with the names of the tenants in their buildings. Landlords usually supply MPAC with whatever names are on their rent roll, typically one name per unit. This source does not include children or other occupants. Beginning in 2014, tenant names are also being received from the National Register of Electors and during an enumeration event, via MPAC's voterlookup.ca online elector update/confirmation website. Name information is no longer collected through the mailout of 'Municipal Enumeration Forms' (MEFs) during municipal election years. To collect names of **children** and other occupants, including the missing birth dates, citizenship confirmations and school support of tenants and owners, MPAC traditionally mailed out 'Request for Occupant Information' (ROI) forms. Compliance is voluntary and returns as low as 20%. In addition, owners and tenants have the option of updating their household occupant information when calling MPAC's Customer Contact Centre.

Factors Affecting Population Counts

In comparison to Statistics Canada, MPAC typically under-reports population numbers for Ontario, primarily in the under 20 to 25 year-old range. The reasons for this are:

- There is no legislated requirement for owners of rental properties with fewer than seven units to supply MPAC with tenant names.
- Historically, although approximately **50%** of owners respond to Occupancy Questionnaires, compliance for tenants has been approximately **20%**.
- When in receipt of properly documented information, MPAC is obliged to change its database accordingly which usually requires the removal of existing names from a property record and replacing them with the new name(s). The process of removing names automatically includes

any children or other occupants currently listed at the identified address. These names are recovered, only if they reappear at a future point through other source data/data-matching.

- Under instructions from Ontario's Deputy Registrar, municipal clerks no longer send MPAC the names of newborns. The cumulative effect since the early 90's has been the slow degradation of OPR numbers, particularly those under the age of 20.

The most accurate municipal population numbers are produced by Statistics Canada based on the most recent census.

(From Beverley Disney
Account Manager, Municipal and Stakeholder Relations Department
Municipal Property Assessment Corporation)

The Honourable Chris Ballard
Minister of Housing / Minister Responsible for the Poverty Reduction Strategy
17th Floor, 777 Bay Street
Toronto, Ontario, M5G 2E5

Dear Minister,

The Middlesex-London Board of Health applauds the Government of Ontario for considering possible amendments to the *Residential Tenancies Act, 2006* (RTA) to encourage the participation of small landlords and private homeowners in the rental housing market, while maintaining strong protections for tenants. The introduction of Bill 124, the *Rental Fairness Act*, enabled the Government to entertain amendments to the RTA to meet goals related to increasing the availability and the affordability of housing. Although Bill 124 does not include any amendments related to no-smoking provisions, the provision of smoke-free clause options in the proposed "prescribed form of tenancy agreement" (Standard Lease), created under Bill 124, warrants consideration.

At its June 15, 2017 meeting, the Middlesex London Board of Health considered Report No. 033-17 "**Smoke-Free Clauses in the Standard Lease Under the Residential Tenancies Act**" and voted to:

1. Receive Report No. 033-17 re: Smoke-Free Clauses in the Standard Lease Under the *Residential Tenancies Act* (*RTA*);
2. Communicate its support for the inclusion of smoke-free clauses in the Standard Lease under the *RTA* by sending a letter to the Honourable Chris Ballard, Minister of Housing/Minister Responsible for the Poverty Reduction Strategy;
3. Forward Report No. 033-17 to Ontario Boards of Health and the Smoke-Free Housing Ontario Coalition to communicate its support for smoke-free housing policy measures; and
4. Direct staff to participate in consultation processes to inform regulatory changes under the *RTA* to increase the availability and enforceability of smoke-free clauses within tenancy agreements.

According to an Ipsos Reid study conducted in 2010, when given a choice, 80% of multi-unit residents would choose a smoke-free building, and in 2011, data from the Rapid Risk Factor Surveillance System (RRFSS) showed nearly two-thirds of those living in multi-unit housing in Middlesex-London supported prohibiting smoking everywhere within multi-unit housing. Nonetheless, despite strong public support and demand for smoke-free accommodations, there are very few smoke-free housing options available. Low-income families have even less choice in the housing market, and often must take whatever housing is available. Those fortunate enough to find subsidized housing may not be able to relocate easily when faced with smoke infiltration from other units. As a result, individuals in our community continue to be exposed to second-hand smoke on a regular basis in their home environments.

No-smoking provisions offer many benefits, including a healthier environment, reduced exposure to second-hand smoke, reduced risk of fire, and lower cleaning and insurance costs. Therefore, smoke-free multi-unit housing should be made available for those who want it, and be offered by those providing private and community/non-profit multi-unit housing.

…////1

In order to make the development of no-smoking provisions more appealing to landlords and increase the smoke-free housing options available in our community, no-smoking clause options should be added to the "Prescribed form of tenancy agreement" (Standard Lease) prescribed by regulation under Bill 124. The proposed "Prescribed form of tenancy agreement" (Standard Lease) described in Bill 124 clearly outlines the agreement between the housing provider and the tenant, including all of the conditions under which occupancy can be terminated. Inclusion of no-smoking clause options to the Standard Lease created under Bill 124 would make it clear to landlords that they can offer no-smoking provisions, and would create a consistent approach to the implementation and enforcement of no-smoking clauses within multi-unit housing tenancy agreements. This would provide landlords with the tools they need and make it as easy as possible to offer smoke-free housing, and would support landlords in ensuring compliance with this expectation between tenant and landlord. If the Standard Lease does not provide an option for smoke-free housing, most landlords and tenants will be under the impression that smoke-free clauses are not allowed. As a result, landlords will be far less inclined to include them and tenants less likely to ask for them.

The health effects from second-hand tobacco smoke exposure are widely known, and the evidence is quite clear that second-hand smoke can drift from one unit to another in multi-unit housing. In fact, the best science indicates that there is no safe level of exposure to second-hand tobacco smoke. About one in five Ontarians (21%) who live in multi-unit housing report exposure to second-hand smoke coming from outside their units. This exposure causes short-term harm, such as exacerbation of asthma or COPD, as well as longer-term health problems. However, tobacco is not the only substance that can affect the reasonable enjoyment and health of tenants within multi-unit housing.

The smoking of cannabis (recreational and medicinal) is a growing concern and a common complaint that the Middlesex-London Health Unit receives from tenants and landlords. When speaking with landlords, property management groups and condo corporations, and tenants within multi-unit housing complexes, the use of marijuana is a growing concern. The health effects from exposure to marijuana smoke is similar to the health effects from tobacco smoke. Regular marijuana smoking has been associated with chronic bronchitis and reduced lung function. The combustion of marijuana creates a smoke that contains many of the same carcinogens as tobacco smoke. While there is some evidence that marijuana smoking can be a risk factor for lung, head, neck and throat cancers, the association is unclear because of dual use of marijuana and tobacco smoking. Exposure to second-hand marijuana smoke has been studied less than second-hand tobacco smoke; however, due to the similarities in composition between tobacco and marijuana smoke, marijuana smoke is likely to be a similar public health concern. Exposure in an unventilated room can cause non-smokers to experience drug effects, including minor problems with memory and coordination, and, in some cases, testing positive for the drug in a urinalysis. The harmful health effects from exposure to second-hand marijuana smoke, regardless of whether or not the marijuana smoked is for medical purposes, warrants health protective regulations. With the coming legalization and regulation of cannabis in 2018, this issue may become even more prominent across the province.

A hookah (also known as a waterpipe, narghile, goza, or hubble-bubble) is a device used to smoke specially made tobacco and non-tobacco (herbal) products called shisha. Hookah is an alternative form of smoking whereby the shisha is heated with charcoal, the smoke from which travels down through the body of the apparatus into a water-filled chamber, which cools the smoke before it is inhaled. Hookah users will then inhale the smoke through hoses attached to the apparatus. Hookah sessions are generally longer and involve deeper inhalation than cigarette smoking. Under the *Smoke-Free Ontario Act* (SFOA), the prohibition on smoking only applies to hookah use if the shisha contains tobacco, and only applies to the common areas of multi-unit housing; however, like cigarettes, a hookah also produces second-hand

…////2

smoke that can be harmful whether or not the shisha contains tobacco or not. Studies of both tobacco-based shisha and "herbal" shisha show that the smoke from both preparations contains many of the same chemicals as cigarettes, such as carbon monoxide and other toxic agents associated with smoking-related cancer, respiratory illness and heart disease. Furthermore, a study of second-hand smoke exposure in Toronto water-pipe cafes showed that indoor air quality values for $PM_{2.5}$, ambient carbon monoxide and air nicotine are hazardous to human health.

Therefore, due to the negative health consequences from exposure to second-hand smoke, the Middlesex London Board of Health encourages the Government of Ontario to consider the need for smoke-free clause options to include tobacco, marijuana and shisha smoke. Additionally, the Middlesex-London Health Unit recommends that any no-smoking clause options indicate the maximum protection possible from second-hand smoke exposure. The language should state what provisions are covered under existing legislation, such as the *Smoke-Free Ontario Act* (SFOA), and what additional provisions are legal, permitted and enforceable under the no-smoking clause. The language should also state examples of the most protective provisions feasible, such as the entire building and property being smoke-free, and include other provisions, such as setbacks from entrances and exits, no smoking on balconies or patios, and designated outdoor smoking areas. These provisions should also state that if the landlord permits a designated outdoor smoking area on the property, it must be far enough away to ensure that second-hand smoke cannot drift into private units or balconies.

Smoke-free multi-unit housing is a critical policy issue and the Ministry of Housing is in a powerful position to signal to the housing community that smoke-free housing is a preferred option and offers tremendous health and property benefits. Adding no-smoking clause options that specify where no-smoking provisions can and cannot be made, and that include all forms of smoking in the "Prescribed form of tenancy agreement" (Standard Lease) created by regulation under Bill 124, would encourage landlords to create spaces where tenants can live without involuntary exposure to second-hand smoke from any source of smoke, whether from tobacco, marijuana, or shisha.

Sincerely,

Jesse Helmer, Chair
Middlesex-London Board of Health

cc. The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
The Honourable Kathleen Wynne, Premier of Ontario
Andrew Noble, Chair, Smoke-Free Housing Ontario Coalition
Ontario Boards of Health

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 033-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 June 15

SMOKE-FREE CLAUSES IN THE STANDARD LEASE UNDER THE *RESIDENTIAL TENANCIES ACT*

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 033-17 re: Smoke-Free Clauses in the Standard Lease Under the Residential Tenancies Act (RTA);***
2) ***Communicate its support for the inclusion of smoke-free clauses in the Standard Lease under the RTA by sending a letter to the Honourable Chris Ballard, Minister of Housing/Minister Responsible for the Poverty Reduction Strategy;***
3) ***Forward Report No. 033-17 to Ontario Boards of Health and the Smoke-Free Housing Ontario Coalition to communicate its support for smoke-free housing policy measures; and***
4) ***Direct staff to participate in consultation processes to inform regulatory changes under the RTA to increase the availability and enforceability of smoke-free clauses within tenancy agreements.***

Key Points

- Second-hand smoke drifts between units in multi-unit housing complexes, and is especially harmful to children, the elderly, those who have chronic health problems and those who are pregnant.
- The current mechanism for enforcement of no-smoking clauses in lease agreements can be cumbersome, and has raised questions about the legality of these policies.
- The opportunity exists to prescribe smoke-free clause options by regulation in the proposed "prescribed form of tenancy agreement" (Standard Lease), under the RTA, to provide a consistent approach for the promotion and enforcement of smoke-free provisions within tenancy agreements.

Second-Hand Smoke Exposure in Rental Housing

Under the *Smoke-Free Ontario Act*, smoking is prohibited in any common area in a condominium, apartment building, or university or college residence, including elevators, hallways, parking garages, entertainment rooms, laundry facilities, lobbies and exercise areas. However, the *Act* does not prohibit smoking in private units, on balconies, or around the entrances to housing complexes. As a result, second-hand smoke exposure continues to be an issue for those living in multi-unit housing complexes. No matter how well built or maintained a building may be, second-hand smoke can seep through shared walls, ventilation systems, doors, windows, shared balconies and gaps around electrical outlets and plumbing.

While second-hand smoke exposure can cause a range of adverse health effects for anyone, it can be especially harmful to children, the elderly, those who suffer from chronic health problems and those who are pregnant. If a tenant is smoking in one unit and the smoke drifts into a neighbouring unit that is supposed to be smoke-free, often the only solution to reducing the unwanted exposure to second-hand smoke is to move and seek housing elsewhere. However, moving may not be feasible for those with disabilities, older adults and those with limited incomes. For those with greater choice and the means to move, smoke-free housing may still not be an option due to the lack of availability in Middlesex-London. Therefore, in 2015, the Board of Health endorsed the actions and priorities outlined by the Smoke-Free Housing Ontario Coalition,

attached as Appendix A, and directed staff to "encourage the Ontario Ministry of Housing to develop government policies and programs to facilitate the provision of smoke-free housing (Report 013-15)."

Enforceability of Smoke-Free Policies

No-smoking provisions within a multi-unit housing environment offer many benefits, including a healthier environment, reduced exposure to second-hand smoke, reduced risk of fire and lower cleaning and insurance costs. Therefore, smoke-free multi-unit housing should be made available for those who want it, and be offered in both the private and community/non-profit multi-unit housing markets. However, the current mechanism for enforcement of no-smoking policies can be cumbersome, and has raised questions about the legality of these policies. It is the responsibility of the landlord to ensure reasonable enjoyment for all tenants, and, if there is a breach, such as drifting second-hand smoke, there must be adequate data to demonstrate frequent and ongoing interference with normal use and enjoyment of the housing unit. According to case law analysis, although the majority of cases taken to the Landlord Tenant Board (LTB) have prevailed in favour of the landlord, LTB decisions are not bound by precedent and may not be pertinent to other situations that appear before the LTB. This means that even if a landlord follows the procedure to enforce a provision in the lease, there is no guarantee of success. If a no-smoking policy is created and cannot easily be enforced, the impact is felt by the landlord and by the tenants, who selected the housing unit based on the guarantee of a smoke-free home. Landlords and tenants desire assurance that smoke-free housing policies are enforceable.

Bill 124, the *Rental Fairness Act* and the Standard Lease

In March 2016, as part of its Long-Term Affordable Housing Strategy, the Ontario Government considered making amendments to the RTA to encourage the participation of small landlords and private homeowners in the rental housing market, while maintaining strong protections for tenants. The introduction of Bill 124, the *Rental Fairness Act*, enabled the Government to entertain amendments to the RTA to meet goals related to increasing availability and affordability of housing. During the public consultation process for Bill 124, the Smoke-Free Housing Ontario Coalition recommended that amendments be made to the RTA to enable landlords to terminate tenancy based on violations of no-smoking provisions in leases. Additionally, advice was provided that no-smoking provisions under the RTA should address smoking of all products, including tobacco, cannabis and shisha, and that the RTA should clearly define areas where no-smoking prohibitions can be prescribed to provide maximum tenant protection from second-hand smoke.

The Government chose not to include smoke-free clauses in the RTA; however, regulations under the RTA are now being developed. The opportunity exists to prescribe smoke-free clause options by regulation in the proposed "prescribed form of tenancy agreement" (Standard Lease). The Standard Lease would outline the agreement between the housing provider and the tenant, including the conditions under which occupancy can be terminated. The inclusion of smoke-free clause options to the Standard Lease would make it clear to landlords that they can include no-smoking clauses, and would provide a consistent approach for the promotion and enforcement of smoke-free provisions within tenancy agreements. It is recommended that the Board of Health communicate its support for the inclusion of smoke-free clauses in the Standard Lease by sending a letter (attached as Appendix B) to the Honourable Chris Ballard, Minister of Housing/Minister Responsible for the Poverty Reduction Strategy.

This report was prepared by the Chronic Disease Prevention and Tobacco Control Team, Environmental Health and Infectious Disease Division.

Dr. Gayane Hovhannisyan, MD, PhD, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

This report addresses the following requirements of the Ontario Public Health Standards (revised May 2016): Foundations: Principles 1, 2; Comprehensive Tobacco Control: 1, 6, 7, 9.

The Corporation of the City of Sault Ste. Marie

Clerk's Department

Malcolm White
Deputy CAO / City Clerk
Corporate Services

May 12, 2017

Algoma Public Health
Dr. Marlene Spruyt
Medical Officer of Health/CEO
294 Willow Ave.
Sault Ste. Marie, ON P6B 0A9

Dear Dr. Spruyt,

Re: Anti Contraband Tobacco

At the regular City Council meeting of the Corporation of the City of Sault Ste. Marie held on May 8, 2017 the following resolution was approved.

Moved by: Councillor F. Fata
Seconded by: Councillor S. Hollingsworth

Whereas on June 25, 2012 Sault Ste. Marie City Council, upon receiving correspondence from the Ontario Convenience Stores Association, passed a resolution to support provincial budget commitments to eradicate contraband tobacco through implementation of additional regulatory, enforcement and other provisions in Bill 186 and amendments to the Tobacco Tax Act to increase fines, give more authority for law enforcement officials and strengthen strategies to address the manufacture and supply of contraband tobacco; and

Whereas additional information found in a 2012 slide deck from Imperial Tobacco Canada Ltd. (ITCL has recently come to light suggesting that the National Coalition Against Contraband Tobacco (NCACT) and the Ontario Convenience Store Association (OCSA) worked on behalf of ITCL to convince Ontario municipalities of the importance of the contraband tobacco problem; and

Whereas the 2012 ITCL slide deck makes clear that the anti-contraband campaign pursued by the NCACT and the OCSA in Ontario is designed in part to

...2

99 Foster Drive, Sault Ste. Marie, ON P6A 5X6
saultstemarie.ca I 705.759.2500 (Ext. 5391) I m.white@cityssm.on.ca

block tobacco excise tax increases and regulation of tobacco products generally; and

Whereas these other campaign objectives were not communicated to municipalities by either the NCACT or the OCSA during meetings with municipal staff or councilors; and

Whereas tobacco excise tax increases are proven to be an effective means of encouraging tobacco cessation; and

Whereas contrary to tobacco industry messaging, impartial research by the Ontario Tobacco Research Unit at the University of Toronto has shown that tobacco excise tax increase do not lead to large increases in contraband; and

Whereas the City of Sault Ste. Marie passed a 2015 resolution to support the 5 in 5 Algoma district strategy to reduce smoking rates by 5% in 2020; a target that requires the protection of our youth from tobacco industry products, tobacco tax increases to encourage smokers to quit and to raise revenue to offset the healthcare costs of tobacco use, which are more than double the current revenue raised from provincial tobacco taxes, to be achieved.

Now Therefore Be It Resolved that the City of Sault Ste. Marie rejects the tobacco industry anti-contraband campaign; and

Further that that the City of Sault Ste. Marie express to the Provincial Government its support of measures to encourage the cessation of smoking, thereby decreasing the significant healthcare costs associated with smoking and its support of measures to enhance enforcement activities designed to reduce the presence of contraband tobacco in Ontario communities.

Sincerely,

Malcolm White
Deputy CAO / City Clerk
Corporate Services
Clerk's Department

1230 Talbot Street, St. Thomas, ON N5P 1G9
p: 519.631.9900 | **f:** 519.633.0468
elginhealth.on.ca

May 15, 2017

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:

Re: Marijuana controls under Bill 178, Smoke-Free Ontario Act, 2016

On May 10th, 2017, at a regular meeting of the Board of Health at Elgin St. Thomas Public Health, letters were brought forward that were supported by the Simcoe Muskoka District Health Unit and Windsor-Essex County Health Unit regarding the inclusion of marijuana as a prescribed product or substance under Bill 178, Smoke-Free Ontario Act amendment, 2016. The Elgin St. Thomas Board of Health supports the position of the Simcoe Muskoka District Health Unit and Windsor-Essex County Health Unit recommending the amendment to include marijuana as a prescribed substance.

If not regulated appropriately, the legalization of marijuana and its use in Canada will be accompanied by significant population health risks particularly as it relates to early and frequent use with a focus on high risk groups such as youth, drivers, those at risk for addiction and mental health disorders, and pregnant and lactating women. There are many lessons that have been learned from successful tobacco control in Ontario which can be transferred to the emerging issue of marijuana. This includes the coordination of prevention, cessation, protection, and enforcement policies which are designated to support each other, leading to minimized risk and improved population health outcomes.

Bill 178, Smoke-Free Ontario Amendment Act, 2016 will allow for the Ontario legislature to prohibit the use of certain products and substances under the Smoke-Free Ontario Act regulatory framework. Specifically, it will allow the legislature to prohibit the smoking of prescribed products or substances in all places where smoking tobacco is prohibited, in addition to other protections and requirements.

This legislation presents a chance to manage the emerging issue of marijuana use in our community. The legislature has the opportunity to list marijuana as a prescribed product or substance under this Act and in doing so, Ontario will be better positioned to reduce the harm caused by smoking and vaping, as well as the exposure to second-hand marijuana smoke of vapor. Research has confirmed the presence of known carcinogens and other chemicals

implicated in respiratory and cardiovascular diseases in the second-hand smoke of marijuana cigarettes. By prohibiting the smoking of all marijuana in all places where the smoking of tobacco is prohibited, children, youth and adults in our communities will have much lower public and second-hand exposure to the use of marijuana.

Elgin St. Thomas Public Health commends the provincial government on amending the Smoke-Free Ontario Act to allow for wider protections. Should enforcement of the amendment fall in part to health units, it is critical that long-term funding accompany the initiative to support comprehensive harm reduction, cessation, protection, prevention and enforcement measures to give health units the opportunity to succeed.

Lastly, it is recommended that the above mentioned protections are expanded into the Electronic Cigarettes Act, where the prohibitions related to use in public spaces have yet to be enacted. The vaping of marijuana will be effectively prohibited in all place where smoking tobacco is prohibited once all provisions of the Electronic Cigarettes Act come into force.

Thank you,

Dr. Joyce Lock, MD, CCFP (EM), FRCP(C)
Medical Officer of Health
Elgin St. Thomas Public Health

Cynthia St. John, MBA
Executive Director
Elgin St. Thomas Public Health

c. Chief Medical Officer of Health of Ontario
Association of Local Public Health Agencies
Ontario Public Health Association
Jeff Yurek, MPP Elgin-Middlesex-London
Municipal Councils in Elgin St. Thomas